

## **Chinese American Attitudes toward Therapy: Effects of Gender, Shame, and Acculturation**

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### **Abstract**

Due to traditional cultural values, Chinese Americans generally possess negative attitudes regarding professional interventions for mental health illness, even though these services have been effective in alleviating psychological distress. Shame, acculturation, gender, and age have been identified as factors that may contribute to the pessimistic attitudes towards therapy, but no empirical research has been conducted on this specific Asian American sub-group. The purpose of this study was to assess the association between these four variables and therapeutic attitudes among 119 Chinese American college students in the United States. Regression analyses confirmed shame, gender, and age as predictive of therapeutic attitudes. Women, older individuals, and those with lower levels of shame were found to have more positive attitudes toward therapy. Results can assist clinicians and mental health professionals to tailor services and strategies that fit the needs of Chinese Americans and support the challenges their clients have regarding the therapeutic experience.

**Key Words:** Chinese American, Therapy Attitudes, Shame, Gender, Acculturation

### ***1. Introduction***

In traditional Chinese culture, people who suffer from emotional and psychological problems have generally sought treatment using a variety of techniques, including seeking advice from an older family member, visiting a doctor, or homeopathic remedies such as acupuncture (Leung, Cheung, & Tsui, 2012). These treatment methods continue to be implemented by Chinese people living in the United States (Qian, Smith, Chen, & Xia, 2001), and using psychotherapy to alleviate mental illness and discomfort is still a relatively new phenomenon within Chinese communities living in the United States (Fang & Wong, 1998). According to the U.S. Census Bureau (2008), Chinese Americans represent the largest Asian group living in the U.S., but they tend to underutilize professional mental health services when dealing with depression and other psychiatric problems (Spencer & Chen, 2004). Although therapy has been shown to be an effective treatment for a variety of psychological disorders (Baucom, Shoham, Mueser, Diauto, & Stickle, 1998), this population may not be receiving effective support for their mental health needs (Chen & Mak, 2008).

While the number of Chinese Americans who suffer from mental health disorders is unclear due to underreporting (Leung et al., 2012), data from the Chinese American Psychiatric Epidemiology Study (CAPES) revealed that only 6 percent of the 1,747 Chinese Americans who reported major depressive and other psychiatric problems sought professional clinical help for their issues (Spencer & Chen, 2004). Examining factors that contribute to resistance of mental health services may target restrictions that could be alleviated and encourage Chinese Americans to consider addressing mental health needs. While significant attempts by the mental health field have been made to promote the value of therapy among this ethnic group, skepticism and a general negative attitude about the effectiveness of therapy in resolving emotional and psychological problems still persists among members of the Chinese and Chinese American population (Kung, 2004).

The idea of using a therapist for assistance with mental health problems is viewed by many Chinese Americans as disrespectful to family members (Chiu, 2004), and disclosing personal information about a family's struggles is generally seen as inappropriate due to strict adherence to a collectivistic (doing what is in the best interest of the group) rather than an individualistic (doing what is best for the person) belief system (Triandis, 1988). The collective nature of Chinese culture socializes individuals to subscribe to the beliefs and values of their family instead of developing their own values and attitudes (Frank, Harvey, & Verdun, 2000). Two crucial tenets of Chinese families are non-disclosure of personal problems and maintaining a competent and respectful public image (Chen, 1998; Lee, 1997). Family members are judged as a whole by the larger society, and public revelations of personal and family issues are vigorously opposed by all individuals. Often shared personal information create a sense of incompetence and inferiority among family members that often produce feelings of shame and embarrassment, because their tribulations may be characterized as deficiencies and subject to intensive social criticism and condemnation for all family members (Fang & Wong, 1998; Lee, 1997). The actions of one person affect not only one's own personal self-esteem and character, but the self-esteem and character of their entire family and ancestors (Fang & Wong, 1998; Lee, 1997).

Besides maintaining a collectivistic perspective, Chinese Americans are taught at an early age to feel the emotion of shame more intensely than other Asian sub-group such as Japan, Korea, and Vietnam (Shaver, Wu, & Schwartz, 1992). Wang (1992) concluded in her study that Chinese parents have a desire to impart the significance and emotional impact of shame into their children's lives, and this was one of the main goals of early childhood development. Fung (1999) conducted a study on nine middle class Taiwanese families to assess parent-child interaction patterns, and found that primary caregivers assumed that their children possessed a rudimentary sense of shame by age two-and-a-half, and that constant reinforcement and guidance using language and modeling were essential to maintain belief and adherence to this emotion (Fung, 1999).

