CHINESE-AMERICANS' PERCEPTION OF THERAPY: A QUALITATIVE STUDY

A DISSERTATION

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To the Associate Vice President for Research and Dean of Graduate Studies:

I am submitting herewith a dissertation written by Kit Seng Ng entitled "Chinese-American's Perception of Therapy: A Qualitative Study." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Marriage and Family Counseling.

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DEDICATION

This dissertation is dedicated to my family of origin, who values and respects the importance of quality education, and their constant support and encouragement.

To the support group members at F.U.M.C.R. for their unconditional support and love.

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ABSTRACT

CHINESE-AMERICANS' PERCEPTION OF THERAPY:

A QUALITATIVE STUDY

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The purpose of this study was to generate data that would help describe the experience and perception of therapy by the Chinese-American clients. The research questions addressed issues related to the length of treatment, the experience of therapy, and the client's expectation of treatment outcomes.

The research sample consisted of 18 adult volunteer subjects who were either permanent residents or citizens of the United States, who were of Chinese descent. Subjects had to be in therapy for no less than 5 visits. Participants were from all over the United States.

Following a pilot study to test the feasibility of such a research study, the applicability of the demographic questionnaire and the interview questions, a qualitative in-depth interview was conducted to generate sufficient data on the perception of the process in therapy. All interviews were audio-taped for coding purposes and assessment

reliability. Content analyses were made from the interview for recurring themes and commonalities in the areas on the length of treatment, experience in therapy, and expectation of treatment outcomes.

This study revealed that Chinese clients do seek therapy when they have problems and that the length of treatment was not a primary concern for them. Second, individual and family therapy seemed to have more appeal than group therapy. Third, they experienced therapy as helpful and pleasant. Most would like to come back to therapy or would recommend therapy to peers. Fourth, there is a definite need for therapists to understand the Chinese culture and communicate in Chinese language.

This study recommends that those who plan to work with this ethnic group need to understand their cultural backgrounds and current concerns in this country. Future study is needed to look at the intervention methods that are most effective for this population.

TABLE OF CONTENTS

CHAPTER

LIST OF TABLES

Tables

CHAPTER I

INTRODUCTION

Statement of the Problem

The focus on the mental health of the Chinese-American minority has virtually been left out of the rapid advancement in the ever-growing field of psychotherapy and psychology (Acosta, Yamamoto, & Evans, 1982; Sue, 1981; Atkinson, Morten, & Sue, 1981). Traditionally, much of the interest and research has focused on the academic achievement of Chinese-American students (DeVos & Abbott, 1986).

Not until the last decade has attention been paid to study and research issues related to the mental health of Asian- and Chinese-Americans (Doi, Lin, & Vohran-Sahu, 1981; Morishima, Sue, Teng, Zane, & Cram, 1979). The majority of the studies on personality and mental health of Chinese-Americans are with college students, mainly from Hawaii, and by a handful of investigators (Meredith, 1966; Sue & Morishima, 1982; Vernon, 1982).

Some of the latest studies on Chinese-American mental health have evolved around the issues of the language barrier in therapy and the need for interpreters

(Shuy, 1983; Tseng & McDermott, 1981). Other researchers have concentrated their efforts on studying the cultural biases on the part of therapists in diagnostic evaluations of Chinese-American clients (Hsu, Tseng, Ashton, McDermott, & Char, 1985).

There are a few studies that have examined Chinese-Americans' preference of therapists. Chinese clients, compared to White clients, expected more direction, empathy, and nurturance from therapists (Yuen & Tinsley, 1981). The issue on preferred modality of therapy also has been generally researched. It appears that a directive, cognitive, and structural approach to therapy is more acceptable compared to the psychodynamic, pharmacolotherapy, and phenomenological approach (Sue & Morishima, 1982; Yamamoto, 1978).

The Chinese family also plays a central role as a resource in supporting the recovery of Chinese-American clients (Lin & Lin, 1978; Shon, 1980). On the other hand, the Chinese family also can serve as potential source of mental health problems. The extent of this dual function served by the Chinese family is complex and not yet adequately researched (Sue & Morishima, 1982).

