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High/ Low Context Communication And Therapeutic Working Alliance Among Asian Americans

Yoshitaro Oba

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HIGH/ LOW CONTEXT COMMUNICATION AND THERAPEUTIC WORKING
ALLIANCE AMONG ASIAN AMERICANS

by

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This dissertation, submitted by Yoshitaro Oba in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.



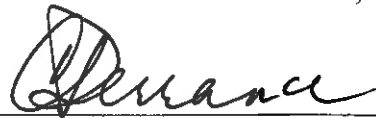
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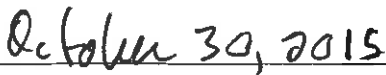
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This dissertation is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.



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Title High/Low Context Communication and Therapeutic Working Alliance among Asian Americans

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Degree Doctor of Philosophy

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ABSTRACT

Asian Americans utilize both high and low context communication styles depending on their values and cultural backgrounds. Their styles of communication are unique cultural factors and individualized by their level of acculturation. This study explored how those communication styles could contribute to the process of forming therapeutic relationships. The results indicated that communication styles were associated with levels of acculturation, help seeking attitudes for mental health professionals, and therapeutic working alliance. In addition, step wise multiple regression analysis indicated that interpersonal sensitivity in communication style and help seeking attitudes were predictor for therapeutic working alliance. These findings indicate how Asian Americans' culture specific factors could influence the therapeutic working alliance and supports the argument that psychotherapists must consider those factors in the therapy process.

CHAPTER I

INTRODUCTION

In 2012, approximately 17 million Asian Americans lived in the United States, and the Asian American population has been increasing more than four times faster than the total U.S. population (Hoeffel, Rastogi, Kim, & Shahid, 2012). Asian Americans do not receive mental health services at a comparable rate to European Americans. A recent report suggested that Asian Americans are less likely to receive professional mental health services, which imply there is a health disparity among Asian Americans, compared to European Americans (Hwang, 2006; Sue, Ka Yan Cheng, Saad, & Chu, 2012). Moreover, Asian Americans reported higher dropout rate for mental health services (Wang, & Kim, 2010). Thus, studying the experience of Asian Americans receiving services in mental health is crucially important.

Studies of mental health service utilization among Asian Americans report several potential barriers to receiving effective psychotherapy. Miller, Yang, Hui, Choi, and Lim (2011) concluded that a high level of acculturation is a predictor in seeking mental health services. Language preference and therapists' racial match with Asian clients might also be predictors for positive therapeutic outcomes (Kim, Zane, & Blozis, 2012). Those studies indicate a gap in needs for and access to mental health services. As evidence, literature reported a lack of access to mental health services, limited understanding of

culture related to mental health issues, and a shortage of culturally sensitive services (Hwang, 2006; Sue et al., 2012). Essentially, Asian Americans face multiple difficulties in receiving effective psychotherapy.

In addition to culture related factors of acculturation, language preference, and racial match, another important factor could be unique communication styles among Asian Americans. Communication is a vital tool in creating and supporting an effective interaction between clients and their therapists. However, communication in psychotherapy has not been studied among Asian Americans. Park and Kim (2008) investigated the influence of cultural values on communication styles. They reported that higher score on measures of Asian values correlated with higher levels of Asian related communication styles, specifically high context communication. Their study indicated that communication styles can be different depending on cultural values. Connections between communication styles and interactions in psychotherapy were not discussed in their study, but their conclusions do have important implications.

Positive interactions between client and therapists in psychotherapy are attributed to a trusting relationship between them. This therapeutic relationship is assumed to contribute to successful intervention. For example, Horvath and Smonds (1991) found that a functional therapeutic relationship was associated with positive treatment outcomes regardless of the length or types of treatment. Moreover, their study showed that a consensus of therapeutic goals and plans between therapists and clients significantly influenced treatment outcomes. Given the centrality of communication to establishing a

trusting and effective relationship, it is important to further examine culturally influenced communication in psychotherapy for Asian Americans.

History of Asian Americans

The history of Asian American immigration and relationships with dominant culture is complex and varied, which is consistent with the tremendous diversity within the category of “Asian American.” To provide a broad overview of this history, three key aspects of history will be examined: early immigration, relationships shaped by war, and the concept of a contemporary model minority.

Early Immigration

In the United States, the first Asians were referred to as “Manila men,” working on Spanish galleys in 1700s (Gudykunst, 2001). In fact, Philippines were colonized by Spain during this time, and Filipinos came to the U.S. as trade workers. Meantime, the Chinese started visiting the U.S. beginning in the late 1700’s as sailors in the Pacific Northwest coast region. Their children were admitted to U.S. schools to learn English, and began to receive high school educations around early 1800s (Lyman, 1970). During the California gold rush, numerous Chinese migrated with the hope of making money to send back to their home towns (Lyman, 1970; Gudykunst, 2001).

Although the government and the public in California initially welcomed the Chinese during the California gold rush, European American miners felt threatened by their presence. Because Chinese culture is collectivistic, new immigrants tended to congregate in large groups to maintain Chinese cultures (Hing, 1993; Takaki, 1998). Eventually, the California government claimed that the well-being of European American

miners was threatened by Chinese miners. As a result, the government discouraged Chinese immigration by imposing a foreign miners' license tax (Hing, 1993). Moreover, conflict developed between the European and Asian workers; subsequently, the U.S. government enacted the Chinese Exclusion Act of 1882 and later excluded Japanese immigrants in early 1907 (Leong, & Okazaki, 2009; Gudykunst, 2001). The Angel Island Immigration station was built in 1910 near San Francisco as the "Ellis Island of the West" (Liu, Murakami, Eap, & Hall, 2009). Many immigrants were detained in Angel Island for several years while Ellis Island released European immigrants within hours (Liu et al., 2009). As a result of being treated like second class citizens by Americans, Asian Americans have struggled with their identities, oppression, and psychological distress.

Filipinos were not initially subject to the Exclusion Act because the Philippines were colonized by the U.S. However, Immigrant Exclusion was applied to potential Filipino immigrants when national independence was accomplished in Philippines (Rabaya, 1970). Whereas Chinese and Japanese immigrants established communities with strong social ties and economic foundation, Filipinos were not welcomed in these communities. Instead, they were oppressed by other Asian groups and Whites. The oppression that they experienced negatively impacted their identity development. They also struggled with their national identity because of their long history of colonization. This strongly influenced the Filipino community, members of which continue to face disproportionately high rates of depression, suicide, and substance abuse (Saw & Okazaki, 2009).

Relationships Shaped by War and Conflict

Following the Japanese bombing of Pearl Harbor in 1941, the U.S. government froze the bank accounts of Japanese Americans and started placing them to internment camps in 1942 (Liu et al., 2009). The federal government started releasing individuals from internment camps in 1944 and by 1945 all Japanese Americans were released (Liu et al., 2009). While Japanese American men were recruited to serve for the military or sent to camp, their family members faced oppression, resulting in race-related trauma (Liu et al., 2009). After the internment camps closed, Japanese Americans remained in the U.S. and established new lives in and around camps rather than going back to their home towns in a little strip of the Pacific coast in the U.S. (Hayakawa, 1971).

Establishing life away from the Pacific Coast increased Japanese Americans' exposure to non-Asian cultures, which facilitated acculturation even while they faced oppression and stigma in White dominant communities (Nagata, 1998; Hayakawa, 1971). In addition, cross-generational effects of internment among Japanese Americans was reported.

Second and third generation Japanese Americans who were not exposed to the experience of World War II demonstrated influence of internment on their identities and even developed stigma regarding interacting with first generation Japanese Americans (Nagata, 1998).

Traumatic experience and oppression continued throughout the Korean War. The Korean War resulted in a stronger political relationship between South Korea and the U.S. (Lee, & Miller, 2009). This contributed to the U.S. adopting Korean children who lost their parents from the War (Lee, & Miller, 2009). Moreover, Korean women often

married U.S. soldiers in order to migrate to the U.S. During the Korean War, American soldiers spent money in South Korea and Japan through prostitution (Sang-Hun, 2009; Latstetter, 2000). Many women who worked as prostitutes were widows who were doing so to feed their children and family. Thus, American soldiers took advantage of these vulnerable women, and that was compounded by the identification of the women as heroines devoted to the Korean War. Such war-based prostitution has created and perpetuated stereotypes of Asian American women as submissive, vulnerable, and sexually exotic (Sang-Hun, 2009), which subsequently contributes to oppression among Asian Americans. For these and other reasons, Korean Americans often questioned their relationships with Americans. Ambivalent and conflicted feelings emerged because of incidents of exploitation and feelings of powerlessness due to depending on the U.S for their protection, economy, and care of war orphans.

The Vietnam War also had a strong influence on Asian Americans. Although both American and South Vietnamese soldiers fought against North Vietnam, the American military had better training and more sophisticated weapons compared to South Vietnamese (Nakamura, 1970). This created a stereotype of Asian as sub-human beings inferior to White Americans. Asian Americans also served as U.S. military in Vietnam War; they suffered from oppression and harassment in their stations because Asian Americans were treated as second-class citizens (Nakamura, 1970; Yoshimura, 1970). Moreover, Vietnamese women were sexually assaulted by soldiers during war (Latstetter, 2000), and were often blamed for American sexual aggression (Yoshimura, 1970). Consequently, Asian women were seen as sexual figures who were submissive and

vulnerable, which reinforced Asian stereotypes. When the war ended, Vietnamese, Cambodians, and Hmong stayed in refugee camps where they were exposed to violence, disease, and death prior to emigrating to the U.S. (Wong, Kinzie, & Kinzie, 2009). They suffered from poverty due to a lack of financial assistance, job training, and language barriers (Wong et al., 2009). Due to this environment, they were exposed to violence, assault, and harassment in their communities. As a result, those South Asian Americans suffered from various stressors such as trauma, acculturation, poverty, and oppression (Wong et al., 2009). The war and conflict influenced mental health issues among Asian Americans, and this history also shaped stereotypes for Asian Americans.

Contemporary Role of “Model Minority”

In recent history, Asian Americans have been viewed as “model minorities.” (Lee, 1999), and this has become an important part of Asian Americans’ identity and stereotypes. . Asian Americans were seen as successfully assimilating into the United States, which resulted in promoting racial equality (Johnson et al., 1995; Lee, 1999). This means Asian Americans have been seen as a minority with equal opportunity to succeed. As model minorities, Asian Americans are often accepted by White American, and Asian Americans are expected to confirm a role of model minority (Chao et al., 2013). Ironically, this role of model minority perpetuates a racial oppression toward other groups of minorities (Tran & Birman, 2010; Uyematsu, 1969). As evidence, the concept of model minority created significant pressure for Asian American youths to succeed in their academic work (Lowe, 2009; Sue, 2003). The concept of model minority also contributed to conflicts with other minority groups. For instance, high level of model

minority beliefs lowered community acceptance among African Americans compared to Asian Americans (Chao et al., 2013). In addition, this concept of model minority is overgeneralized across various Asian American groups (Tseng, Chao, & Padmawidjaja, 2007). Such overgeneralization perpetuates internalized oppression (Sue, 2003) among some Asian American groups who present low educational achievement and/or are in lower socio economic status groups (Johnson et al., 1995). Moreover, this concept influences help seeking behaviors for mental health services among Asian American. As evidence, higher scores of model minority and lower socioeconomic status predicted lower attitudes toward seeking psychological help (Kim, & Lee, 2013; Gupta, Szymanski, & Leong, 2011). Since Asian Americans are seen as successful minorities and confirm the role of model minority, Asian Americans may be less likely to seek or use mental health services.

Overall, Asian Americans struggled with their identities, suffered from physical and psychological trauma, and faced psychological distress attributed to Asian stereotypes. The first generation of Asian Americans was challenged to fit into the Western cultural norms, and their stress was exacerbated due to language barriers, oppression, and trauma (Okazaki, Lee, & Sue, 2007). They exposed their children to both Asian and Western cultures with the hope of integrating their Asian and American identities. In this way, their culture, identity, value and language were integrated even as they were being marginalized by European Americans. Moreover, a concept of model minority influences Asian Americans' identity. Consequently, Asian Americans present unfavorable attitudes in seeking help despite equal or higher levels of psychological

distress, which is strongly influenced by historical trauma, oppressions and a concept of model minority.

Mental Health Issues among Asian Americans

Although the Civil Right Act of 1963 focused on equal opportunity for minority peoples to access government services including mental health, an assumption that Asian Americans are all successful minorities has contributed to less attention being directed to the needs for mental health among Asian Americans (Nguyen, Shibusawa, & Chen, 2012; Sue, Sue, Sue, & Takeuchi, 1995). However, the concept of model minority must not be a reason to have less attention on the mental health needs of Asian Americans. In this section, various mental health needs among Asian Americans are identified and discussed, including (a) historical trauma associated with mental health issues, (b) mental health by age groups, (c) religions, (d) family, (e) beliefs about mental health, and (f) financial factors associated with needs of mental health in subgroups of Asian Americans.

Based on the history of Asian Americans, studies have been published that address oppression, acculturation, family systems, treatment outcome, trauma, and gender and sexuality studies. For instance, Japanese internment camp caused the trauma of being split from their family members, living in harsh environments, and experiencing violence in the camp also resulted in physical and psychological distress, and this trauma also influenced next generations (Nagata, 1998; Kim, Nagata, & Akiyama, 2014). This is one example of a specific Asian American subgroup experience, which cannot be generalized to Asian Americans in general. In fact, a closer examination of the reality for

Asian Americans suggests that such assumptions are inaccurate; therefore, their needs for mental health have not been met yet.