These studies support the argument made by researchers and anthropologists who have categorized Chinese society as being a culture that is "shame based" or "shame socialized" (Benedict, 1946; Fung, 1999). The distinguishing traits that separate a shame socialized or shame focused culture from one that does not place great emphasis in this emotion is that, 1) members of this culture are explicitly required to achieve a strong sensitivity to shame and to other people's opinions, judgment, and evaluation of them and their family; 2) members are taught at a very young age to recognize shame in their lives and to be aware of this emotion; and 3) members will conceal personal problems and difficulties in order to avoid dishonoring themselves and their family of origin (Schoenhals, 1993). Individuals raised in a Chinese culture tend to see shame as 1) an extremely negative emotion that also affects the cognitive and behavioral aspects of their lives; 2) an emotion that is not mutually exclusive to their own personal life and experience, but transferable to family members as well, due to the value of collectivism; and 3) an emotion that intensifies if other people become aware of their physical and mental failures (Andrews, Qian, & Valentine, 2002; Frank et. al, 2000).

The cultural value of shame is viewed as especially salient for Chinese American clients seeking help for emotional and personal problems, because disclosure of problems to a person outside of the immediate family can lead to embarrassment for the individual and his or her family (Zane & Yeh, 2002). Shame has been identified as being a main reason why most Chinese Americans have a negative attitude about the therapeutic process (Chen & Mak, 2008; Ma, 2000). Lee (1989) has suggested that this population does not seek therapeutic help because they worry about the stigma that is attached to this process and how this disgrace would be transferred to and create problems for their family members. Some researchers have hypothesized that Chinese Americans assume that therapy will only serve to enhance the sensation of embarrassment and increase the negative scrutiny placed on their family of origin (Chew, 1995; Qian et. al, 2001), therefore they have a greater tendency to avoid therapy and overall have more negative attitudes regarding the therapeutic process (Qian, Way, & Rana, 2008; Spencer & Chen, 2004).

Although researchers have discussed the potential association between shame and therapy attitudes among Chinese Americans, there has been minimal empirical research done to test this relationship within this ethnic sub-group. A review of the literature found that the majority of the research has focused on therapeutic attitudes of Asian Americans as a whole, or has assessed other specific sub-groups such as Japanese, Filipino, Korean, and Vietnamese (Atkinson & Gim, 1989; Atkinson, Whiteley, & Gim, 1990; Leong, 1994; Leong, Wagner, & Kim, 1995; Ma, 2000; Solberg, Choi, Ritsma, & Jolly 1994; Ying & Miller, 1992).

What has emerged from the literature is the importance of assessing the influence of other contextual factors on therapy attitudes among Asian Americans, specifically acculturation (Leung et al., 2012) and gender (Suinn, 2010). Researchers have also expressed the need to examine the diversity in beliefs and values that exists among the 43 Asian American ethnic groups, and how these differences affect the way these groups view the therapeutic process (Hwang, Wood, Lin and Cheung, 2006). Two studies have assessed the influence of shame and acculturation (Leong, Kim, & Gupta, 2011) and stigma, gender, and acculturation (Shea & Yeh, 2008) on therapy attitudes with Asian American samples. To date no studies have examined the association between acculturation, gender, and shame and therapy attitudes specifically with Chinese American college students, and how these variables interact with each other to influence therapy attitudes.

Another area that has received little attention in the literature on Asian American therapy attitudes is age, and whether being younger or older has an influence on an individual's perspective on clinical interventions. Available research has produced inconsistent results, and hypotheses related to coping styles, identity development, primary support group, and self-esteem have been developed to try and explain the variance in mental health viewpoints among different age groups (Gonzalez, Alegria, & Prihoda, 2005). There have been a few studies that have examined the influence of age on therapy attitudes among Asian Americans, and a review of the literature found no studies assessing this variable among Chinese Americans. This study tested this variable within this Asian sub-group in an effort to add to existing studies.

Given the significant value that Chinese society places on shame and the potential effect this emotion has on therapy attitudes, it becomes important to assess the nature of this association to determine if it is similar to previous studies and to discuss potential implications for clinicians and mental health professionals working with this population. Gender is an important factor because research indicates that males and females differ on overall feelings regarding therapy (Addis & Mahalik, 2003; Ang, Lim, Tan, & Yau, 2004), but more research is needed to determine if this pattern exists among Chinese Americans and how gender and shame affect therapy attitudes. Acculturation has been shown in the literature to influence therapy attitudes among Asian Americans (Leong et al., 2011; Shea & Yeh, 2008).

Acculturation is seen as the degree in which the attitudes, behaviors, values, and identities of persons from one culture become modified and more similar to that of their host culture, as a result of contact with that host culture's norms and traditions (Moyerman & Forman, 1992). The attitude that Chinese Americans have towards therapy depends on their level of adherence to Chinese and Western cultures (Fu, 2002), and their acculturative status can influence the impact that shame has on their therapeutic perspective (Fung & Wark, 2007).

While the independent effect of gender (Ang et al., 2004) and acculturation (Suinn, 2010) on therapeutic attitudes among Asian Americans has been documented, there is a dearth of information regarding the independent effects of shame and the effects of shame, acculturation, age, and gender on therapy attitudes. A review of the literature found one study (Shea & Yeh, 2008) that examined all four variables and one study (Leong et al., 2011) that examined shame and acculturation within an Asian American sample, but more research on the effects of these four variables on therapy attitudes needs to be conducted among Chinese Americans. The purpose of this study was 1) to examine the independent or main effects of shame, acculturation, age, and gender on therapy attitudes, and 2) to assess if any of these variables have a stronger association with therapy attitudes. The use of college students as the sample group has been done in previous studies (Leong et al., 2011) and researchers believe that college students can constitute a part of the larger Asian American community (Leong et al., 2011).