Leong (1986), in his extensive review of the literature on psychotherapy with Asian-Americans, made special reference to Chinese-Americans and alluded to the need to

address clinical issues related to treatment with Chinese-Americans. Some of the key areas he believes deserve more clinical research are as follows: the outcome of therapy, clients expectations of therapy, elements effective in treatment outcomes, cultural factors affecting treatment, and specific therapeutic interventions relevant to Chinese clients.

Purpose of the Study

The number of Chinese-Americans who seek therapy is very low. There is also a lack of empirical studies on the clinical information related to treatment issues with Chinese-Americans. The purpose of this study was to conduct an exploratory research to determine the length of treatment, the experience in therapy, and the expectations in treatment outcome by Chinese-American clients. This study provided qualitative data that will assist the helping professions, society, and researchers in understanding Chinese-Americans' need for therapy.

Research Questions

This study pursued the following research questions:

1. What length of treatment is expected by Chinese-American clients?

2. What experience do Chinese-American clients have in therapy?

3. What expectations do Chinese-American clients have toward treatment outcomes?

Research Design

Using a qualitative approach, the researcher conducted in-depth interviews with 18 Chinese-Americans who have spent a minimum of 5 sessions in therapy. They were questioned concerning the length of treatment, their experience as a client in therapy, and their expectations on the treatment outcomes. The interviews were taped, transcribed, and examined for emerging themes and patterns.

Definition of Terms

The following definitions are established for use in this study.

Chinese-Americans--Refer to immigrants or those locally born who are of Chinese descent.

Psychotherapy--A process of verbal and/or non-verbal interactions that facilitate change.

Assimilation--The total acceptance and absorption of a foreign culture by rejecting one's original culture (Sue & Sue, 1983).

Acculturation--The willingness to accept another culture into one's original culture without giving up the original culture.

Expectation--"The state of looking forward or the mental attitude of one who anticipates before something happens" (Webster Dictionary, 1971, p. 797).

Perception--"The integration of sensory impressions of events . . . derived from past experience " (Webster Dictionary, 1971, p. 1675)

Delimitations

The study is subject to the following delimitations:

1. Subjects in this study were limited to Chinese adults over the age of 18.

2. Subjects in this study were limited only to subjects of Chinese descent.

3. Subjects were from all over the United States of America.

Theoretical Perspective

Therapists who have worked with Chinese-Americans will realize that there is a strong emphasis on cohesion, role definition, interconnectedness, and a sense of duty

to both the family and society. The foundations of the study come from some of the key concepts found in functional theory which are very similar to the Eastern philosophies dating back more than 2000 years in Eastern history.

In the Western world, functional theory comes from the early influence of natural sciences. Biology and human-social behavior were especially influential in developing the functional approach (Rossides, 1978). One of the key assumptions is that biology as a science is organized around the idea that each organ, or part of the system, performs a function or functions essential to the survival of the organism to which it belongs (Timasheff, 1967). The principle of the interdependence of the organs is stressed. Functional theory during the industrial revolution moved to a different assumption. The emphasis was on differentiation in allocation of scarce rewards, such as income, power, or prestige that were based on the functional importance of each job and the amount of talent and training required or often known as the "the hierarchy of talent" (Parson, 1953).

In the study of the mental process during the late 1990s, various analytical schools described the component parts of the mental process (i.e., cognition, emotion, and volition) but were unable to grasp its unity. Later, the

development of the Gestalt (configuration) school maintained that the mental process must be studied in the context of the whole because the meaning of every element varies in accordance with the total configuration of which it is a part (Timasheff, 1967).

The essence of functional theory emphasizes the concept of role differentiation as defined by norms that delineate the rights and duties of role occupants at different developmental stages (Timasheff, 1967). Therefore, social institutions such as law, religion, rituals, representation, and education all serve to maintain cohesion and solidarity in society.