When compared to other groups of color by age, Asian Americans have high mental health needs particularly among adolescent, young adult female, and elders (Nguyen et al., 2012). Female Asian American adolescents and young adults have higher risk of suicide when compared to others in their age groups (Nguyen et al., 2012). Furthermore, Asian American elders have higher risk of depression than white elders (Mui, & Shibusawa 2008). These high needs have been reported, even though Asian Americans are more likely to underreport mental health needs. Stigma toward those mental health disorders and usage of mental health services seemed to be a key to preventing Asian Americans from utilizing mental health services, as measured by a scale of Attitudes toward Seeking Professional Psychological Help Scale (ASPPHS). However, the ASPPHS may not adequately capture likelihood of behaviors to seek mental health services (Mackenzie, Knox, Gekoski, & MacAulay, 2004; Ting, & Hwang, 2009).

Religious beliefs may lead Asian Americans to see the connection between health and illness uniquely. As evidence, traditional Asian Americans may believe the mind and body are integrated into their conceptualization of health, and that health is balanced by their behaviors and environment (Nguyen et al., 2012). When this integration becomes imbalanced, they assume their minds and bodies catch illnesses. They view illness as their responsibility. They feel responsible to care for their body, mind, family, and religion. As a result, they feel shame due to their mental illness because of their own

irresponsibility. Moreover, in Hinduism or Buddhism, karma or reincarnation leads Asian Americans assume their presenting illness, distress, and hardship are attributed to their previous existence (Ano, Mathew, & Fukuyama, 2009; Yeh, & Kwong, 2009). Their suffering came from their irresponsibility's, so they assume their distress would not be treated and must take care of it by myself to devote in religious practice. This assumption also induces a sense of shame. Consequently, Asian Americans have higher stigma to seek mental health professionals due to their shame of not taking care of themselves (Ano et al., 2009).

Inaccurate assumptions about mental disorders, influenced by family values, prevent Asian American from seeking services. Mental illness is frequently seen as a genetic disorder among Asian Americans (Nguyen et al., 2012). Thus admitting mental illness brings shame on the entire family, because family members would be viewed as not meeting their responsibility to take care of the family member with the disorder. This belief can prevent Asian Americans from accessing mental health services even if they need help. A lack of knowledge about mental illness, access to resources, and the importance of meeting family obligations magnify isolation among Asian Americans (Nguyen et al., 2012). Moreover, there is a strong belief that seeking help to share concerns with strangers is not for Asian Americans (Tewari, 2009). Assumptions about mental disorders appeared to a barrier to seek professional help.

Since Asian Americans have various backgrounds, Asian Americans have various barriers to receive mental health services: (a) clients' suspicions for services, (b) financial barriers, (c) accessibility, and (d) a lack of culturally sensitive services. First, Asian

Americans' beliefs about mental illness and attitudes toward seeking mental health services might vary (Tewari, 2009). Mallinckrodt, Shigeoka, and Suzuki (2005) reported an Asian American study that etiology belief was influenced by their acculturation level. Highly acculturated Asian Americans tend to have more accurate knowledge about mental disorders than low acculturated individuals. This study indicated acculturation might be associated with positive attitudes in using mental health services. Acculturation is a significant factor in influencing one's beliefs, values, and behaviors. Asian Americans might have various differences, which might make it difficult to determine their needs to promote mental health services.

Group differences among Asian Americans can influence views of etiological beliefs and usage of mental health services. For instance, Christianity/Catholicism and colonial mentality are central to Filipino American experience (Sanchez, & Gaw, 2007). Based on their history, they have been exposed to Western cultures and medicine much more than other Asian American groups (Sanchez, & Gaw, 2007). Because of their colonial mentality, which is a form of oppression among Filipino and Filipino American (David, & Okazaki, 2006), they experience inferiority to Western culture, a view of mental health is different when compared to other groups of Asian Americans. David (2010) discussed that Filipino Americans might be more open and accepting of traditional approaches of mental health services; however, his results indicated mistrust of Western culture seemed to prevent Filipino Americans from seeking psychological services. Moreover, they have lower educational completion compared to East Asian group (Ogilvie, 2008). Their issues surrounding mental health issues are different from other

Asian groups (Saw, & Okazaki, 2009). Therefore, considering cultural differences among Asian American groups is necessary.

In addition to education and religious differences, Asian American groups have different degrees of financial problems, which can be related to mental health services. Whereas the overall Asian Americans poverty rate is about 10%, some Asian groups have considerably high poverty rate (Hmong: 27.7%, Bangladeshi: 23.6%, and Cambodian: 19.1%) (Takei, & Sakamoto, 2011). A lack of familiarity in utilizing services and resources to afford insurance among Asian immigrants are also barriers to seek professional help (Johnson et al., 1995). Those financial issues make it challenging to afford and seek mental health services among Asian Americans. Moreover, a lack of culturally sensitive services might be the most relevant barrier for Asian Americans (Tewari, 2009). A lack of training to work with Asian Americans among mental health professionals and clients' suspicions in using mental health services contribute to disparity for mental health services. In this way, Asian Americans have culturally unique issues that do not meet their needs of mental health services. Therefore, seeking services and receiving competent services is challenging.

Research Issues in Asian American Studies

Conducting psychology research with Asian Americans is also challenging. As discussed, Asian Americans have various backgrounds and history, which present unique issues among Asian groups. Yet, Asian groups commonly present issues related to oppression, historical trauma, and acculturation, and all are underserved in regard to mental health needs. These unique and common factors make study of Asian American

study difficult. Especially, Asian American study may focus on one particular ethnic minority group, and this may or may not generalize beyond the group (Sue, 1999).

Moreover, barriers to quality research with Asian Americans include a lack of culturally valid measurement tools, sampling issues, and a weakness of existing theories. In this section, those barriers and a lack of research in communication are discussed.

Researchers face a conflict between considering validity of measurement and avoiding minority research. Measurement is not routinely validated for minority studies, which requires researchers to work on scale validation prior to conduct research (Sue, 1999). Moreover, measurement itself would not be adequate due to cultural differences. Thus, researchers may need to construct scales prior to answering their research questions. Because this extra work increases the costs in both money and time, researchers often modify or simply avoid minority research. Consequently, the literature in psychology relevant to Asian Americans has a dearth of culturally valid research.

For instance, early research of therapeutic outcomes includes a lack of validation on measurements. Atkinson, Maruyama, and Matsui (1978) conducted therapeutic outcomes regarding Asian Americans' perceptions toward their therapists' credibility and utility. Their results showed Asian Americans preferred a direct approach and did not perceive differences based on therapists' race/ethnicity, whether White or Asian. Participants' preference was measured by Counselor Effectiveness Rating Schedule (CERS). The CERS was validated by participants who are Caucasian college students and the validity of the measure among Asian Americans was not discussed (Atkinson, & Carskaddon, 1975; Atkinson, Maruyama, & Matsui, 1978). Likewise, Gim, Atkinson,

and Kim (1991) conducted a study which reported that the ratings of therapists by Asian American clients was influenced by an interactions of variables including acculturation, therapists' cultural sensitivity, and therapists' race/ethnicity. Two measurements were utilized in this study: CERS and Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA). Although CERS was validated through college student sample by Atkinson and Wamold (1982), cultural difference was not considered. Moreover, SL-ASIA has been criticized for relying on a unidimensional construct of acculturation; as a result, enculturation can confound acculturation (Kim, 2007). These two Asian American studies showed a lack of validity on measurement, yet they are widely cited and used as foundations for other multicultural research. This can lead to misinterpretation or misrepresentation of the results of these studies and future research.

Secondly, data collection for Asian Americans is challenging. Sue and Sue (2003) noted that community connections are important to effectively recruit participants, which can be difficult because of a lack of familiarity in Asian American research and cultural mistrust. In addition, accessing communities can be challenging depending on geographic locations. In fact, Asian Americans live primarily on the West Coast and that is where researchers can most directly access their communities (Hoeffel, Rastogi, Kim, & Shahid, 2012). For researchers in other parts of the country, utilizing college students or conducting study online allows researchers to gain Asian Americans sample. However, college students are a biased sample that does not represent general population, and online studies can include a lack of reliability (Sue, 1999). Research in using college students or people from online presents concerns regarding generalizability. Therefore,

those sampling issues can contribute to difficulty conducting and generalizing Asian American studies.

As evidence, participants were college students in both the Atkinson et al (1978) and Gim et al (1991) studies. In addition, in study of Meyer, Zane, and Cho (2011), 171 college students were recruited to investigate racial match effect on Asian American's psychological process. The results showed racial match leads to perceived similarity that is associated with greater support, stronger working alliance and therapist's credibility (Meyer et al., 2011). Although their study presented racial match affect and psychological process, sampling issues were not discussed. Participants' average ages were 18.94 years old and 67% were born in the U.S., which indicates they might have more exposure to counseling from Asian American therapists. Results can be different if Asian Americans do not have experience for counseling or less exposure to cultural sensitive services due to their geographic locations. It is crucially important to assess limitations that may be due to the study sample.

Thirdly, weakness of existing theory is also a barrier to conducting Asian American research. Existing theories in psychotherapy are Western centered; thus, minority studies require including a concept of uniqueness of the population that represent their issues different from studies for majority. This means Asian American research is required to critically analyze a theoretical framework. As a result, Asian American research requires scientists to go through more steps prior to conduct research.

For example, uncertainty and reduction theory of initial interaction was utilized in a study by Gudykunst and Nishida (1984). Based on this theory, they hypothesized that

Asian Americans show affirmative behaviors in order to reduce uncertain feelings of others and attempt to find similarities in others when they meet others from different races, ethnicities and cultures, (Gudykunst, & Nishida, 1984). Their study indicated that Asian Americans would seek similarity in others in a stage of developing rapport. Based on this study, researchers attempted to determine how perceived similarity influences the therapeutic relationships. Asian American clients rate high similarity ratings when they saw Asian American therapists when compared to seeing European American therapists (Kim, & Atkinson, 2002). As discussed previously, Meyer et al (2011) reported that racial match might facilitate working alliance in psychotherapy). However, a meta-analysis study concluded that racial match did not increase the probability for clients to return or continue psychotherapy (Maramba & Hall, 2002). Such mixed results indicate the need to explore culture-specific factors.

Asian American researchers have begun to integrate cultural specific factors in a theoretical frame work through their investigations. For example, one study showed that clients' sense of support from their therapists improved when European American therapists intentionally use some phrase in their clients' Asian languages rather than English (Zhang, & Dixon, 2001). Moreover, clients' factors might be related to therapeutic outcomes because acculturation level and communications styles might be predictors in using mental health services (Gim et al., 1990; Oguri, & Gudykunst, 2002). Those studies indicate that if Asian Americans are not able to gain a sense of support from their therapists, racial factors potentially play a role impact on therapeutic outcomes.

Characteristics such as communication and language can also be important points of similarity or difference. Language preference is an important factor when conducting therapy with Asian American clients (Bernal, Bonilla, & Bellido, 1995; Zane et al., 2005). Expressing concerns in therapy in a second language might be a challenge for Asian Americans with English as a second language. Communication styles, culture, and language impact interpersonal communications (Samover, Porter, & Mcdaniel, 2012), which may influence Asian Americans' experiences in therapy. Receiving therapy in preferred language among Asian Americans might lead to increased satisfaction and improved therapeutic outcomes (Meyer et al., 2011; Kim et al., 2012). Those studies indicate therapy with preferred language seems to induce positive outcomes. Using preferred languages in therapy may minimize clients' frustration with expressing their concerns to therapists and maximize their psychological process through interaction with therapists. Therefore, preferred language enables Asian American clients to gain positive experiences in therapy.

However, recent reports showed that, regardless of language match with therapists, Asian American clients who prefer non-English therapists report worst therapeutic outcomes (Kim et al., 2012; Zane et al, 2005). Moreover, Kim et al (2012) stated that clients with non-English preference report worse experience during the treatment period. The authors concluded that race/ethnicity might be a factor in describing this result. Their results indicate that clients who prefer services rather than English might be a predictor for low therapeutic outcomes because of language barriers and cultural differences, suggesting this is a unique factor among Asian Americans. Sue

(1994) pointed out the fundamental conflict between the western roots of counseling and the values of traditional Asian cultures, and this conflict may be reflected in language preference. However, those factors may or may not be related to the therapeutic outcomes. In a meta-analysis, Griner and Smith (2006) concluded that intervention with preferred language was more effective than English with Asian Americans. However, their evidence may not be enough to fully understand the relationship between language preferences and therapeutic outcomes. Language preference would not capture interactions that occurred between therapists and clients, which has a strong influence on the therapeutic relationship.

One potentially important factor of communication has been neglected in psychotherapy research, that of communication styles specific to high- context or low- context communication. Park and Kim (2008) posited that acculturation levels might predict preference for communication style, specifically high or low context communication. Although they did not examine communication in a therapeutic context, their findings (explicated in the next section) do have implications for psychotherapy research. In psychotherapy, communication styles should not be ignored in building rapport in addition to focusing on racial match, language preference, and therapists' therapeutic approach. Communication styles encompass non-verbal expression, meanings and emotions behind a sentence. Those communications also contribute to building a therapeutic relationship. In this study, the impact of communication styles on therapeutic outcomes was examined.

CHAPTER II

LITERATURE REVIEW

Psychotherapy and Communication

Psychotherapy is the application of clinical methods to help people to change or modify their behaviors, cognitions, and emotions as related to their presenting problems (Prochaska, & Norcross, 2010). Interactions between therapists and clients are vital activities in psychotherapy, in which clients bring and express their issues to their therapists verbally. Therapists then explore clients' issues by using clinical skills in reflecting clients' feelings, paraphrasing the clients' words, asking questions, etc. Communication is a principal component of conducting psychotherapy to build rapport, explore intrasychic conflicts, and intervene in clients' issues. Therefore, awareness of differences in communication styles is a crucially important factor for effective psychotherapy.