It is important to note that some researchers (Atkinson, Lowe, & Matthews, 1995; Kim & Omizo, 2003) have made distinctions regarding therapeutic perceptions in Asian American populations. The first perspective concerns attitudes towards seeking professional psychological help for general issues while the second is the willingness to see a professional clinician for specific types of problems. As a result of this distinction, multicultural counseling researchers and theorists have noted that Asian Americans tend to have less positive general attitudes toward using professional therapists (Kim & Omizo, 2003) but may be more willing to see a counselor for specific, tangible issues such as academic failure or career goals (Atkinson, Morten, & Sue, 1998). For this study, the focus is on the first construct of therapy attitudes, with therapy defined as professional help and advice for emotional and psychological problems. Although there are various forms of therapy that are available to the public, including individual, couple, family, and group, this study is not focusing on any specific type when looking at therapy attitudes.

The focus is on the role that shame, gender, and acculturation play in Chinese American college student attitudes and feelings about therapy. It is hoped that assessing these three variables will produce new information about some of the reasons for the attitudes Chinese American college students have toward therapy.

## **2. Literature Review**

### **2.1. Shame**

Empirical studies that have examined the association between shame and therapy attitudes among Asian Americans are limited, but overall results suggest that higher levels of shame are associated with more negative attitudes toward therapy (Shea & Yeh, 2008; Zane & Yeh, 2002). Komiya, Good, and Sherrod (2000) found that Asian American undergraduate students who perceived therapy as a stigmatizing process had less favorable attitudes with using this service, which supports findings from Miville and Constantine's (2007) study that surveyed 201 Asian American college women and found that individuals with higher levels of stigma regarding counseling had lower willingness to seek counseling for their mental health issues. These two studies highlight the belief among Asian American college students that therapy can be an embarrassing activity to engage in, but they did not directly measure the level of shame within individuals and how that affected their therapeutic attitudes. Leong et al. (2011) assessed shame (i.e., loss of face) levels among Asian American college students and found that those who possessed higher shame scores also had significantly lower positive attitudes towards therapy. Although these studies provide relevant information on the effects of shame on therapy attitudes, further analysis is needed, particularly as it pertains to the Chinese American population.

### **2.2. Acculturation**

Acculturation is seen as an important variable to examine due to the different cultural perspectives that people from an Asian background bring to the United States in regards to the mental health profession (Shea & Yeh, 2008). How much a person is able to adapt and subscribe to the values and behaviors of a Western society can affect their perceptions towards therapy. In his review of acculturation studies conducted from 2000 to 2009, Suinn (2010) found that a majority of the research supported the argument that higher levels of acculturation was associated with more positive attitudes towards seeking professional assistance and greater tolerance of stigma associated with the therapeutic process among Asian Americans. It is important to note that some research has found that acculturation is not associated with therapy attitudes or that this variable had a negative relationship with therapeutic attitudes. Atkinson, Lowe, and Matthews (1995) found that acculturation levels had no effect on Asian American's students' willingness to see a counselor, and Solberg, Choi, Ritsma, and Jolly (1994) found that lower acculturated Asian American college students were more likely to have positive attitude for seeking help from a variety of sources.

The study also found that 37% of the students indicated that they would be likely to utilize a counseling center to deal with interpersonal concerns. The differences that have emerged in some of the research may be attributed to the inclusion of a wide variety of Asian Americans into the sample group, which can create equivocal results due to variations in personal experiences, beliefs and values. More research needs to be conducted on this contextual factor to see if the overall findings regarding acculturation and therapy attitudes apply to specific Asian sub-groups. Given the existing information on acculturation and therapy attitudes, it was hypothesized that acculturation would be predictive of overall therapy attitudes among Chinese American college students, in that higher levels of acculturation would be associated with more positive therapy attitudes.

### **2.3. Gender**

Studies on gender and therapy attitudes indicate that overall and across different ethnic groups, females are significantly more likely than males to 1) have more positive general attitudes towards seeking professional psychological help (Ang et al., 2004), 2) be more willing to recognize the need for professional assistance (Johnson, 1988), and 3) had more confidence in their mental health practitioner (Leong & Zachar, 1999). The negative attitudes exhibited by men regarding therapy has been attributed to the socialization of males in general to be more self-reliant, achievement oriented, and emotionally restricted, which are traits viewed to be contradictory to the therapeutic process (Mo & Mak, 2009). When examining gender attitudes regarding therapy among Asian Americans, however, a few studies have found no significant differences between Asian American males and females (Atkinson & Gim, 1989; Atkinson et al., 1995).