Functionalism also sees the social life of a person as a whole, a functional unity, and society as an equilibrium or homeostasis state (Azacki, 1979). This approach further proposes that all forms of human activity and all human institutions are interconnected. Van Den Berghe (1969) summed up the functionalist view in this succinct manner,

> Although integration is never perfect, social systems are fundamentally in a state of dynamic equilibrium i.e., adjustive responses to outside charges tend to minimize the final amount of change within the system. Dysfunctions, tensions and deviance do exist and can persist for a long time, but they tend to restore themselves in the long run. (p. 202)

Using this model, this study investigated how therapy was experienced and perceived by Chinese-Americans. Each subject was asked to describe their experience in therapy.

Summary

The need to look at the clinical implications in therapy for Chinese-Americans has been long overdue. The traditional focus and research had been on the academic achievement and the scholastic ability of Chinese-Americans students. Few studies have looked at the impact of therapy and other related clinical issues on Chinese-Americans.

This study looked at the perception and experience of therapy by the subjects who have spent a considerable amount of time in therapy. It was out of the subject's personal experience that certain patterns and hypotheses were drawn.

CHAPTER II

LITERATURE REVIEW

Introduction

The review of literature examined the different characteristics of the perception and experience in therapy. The following aspects of therapy were discussed: length of treatment, experience in therapy, and client's expectation of treatment outcomes.

Length of Treatment

From as early as the 1960s, there has been a strong emphasis to focus on the duration of outpatient treatment. Due to the added pressure from diminishing government funding and the movement into integrated community mental health, mental health providers have had to find inventive methods that require less staff time and yet offer a satisfactory level of service (Beck & Jones, 1973; Garfield, 1980; Verny, 1970; Wells, 1982; Zuk, 1978).

Marmor (1979) believes that the field of mental health is about to experience a major revolution. He predicts that the development of third-party payers, together with the imminence of some form of national health insurance,

providers will be under pressure to find shorter, more broadly applicable, and more efficient techniques of therapy. As a consequence, treatment is anticipated to be briefer in group therapy, behavioral therapy, and family therapy.

Several researches have studied the different outcomes on the length of treatment. Langsley (1978) conducted a study of both private and public state-supported clinic psychiatrists. The study did not include consultants, incomplete treatment, or drop-outs. A total of 4,072 cases were reported by 298 psychiatrists. It was found that the median number of office visits, across all diagnoses, was 12.8 for private psychiatrists and 10.3 for clinic practitioners. Contrary to popular beliefs, psychiatrists as a group do not predominantly practice long term treatment, and even the more severe disorders do not necessarily receive lengthy treatment.

Koss (1979), in another study, completed a somewhat similar study with psychologists instead of psychiatrists. The 100 subjects gathered in the study comprised all persons who attended one visit with the clinician. The central finding was that the length of treatment for 97% of the sample was 20 interviews or less.

Beck and Jones (1973) also examined 3596 cases from different family service agencies to determine the length of

treatment. The research concluded that there was a marked trend toward the utilization of short-term treatment, particularly for child related problems which averaged 5 to 9 sessions.

There is no research on the effects of long term treatment. This does not mean that clients may not require extended therapy, but rather the effects of additional gains have been found in short-term intervention. There are a number of areas in which the evidence for the effectiveness of short-term treatment is especially strong. These include conflictual marital relationship, the emotional and social problems of children and adolescents, and the crisis of individuals and families (Wells, 1982). Researchers have suggested evidence from studies of the therapeutic process that the most significant changes occur early in the treatment and are followed by a period of diminishing effectiveness (Haley, 1976; Meltzoff & Kornreich, 1970; Watzalwak & Coyne, 1980; Weiner-Davis, de Shazer, & Gingrich, 1987). This further supports the theme of the vigorous first moment of contact with the client. The beginning stage of therapy can create an atmosphere where learning, problem solving, or change can take place. Wells (1970) proposed five essential goals for the initial interview:

1. Creating a hopeful atmosphere;

2. Demonstrating understanding of the client's emotional state;

3. Locating major problems in living;

4. Establishing a contract to work upon a designated problem; and

5. Giving the client an initial task.

Models of Treatment

Models of intervention with clients have evolved over time. Some eras that considered mental illness as possession by demons, others were judged to be witches and killed. As recently as the 1940s and 1950s, depressed patients were lobotomized, and in the 1950s and 1960s homosexuals were given electroshock therapy (Rutan & Groves, 1992). Piper (1988) and Lubersky (1988) have estimated that there are roughly 150 forms of therapy. Theories, even the very best ones, come and go. The researcher will examine three major models: psychodynamic, behaviorial, and eclectic models. The rationale for choosing these models stemmed from the researcher's experience, along with other Chinese therapists, that these three models have been most commonly used in working with Chinese-American clients.

Psychodynamic Model

Psychodynamic theory is the earliest cornerstone for modern counseling and psychotherapy. Of the several hundred

different therapies in use today, most of them have derived some fundamental formulation, techniques or impetus from psychodynamic system (Gay, 1988; Gilliland, James, Roberts, & Bowman, 1984; Henrik, 1980). The founder, Sigmund Freud, was very much influenced by Ernest Bruche, a prominent physiologist who pioneered the concept of exchanges of energy within the personality.

In the 1890s, Freud began a self-analysis of his own unconscious forces, and during this time wrote "Interpretation of Dreams." In 1901, Freud published "The Psychopathology of Everyday Life," "A Case of Hysteria," and eventually "Three Essays on Sexuality" which launched Freud's psychoanalysis movement (Belkin, 1980: Francher, 1973).

During the 20th Century, two schools of psychoanalytic theory have claimed to rediscover psychoanalysis. In the United States, Kohutian self-psychology has sought to broaden the understanding of the two-person field to encompass a complex landscape of connectedness between patient and analyst. Meanwhile, continental psychoanalysis adheres to the radical appreciation of the unconscious processes. It further emphasizes the alienation of human consciousness from self-knowledge, and the corresponding margin of separateness between persons (Hamburg, 1992). Freudian psychology is a psychology of the conflicting

forces inherent in the dualistic nature of mankind. The conflicting dualism of the mind can be dichotomized into conscious and unconscious. It is through conflicts of the conscious vs. unconscious, and the biological motivating forces in people vs the social tempering forces in the environment that the personality develops (Arlow, 1979; Herink, 1980).

Psychoanalytic methods of treatment are known to be very passive. With daily interviews, the treatment process could take months or years. One of the on-going developments of this theory is that modern analysts are more active and systematic in planning treatment. There also has been the emphasis on the use of various techniques in a more flexible manner (Patterson, 1980). The goal is to develop a more cost contained procedure in terms of time and effort by adapting the techniques to the individual case.

The techniques of psychoanalysis grew from Freud's earliest work with hysterical patients. He employed extensive hypnosis to relieve hysterical symptoms. Freud later moved to using free association to make unconscious material conscious and thereby promoting insight and understanding. Finally, the mechanism of transference is utilized by clients to gain insight to resolve neurotic conflicts (Arlow, 1979; Belkin, 1980; Gilliland et al., 1984; Langs, 1973). The emphasis later switched to the

transference of the relationship rather than on the transference of neurosis, which may not be allowed to develop (Arlow, 1979; Patterson, 1980).

There are several limitations associated with traditional psychoanalysis, particularly when considering that the method was developed 100 years ago in the Victorian society. One of the major drawbacks is the amount of time required to complete analysis, the course of which may require several years. Also, associated with the length of treatment is the monetary expense, which makes analysis a privilege of the affluent. Although analysis is known for its use in some areas, many present day problems are much more suited to specialists who can provide help more quickly and less expensively.

Behaviorial Model

The original component of behavioralism is based on the work of Pavlov in the 60s and Hull in the 40s. Experts like Watson and Rayner applied the work of Pavlov to desensitize children to small furry animals. The first large scale clinical application was in the late 1950s by Wolpe and Skinner who introduced systematic desensitization by reciprocal inhibition (Gilliland et al., 1984).