Given that communication is central to psychotherapy, differences in communication styles might result in ineffective therapy services. Unfortunately, communication styles among Asian Americans in psychotherapy have not been explored (Wang & Kim, 2010), even though there is some evidence that communication styles are influenced by culture and racial differences. Differences in communication styles could affect psychotherapy.

Those differences in communication styles might vary depending on individual experiences. About 60 % of Asian Americans are foreign born, and the rest have various experience expose to Asian communication (Grieco et al., 2012; Hwang, 2006). Exposure to Western cultures could change communication styles, and this process might be unique based on levels of acculturation (Xu, 2010). Kim (2007a) defined parallel acculturation and enculturation process among Asian Americans. His model presents cultural identity as a bilinear process in which Asian Americans can have both Asian and Western culture and values simultaneously. Growing up in an Asian family, speaking multiple languages, and being exposed to Asian cultures from their communities will contribute to culture specific communication styles among Asian Americans (Gudykunst, 2001). Likewise, they are exposed to American culture and communication styles that will shape new styles of communication. These findings indicate that Americans have diverse backgrounds due to variations in cultural exposure, and their communication styles can vary based on their experiences and values of several cultures. Thus, cultural sensitivity in communication styles is necessary in therapy services.

Among Asian Americans, communication styles might be different depending on their national heritage and acculturation levels. For example, South Asian or South Asian Americans would be openly communicative with others when compared to East Asian (Gudykunst, 2001). Their emotional expression would be directive and expressive, so others would feel friendly or open-minded based on their communication styles. This communication styles may influence how they make connections with others from different racial or ethnic groups.

Using silence to include underlying meaning is common among East Asians. Japanese and Chinese have a phrase of “Being silent is gold.” (Kakutani, 2007) This belief encourages them to use silence more often in communication, and therapists will be expected to understand the meaning of silence. However, perception of silence may not be common across all Asian groups, based on studies which demonstrate lower internal consistency in measurements of perception of silence in communication (Gudykunst et al., 1996; Gudykunst, 2001). Again, communication styles appeared to be different based on cultural values.

Furthermore, generation is also likely to influence communication styles among Asian Americans. Based on acculturation experiences, first generations can be different from that of second or third generations. Asian Americans would utilize different styles of communication based on others they are interacting with, their inter-cultural experiences, and their own uniqueness (Gudykunst, 2001). In therapy, Asian Americans might have different experiences based on their and therapists’ communication styles that can vary depending on individuals.

Components of culture and individual differences in communication styles make complexity in relation to psychotherapy. Each Asian group presents unique communication styles in connecting others. Therefore, exploring different of communication styles depending on Asian groups is necessary to capture uniqueness of each group of Asian Americans.

High/Low Context Communication

Hall (1976) first presented the concept of High/low-context communication. In high-context communication, information which people exchange is influenced by the physical contexts or internalized in the person (Samover, Porter, & Mcdaniel, 2012), and the people involved in the exchange are expected to make assumptions based on those contexts. People with a high context communication style present little expression of the message and context and expect others to interpret the underlying message and context.

For example, subjects in sentences are often skipped when people communicate in Japanese (Kato, 2005), which is a high context language. Instead of stating emotional experience such as “私は映画を楽しく見ました。(I enjoyed watching a movie),” Japanese people express their excitement of movie as “映画は楽しかったです。(Enjoyed movie).” When speakers talk about a movie, both speakers and listeners assume speakers watched the movie. If speakers talk about others having watched a movie, they will specify who watched the movie. Listeners must interpret what speakers express in the sentence within the larger contexts. Although this example is Japanese, similar communication styles were reported in Chinese and Korean populations (Tseng, 2005; Saito, 2006).

In high context communication, people are expected to read nuances between sentences. Kakutani (2007) provided an example of difference of communication styles among Japanese and American people. American people describe their opinions logically by bringing reasons “I think A because of B. That’s why I would like you to do C.” (Kakutani, 2007). On the other hand, Japanese people use “that” or “it” instead of

reasons “That is why...thank you for your generosity.” (Kakutani, 2007). For people in high context situations, understanding includes the various meaning in a sentence integrated from an environment, customs, routine life work and contexts, and they expect others to mutually understand the meaning behind the sentence without verbalization. Interpreting how others think and feel is necessary to maintain effective communication with high contexts.

On the other hand, low context communication includes detailed explicit codes through verbal communications (Samover et al.,2012). In low context cultures, people are expected to express their contexts in a logical and clear manner so that readers can understand the meaning of the communication. People in low context situations express their thoughts verbally and in specific ways as opposed to people in high context situations. The sentence has literal meaning in specific ways (Samover et al.,2012). It is the messengers’ responsibility to ensure the receiver understands the meaning of the communication. In low context communication, the messages people provide are obvious and clear, and require less experience or training in cultural nuance to understand what is being explicit in communication (Reardon, & Miller, 2012; Heylighen, & Dewaele, 2002). As an example of American people’s communication above, people who understand English will be able to capture most information presented through oral communication.

Because of the difference between high or low context communication styles, conversation between people using different styles may cause misunderstandings that can influence interpersonal relationships. For instance, in the following excerpt from

Amy Tan's novel, *The Joy Luck Club*, the U.S born daughter expressed confusion when she talked about two different soups with her Chinese mother:

The week before she died, she called me, full of pride, full of life: "Auntie Lin cooked read bean soup for Joy Luck. I'm going to cook black sesame-seed soup."

"Don't show off," I said.

"It's not showoff." She said the two soups were almost the same, *chabudwo*. Or maybe she said *butong*, not the same thing at all. It was one of those Chinese expressions that means the better half of mix intentions. I can never remember things I did not understand in the first place. (Tan, 1989, pp. 19).

Different communication styles between a mother and a daughter can lose contexts in communication. As a result, children of immigrants are unable to recognize their parents' identities in context (Graffner, 2012). Thus, different communication styles can be a barrier to interpret meanings in conversation.

In therapy, a client with high context communication styles expresses his or her issues within a context rather than directly stating their issues. For example, the Filipino American client expresses her pressure about academic work by complaining of fatigue, sleepless, and loss of interests in fun activities in therapy sessions (Kim, 2011). Her pressure may be attributed to compensation of parents' hard work in supporting the client's education, a lack of emotional support from her friends, and high expectation to be a role model to her entire family. However, the client would verbalize a deadline of

assignments, pressure to maintain high grades, and restlessness in her life while her guilt of support from parents, isolation from friends, and pressure of being role model in her family are not verbalized. Moreover, she may not directly express her interest in changing her major because of her family's encouragement. Low context therapists must be aware of clients' non-verbalized issues and explore stories within the contexts in order to effectively approach clients' issues and their needs. In addition, Asian Americans show culture related tendency to hide emotions. For example, when an individual's problem can disrupt a harmony such as facing mental health problems that induce a sense of stigma in an entire family, Asian Americans are expected to hide their problems (Sue, 1998). This client might discuss her interest in changing major with her family indirectly such as "What if someone studies X?" (Hong, & Ham, 2001). In this way, she can maintain harmony while she figures her family's reactions out. Such variance in communication is one important reason that approaching clients' issues must be modified based on culture.

Considering the fact that over half of Asian American are foreign-born and their family may influence high context culture, many Asian Americans might engage in a high context communication style. Park and Kim (2008) discovered collectivism and lower adherence to European American values might be a predictor for high interpersonal sensitivity and inferring meaning, indicating a high context communication style. They focused on the value of European American culture and emotional control related to communication styles. As they mentioned in their study, research in Asian American's communication style is limited. However, there are a few research studies that have

examined cultural comparison in communication. For example, Japanese students have higher level of confidence in predicting others' behaviors and feeling (Gudykunst, & Nishida, 1984). Their discovery showed Japanese people used high context communication styles to interact with others and interpret them within contexts via interactions. As supported their studies, Japanese people rated higher on high context communication than that of Americans (Richardson, & Smith, 2007). Moreover, Indian students scored high context communication style compared with American students (Kapoor, Hughes, Baldwin, & Blue, 2003). Those studies showed high context communication among people from Asian countries.

Okazaki (2000) concluded differences of psychological symptom reported among Asian American college students, compared to White American college students. Although this study did not directly focus on the communication styles, the differences in symptom report indicated cultural differences in self-expression. Their results indicated there was a difference between Asian and White college students in their report, which might be a reflection of cultural differences. Asian Americans express their internal and external concerns with indirect contexts which might be different from European Americans. Therefore, their communication styles seem to be crucially important components for therapists to capture symptomatology in psychotherapy.

Although the literature supports cultural sensitivity as important to multicultural competency (Sue, & Sue, 2012), research in communication styles in psychotherapy has been sparse. Samover et al. (2012) asserted that communications crossing different cultures must be achieved with an understanding of culture. Due to the difference of

cultural background between Asian clients and non-Asian therapists, working alliance, therapeutic satisfaction, and therapeutic outcome might be negatively influenced. When therapists are culturally different from that of clients, cultural differences must be considered. Highly acculturated Asian Americans tend to flexibly shift communication styles with therapists, and they are likely use mental health services at a greater rate than low acculturated individuals (Meyer et al., 2011). In this way, highly acculturated Asian Americans would be able to gain a sense of similarity stronger than low acculturated Asian Americans. Mismatch of communication styles may magnify a sense of distance from therapists that can influence on therapeutic outcomes.

Acculturation

Acculturation is defined as a common adaptive experience of people who were raised in one culture and relocated to a new or difference culture for an extended period (Samover, Porter, & Mcdaniel, 2012). This concept explains acculturation as an inverse process in that people become dominated by a new culture and have less involvement in original one or vice versa. Acculturation levels can vary among Asian Americans.

Kim (2007a) pointed out that foreign born Asian American might have completely different acculturation process compared to several generational Asian Americans because of their experience of exposure to Asian cultures. When people from Asia immigrate to the U.S., life style change will challenge them to adapt in new culture including understanding customs. Asian immigrants adapt their norms fit into the U.S. system of society, speaking English as a second language, coping with experience of discrimination, and developing their identities as an American.

On the other hand, people who are born in the U.S. might have different acculturation experience. Their parents may or may not speak languages other than English, they may or may not have been exposed to English since at birth, Asian culture or community may or may not be available depending on their family and geographic locations, and their norms are developed in the U.S. throughout their childhood. Those individuals face their identity as either Asian or American (Okazaki, Lee, & Sue, 2007). However, they will face experiences of discrimination and identity development as an Asian American. Kim (2007b) concluded acculturation might be a predictor for help seeking behaviors, usage of mental health services, and potentially other unknown factors.

Greater acculturation was associated with seeking mental health services among Asian American students (Miller et al., 2011). Asian American who have positive attitudes toward acculturation or are highly acculturated into American cultures may view mental health services as a source of help and feel less stigmatized in using those services. This means their values on mental health services and help seeking is acculturated. Moreover, when they utilize those services, they would have more positive experiences because their values fit into Western norms that match those services. As evidence, Meyer et al. (2009) reported U.S. born Asian Americans scored positive attitudes in using mental health services compared with that of foreign born. Since U.S. born Asian Americans might report higher acculturation level due to their substantial experiences staying in the U.S., the authors indicated an acculturation and English proficiency might influence them.

Acculturation includes a change in communication styles. The acquisition of the new cultural practice is associated with learning new language (Samover et al., 2012). U.S. and foreign born Asian Americans will challenge in their communication styles although their acculturation experience in communication styles can vary. For example, longer stay in the U.S. would shape communication traits among Chinese immigrants (Hsu, 2010). As exposed to lower context communication, their new communication style was developed. A level of acculturation might be associated with forming new communication style that fit into lower context communication style (Xu, 2010). Their results indicated that acculturation might lead Asian Americans use low context communications to engage in effective communications with people with low context communication style. Based on the bilinear model of acculturation (Kim, 2007a), they consciously or unconsciously shift their communication styles that might happen in therapy room.

No research has yet been found that focused on high or low context communication in relation to acculturation and the client-therapist dyad. A study was conducted to investigate if direct or non-direct approach would be associated with therapists' evaluation among Asian American students (Atkinson et al., 1978). The study defined direct approach as rational, problem focused approach and non-direct approach as reflective and affective approach. Direct approach was more valued by Asian Americans regardless of therapists' race/ethnicity and authors concluded Asian Americans would prefer clear, logical and structural approach. Direct or non-directive approach is focus on their way in approaching a presenting issue. Direct or non-directive approach may

influence the way clients and therapists express in therapy sessions. However, this study did not focus on how communication styles influence a working alliance.

High or low context communication is the way exchange information: high context is the way present information in surface with cues with an assumption of others to interpret their contents; low context present information in specific and detailed including contexts. Therefore, direct approach might be preferable for Asian Americans because they involve in high context communication with non-Asian therapists who would not understand or potentially misunderstand contexts of clients' stories. Asian American clients prefer clear and structural approach which is more predictable than indirect approach (Hong, & Ham, 2001). As a result, they will express their concerns effectively within high contexts. Preference on direct approach is an indication of high context communication among Asian American. Acculturation might affect clients' flexibility in shifting communication styles that promote communication with their therapists effectively. Therefore, acculturation might be a factor to influence communication styles.