To address this discrepancy, Nam, Chu, Lee, Lee, Kim, and Lee (2010) conducted a meta-analysis of 14 empirical articles to assess gender differences in therapy attitudes among Caucasian American, Asian American, and Asian college students. Their results indicated that while significant gender differences existed, the effect size among the Asian students was not as large as the effect size among the Asian American students. Nam et al., (2010) contend that both Asian male and female students had stronger adherence to Asian values of collectivism and family honor, therefore their attitudes regarding therapy would be similar because of their shared cultural beliefs. For the Asian American male and female college students, their therapy perspective would depend on their level of acculturation to Western culture. Individuals who had greater assimilation to Western beliefs would have more positive therapy attitudes and thus gender differences in this group would be greater than in the Asian group (Nam et al., 2010), which supports previous studies that have examined the effects of acculturation on therapy attitudes.

Very few studies have examined gender differences regarding therapy attitudes within the Chinese and Chinese American population. Traditional Chinese culture has organized male and females into distinct gender roles and responsibilities, with men assigned to perform and fulfill the instrumental and practical tasks and females assigned to perform the affective and household tasks. The male is expected to be the head of the household and responsible for maintaining their family's social status and honor (Ho, 1991). Chinese males are socialized at an early age to present a respectful and proper demeanor, and to exhibit behaviors that showcase their abilities as a well-mannered and educated person (Jung, 1998). The culture educates and expects the male to be in control of all family and social situations and problems that may come up in the course of daily life (Jung, 1998). The males are required to stay loyal and faithful to their family of origin, obtain the highest educational degree possible, secure a job that affords them a high salary and high status, and create a family that is financially and academically successful (Ho, 1991). For Chinese females, societal and family expectations center on women being the primary care providers for their husbands and children (Uba, 1994). Females are expected to maintain the emotional and psychological functioning of family members and focus on developing healthy and satisfying inter-personal relationships between them, their husbands, and their children (Uba, 1994).

If Chinese males and females are unable to meet these cultural expectations, they may become ashamed and embarrassed over their failures and inadequacies, and the principles of collectivism could enhance this emotion because of the transference of negative criticism to their family of origin (Ho, 1991). Attending therapy to discuss their issues might serve to increase these negative emotions, and while both Chinese males and females have to maintain these role expectations, some researchers have suggested that shame generally carries a heavier burden for Chinese males because of greater expectations of role fulfillment. Chinese males have a lower margin of error than Chinese females because Chinese culture generally endorses masculinity more than femininity (Chang & Subramaniam, 2009; Wu, Levant, & Sellers, 2001) and expects males to succeed in all areas of social and familial responsibilities, whereas Chinese females are afforded more latitude when they are deficient in their role behaviors. This cultural distinction might attribute to Chinese males being more reticent when it comes to exposing their problems and tend to view therapy with more pessimism than their female counterparts (Jung, 1998). They do not want other people to know about their inabilities and flaws, and talking about their problems to strangers may increase the shame they feel as a person who has failed in their endeavors and goals (Jung, 1998).

The few studies that have been conducted on gender and therapy attitudes among Chinese Americans support these arguments. Tata and Leong (1994) found that Chinese American females had more positive attitudes than Chinese American males regarding therapy. Chang (2007) reported more favorable attitudes towards seeking psychological help among female Chinese college students than male Chinese college students in Taiwan. These gender differences highlight the idea that higher endorsement of masculinity and indoctrination of this attitude at an early age can lead to more negative attitudes among Chinese males (Wu, Levant, & Sellers, 2001).

#### ***2.4 Gender Differences in Shame and Acculturation Levels***

Another aspect related to gender differences that require further investigation is whether males or females exhibit higher levels of these shame and acculturation. This is important to explore because knowledge of shame and acculturation levels in Chinese American males and females can inform the type of therapeutic interventions that clinicians and mental health professionals utilize with this population, and potentially help develop strategies that are sensitive to the needs of Chinese American college students based on their experience of shame and adherence to cultural norms that support the efficacy of therapy.

College males were found to possess higher levels of self-stigma (internalization of negative societal beliefs regarding mental health illness which creates perceptions of inferiority, inadequacy, or weakness) than college females regarding therapeutic services (Vogel, Wade, & Haake, 2006), and Fogel and Ford (2005) found that Asian American males possessed higher levels of stigma regarding emotional problems with their friends and employer but not their family members. This is interesting because the expectation is that Asian American males might be more sensitive to shame as it relates to family members discovering they had a mental illness, as opposed to their friends and supervisors. This finding might have been due to the inclusion of multiple Asian American sub-groups with diverse beliefs and values, which makes the parsing of Asian Americans into their respective groups important in order to assess if generalized findings apply specifically to Chinese Americans.