Since the 1960s, behaviorism has grown extensively in clinical practice. Some of the modern methods that developed its roots from behaviorism are: emotive imagery,

rational emotive ideas, systematic desensitization, cognitive behavior modification, and covert sensitization (Beck, 1976; Ellis, 1977; Grieger & Grieger, 1982).

Modern behaviorism has focused largely on the internal processes, which stem from simple stimulus response behavior to the emission and control of complex cognitive patterns (Patterson, 1980). Behaviorists have paid more attention to the learning theory than to the development of the behavioral model of human personality. It further assumes that individuals develop personality through maturation and the laws of learning. Therefore, for most behaviorists, what most closely fits the personality theory is actually the learning theory (Chambless & Goldstein, 1979).

Ludin (1977) adequately summed up 10 tenets of behaviorism:

1. Environmental variables determine responses. Once the variables are known, the behavior can be predicted and controlled.

2. All behaviors can be divided into operant and respondent classes.

3. Personality is shaped by the use of reinforcers-both positive and negative.

4. Behavior may be changed by weakening or withholding reinforcement by a process called extinction.

5. Personality develops by a process of discrimination from the generalization of responding.

6. Personality is shaped or differentiated by a variability of responding, which also involves selective reinforcement.

7. Many aspects of personality are controlled by aversive stimuli that can result in escape, avoidance, punishment, or anxiety.

8. Personality is controlled by aversive stimuli that can result in escape, punishment, or anxiety.

9. Behaviors are maintained by a series of conditioned reinforcers which start out as neutral stimuli by pairing with primary reinforcers. If conditioned reinforcers are not paired with primary reinforcers from time to time they lose their power.

10. Behavior can be maintained by reinforcers delivered regularly or intermittently.

Behaviorists utilize techniques that change maladjustive behavior directly without the need for insight. Strategies are directed toward dealing with overt and covert behavioral change. Clients are viewed as agents who operate and influence their own environments rather than responding to their genetic histories and the environmental influences that control them (Gilliland et al., 1884; Patterson, Reid, & Dishion, 1992; Wolpe, 1986).

Some of the methods used by behaviorists to change behavior are modeling, role playing, assertive training, aversion therapy, flooding, implosive therapy, and biofeedback. The focus of these techniques is to identify success in terms of measurable outcomes. Related to measurable outcomes, defining and directly attacking a specific problem is one of the characteristics of behavioral therapy (Carey & Bucher, 1986; Garfield, 1981; Kazdin, 1989). Behaviorists utilize techniques that change maladjustive behavior directly without the need for insight.

In general, behavioral therapy is not a single system of helping. It is a family of systems, formulations, and strategies (Garfield, 1981). Behavioral systems have continued to evolve and change since the days of Pavlov and Watson. The changes have become broader and more pragmatic each year. Current behavioral therapy offers a wide range of strategies for helping clients with diverse backgrounds and problems.

Eclectic Model

The focus on eclecticism in psychotherapy has been gaining ground since the mid 1940s. Thorne (1950) developed the first systematic position, which he intended to gather the different methods in therapy and evaluate them empirically. After Thorne's effort, the movement toward eclecticism became broad-based and multifaceted. It

contains different arrays of theories, or parts of the theories (Adler, 1963; Carkhuff, 1969; Egan 1975; Ellis, 1979; Freud, 1949; Roger, 1951; Skinner, 1953; Thoren, 1968).

Brammer and Shostrom (1968) continued another phase of development within the eclectic position. They tried to integrate a broader framework in therapy which included helping people with philosophical concerns regarding the meaning and purpose of living, the mastery of their environment, and helping them achieve self-understanding. From the late 1960s through the 1980s, there was a resurgence of the eclectic approach with other theories. The earliest inclusion was the developmental model which incorporated effective relationship training (Carkhuff & Berenson, 1977), the goal-oriented systematic model (Egan, 1975), the cognitive-ecological maps (Blocher, 1974), and the system of intentional counseling (Ivey & Simek-Dowing, 1980).

Proponents of eclecticism have debated on how to incorporate parts of different major theories to form an eclectic stance (Carkhuff & Berenson, 1977). A less popular view suggested bits and pieces from a wide spectrum of theories and methods to formulate an eclectic stance.