Suinn-Lew Asian Self-Identity Acculturation Scale has been widely used for Asian American studies. This scale is based on an assumption of acculturation as a unilinear model that Asian Americans involve in American cultures while they stay away from the original culture. This scale was a predictor for ethnic identity, and attitudes toward help-seeking (Kim, 2007a). However, inconsistency of results for this measurement was reported in studies (Kim, 2007a; Mallinckrodt, Shigeoka, & Suzuki,

2005). Both concepts of Acculturation and enculturation enmeshed in the scale, which might result in fail to measure level of acculturation in their studies.

Enculturation is defined as a maintenance of culture of origin that may or may not be along with a process of acculturation. Among Asian Americans, enculturation is considered to be the maintenance of their native culture while people are in American culture (Kim 2007b; Miller 2011). Kim and Abreu (2001) stated that acculturation and enculturation process can be different depending on individuals. Acculturation score in SL-ASIA confounded against enculturation (Suinn, Khoo, & Ahuna, 2011). However, acculturation and enculturation can happen in different levels in an individual. Zhang and Moradi (2012) reported different construct between acculturation and enculturation. Although both concepts correlated in their report, both concepts are distinct. Consequently, researchers have shifted from using SL-ASIA to the scale which can capture multidimensional acculturation.

Based on a multidimensional model, acculturation consists of three constructs: cultural engagement, behaviors and values. The purpose of the Asian American Multidimensional Acculturation Scale (AAMAS) is to assess Asian American norms of engagement in both their cultures and the European American culture. This scale was created based on SL-ASIA to capture three dimensions including culture of origin, Asian American and European Americans (Chung, Kim, & Abreu, 2004). AAMAS encompasses involvement of cultures which is associated with a level of acculturation. AAMAS capture a part of acculturation and additional scales are needed to fully reveal various aspects of acculturation. In addition, a level of acculturation is associated with

behaviors. Acculturation Rating Scales for Mexican Americans (ARSMA-II), designed to capture behaviors which associated with a level of acculturation, was validated for Asian Americans (Lee, Yoon, Liu-Tom, 2006). Acculturation is defined in a bi-dimensional model in this scale. The more Asian Americans involve in European American related behaviors, the less they involve in behaviors related to Asian American cultures. Furthermore, acculturation process influences one's values. This value is assessed by European American Values Scale for Asian Americans – Revised (EAVS-AA-R) (Hong, Kim, & Wolfe, 2005). Values of European cultures indicate a level of acculturation. Overall, those three constructs are a concept of acculturation.

Help Seeking Attitudes

Attitudes toward seeking mental health services are another important component that can influence a therapeutic relationship. Fisher and Turner (1970) stated help seeking is influenced by internalized attitudes for mental health services and individual openness to new experience, and they developed a measure of attitudes toward professional help for psychological disturbance. Four factors were standardized in this measure of the Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS): recognition of need for psychological help, stigma tolerance, interpersonal openness, and confidence in mental health professionals (Fisher, & Turner, 1970).

ATSPPHS has been used in research with Asian Americans to determine how culture specific factors-including acculturation, enculturation, self-concealment, family conflicts attributed to acculturation gap, collectivism and individuals' flexibility-influence help seeking attitudes. For example, Asian Americans openness to seek

psychological services may depend on their acculturation and enculturation levels (Atkinson, & Gim, 1989; Miller et al., 2011). A level of exposure to Western cultures integrates into values and behaviors among Asian Americans that are associated with help seeking attitudes. Moreover, a high level of self-concealment was a predictor for a low help seeking attitudes, and family conflicts attributed to acculturation gap, collectivism, and individuals' flexibility were not associated with help seeking behaviors (Miller et al., 2011; Masuda, & Boone, 2011; Omizo, Kim, & Abel, 2008). Self-concealment, individual flexibility, and acculturation gap are to be theoretically predictable for help seeking behaviors. Limitation in measuring help seeking attitudes associated with help seeking behaviors might be a factor that prevents supporting theories based on data. Although ATSPPHS has been used widely in research for help seeking attitudes, this scale did not capture help seeking behaviors among Asian Americans.

Mackenzie, Knox, Gekoski, and Macaulay (2006) pointed out an inconsistency in the ATSPPHS's assessment of attitudes toward seeking mental health services due to a lack of conceptualization, inconsistency in its evaluation, and a lack of validity. Four issues were identified in their study: inappropriate choice of samples for scale validation, outdated language, conceptual limitation, and unresolved methodological concerns. The ATSPPHS was validated by using college students, which did not reflect representatives in community who need psychological professional helps. The ATSPPHS contains male pronouns, which is considered as outdated language and potentially negatively influence responders. The ATSPPHS assesses attitudes in seeking mental health services, which does not reflect likelihood among participants use mental health services because items

do not include behavioral intentions. The scale contains a lack of connection between attitudes and behaviors. Due to a limited statistical method in which the scale was analyzed by exploratory factor analysis, and confirmatory factor analysis was not available at that time, representations of data by factors were unknown. In addition, there was a risk of type II error due to fewer choice of response because ATSPPHS is 5 point Likert scale (Rasmussen, 1989). Based on those unsolved issues, Fisher revised ATSPPHS short form; however, the revision did not fully resolve the limitation of the scale. Thus, Mackenzie et al (2006) revised ATSPPHS to create a scale of Inventory of Attitudes toward Seeking Mental Health Services (IASMHS), with modification in conceptualizing help seeking attitudes, which are associated with help seeking behaviors for mental health services.

The IASMHS consists of three factors: psychological openness, help-seeking propensity, and indifference to stigma (Mackenzie, et al, 2006). The authors added some questions to assess prediction of improvement in using mental health services, modified to gender free language, used the phrase “psychological problems” rather than “emotional problems”, and replaced the scoring systems with a 7 point likert scale. They normed IASMHS by using a community sample for factor analysis and college students for replication. The IASMHS was validated for their study and it can also predict likelihood to utilize mental health services.

The IASMHS was also used with Filipino Americans. David (2010) tested help seeking attitudes among Filipino Americans in relation to generational status, Asian values, loss of face and cultural mistrust. The results showed each subscale of the scale

was influenced by those predictor variables which presents cultural uniqueness in Filipino Americans. The IASMHS's scale performance was good by Cronbach's alphas: .88 (psychological openness), .84 (help-seeking propensity), and .76 (indifference to stigma). However, this study is limited based on their focus only on Filipino Americans, who are different from other Asian American groups. Filipino Americans integrate Western cultures more than other Asian groups because of long history of colonization from Spain and the U.S., which was associated with English proficiency, religion (Catholics or Christian), and colonialism which strongly influences individualism (Nadal, 2009). Therefore, in this study, scale performance and analysis of each subgroup of Asian American was necessary.

Help seeking attitudes is a predictor for therapy working alliance. Wade, Post, Cornish, Vogel, and Tucker (2011) tested self-stigma reduction by a single session of group counseling. The result reported participants' intention in seeking counseling were a predictor for therapy working alliance. Moreover, a lower level of stigma in seeking help was a predictor for intention to seek help. Their study indicated that therapy working alliance was influenced by both stigma and intention in seeking help. Therefore, when test working alliance, help seeking attitudes including the clients' level of stigma is a very important factor.

However, the relationship between help-seeking and working alliance in a relationship between therapists and Asian clients is not clear. Since Asian Americans tend to hide their issues that can violate harmony in family, friendship or work relationships (Sue, 1998), cultural tendencies can influence help seeking attitudes in

addition to stigma and individual openness. As evidenced, self-concealment, individual intention to hide negative or distressing secrets, was a predictor for help seeking attitudes among Asian Americans (Masuda, & Boone, 2011). High levels of self-concealment are indication of willingness to hide personal concerns due to stigma. Therefore, stigma in seeking help might be related to therapeutic working alliance. Research does not go beyond this concept which is going to be tested in this study.

Acculturation is another important factor that might be related to help seeking attitudes. Highly acculturated individuals may likely seek professional help among Filipino Americans (David, 2010). On the other hand, other studies showed seeking help attitudes was not predicted by acculturation levels (Ruzek, Nguyen, & Herzog, 2011; Ting, J. Y., & Wei-Chin, H, 2009). Those studies might have failed to capture a significant relationship between help seeking and acculturation due to a measurement limitation since Ruzek et al (2011) utilized a set of questionnaire they originally created and Ting et al (2009) used ATSPPHS. A presence of cultural and individual components can contribute to help seeking attitudes. Avoidant coping skills were associated with negative therapeutic outcomes among Asian Americans, and this coping skill implies the individual degree of sharing problems with others and help seeking behaviors (Kim et al., 2012; Carver, Scheier, & Weintraub, 1989). Cultural and individual components are Asian Americans acculturation levels in seeking professional help, attitudes in using counseling services that can be influenced by values from their family or community. In addition, individual components that influenced by acculturation can be their openness in seeking services.

Language proficiency might be a predictor for help-seeking attitudes (Chu, Hsien, & Tokars, 2011; David, 2010). When Asians are seeking help, sharing concerns by using a language is a vital task to receive professional services. If English is a second language or sharing personal concern in non-English language is preferable among Asian Americans, this can potentially create a barrier in receiving professional help. Moreover, even if they prefer English, their communication styles influence their expression. High context communicators use a silent and feelings to guide their and others' behaviors by indirectly expressing their concerns. Lower context communicators may not fully capture contents from high context communicators, which can impact working alliance. Thus, language proficiency is a part of communication to express concerns to others when Asian Americans seek help, and different communication styles might be associated with help seeking attitudes. Therefore, among Asian Americans, help seeking attitudes might be another component independently influences therapeutic alliance.

Working Alliance

Working alliance is a key to the construct of psychotherapy. It is defined as trust of the therapeutic relationship in which clients accept and follow treatment sincerely (Bordin, 1979). Working alliance encompasses three dimensions of therapeutic relationships: goal, bond and task. The goal is a client agreement for psychotherapy (Bordin, 1979). A bond is a nature of relationship between therapists and clients, which includes the dynamic of therapists as caretakers or consultants in helping clients (Bordin, 1979). The degree of bond is in proportion to clients' openness to share their experience of therapy that contributes to maintain therapeutic relationship. Task is collaboration

between clients and therapists through psychotherapy (Bordin, 1979). Agreement of task is a dimension for working alliance. Clients are expected to share their experiences, concerns, and work on assignment if therapists provide. Bordin (1979) argued that mental health professionals are expected to assess and improve their work by using the concept of working alliance.

By using this concept of working alliance, Horvath and Greenberg (1989) constructed a scale of working alliance with three subscales of goal, bond, and task. The scale has demonstrated validity, and results suggested potential of flexibility to apply to therapy provided from various theoretical orientations (Horvath, & Greenberg; 1989; Tracey, & Kokotovic, 1989). Working alliance was a predictor for therapy outcomes and clients' change, rated by therapists (Walling, Suvak, Howard, Taft, & Murphy, 2012). Further, working alliance was predictive of therapeutic outcomes regardless of types of treatment (Horvath, Del Re, Fluckiger, & Symonds, 2011).

Henschel (2005) discussed working alliance as a predictor for therapy outcomes and communications between clients and therapists. Communication is a vital activity in psychotherapy, and it contribute to components of goals, bond, and task in the working alliance. Through communication, clients and therapists set up therapy goals by exchanging information. They work on tasks to reach therapy goals in that clients share their experiences, and therapists reflect emotions and ask questions to facilitate processing clients' issues. Those interactions contribute to developing bonds between clients and therapists. Henschel described those interactions as 'Meta-communications' that include verbal interactions as well as indirect communications such as transference,

counter transference, and therapeutic process (p. 16). Clients' emotional experiences and the dyad with therapists are directed by those communications. Clients may not directly express their feelings and interpersonal issues connected to their presenting issues, so therapists must interpret or explore clients' issues (Crits-Christoph, Gibbons, Crits-Christoph, Narducci, Schamberger, & Gallop, 2006). Non-verbal interactions such as smiling, leaning forward, and facial expression are signs from clients, which enables therapists to direct sessions and assess levels of rapport. Those verbal and non-verbal interactions are strongly influenced by cultures.

Although communication is a base to develop working alliance, the influence of communication in working alliance has not been well expanded. In one recent study, the impact of communication skills training for oncology clinicians was investigated, and training did not improve working alliance (Meystre, Bourquin, Despland, Stiefel, & de Roten, 2013). However, their results showed that clinicians' response to their patients were predictors for working alliance. They coded sessions and rated agreement, approval, laughter and jokes as positive talk, and criticism and disagreement as negative talk. . The result supported positive talk contributed to working alliance. Thus, verbal communication has an impact on working alliance. In addition, therapists' nonverbal sensitivity predicted higher working alliance (Grace, Kivlighan, & Kunce, 1995). Therapists' awareness of clients' nonverbal behaviors led to clients' sense of being understood by therapists, which was associated with high working alliance. Those two studies showed influence of communication in working alliance. However, cultural

difference and high/ low communication styles were not focused and how those factors influence working alliance are unknown.

High/low communication styles depend on individual acculturation levels among Asian Americans. Park and Kim (2008) explored how Asian Americans participants' values of Asian and European American cultures influence their communication styles. Their results showed precise, interpersonal sensitivity, and indirect communication were influenced by a degree of values European American values, suggesting participants acculturation levels which impact on European American values contributed to their communication styles. Thus, working alliance may be influence by high/low context communication styles.

Moreover, help seeking attitudes was positively correlated with working alliance (Liu, 2003). Help seeking attitudes assess participants' willingness to use mental health services; therefore, positive attitudes were a sign to make rapport with therapist which are associated with positive working alliance. However, this study utilized a short form of ATSPPH, which may not reflect participants' likelihood in using mental health services. This means the study did not fully capture the relationship between help seeking and working alliance. Moreover, the study was conducted between Caucasian clients with Asian American therapists. This dyad can influence working alliance and if clients' and therapists' ethnicity and communication styles were different from this study, the relationship between working alliance and help seeking behaviors may be different.