Studies have shown that Asian American female college students have higher acculturation levels in language and higher levels of enculturation in social behaviors than Asian American male college students (Lee, Yoon, & Liu-Tom, 2006) and Vietnamese female immigrants acculturated quicker than their male counterparts (Chung, Bemak, & Wong, 2000). These findings suggest that Asian American females generally have less difficulty transitioning to a new culture, and being able to adapt to a belief system that endorses the merit of clinical interventions might affect the therapeutic process and relationship between mental health professionals and their clients, therefore this study attempted to assess these two variables to determine if male and female college student differed in their levels of shame and acculturation.

### **2.5. Age**

Research on the effect of different age groups on therapy attitudes has found inconsistent results. Generally speaking, older adults are believed to possess more negative help-seeking attitudes and higher sensitivity to shame and stigma associated with mental illness (Lebowitz & Niederehe, 1992). Empirical findings have been contradictory where older adult attitudes towards therapy have been found to be overall more positive than younger adults (Berger, Levant, McMillan, Kelleher, & Sellers, 2005) while other studies have found that young adults were more likely to have positive opinions about mental health interventions than older adults (Tijhuis, Peters, & Foets, 1990). This discrepancy also emerges in the few studies that have examined age and therapy attitudes among Asian Americans. Yeh (2002) found no predictive ability of age on therapy attitudes across a sample of junior high, senior high, and college-age Taiwanese students in Taiwan, whereas Shea and Yeh (2008) reported more positive help-seeking attitudes among older Asian American college students. This lack of clarity highlights the need to continue to assess the influence of age on therapy attitudes and whether this association exists within Chinese American college students. Gonzalez et al. (2005) reported that the younger adults in their study had more negative attitudes towards therapy than older adults, but this perspective toward therapy improved with age. This is consistent with Shea and Yeh's study but both papers examined individuals from diverse ethnic backgrounds. Specific Asian sub-groups need to be assessed to determine if the lack of predictive ability of age on therapy attitudes found in Yeh's (2002) research applies to the Chinese American population.

### **2.6. Effects of Shame, Acculturation, Age, and Gender on Therapy Attitudes**

Although studies have examined the influence of shame, acculturation, and gender on therapy attitudes among Asian Americans, there is a paucity of data that has examined all three of these factors and their relationship to perspectives regarding professional help. Shea and Yeh (2008) conducted multiple regressions analyses on 219 Asian American undergraduate and graduate students and found that while adherence to Asian values, gender, and stigma generated from receiving psychological treatment were associated with therapeutic attitudes, adherence to Asian values had the most significant association ( $\beta = -.019, p < .01$ ). The researchers also assessed the mediation effect of stigma related to receiving psychological support on the association between adherence to Asian values and therapy attitudes but did not find significant results.

Leong et al. (2011) examined shame and acculturation levels in their study of 134 Asian American college students and found that acculturation was positively correlated with therapy attitudes and shame was negatively correlated with therapy attitudes. When entered into a regression analysis, however, higher acculturation levels were significantly associated with more positive attitudes toward help-seeking, whereas shame (i.e., loss of face) had a trend towards significance ( $p = .06$ ). The researchers contend that shame does have a relationship with overall therapy attitudes but that acculturation seemed to have a stronger effect on this variable.

There are currently no empirical studies that have examined shame, acculturation, and gender in a Chinese American population and which variable has a greater influence, if any, on therapy attitudes. In their recommendations, Shea and Yeh (2008) acknowledge that the effects of culture, gender, stigma, and help seeking attitudes is complex and requires further investigation in order to test theoretical arguments made in the literature. Although empirical research conducted on the general Asian American population has found acculturation to have a stronger positive association with therapy attitudes, the salience of shame within Chinese culture creates doubt as to which variable would have a stronger association with therapeutic perspective. Because of this uncertainty, exploratory analyses were conducted to examine the relationships of age, gender, shame, and acculturation on therapy attitudes among Chinese American college students.

### **3. Method**

#### **3.1. Participants**

Data collection began in October 2011 when an email explaining the purpose and design of the study was sent to various Asian American and Chinese American student organizations and culture clubs at universities located in Maryland and California. IRB permission was granted from each institution where students participated. Individuals who were interested in participating were asked to click on a link in order to complete the online informed consent form, demographic questionnaire, and three survey questionnaires. In order to increase the sample size, further data collection was done in February 2013 when students were approached in person and asked to complete the questionnaires. A total of 119 Chinese American college students were recruited for the study. None of the participants had attended a therapy session before and all of the participants were born in the United States but had first generation immigrant parents who were born in China, Hong Kong, or Taiwan and spoke fluent Mandarin, Cantonese, and/or Taiwanese.

Chinese American students responded to a cross-sectional survey that included demographics questions, the Experience of Shame Scale, Chinese Acculturation Inventory, and The Attitudes Towards Seeking Professional Psychological Help Scale. Of the 119 students who responded, 54 (45.4%) were female, 65 (54.6%) were male, and their ages ranged from 18 to 31 years old ( $M = 22.17$ ;  $SD = 3.17$ ). A majority of the respondents were seniors ( $n = 53$ ; 44.5%), but all levels were represented with 10 Freshmen (8.4%), 25 Sophomores (21.0%), and 31 Juniors (26.1%).