Brammer (1969) proposed an emerging eclecticism developed from research and experience that reveals common

parameters of counseling that come from a thorough study of all theoretical positions. The objective is to develop a systematic synthesis that will incorporate all valid knowledge about behavior. Thorne (1967) and Peterson (1980) feel that an eclectic approach to treatment is the only approach which is global enough in its scope to effectively deal with the broad spectrum of factors potentially influencing the integrative process.

The following are six concepts that formulate the backbone of eclectic model which Gilliland and Davis (1976) say are crucial when fostering a concrete treatment plan.

1. The client initially needs to explore concerns on a deeper level and the need for the gradual development of mutual trust with the therapist.

2. The client and therapist will work on ascertaining the etiological base of the presenting problems.

3. The client is encouraged to enumerate and verbalize as many viable alternatives. Counselor may use open-ended questions to clarify client's options.

4. The therapist may utilize role playing, suggestions, and action steps to assist the client in deciding on appropriate alternative in view of the client's past level of performance.

5. The client is to commit to workable action steps. The commitment is specific toward successful goals and desired behavior.

6. Based on action and commitment at the previous session, both client and counselor review and assess the level of goal attainment in terms of the client's needs, feelings, and coping skills.

Eclecticism is not without its share of its criticism. Carl Rogers referred to the attempts of eclecticism as a way of blocking scientific progress in the field of psychotherapy which impedes upon decreasing objectivity and leads to nowhere (Rogers, 1951).

Client Expectation of the Treatment Outcomes

Therapy is often seen as the last resource for individuals or families who need help. Often, clients bring along their expectations which, in turn, affect the course of therapy. Schlesinger (1984) studied alcoholic couples and reported three basic expectations from the couples in therapy. He concluded from his study that <u>retribution</u> is the hardest to elicit especially when the non-drinking spouse plans to inflict pain on the drinking spouse for the period of heavy drinking. <u>Restitution</u> is usually easy to illicit in therapy, since non-drinking spouses often expect payment for their suffering. Once the couples moved beyond

retribution and restitution, the desire for refuge against future disruptions caused by the spouse's return to drinking may surface.

Different researchers have studied the client's expectation in relation to the outcome of therapy. Efron and Venendaal (1993) found that the effectiveness of therapy occurs when the therapeutic techniques match the client's expectation. This allows clients to accomplish their goals with the limitations imposed by life instead of regretting what they cannot do or cannot have by most therapies.

In order to make the most out of therapy, some researchers emphasized the need to explain precisely the goal of therapy so as to allow clients to feel a sense of personal control in the process of therapy (Teitelman & Priddy, 1985). This also helps clients to achieve a form of empowerment and to reduce their learned helplessness, thereby increasing the success of therapy (Stark & Kane, 1983). Other researchers like Wilcoxon (1991) and Barker (1986) went so far as to suggest that clients should be given written guidelines at the beginning of each session to help clarify their expectation prior to therapy. Specific forms and content guidelines are noted for areas such as confidentiality, record keeping, appointment, fees, after-hours calls and emergencies.

The value and effectiveness of pre-therapy education which may range from 1 to 3 hours of role playing and watching live tapes have shown to help encourage realistic expectations of therapy, reduce anxiety, and enhance client's motivation and attitude to remain in therapy (Butts, 1986; Deane & Spicer, 1992). It also further enhances client's expectations and reduces premature termination from therapy (Flower, 1984).

When studying the expectations of therapy by children and their parents, researchers found that most have positive expectations on the outcome of therapy (Bonner & Everett, 1986; Greenstone, 1984). Most of the unrealistic and inaccurate expectations of therapy are from the lower socioeconomic status clients and substance abusers (Stark & Kane, 1983).

Govaerts and Olsen (1983) found that clients who are most resistant to therapy also have much higher expectations as to the effectiveness of therapy compared to those clients who are in compliance with therapy. Clients who terminate therapy prematurely have lower expectations of therapy than those who continued in counseling (Gunzburger, Hegeler, & Watson, 1985).