Rationale and Purpose of Study

The purpose of the study was to explore communication styles among Asian Americans as unique factors in forming therapeutic working alliance. Research in communication styles has not been conducted since Park and Kim examined the construct in 2008. Although the concepts of language preference and client perceptions of therapists have been studied, communication styles have not been examined (Kim, Zane, & Blozis, 2012; Meyer, Zane, & Cho, 2011). Thus, those reports did not capture how cultural differences impact the working alliance in therapy among Asian Americans.

The purpose of this study was to determine how culturally unique factors contribute to working alliance among Asian Americans. Based on supporting literature, the model of working alliance in Asian American was proposed (see Figure 1). Since acculturation and help seeking attitudes are associated with working alliance, I hypothesized that the relationship between acculturation and working alliance would be mediated by communication styles. This was supported by the study of clients' perceptions that have been associated with working alliance among Asian Americans (Meyer, Zane, & Cho, 2011). Since clients' perceptions for their therapists are developed by interactions in therapy sessions (Kim, Zane, & Blozis, 2012; Zane et al, 2005), communication styles might be a factor influence working alliance. Moreover, help seeking attitudes is an independent predictor for working alliance (Wade et al, 2011). Based on a relationship between communication styles and working alliance, the model assumed that communication styles might be a mediator in the relationship between help seeking attitudes and working alliance.

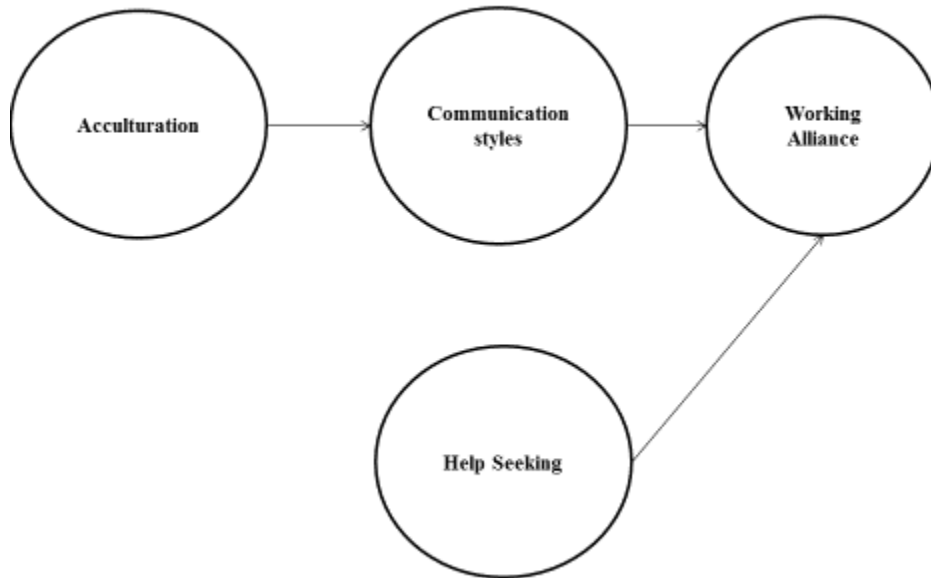


Figure 1. The model 1: Working alliance among Asian American with help seeking and acculturation mediated by communication styles.

A second model was also tested (see Figure 2). Instead of defining communication styles as a mediator, this model identified communication styles, acculturation and help seeking attitudes as independent factors that contribute to working alliance. The literature has implied associations between these three factors and working alliance (Kim, Zane, & Blozis, 2012; Meyer, Zane, & Cho, 2011), and interactions between communication styles, help seeking attitudes, and working alliance have not yet been tested. Therefore, this model examined if working alliance is predicted by communication styles, acculturation, and help seeking attitudes.

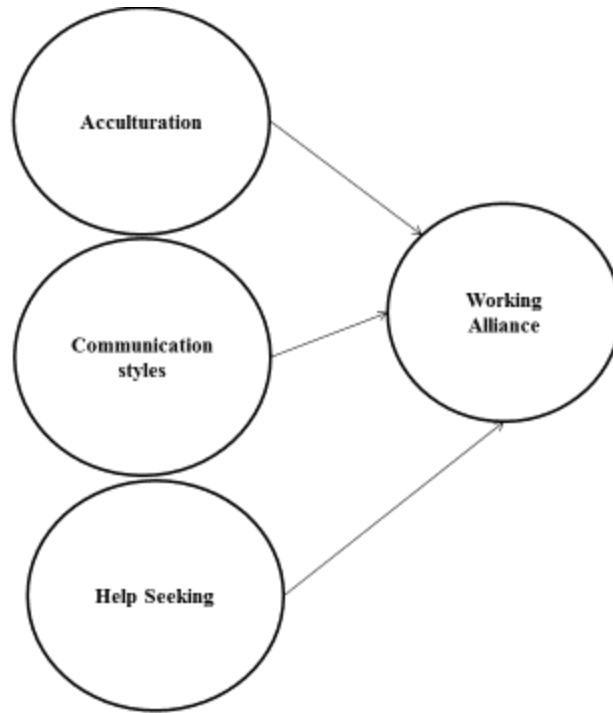


Figure 2. The model 2: Working alliance among Asian American with help seeking, acculturation, and communication styles.

CHAPTER III

METHODS

Participants

Participants for this study were recruited through advertisements to Asian American organizations and Amazon Mechanical Turk. All participants were over 18 years old and have utilized and/or utilizing individual counseling service. The total number of participants who began the survey was 141. Of these, 122 completed enough of the survey for their data to be considered usable (fewer than five missing response). Of the responds respondents who completed the survey, 55 identified as female, 66 as male, and one transgender. Participants ranged in age from 19 to 79, with a mean age of 30.4 (SD = 9.3, median = 29.0). In regard to participants' race/ethnic background, 41 participants were Chinese (33.1%), 10 were Korean 8.1%, 5 were Vietnamese (4.0%), 11 were Indian (8.5%), 12 were Filipino (9.7%), 13 were Japanese (10.5%), 4 were Thai (3.2%), 3 were Malaysian (2.1%), 4 were Pakistani (3.2%), 5 were Cambodian (4.0%), 3 were Hmong (2.1%), 3 were Laotian (2.1%), 4 were Taiwanese (2.8%), 2 were Bangladeshi (1.4%) and 12 were other (9.7%). With regards to sexual identity, 80.6% ($n = 100$) identified as heterosexual, 7.3% ($n = 9$) identified as bisexual, 5.6% ($n = 7$) identified as lesbian, 4.0% identified as Gay ($n = 5$), and 0.8% ($n = 1$) identified as other. Regarding participants education, 2 participants (1.4%) completed 8th grade, 3 (2.1%)

completed some high school, 13 (9.2%) graduated high school, 18 (12.8%) have some college, 16 (11.3%) hold associate degree, 46 (32.6%) hold bachelor's degree, 19 (13.5%) has master's degree, and 9 (6.4%) has either professional or doctoral degree. 69 participants (48.9%) reported their therapists' race/ethnic identity as White, 5 (3.5%) reported Black, 9 (6.4%) reported Hispanic, 5 (3.5%) reported Native American, 31 (22.0%) reported Asian, 6 (4.3%) reported Multiracial and 1 (0.7%) reported unknown. Regarding employment status, 73 participants (51.8%) were employed for wages, 15 (10.6%) were self-employed, 19 (13.5%) were unemployed, 3 (2.1%) were homemaker, 14 were students (9.9%) and 2 (1.4%) were retired.

Measures

Communication Styles

The High and Low context communication scale (Gudykunst et al., 1996) was used to assess participants' communication styles. The scale consists of 38 items, which participants rate using a 7 point rating scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Seven subscales were selected, which indicates high/low context communication styles. Subscales that indicate high context communication style are: ability to infer other's meaning, indirect/ambiguous communication, interpersonal sensitivity to other's feelings, and perception of silence. On the other hand, subscales that indicate low context communication style are: using feelings to guide behaviors, nonverbal expressiveness, preciseness, and communicator image. Reliability of the total and subscales in this study was reported on Table 1. Higher score reflects high context communication. Since Asian Americans are diverse populations that reflect unique

characteristics based on their origins, subscale has previously been focused rather than total score (Gudykunst et al., 1996; Kapoor, Hughes, Baldwin, & Blue, 2003). For example, Filipino Americans show more openness compared to other Eastern Asians including Chinese, Korean and Japanese (Gudykunst, 2001). However, the difference of communication styles based on subscales will not reflect the purpose of the study in assessing high/low context communication styles.

Table 1. Reliability of Communication Styles.

Subscale	Cronbach Alphas
Total	.84
<i>High Context Communication</i>	
Sensitivity	.74
Inferring Meanings	.87
Indirect	.88
Positive Perception of Silence	.81
<i>Low Context Communication</i>	
Nonverbal Expressiveness	.78
Using Feelings to Guide Behavior	.84
Communicator Image	.85
Precise	.73

Acculturation

The Asian American Multidimensional Acculturation Scale-European American (AAMAS-EA) was used to assess participants' involvement in European cultures that reflects a level of acculturation (Chung, Kim, & Abreu, 2004). The scale contains 15 items, with a 6-point rating scale ranging from 1 (*not very much*) to 6 (*very much*). The scale has four subscales: acculturation identity, acculturation language, acculturation

knowledge, and acculturation food. Reliabilities in this study were .91 on a total score. Subscale showed good internal consistencies: .87 for acculturation identity, .96 for acculturation language, .79 for acculturation knowledge, and .86 for acculturation food. .

Help Seeking Attitudes

The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; Mackenzie et al., 2006) is a 24-item measure consisting of three subscales: (a) psychological openness, (b) help seeking propensity, and (c) indifference to stigma. Each item consists of a statement scored on a 5-point rating scale ranging from 1 (*disagree*) to 5 (*agree*). This measurement was used to assess participants' help seeking attitudes for mental health services. David (2010) used this scale for Filipino Americans, and he reported reliability of subscales: .88 for psychological openness, .84 for help seeking propensity, .76 for indifference to stigma. Reliability for total items in this study was .88. Subscales' internal consistencies were .79 for psychological openness, .80 for help seeking propensity, and .84 for indifference to stigma.

Working Alliance

Client– counselor working alliance was assessed via participant self-report using the 12-item Working Alliance Inventory (WAI-SF; Tracey & Kokotovic, 1989). This is 7-point rating scale and assesses participants' perception of the relationship with their therapists. This measurement has been used with Asian Americans and the reliability for total items was .93 (Meyer, Zane, & Cho, 2011). Cronbach alpha for a total score was .92 in this study. The scale consists of three subscales: task, bond and goal. Internal consistencies for subscale in this study were .87 for task, .89 for bond, and .69 for goal.

Analysis

SPSS 18.0 and Amos Structured Equation Program 18.0 were utilized for statistical analysis. T-test were conducted to determine if there were significant differences based on gender, ethnic groups and therapy status. Multivariate normality is recommended for path analysis that includes ANOVA and MANOVA (Thompson, 2000). The number of participants in each ethnic group were fewer than 10 except for Chinese. Thus, group differences among all ethnic groups were not conducted. Instead, participants were divided into two groups, Chinese and non-Chinese, for conducting T-test to determine group effect on data. Participants were also divided by whether they were in on-going therapy when they responded to the survey or they were not currently in therapy when completing the survey.

Bivariate regression and correlation were conducted to determine relationships between variables for both total scores and subscales. The purpose of this analysis to identify influential relationships among variables and define liner relationship between predictive variables and a criterion variable. This analysis is also beneficial to explore factors that contribute to results of path analysis with latent variables.

Confirmatory Factor Analysis was conducted to assess the adequacy of the measurement model as the step in path analysis with latent variables. When conducting factor analytic model, confirmatory factor analysis was a necessary step to select latent variables for model testing (Hatcher, 1994). Chi- square, the root mean square error of approximation (RMSEA) and the Comparative –fit index (CFI) were utilized for analysis.

Good model fit for Chi-square must have larger than .05 on its p value, smaller than .05 on RMSEA, and larger than .9 on CFI (Hatcher, 1994; Kelly, & Lai, 2011).

Maximum likelihood estimation was used for structural modeling procedures for model 1 and model 2. Chi square, normed-fit index (NFI), Tucker Lewis Index (TLI), CFI, and RMSEA were utilized for determining model fitness. NFI were suggested to state that the cut-off criteria should be more than .9 (Hu & Bentler, 1999). Good fit for TLI score should be closer to 1 and cut off score is .9. CFI show have a value greater than .9 is needed for indication of good fitness (Hu, & Bentler, 1999). Adequate models should show an RMSEA of approximately .08 or less (Martens, 2005).

CHAPTER IV

RESULTS

Preliminary Analyses

Three preliminary analyses were conducted to examine if there were differences due to group status, including gender, ethnic group and therapy status on communication styles, The Asian American Multidimensional Acculturation Scale-European American (AAMAS-EA), the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS), and Working Alliance Inventory (WAI). Data were divided into male and female groups and t-tests were conducted for all measurements. In regarding to ethnic group analysis, data were divided into Chinese and non-Chinese groups since Chinese were the largest participants and the only ethnic group to contain more than 30 participants. T-tests were conducted for all measurements. Lastly, data were divided into participants who were in therapy or not when they responded to the survey, and t-tests were again used.