#### **3.2. Measures**

##### **3.2.1. Shame**

Shame was measured using the Experience of Shame Scale (ESS; Qian, Andrews, Zhu, & Wang, 2000). The ESS is a 25-item questionnaire that is based on an interview measure developed by Andrews and Hunter (1997) in which participants were asked direct questions on four areas of characterological shame: (1) shame of personal habits, (2) shame in manners with others, (3) shame in the sort of person (you are), and (4) shame about personal ability; three areas of behavioral shame: (5) shame about doing something wrong, (6) shame about saying something stupid, and (7) shame at failing in a competitive situation; and bodily shame: (8) feeling ashamed of (your) body or any part of it (Qian et. al, 2000). For each of the eight areas of shame covered by the ESS there are three related items that address the emotional, cognitive, and behavioral component of that particular category. Participants indicate one of four responses to each of the 25 questions: (1) Not at all, (2) A little, (3) Moderately, and (4) Very much. As shame is viewed somewhat differently in Chinese culture, the ESS was modified in this study by the authors to include questions about a person's family. There are nine additional questions that were added to the original version of the ESS, bringing the total number of questions to 34 and changing the possible range of scores to 34-136. The family questions follow the same format of the original 25, meaning that there is an emotional, cognitive, and behavioral component to each of the three new areas of shame as they relate to a person's family. The nine questions all fall into the subscale of behavioral shame.

The ESS was first used with a group of Chinese college students ( $n = 946$ , 456 males and 490 females) from several universities in Beijing, and has been tested with a group of Caucasians college students ( $n = 163$ ) attending the University of London College in the United Kingdom (Andrews et al., 2002). The internal consistency of the ESS when used on the Chinese students was .90, while the score for the Caucasian students in the UK was .92 (Andrews et. al, 2002; Qian et. al, 2000).

Test-retest reliability of the ESS for the Chinese students was reported at .88 after a 3-week period, and the ESS produced a score of .83 after a period of 8 weeks for the United Kingdom students (Andrews et. al, 2002; Qian et. al, 2000) Each of the three subscales produced good values in regards to internal consistency for both the Beijing and UK students. In the current study, the ESS was found to have high internal reliability (Cronbach's  $\alpha = .96$ ).

### 3.2.2 Acculturation

#### 3.2.2. Acculturation

The level of acculturation within an individual will be measured using the Chinese Acculturation Inventory (CAI; Fu, 2002). This scale is adapted from Mendoza's (1989) Cultural Life Style Inventory (CLSI), which was aimed at measuring acculturation in Mexican-American adolescents and adults. The CAI looks at which cultural lifestyle (American or Chinese) a person prefers to adopt for his/her life (Fu, 2002). The questions ask what kind of music a person listens to, the type of newspapers or books they read, and the types of programs that they watch. The CAI also examines language preference, ethnic identification and pride, and preference for social and cultural activities (Mendoza, 1989). Each choice on the CAI is coded with a specific number ranging from 1 to 5, with 1 being the lowest of the acculturation scale and 5 being the highest acculturation level a person could possibly be. Scores can range from 23 to 115. The original CLSI was administered to a sample of 185 Mexican-Americans, ages 16-52. The CAI was tested on a sample of 150 Chinese Americans, ages 18-55. Cronbach alphas for the original instrument (CLSI) ranged from .84 to .91, and test-retest reliability ranged from .88 to .95 (Mendoza, 1989). For the CAI, Fu (2002) tested the reliability of the instrument using Cronbach's alpha, and obtained a coefficient of .62 with the population group. The CAI had a similar high level of internal consistency reliability with the sample of Chinese American students in this study (Cronbach's  $\alpha = .81$ )

#### 3.2.3. Attitudes towards Therapy.

The Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970) was used to measure the variable. The ATSPPH is a questionnaire that contains 29 items and measures responses based on a four point Likert scale... (0) Disagree, (1) Probably Disagree, (2) Probably Agree, (3) Agree... with 11 questions stated positively and 18 stated negatively (Fischer & Turner, 1970). The questionnaire asks the individual to respond to negative statements about going to therapy and positive statements about going to therapy. The 29 items are divided into four subscales: 1) Recognition; recognizing the need to seek out professional counseling, 2) Stigma Tolerance; the ability to tolerate the shame that goes into coming to therapy, 3) Interpersonal Openness; the ability to share openly with people other than close friends and family members problems and difficulties, and 4) Confidence in mental health practitioner; the belief that a therapist or counselor is competent and can be of help and assistance. In this study the Stigma Tolerance subscale was removed from the ATSPPH, due to the fact that the ESS was already being used to measure shame levels in Chinese American college students. A total score for the scale was used for analysis and ranged from 34 to 136.