Cultural expectations in therapy have recently gained much attention in the study of ethnicity and mental health (Earl, 1985). Each minority group has its own norms and

mores that govern and shape their expectations toward therapy. The issues get to be more complex when the provider of therapy is not from the same ethnic group. The Chinese clients traditionally have expectations that therapy is a viable way to help them to identify any presenting problems. They expect therapy to be task-oriented, directive, active, and goal-setting (Hong, 1989; Sue, 1981; Sue & Morishima, 1982; Tamara & Lau, 1992; Yue, 1992). Chinese clients also tend to exhibit lower levels of verbal and emotional expressiveness than Whites (Fukuyama & Greenfield, 1983; Sue, 1981; Sue & Morishima, 1982). African American clients on the other hand, bring a set of different expectations to therapy. The issues seem to evolve around economic factors, poverty, historical factors, racism and discrimination (Palmer, 1980; Priest, 1991). African clients, per se, expect both the therapist and therapy to be highly verbal and directive. The therapist is supposed to initiate an active therapeutic alliance with the client (Uzoka, 1983). Asian Indian clients, like most non-western clients expect the therapist to be more directive and authoritarian. The Freudian approach is regarded by most Asian Indian clients to be ineffective and too time consuming (Reddy, 1988).

Experience in Therapy

Much research has been done on client's expectations prior to their experience in therapy. Subjects have experienced and expressed a wide range of emotions from their experience. Parents who lost their children from suicide have sought relief from their painful grief, shame, self doubt, and confusion. Their experience in therapy was described as being accepted and understood (Hatton & Valente, 1981). Other subjects disclosed that their therapy experience has helped to improve social skills, reconnecting with others, increase trust level, and deal with issues related to anger, loss, and hope for their future (Lubell & Soong, 1982).

Recent research has also focused on more specific experience of clients in therapy. The subjects listed both the benefits as well as the risks before going to therapy. The most frequently cited benefits were solving problems, having someone to talk to, learning new things, and making positive changes with expanded systems over the developmental life span. The most frequently identified risks were self-disclosure, discomfort with the therapist, violation of confidentiality, poor therapy effectiveness, over intrusiveness, and lack of respect for privacy (Conran

& Love J, 1993; Kaser-Boyd, Adelman, & Taylor, 1985; Taylor & McClain, 1987).

The experience in therapy has been studied by different theories and schools of thought. One of the most significant experiences in therapy stems from the experiential relationship with the therapist. Conell and Russell (1992), in a study relating to clients and therapist relationship, found that therapists have a significant role in building the moment-to-moment contact with the client in order for the client to grow. Clients need to experience a high level of trust.

Clients tend to remember their experience with their therapist first before remembering what they did in therapy. This brought up an often forgotten aspect of the experience in therapy, in that the therapist needs to be as prepared for therapy as the client (Corazzinni & Heppner 1098). Therapists also are remembered often by their ability to display empathy, warmth, and genuineness (Pebbles, 1980). This often is most applicable to clients who have problems trusting authority resulting from passed unpleasant experiences.

Research in the perception of the therapy experience has generally shown some very positive outcomes with different age and sex groups. Adolescent experts (Kaser-Boyd et al., 1985; Meyer & Zegans 1975) concluded

that adolescents who have been to therapy revealed that their experience with therapy was rewarding, meaningful, effective, and successful. With lesbian clients, there seems to be a high usage of therapy to deal with societal oppression in complicating normal developmental tasks and daily living. Lesbian clients tend to focus on introspection and personal growth in their experience in therapy (Morgan & Eliason, 1992).

Greenberg, James, and Conry (1988) studied the experiences of 21 couples in therapy. After 4 months of therapy, with about 8 sessions of therapy for each couple, the study concluded that the couples were able to express their feelings more, receive appropriate validation, change interpersonal perception, acquire understanding, and taking responsibility for experience. Dorfman (1987) emphasized other change processes as part of adult clients experience in therapy. The report of reduced fears and anxiety and thus increased ability to deal with pressures in a nonpressured manner has been common experience resulting from therapy. There also have been reports of developing subjective self-observation skills and shift cognitions, resulting in attitude and belief changes.