In terms of gender group, there were statistically significant differences in the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS). Female participants scored higher on psychological openness, $t(121) = -2.31, p = .023$, and they also scored higher on indifference to stigma, $t(121) = -2.04, p = .044$. Male participants were less open to sharing their mental health concerns ($M = 23.28, SD = 5.86$) than

female participants ($M = 25.87, SD = 6.58$). Male participants presented with higher stigma in seeking mental health services ($M = 24.22, SD = 6.61$) than female participants ($M = 26.69, SD = 6.78$). In addition, the total score on the IASMHS was significantly higher for male than female participants, $t(120) = -2.00, p = .048$. Male participants scored lower on their attitudes in seeking help ($M = 77.65.95, SD = 13.29$) compared to female participants ($M = 82.96, SD = 14.34$). The rest of the scales did not show statistically significant differences based on gender group, including communication styles, The Asian American Multidimensional Acculturation Scale-European American (AAMAS-EA), the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS), and Working Alliance Inventory. By ethnic group, no scores were different based on Chinese or non-Chinese group.

By therapy status, there were statistically significant differences in subscales of Communication Style: precise, $t(128) = -2.04, p = .043.$, nonverbal expressiveness, $t(129) = 2.13, p = .035.$, and indirect, $t(127) = 2.32, p = .022$. Participants who were in ongoing therapy express themselves less precisely ($M = 20.37, SD = 4.59$) than participants who were not currently in therapy ($M = 21.95, SD = 4.15$). Participants who were in ongoing therapy appeared to have more frequent communication by using nonverbal expression ($M = 16.24, SD = 3.59$) compared to participants who were not currently in therapy ($M = 14.73, SD = 4.48$). Likewise, participants who were in ongoing therapy communicate indirectly ($M = 14.93, SD = 5.88$) more than participants who were not currently in therapy ($M = 12.68, SD = 4.94$). There was a statistically significant difference in acculturation language $t(129) = -3.12, p = .002$ depending on participants' therapy status.

Participants who were in ongoing therapy were rated as less acculturated in their English language ($M = 15.74$, $SD = 3.47$) compared to participants who were not in therapy ($M = 17.27$, $SD = 1.64$).

Influential Relationships between Variables

Correlation among all subscales of communication styles, help seeking attitudes, acculturation and working alliance were reported in Table 2.

Correlations among total scores of utilized measurements are reported in Table 3. Most inter-correlations among communication styles, help seeking attitudes, acculturation and working alliance showed significant correlations, ranging from weak to strong correlations. However, communication styles and help seeking attitudes did not show a significant relationship.

Table 2. Means, Standard Deviations, and Correlations of All Variables.

Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. COM_precise	21.10	4.45	1																	
2. COM_nonverbal	15.55	4.08	.140	1																
3. COM_communicator	20.11	4.96	.242**	.156	1															
4. COM_inferring	20.95	4.89	.439**	.150	.566**	1														
5. COM_indirect	13.88	5.56	-.185*	.104	-.233**	-.259**	1													
6. COM_interpersonal	17.38	3.58	.399**	.064	.395**	.573	-.251**	1												
7. COM_guide	23.80	5.54	.263**	.320**	.388**	.408**	.041	.364**	1											
8. COM_silence	17.37	4.32	.082	-.105	.287**	.079	-.142	.213*	.006	1										
9. HS_openess	24.40	6.28	-.240--	.008	.074	.014	-.393**	.049	-.054	.168	1									
10. HS_helpseeking	30.34	5.15	.201*	.159	.299**	.394**	-.338**	.525**	.383**	.106	-.171	1								
11. HS_stigma	25.41	6.90	-.075	.009	.138	.171	-.341**	.117	.144	.293**	.579**	.306**	1							
12. AC_identity	25.74	6.08	.097	.005	.299**	.260**	-.228*	.385**	.187*	.035	-.081	.375**	-.156	1						
13. AC_language	16.43	2.90	.320**	-.108	.089	.251**	-.426**	.264**	.101	.079	-.121	.334**	-.145	.357**	1					
14. AC_knowledge	18.86	3.71	.156	.077	.309**	.239**	-.161	.370**	.355**	.150	-.189*	.351**	-.178*	.705**	.458**	1				
15. AC_food	9.32	2.37	.034	.079	.127	.109	-.052	.130	.213*	-.089	-.128	.189*	-.131	.642**	.333**	.705**	1			
16. WA_task	19.96	4.59	.151	.109	.251**	.292**	-.178*	.368**	.323**	.129	-.222*	.604**	-.350**	.268**	.290**	.329**	.218*	1		
17. WA_bond	20.25	4.80	.117	.119	.294**	.368**	-.211*	.390**	.287**	.112	-.258**	.612**	.336**	.292**	.235**	.356**	.223*	.858**	1	
18. WA_goal	19.63	4.24	.212*	.073	.272**	.316**	-.416**	.431**	.201*	.113	.279**	.636**	-.407**	.243**	.246**	.287**	.111	.686**	.688**	1

Note: N = 122. COM_precise = Communication Styles Precise, COM_nonverbal = Communication Styles Nonverbal Expressiveness, COM_communicator = Communication Styles Communicator Image, COM_inferring = Communication Styles Inferring Meanings, COM_indirect = Communication Styles Indirect, COM_interpersonal = Communication Styles Interpersonal Sensitivity, COM_guide = Communication Styles Using Feelings to Guide Behavior, COM_silence = Communication Styles Positive Perceptions of Silence, HS_openess = Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) Psychological Openness, HS_helpseeking = IASMHS Help Seeking Propensity, HS_stigma = IASMHS Indifference to Stigma, AC_identity = Asian American Multidimensional Acculturation Scale European American (AAMAS-EA) Acculturation Identity, AC_language = AAMAS-EA acculturation language, AC_knowledge = AAMAS-EA acculturation knowledge, AC_food = AAMAS-EA acculturation food, WA_task = Working Alliance Inventory (WAI) Task, WA_bond = WAI Bond, and WA_goal = WAI Goal. ** $p < .01$. * $p < .05$.

Table 3. Means, Standard Deviations, and Correlations of All Scales with Total Scores.

Variable	<i>M</i>	<i>SD</i>	Communication	Help Seeking	Acculturation	Working Alliance
Communication	150.50	18.79	1			
Help Seeking	80.42	14.00	.148	1		
Acculturation	70.54	12.26	.242**	.305**	1	
Working Alliance	59.84	12.43	.331**	.567**	.349**	1

Note. *N* = 122. Communication = Communication Styles, Help Seeking = Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), Acculturation = Asian American Multidimensional Acculturation Scale European American (AAMAS-EA) and Working Alliance = Working Alliance Inventory. ** *p* < .01. * *p* < .05.

Analysis of Working Alliance as Criterion Variables

Multiple regression was conducted between total and subscales of working alliance, communication styles, help seeking attitudes, and acculturation. Working alliance was defined as the criterion variable and communication styles, help seeking attitudes, and acculturation were stated as predictive variables. The results indicated that the total score of working alliance is predicted by communication style, help seeking, and acculturation (Table 4). The regression equation was significantly related to the working alliance, $R^2 = .37$, $F(3,113)=22.39$, $p < .01$.

Table 4. Working Alliance Predicted by Communication Style, Help Seeking Attitude, and Acculturation.

Variable	<i>b</i>	<i>sr</i> ²	<i>b</i>
Communication	0.234*	0.051	0.155
Help Seeking	0.485**	0.215	0.424
Acculturation	0.101	0.009	0.100

Note. *N* = 117, ** *p* < .01. * *p* < .05.

The prediction model of the task of working alliance predicted by all subscales of communication styles, help seeking, and acculturation was analyzed (Table 5). The result indicated that the prediction model was statistically significant, $R^2 = .41$, $F(15,101)=4.61$,

$p = .000$. However, the help seeking scale in IASMHS was the only statistically significant factor to contribute to the task.

Table 5. A Task of Working Alliance Predicted by All Substances of Communication Style, Help Seeking Attitude, and Acculturation.

Variable	b	sr^2	b
COM_precise	-0.003	0.000	-0.003
COM_nonverbal	-0.026	0.000	-0.028
COM_communicator	0.134	0.009	0.120
COM_infering	-0.055	0.000	-0.051
COM_indirect	0.117	0.007	0.095
COM_interpersonal	0.066	0.002	0.084
COM_guide	0.021	0.000	0.018
COM_silence	-0.041	0.001	-0.041
HS_openness	0.050	0.000	0.050
HS_helpseeking	0.489**	0.137	0.489
HS_stigma	0.194	0.020	0.194
AC_identity	-0.114	0.005	-0.114
AC_language	0.034	0.000	0.034
AC_knowledge	0.101	0.002	0.101
AC_food	0.028	0.000	0.028

Note. N = 117, ** $p < .01$. * $p < .05$.

The prediction model of the bond in working alliance predicted by all subscales of communication styles, help seeking, and acculturation was analyzed (Table 6). The prediction model was statistically significant, $R^2 = .44$, $F(15,101)=5.28$, $p < .01$. However, the help seeking in IASMHS was the only statistically significant factor to contribute to the bond.

Table 6. A Bond of Working Alliance Predicted by All Subscales of Communication Style, Help Seeking Attitude, and Acculturation.

Variable	b	sr^2	b
COM_precise	-0.025	0.000	-0.029
COM_nonverbal	-0.022	0.000	-0.026
COM_communicator	0.097	0.005	0.094
COM_infering	0.069	0.004	0.069
COM_indirect	0.045	0.007	0.040
COM_interpersonal	0.060	0.001	0.083
COM_guide	-0.067	0.001	-0.060
COM_silence	-0.054	0.003	-0.058
HS_openness	0.085	0.002	0.064
HS_helpseeking	0.487**	0.004	0.450
HS_stigma	0.132	0.135	0.092
AC_identity	-0.133	0.009	-0.104
AC_language	-0.079	0.006	-0.139
AC_knowledge	0.204	0.001	0.265
AC_food	0.049	0.000	0.100

Note. N = 117, ** $p < .01$. * $p < .05$.

The predictor model of the goal of working alliance, predicted by all subscales of communication styles, help seeking, and acculturation, was analyzed (Table 7). The regression equation was significantly related to the goal of working alliance, $R^2 = .51$, $F(15,101)=6.93$, $p < .01$. However, the help seeking in IASMHS was the only statistically significant factor contribute to the goal.

Table 7. A Goal of Working Alliance Predicted by All Subscales of Communication Style, Help Seeking Attitude, and Acculturation.

Variable	b	sr^2	b
COM_precise	0.099	0.007	0.099
COM_nonverbal	-0.025	0.000	-0.026
COM_communicator	0.149	0.012	0.125
COM_infering	-0.105	0.005	-0.089
COM_indirect	-0.155	0.013	-0.117
COM_interpersonal	0.140	0.009	0.167
COM_guide	-0.106	0.006	-0.083
COM_silence	-0.146	0.001	-0.137
HS_openness	0.023	0.000	0.015
HS_helpseeking	0.198**	0.223	0.400
HS_stigma	0.201	0.002	0.122
AC_identity	-0.167	0.010	-0.114
AC_language	-0.094	0.005	-0.144
AC_knowledge	0.246	0.002	0.276
AC_food	-0.117	0.005	-0.205

Note. N = 117, ** $p < .01$. * $p < .05$.

Testing Models

The path analyses with latent variables were conducted in order to test the major hypothesis of the study. The result indicated a poor fit for hypothetical model 1. The reported score was $\chi^2 (131, n = 122) = 348.95, p < .001$; NFI = .70; TLI = .71; CFI = .78; RMSEA = .11 (Figure 3). Thus, latent variables were analyzed for fitness of manifest variables. The model 2 also indicated a poor fit. The score was $\chi^2 (129, n = 122) = 326.01, p < .001$; NFI = .71; TLI = .73; CFI = .80; RMSEA = .10 (Figure 4).

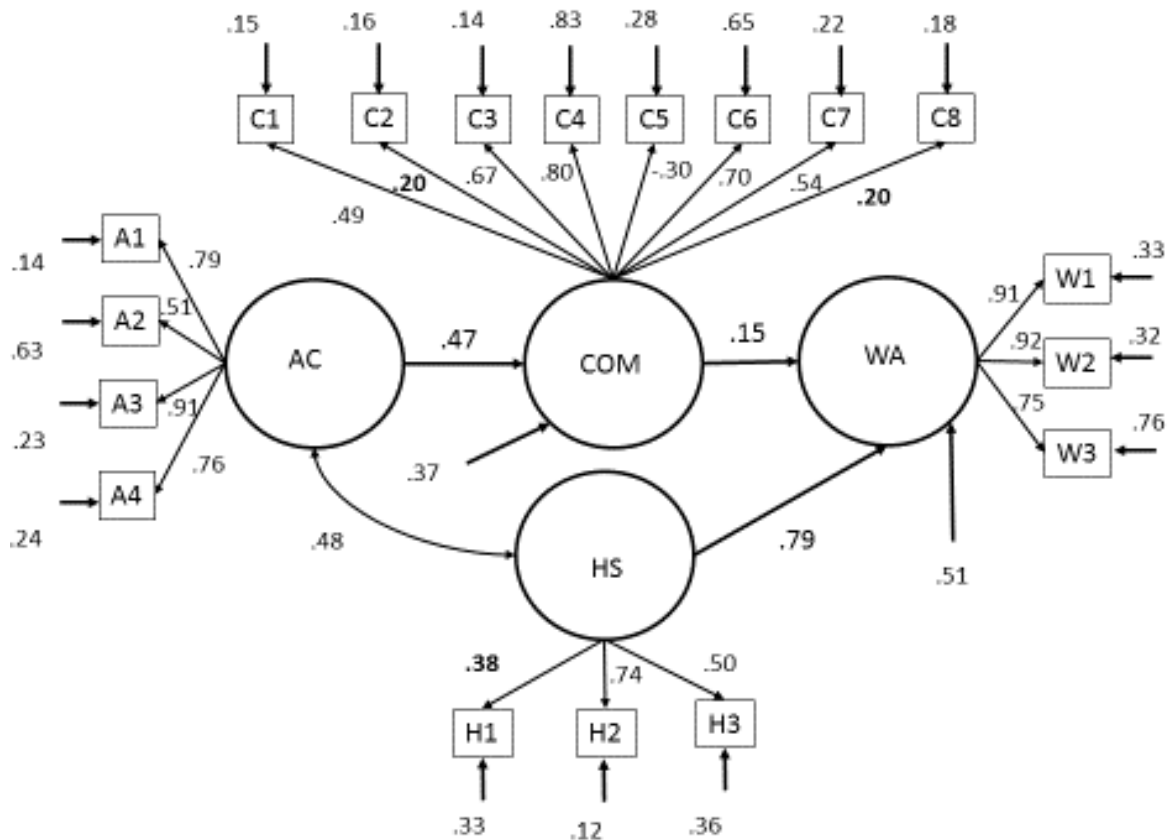


Figure 3. Theoretical Model 1. N =122. Latent variables: COM = Communication Styles, HS = Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), AC = Asian American Multidimensional Acculturation Scale European American (AAMAS-EA) and WA = Working Alliance Inventory. Manifest variables: C1 = Precise, C2 = Nonverbal expressiveness, C3 = Communicator image, C4 = Inferring meanings, C5 = Indirect, C6 = Interpersonal sensitivity, C7 = Using feelings to guide behavior, C8 = Positive perceptions of silence, H1 = Psychological openness, H2 = Helpseeking propensity, H3 = Indifference to stigma, A1 = Cultural identity, A2 = Language, A3 = Cultural knowledge, A4 = Food, W1 = Task, W2 = Bond, and W3 = Goal. Bold numbers indicate standard coefficient with $p < .05$.