Two studies were done on Caucasian students, and Cronbach's alphas for the two studies were calculated to be .83 (n=212) and .86 (n=406), and test-retest reliabilities ranged from .86 for a two-week interval to .84 for a 2-month interval (Fischer & Turner, 1970). The ATSPPH has since been used on Asian American college students (Tata & Leong, 1994), Vietnamese American college students (Atkinson et al., 1984), Taiwanese high school students (Yeh, 2002), Asian American adults (Atkinson & Gim, 1989), and African American adults (Healy, 1998), with internal reliability scores for these studies ranging from .80 to .86. In the present study of Chinese American students, the internal reliability was high (Cronbach's  $\alpha = .82$ )

## 4. Results

Data was entered into IBM SPSS Statistics 19 for analysis. To examine gender differences, *t*-tests were performed. Chinese women were found to have significantly higher levels of shame ( $t(117) = 2.38; p = .02$ ) and more positive attitudes toward therapy ( $t(117) = 4.39; p < .0005$ ) than Chinese men. Chinese women and men demonstrated similar acculturation levels ( $t(117) = -.62; p = .54$ ). See Table 1 for means and standard deviations. In order to examine attitudes toward therapy for Chinese American men and women, a hierarchical multiple regression was performed. The effects of age, gender, shame, and acculturation on attitudes toward therapy were examined. The assumptions for the analysis were met (Cohen, Cohen, West, & Aiken, 2003). The model was significant ( $F = 8.91; p < .0005$ ) and accounted for 23.8% (adjusted  $R^2 = .21$ ) of the variance in attitudes toward therapy.

Gender and age were entered first as a set of demographics and accounted for 16.7% of the variance and after controlling for gender and age, shame and acculturation accounted for 7.1% of the variance. Acculturation levels were not related to attitudes toward therapy; however, women, older individuals, and those with lower levels of shame were found to have more positive attitudes toward therapy (see table 2). Shame had a slight impact on attitudes toward therapy; however, women tended to score 11 points higher on the attitudes toward therapy scale than men and for every one year increase in age, respondents scored about 1 point higher on the scale.

## **5. Discussion**

Asian Americans are generally less inclined to utilize mental health services because of the shame that is associated with this type of intervention. While researchers have argued that it is important to examine these variables, limited studies have been conducted on this diverse ethnic group to determine the validity of this association, and no data exists for the Chinese American population. This study examined the effects of shame, acculturation, gender, and age on therapy attitudes among Chinese American college students. Results indicated that females had higher shame levels and more positive therapy attitudes than males, both males and females had similar levels of acculturation, and shame and age but not acculturation was predictive of therapy attitudes.

The fact that females exhibited significantly higher levels of shame contradicts the hypothesis that Chinese American males would have greater feelings of shame, and this outcome warrants further empirical investigation. Previous research has indicated that males tend to experience more self-stigma than females (Voegl et al., 2006) but for this particular group this was not true. Acculturation to a more Westernized belief system has been argued to lower the levels of self-stigma that individuals feel about the therapeutic process (Fung & Wong, 2007), and it is unclear if acculturation has an effect on shame levels with the females in this group and the nature of this association. It would appear from the findings that acculturation is creating a unique effect on Chinese American females' shame levels in a manner not seen in previous studies.

Chinese American female college students had more positive help-seeking attitudes, which confirm previous studies regarding female perceptions regarding mental health support services (Ang et al., 2004). The results also reflect what has been found with Asian American females and support the hypothesis that within the Chinese American population females have better opinions about therapy than their male counterparts. Acculturation levels were the same for both males and females, which contradicts previous studies indicating that Asian American females tend to display higher adherence to Westernized values than Asian American males. This similarity might be due to the fact that this sample consisted of college students studying at universities where they would be exposed to diverse perspectives and philosophies, which would allow both gender groups equal opportunity to experience American culture.

Findings from this study supported the hypotheses that shame and age are predictive of therapy attitudes. Specifically, older students had more positive attitudes toward therapy and those with higher levels of shame had more negative perceptions regarding clinical interventions. Gonzalez et al., (2006) argued that young adults (i.e., those turning 18) may have a greater need for and concerns about revealing personal information and not wanting that disclosure to become public knowledge. As individuals progress forward in their development stage, these perspectives may change with more experience, identity, and especially knowledge of the mental health field. Studies have shown that older adolescents (i.e., juniors and seniors in high school) have limited information about mental health treatment services but their comprehension of potential benefits improved as they got older (Dubow, Lovko, & Kausch, 1990). These factors might be contributing to the finding that age is positively associated with therapy attitudes among Chinese American college students.

Shame being predictive of therapy attitudes is an important outcome that replicates the findings from Leong et al's., (2011) study that found loss of face (i.e., stigma or shame) had an inverse relationship with therapy attitudes. This study validates the notion that shame is a relevant issue among Chinese Americans and that this variable factors into their perceptions towards therapy. The lack of a significant association between acculturation and

therapy attitudes matched with previous research that did not find any relationship between these two variables (Atkinson et al., 1995; Solberg et al., 1994). Kim, Atkinson, and Yang (1999) have argued that many Asian Americans who immigrate over to the United States tend to adopt the behaviors and mannerisms of their host country more quickly than they do the actual values and beliefs of that country.