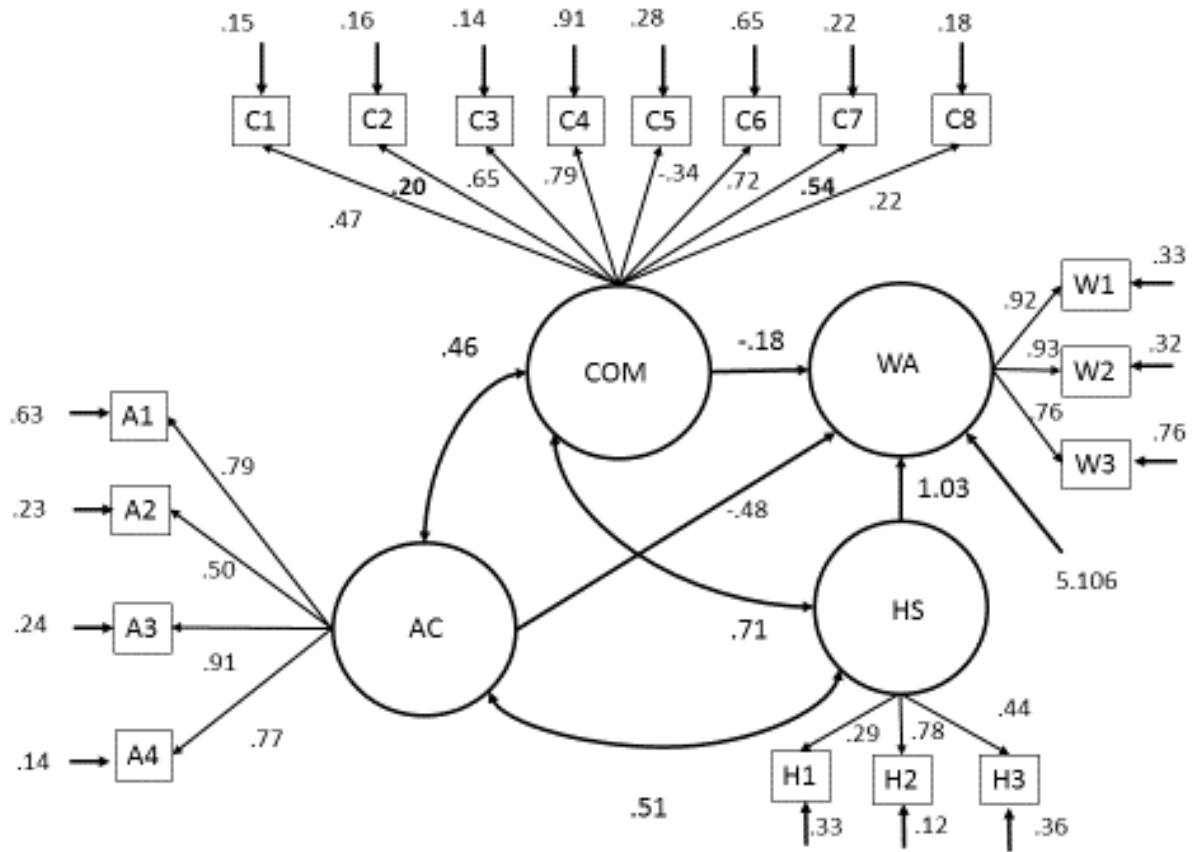


Figure 4. Theoretical Model 2. N =122. Latent variables: COM = Communication Styles, HS = Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), AC = Asian American Multidimensional Acculturation Scale European American (AAMAS-EA) and WA = Working Alliance Inventory. Manifest variables: C1 = Precise, C2 = Nonverbal expressiveness, C3 = Communicator image, C4 = Inferring meanings, C5 = Indirect, C6 = Interpersonal sensitivity, C7 = Using feelings to guide behavior, C8 = Positive perceptions of silence, H1 = Psychological openness, H2 = Helpseeking propensity, H3 = Indifference to stigma, A1 = Cultural identity, A2 = Language, A3 = Cultural knowledge, A4 = Food, W1 = Task, W2 = Bond, and W3 = Goal. Bold numbers indicate standard coefficient with $p < .05$.

Analyses of Measures as Latent Variables

Confirmatory Factor Analysis was conducted to determine if the latent variables (Communication, Help seeking attitudes, Acculturation and Working alliance) were appropriately measured by their indicators (Table 8). The result indicated poor fit

between communication and acculturation. This means each scale might include items with low factor loading for latent variables.

Table 8. Confirmatory Factor Analysis for Measures of Communication Styles, Help Seeking, Acculturation and Working Alliance.

Measure	Chi-square (X^2)	RMSEA	CFI
Communication	1284.28**	0.085	0.751
Help Seeking	407.37**	0.067	0.841
Acculturation	282.92**	0.130	0.873
Working Alliance	125.00**	0.102	0.932

Note. N = 122, ** $p < .01$.

Stepwise Multiple Regression as Post-Hoc Analysis

Since the proposed models were not supported, stepwise multiple regression was conducted to identify predictive variables uniquely contributing to the working alliance. Among subscales of high/low context communication styles, correlations were observed among the high context subscales (See Table 9).

Table 9. Inter-correlation between Subscales of High Context Communication Style.

	COM_infering	COM_indirect	COM_interpersonal	COM_silence
COM_infering	1	-.259**	.573**	.079
COM_indirect		1	-.251**	-.142
COM_interpersonal			1	.213*
COM_silence				1

Note. N = 117, ** $p < .01$. * $p < .05$.

Those relationships suggest that the measurement for communication style should be explored based on subscales rather than total scores. Indirect is negatively correlated with interpersonal and silence. Those three concepts were high context communication style, and those subscale were confounded. According to the result of multiple

regression above, interpersonal sensitivity appeared to have the strongest influence on the working alliance. Based on these findings, stepwise multiple regression was conducted to define unique contribution for interpersonal sensitivity to working alliance. The model was statistically significant, $F(3, 115) = 24.551, p < .001$, and accounted for approximately 40% of the variance of working alliance ($R^2 = .39$, Adjusted $R^2 = .375$).

Table 10. Stepwise Regression Analysis of Acculturation, Help Seeking and Interpersonal Sensitivity on Working Alliance.

Variable	b	sr^2	b
Acculturation	0.073	0.067	0.073
Help seeking	0.401	0.430	0.457
Interpersonal Sensitivity	0.947	0.251	0.274

Note. N = 119

With the sizeable correlations between the predictors, the unique variance explained by each of the variables indexed by the squared semipartial correlations, was low to moderate: acculturation, help seeking, and interpersonal sensitivity uniquely accounted for approximately 6.7%, 43%, 25.1% of the variance, respectively. Inspection of the structure coefficients suggests that help seeking and interpersonal sensitivity in a high context communication style were very strong indicators of working alliance.

CHAPTER V

DISCUSSION

Interpretations

Forming therapeutic relationships involves multiple factors that appear to influence the process of psychotherapy. Past studies about Asian Americans have been conducted on racial differences, help seeking behaviors, and acculturation. Although forming a therapeutic relationship is facilitated by communication between clients and their therapists, none of these studies focused on communication styles among Asian Americans. Thus, the purpose of this study was to explore communication styles and how they influence Asian Americans in psychotherapy. This study examined how Asian Americans' unique factors influence relationships between therapists and Asian American clients.

The results of inter-correlation between latent variables showed influential relationships. Communication styles appeared to have a significant relationship with therapeutic working alliance. This means communication styles can be a predictor for therapeutic working alliance among Asian Americans. Past studies only focused on Asian American clients' perception about therapists in regard to therapeutic working alliance (Kim, Zane, & Blozis, 2012; Zane et al, 2005). Thus, this study identified communication styles as a new factor influencing therapeutic working alliance.

Participants' attitudes in seeking professional help were also a predictor for therapeutic working alliance. When Asian Americans are open to utilize mental health professionals, a working alliance between Asian American clients and their therapists increased. Furthermore, both communication styles and help seeking attitudes were predicted by acculturation. This means a presence of cultural and individual components were predictors for attitudes to seek professional help and their ways to express concerns to their therapists. Inter- correlations showed factors of communication, acculturation, and help seeking attitudes were predictors for therapeutic working alliance among Asian Americans.

However, poor fit in confirmatory factor analysis on each scale was observed in analysis. Scales including communication styles, acculturation, help seeking attitudes, and working alliance did not capture latent variables as predicted. Although internal consistency for all scales showed good psychometric properties with significant inter-correlation between scales, path analysis with latent variables did not show statistically meaningful relationships. Consequently, relationships between latent variables in observed models did not fit with any theorized model.

Among those predicted variables, help seeking attitudes was a strong predictor for therapeutic working alliance. This finding is consistent with and also extends previous research. Although the intention to hide negative or distressing secrets was previously identified as a barrier to forming a therapeutic working alliance (Masuda, & Boone, 2011), openness to seek professional help might be a factor for therapeutic

working alliance among Asian Americans. Therefore, help seeking attitudes are important factors when forming a therapeutic working alliance.

In addition, according to the post hoc analysis, interpersonal sensitivity in high context communication style was the strongest factor in predicting therapeutic working alliance, along with acculturation and help seeking attitudes. The result suggested that forming therapeutic working alliance was dependent on the degree of client's interpersonal sensitivity such as following flow of conversation, awareness of own impact on others, and active listening. Therefore, the client's openness to seeking help and their interpersonal skills appeared to be vital factors in forming therapeutic relationship among Asian American clients.

Furthermore, acculturation appeared to be less impact on working alliance when compared to communication and help seeking attitudes. An average of acculturation level was relatively high ($M = 70.54$, possible range 0-90). Participants' high level of acculturation might be one possible explanation for the limited effect acculturation.

In summary, the results showed statistically significant relationships between communication styles, acculturation, help seeking attitudes and working alliance among Asian Americans. Inter-correlations between latent variables were mostly consistent with the literature. Multiple regression indicated that communication styles, acculturation and help seeking attitudes were significantly accounted for by therapeutic working alliance. While observed models in this study did not fit theoretical models, a poor fit in confirmatory factor analysis on each scale appeared to affect the result. The post hoc

analysis indicated that interpersonal skills in communication styles and one's openness in seeking help are important factors for therapeutic working alliance.

Limitations

Small sample sizes across ethnic groups prevented analysis of ethnic group differences, thus making it impossible to assess whether ethnicity influenced scores on each scale. For instance in communication styles, Southern Asians are more openly expressive while Eastern Asians value being silent when interacting with others (Gudykunst, 2001). Those cultural differences can reflect their response to communication styles. In this way, different values potentially yield different results in acculturation, help seeking attitudes, and working alliance. Those differences could influence internal consistencies in measurements, and different statistical relationships between latent variables. Therefore, group analysis is a vital step to analyze a result. However, due to a small sample with various ethnic groups in the current study, only Chinese and non-Chinese comparison was conducted. Existence of ethnic groups among Asian Americans potentially confound the results.

The utilized measurements appeared to present psychometric issues. All scales in this study have been previously utilized and reported good internal consistencies (Chung, Kim, & Abreu, 2004; David, 2010; Gudykunst, 2001; Myeer, Zane, & Cho, 2011). However, although all tested scales also showed mostly good internal consistencies in this study, none of the scales have tested confirmatory factor analysis for Asian American samples in the past. According to the result of confirmatory factor analysis, all measurements showed poor fits. This means items in each measurement did not

psychometrically support the expected latent variables. Potential explanation might be a heterogeneous sample in this study. Due to a small sample of each ethnic group, further analysis is limited to explore psychometric issues. Consequently, psychometric issues in utilized measurements remained in the present study.

Overall, this study's limitations were sample size and measurements. Since various ethnic groups were in the data, cultural differences potentially influenced the result. In addition, utilized measurements showed poor fit in confirmatory factor analysis. Small sampling of each ethnic group prevented from analyzing group effect. Thus, sample size and measurement issues limit exploring reasons for a poor fit in observed models.