These behaviors and habits are generally learned first because they allow the person to fit in as quickly as possible, and provide financial opportunities for them to try and start making a living in a strange land (Kim et al., 1999). As a result of this dichotomous living, children grow up adhering to Chinese traditions and expectations, but maintain U.S. customs when dealing with their peers, friends, and people in general. So a college student could be acculturated to American interests and habits, but their belief system is still based in Chinese philosophy. As a result, how they feel and think about therapy is influenced by Chinese rather than American values, and so their sensitivity to shame and reluctance to share with others about their personal problems may have more of a role in determining their attitudes towards psychotherapy, because it is coming from beliefs rather than behaviors. This notion may explain why acculturation did not have an effect on therapy attitudes, because the CAI focuses on behaviors as oppose to values and beliefs. So from the perspective of these students, they were acculturated in terms of their daily social interactions, but the inherent values that guided their cognitions and emotions were based on Chinese philosophy, and thus they would still feel shame about going to therapy even though their outward appearance displayed a Western lifestyle.

### ***6. Limitations and Future Research***

This study utilized Chinese American college students at a variety of universities in Maryland and California, so generalization of findings to other Asian sub-groups and age groups cannot be made. This study examined the effects of shame, acculturation, gender, and age on therapy attitudes but did not assess interaction effects among these variables. This is an important area to conduct future research, particularly as it pertains to the nature of the relationship between gender, shame and acculturation. Chinese American females had similar acculturation levels and significantly higher levels of shame than Chinese American males, but it is unclear how acculturation and shame interact with each other and what the outcomes would be on therapy attitudes for males and females. Path analysis of shame, acculturation, and age by gender of the participant could provide a clearer, more comprehensive and complex picture of the association among these four variables and their effects on therapy attitudes.

### ***7. Clinical Implications***

Awareness of the salience of shame and the role that age and gender play in the lives of Chinese American college students can help therapist and mental health clinicians to be more sensitive to the needs and issues within this population and to tailor services and interventions that can address these specific areas. Prior to working with this population, mental health professionals should conduct outreach with Chinese American communities and student organizations to educate individuals about the therapeutic process. There may be the belief in the Chinese American community that therapy will increase the experience of shame, therefore effort should be made to incorporate therapeutic models that advocate finding solutions and assistance to problems in a quick, efficient, and tangible manner, such as solution focused, structural, and cognitive behavioral therapy. These clinical interventions could allow for effective support and guidance without the risk of overexposure of personal mistakes and flaws.

Clinicians should also be aware of the age of their clients and how this can affect the effectiveness of therapy. Therapists may need to change their interaction and treatment plan when working with freshman who may be more skeptical about the intervention and therefore become reticent during therapy sessions. Therapists may need to spend time building rapport with younger clients and being patient with any challenges to their expertise or the efficacy of mental health treatment. With older students this may not be as necessary but therapists and clinicians should still be aware of the impact of shame and how it can potentially hinder the therapeutic progress. The gender component is interesting in that the females in this study exhibited both higher levels of shame and more positive help-seeking attitudes than the males. This could mean that while Chinese American females are experiencing more self-stigma this does not prevent them from viewing professional services as a viable option for their issues. Therapists should be aware of the possible internal conflict that can occur with Chinese American women, and they may need to first address this issue of divergent emotions before moving to the main issues or concerns, otherwise the process can get stuck as clients struggle with their feelings and uncertainty over the correct action to follow.

## 8. Conclusion

The findings from this study appear to show support that age, gender, and shame among Chinese Americans has a significant effect on the way that they view the therapeutic process. Given the results from this study, future research should examine the various ways that therapy can be promoted and shared with members of the Chinese American population, as well as looking at which type of interventions or technique might better help alleviate the fear and trepidation that Chinese American clients have about the therapeutic process. Therapists can hopefully find ways to incorporate existing findings into their interventions and philosophy in order to provide effective and efficient mental health services to this ethnic population.

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**Table 1**  
**Means for Perceived Stress Scale**

Gender	n	Shame		Acculturation	Attitudes
		M	(SD)		
Female	54	87.87	(19.40)	71.87 (14.52)	38.43 (12.68)
Male	65	78.98	(21.04)	73.49 (13.94)	29.20 (9.67)
Total	119	83.02	(20.71)	72.76 (14.17)	33.39 (12.01)

**Table 2**  
**Multiple Regression Statistics for Attitudes Toward Therapy\***

(Step) Predictor B	SE B	$\beta$	t	p	R <sup>2</sup>	Change	R <sup>2</sup>	p
Constant	27.66	9.90		2.80	.006			
(1) Gender	-11.54	2.06	-.48	-5.60	.000	.167	.167	<.005
(1) Age (years)	.935	.34	.25	2.77	.007			
(2) Shame	-.159	.05	-.28	-3.08	.003	.238	.071	.006
(2) Acculturation	.062	.07	.07	.87	.385			

\*Figures from final step of model