Clinical Implications

This study explored Asian Americans' unique factors in psychotherapy. Interactions between those factors have not been studied. Interpreted results showed important relationships between those factors. Clinical implications are discussed in regard to working alliance, communication styles, and help seeking attitudes.

The study supported the recommendation that therapists must consider communication styles, acculturation levels, and help seeking attitudes when they form working alliance with Asian American clients. Regardless of types of treatment, working alliance is considered to be a strong predictor for therapeutic outcomes (Horvath, Del Re, Fluckiger, & Symonds, 2011). Three factors, including communication styles, attitudes to seek professional help, and acculturation, were important factors to therapeutic working alliance although observed models did not support theoretical models.

Therefore, therapists should consider those factors in forming working alliance regardless of types of treatment therapists provide.

Clients' interpersonal sensitivity in communication styles must be focused when therapists establish relationship with Asian American clients. The current literature in culturally sensitive therapy focused on cultural differences between clients and therapists, which can potentially create a barrier in forming therapeutic relationship. For instance, Sue (2008) stated that culturally specific presentation may potentially have unknown issues and concerns hidden by cultural differences. Based on an assumption of cultural differences, discussing cultural differences in the stage of forming relationship has been encouraged and facilitate therapeutic working alliance. However, the result of this study indicated that interpersonal skills in communication rather than other Asian specific communication styles was a predictor for therapeutic working alliance. Thus, when forming relationship, interpersonal sensitivity and openness in seeking help must be a primary focus rather than cultural differences. Facilitating one's openness in seeking professional help and acknowledging their interpersonal skills were keys to form therapeutic relationship. Cultural difference must be focused when interpreting collected information for case formulation. Clarifying clients' reports and cultural implication are necessary in understanding clients' presenting issues.

Previous research has demonstrated that help seeking attitudes are associated with clients' stage of change. Norcross, Krebs and Prochaska (2011) stated that clients' readiness of change requires matching process in psychotherapy and therapeutic relationships. Selecting therapeutic activities based on clients' readiness while forming

therapeutic relationships is necessary process to facilitate change in clients. The findings of the current study indicated that help seeking attitudes are particularly strong factors influencing the working alliance among Asian American clients. This means client factors could strongly impact working alliance because Asian American clients who openly seek professional help tend to show high therapeutic working alliance. Discussing clients' attitudes and stigma in seeking professional help might increase clients' openness to therapists. In this way, they form therapeutic working alliance which can also facilitate clients' readiness for change. Therefore, focusing help seeking attitudes in psychotherapy in early treatment can increase working alliance that facilitate clients' change.

In conclusion, the study provided new factors that can contribute to working alliance among Asian American clients. Regardless of clinical approach, communication styles, acculturation and help seeking attitudes should be considered in forming working alliance. Interpersonal sensitivity must be primary focus in the stage of forming relationship rather than focusing on cultural differences between clients and therapists. Approaching help seeking attitudes could facilitate working alliance and progression in stage of change in psychotherapy. Hence, this study identified a crucial field in psychotherapy research for Asian Americans.

Future Research

Conducting psychology research in Asian Americans is challenging because of Asian Americans' various backgrounds and history, which represent each Asian group uniquely. Sampling issues and a lack of psychometrically tested measurements require

more research in Asian Americans. Due to those issues, Sue (1999) discussed unclear association between one Asian group, Asian Americans, and White mainstream populations prevents scientists from generalizing theories established in their studies. Scientists have struggled with constructing theories from past Asian American studies, which becomes a barrier to conducting further research.

This study suggested a new agenda to fulfill gaps between proposed theories and observed results. The results of the study and limitation highlight what is needed to analyze relationships between an Asian ethnic group and Asian Americans, and determining utilized scales. Four steps were defined for future studies: ethnic group analysis, determination for generalizability, establishing psychometric properties, and analyzing internal consistencies in working alliance inventory.

The first step is to explore differences between ethnic groups in Asian Americans. Although Asian Americans appeared to engage in a high context communication, their expressions can be different depending on their ethnic groups. Their cultural values can affect scores in measurements. This determination should also expand to help seeking attitudes, acculturation, and working alliance because of results from confirmatory factor analysis. Group analysis provides culturally specific factors in each ethnic group and this step reflects uniqueness in psychotherapy among Asian Americans.

This leads to a step to determine generalizability from each ethnic group to Asian Americans in communication styles. Conflicting values among Asian American group could cause inconsistent results, and culture specific factors may be hidden for a specific Asian group. Therefore, this investigation would lead a selection of population for future

research, Asian Americans or an Asian ethnic group in order to prevent marginalization in Asian American research.

In addition, each scale should be examined to assess its psychometric properties for Asian American populations and each ethnic group. Due to cultural differences between ethnic groups in Asian Americans, testing psychometric properties by each group is necessary because each scale presented a poor fit when conducting confirmatory factor analysis. This means each scale requires further analysis including item performance, factor loadings with exploratory factor analysis (DeVellis, 2012). Based on this analysis, revising and removing items might be necessary and this process requires additional data collection. Then, confirmatory factor analysis should be completed in another sample to confirm fitness for latent variables. While this process requires extensive work, establishing psychometric properties would inform culture specific factors and universal factors in Asian Americans. Therefore, analyzing scales is a necessary process.

Furthermore, the therapeutic goal in working alliance require further analysis due to a low internal consistency. In addition to ethnic group and psychometric property analysis, exploring reasons for termination in psychotherapy potentially provide reasons for low internal consistency for working alliance inventory. Analysis of groups defined by reasons for termination could potentially demonstrate differences in strength of the working alliance. Unfortunately, this study did not explore reasons to terminate psychotherapy. Some participants may terminate sessions due to financial difficulties,

moving out, personality mismatch, etc. Those factors also impact therapeutic goal in working alliance; thus, analyzing goals in working alliance is necessary.

Finally, the study provided important guidance for future research. Determining generalizability in communication styles, acculturation, help seeking attitudes and working alliance is necessary to conduct further research. Establishing psychometric properties in utilized measurements potentially provides culture specific factors and universal factors in Asian Americans. Therapeutic goal in working alliance requires further analysis due to potential reasons for termination. Hence, the study discovered other unknown phenomena in psychotherapy that leads to continuous research in Asian Americans.

APPENDICES

APPENDIX A
DEMOGRAPHIC QUESTIONS

1. Please indicate your age.
2. Please indicate your nationality.
3. What is your highest education?
 - No schooling completed
 - Nursery school to 8th grade
 - Some high school, no diploma
 - High school graduate, diploma or the equivalent (for example: GED)
 - Some college credit, no degree
 - Associate degree
 - Bachelor's degree
 - Master's degree
 - Professional degree
 - Doctorate degree
3. Please indicate which best describes your ethnic/racial background.
 - Chinese
 - Korean
 - Vietnamese
 - Indian
 - Filipino
 - Japanese
 - Thai
 - Malaysian
 - Singaporean
 - Other _____
4. Which best describes your gender identity ?
 - Male
 - Female
 - Transgender
 - Other _____

5. Which best describes how you self-identify in terms of sexual orientation?

Heterosexual

Bisexual

Lesbian

Gay

Other_____

7. What was your therapist race/ethnicity? If you have several, pick one you saw most recent.

White/Caucasian

Black/African American

Hispanic/Latin

Native American/American Indian

Asian/Pacific Islander

Don't know

Multiracial / Other (please specify)

8. Are you currently...?

Employed for wages

Self-employed

Out of work and looking for work

Out of work but not currently looking for work

A homemaker

A student

Military

Retired

Unable to work

9. Are you currently in therapy? If not, how much time passed since termination?

APPENDIX B

COMMUNICATION STYLES

Direction: Choose a response that fits your communication styles: Strongly Disagree, Disagree, Somewhat Disagree, Neutral, Somewhat Agree, Agree, Strongly Agree

1. I try to be accurate when I communicate.
2. When I engage in discussion, I try to cover all possible issues.
3. I do not like interacting with others who do not give a firm 'yes' or 'no' response to questions.
4. I am a very precise communicator.
5. In arguments, I insist on very precise definitions.
6. People always seem to know my moods from my nonverbal behavior.
7. People can easily read my emotional state from my facial expressions.
8. When I strongly feel an emotion, I show it.
9. I show my anger when people make me angry.
10. The way I communicate influences my life positively.
11. I am a very good communicator.
12. I find it easy to communicate with strangers.
13. In a small group of strangers, I am a very good communicator.
14. I find it easy to maintain a conversation with a member of opposite sex whom I just met.
15. I catch on to what others mean even if they do not say it directly.
16. I am able to recognize subtle and indirect messages.
17. I am very good at knowing the feelings other people are experiencing.
18. Even if I do not receive a clear and definite response from others, I can understand what they intend.
19. Usually, I can read another person 'like a book.'
20. I am evasive when I communicate with others.
21. I communicate in an indirect fashion.
22. I am ambiguous when I communicate with others.
23. When pressed for an opinion, I respond with an ambiguous position.

24. Others have to guess what I mean when we communicate.
25. I maintain harmony in my communication with others.
26. I qualify (e.g., use 'maybe' 'perhaps') in my language when I communicate.
27. When I turn down an invitation, I make sure that the other person is not offended.
28. I listen carefully to people when they talk.
29. If I have something negative to say to others, I will be tactful.
30. I use my feelings to determine how I should communicate.
31. I listen to what my 'gut' or 'heart' says in many situations.
32. I use my feelings to guide my behavior more than most people.
33. I orient to people through my emotions.
34. My emotions tell me what to do in many situations.
35. I find silence awkward in conversations with people I've just met.
36. I can sit with another person, not say anything, and still be comfortable.
37. I feel comfortable with silences in conversations.
38. I do not like conversational silences.

APPENDIX C

INVENTORY OF ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES (IASMHS)

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

1. There are certain problems which should not be discussed outside of one's immediate family
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know everything about oneself.
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
9. People should work out their own problems; getting professional help should be a last resort.
10. If I were to experience psychological problems, I could get professional help if I wanted to.
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

12. Psychological problems, like many things, tend to work out by themselves.
13. It would be relatively easy for me to find the time to see a professional for psychological problems.
14. There are experiences in my life I would not discuss with anyone.
15. I would want to get professional help if I were worried or upset for a long period of time.
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.
17. Having been diagnosed with a mental disorder is a blot on a person's life.
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.
20. I would feel uneasy going to a professional because of what some people would think.
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

APPENDIX D

ASIAN AMERICAN MULTIDIMENSIONAL ACCULTURATION SCALE- EUROPEAN AMERICAN (AAMAS-EA)

Instructions: Use the scale below to answer the following questions. Please circle the number that best represents your view on each item.

Not very well Somewhat Very well
1 2 3 4 5 6

1. How well do *speak* the language of English?
2. How well do you *understand* the language of English?
3. How well do you *read and write* in the language of English?
4. How often do you *listen to music or look at* movies and magazines from the White mainstream groups?
5. How much do you *like* the food of the White mainstream groups?
6. How often do you *eat* the food of the White mainstream groups?
7. How *knowledgeable* are you about the history of the White mainstream groups?
8. How *knowledgeable* are you about the culture and traditions of the White mainstream groups?
9. How much do you *practice* the traditions and keep the holidays of the White mainstream culture?
10. How much do you *identify with* the White mainstream groups?
11. How much do you feel you *have in common with* people from the White mainstream groups?
12. How much do you *interact and associate with* people from the White mainstream groups?

13. How much *would you like to* interact and associate with people from the White mainstream groups?

14. How *proud are you* to be part of the White mainstream groups?

15. How *negative* do you feel about people from the White mainstream groups?

APPENDIX E

WORKING ALLIANCE

Instruction: Choose answer which describe the relationship between your therapist and you the best.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.
2. What I am doing in therapy gives me new ways of looking at my problem.
3. I believe my therapist likes me.
4. My therapist does not understand what I am trying to accomplish in therapy.
5. I am confident in therapist's ability to help me.
6. The therapist and I are working towards mutually agreed upon goals.
7. I feel that my therapist appreciates me.
8. We agree on what is important for me to work on.
9. My therapist and I trust one another.
10. My therapist and I have different ideas on what my problems are.
11. We have established a good understanding of the kind of changes that would be good for me.
12. I believe the way we are working with my problem is correct.

APPENDIX F

INFORMED CONSENT

The following information is provided for you to decide whether you wish to participate in the present study. Participation is strictly voluntary. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

I am interested in studying Asian Americans' communication, acculturation, and a sense of support. The purpose of this study is to determine how those factors apply to therapy. I am recruiting participants who identify themselves as Asian American and have experience using therapy.

If you participate in this study, you will respond to online survey that asks questions about communication, acculturation, and support as well as demographic questions. The survey will last 30-40 minutes.

There is no direct benefit to you from participation in this study; however, I believe that this study will increase a scientific understanding of communication, acculturation, and support. There is no known harm from answering the questionnaires. Your answers will always remain confidential. The only identifying information I may collect from you is your email address and ONLY if you decide to join a raffle for a \$50 Visa gift card. Your email address will be kept separate from your response. I will award two gift cards in the raffle and will discard the email address after the raffle is completed.

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies, the University of North Dakota Research Development and Compliance office, and the University of North Dakota Institutional Review Board.

If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research, you may contact the University of North

Dakota Institutional Review Board at (701) 777-4279. Please call this number if you cannot reach research staff, or if you wish to talk with someone else.

_____ I DO NOT give my consent to participate in this study.

_____ I DO consent to participate in this study. I have read and understood the above. I am aged 18 years or older, and identify myself as Asian American, and have experience in psychotherapy.

Sincerely,

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