Certain research focused on clients using metaphorical terms which have philosophical and clinical implications to express their experience in therapy. Hamburg (1988),

observed the term "house" as one of the most common metaphorical expressions. Often, "house" implies issues of containment, safety, protection, entrapment, dwelling, hiding, and boundaries. Smith (1978), further stresses that clients can create for themselves an altered state of consciousness which is a profoundly real subjective state like a hypnotic trance in their therapeutic experiences.

From the multi-cultural perspective, the experience of therapy tends to enhance the emotional and cultural pride. Costantino, Malgady, and Rogler (1988) concluded that Hispanic clients after therapy increased in self-disclosure, self-confidence, learned adaptive mechanism for coping with stress, and gained pride in being Puerto Rican. With Indians clients (Kahn, Lewis, & Galvez, 1974), the result was also reported as positive. Follow-up data revealed a marked drop in the numbers of arrests and school absences. It is also concluded that therapy is feasible in spite of significant cultural-psychological contraindications associated with Indian participants who are juvenile delinquents.

Summary

In this chapter, research was cited pertaining to the various aspects on the length of treatment, modalities of theories in treatment, expectation of treatment outcomes, and experience in therapy. Careful details were reviewed

with references to the population involved in this study. The review of the research information served as the foundation of this study for the research questions and data collection.

CHAPTER III

PROCEDURES

The purpose of this research was to study the way Chinese-Americans experience and perceive therapy. A qualitative approach was used to ensure a systematic collection of the data. The in-depth interview allowed the subjects to describe (a) the length of treatment, (b) their experience in therapy, and (c) the client's expectation of treatment outcomes.

Description of Sample

The subjects of this study were 18 adults. In order to qualify as subjects, individuals had to be of Chinese descent, permanent residents or citizens of the United States of America, over the age of 18, and to have completed at least five sessions in therapy. The therapists in this study may not be of Chinese descent. Subjects who had been to see two or more therapists were asked to share their experience with only one particular therapist. Subjects excluded from this study were individuals who resided in the United States with an intention of returning to their

homeland (i.e., business persons, visitors, as well as those who are here on student visas).

Sample Selection

The sample of this study was obtained from service agencies and clinicians who were in private practice, Asian Family Services, and University Counseling centers. Chinese clients were informed by the their therapists concerning the purpose of the study and were invited to participate with full written consent.

Instrumentation

A questionnaire (see Appendix A) was used for the purpose of obtaining demographic information. The primary method of data collection was an in-depth interview. Questions in the interview (see Appendix B) were related to the specific research questions in Chapter I. In addition, probes were used; such as open-ended questions; active listening using appropriate body language; and positive feedback.

Pilot Study

A pilot study was conducted on 2 Chinese-American clients to determine the feasibility of such a research study and the applicability of the demographic questionnaire

and semi-structured interviews (see Appendixes A and B). The clients were located through a therapist in private practice. A demographic questionnaire and participation consent form were given to the participants prior to the interview. The subjects were able to answer the demographic questionnaire without any major difficulty. The demographic information provided pertinent information in knowing the general background of the subjects for analysis. The subjects also provided important feedback regarding changes in the interview questions. The pilot project did determine that information on the experience and perception of therapy could be obtained by the interview. The demographic characteristics proved to be very useful in understanding the broad diverse backgrounds of the subjects and other information that laid the ground work for the indepth interview. The 2 Chinese-American clients who participated in the pilot study also were included in this study.

Procedures for Data Collection

Subjects' names were obtained through Asian sponsored family agencies, private practitioners, and University Counseling centers. If subjects agreed to participate, arrangements were made for a personal interview. Interviews were conducted at the home of the subject or in the office of the researcher.

At the scheduled interview, the researcher assisted subjects in filling out the demographic questionnaire and the participation consent form. Unless subjects refused to be audio recorded, the taping process was started, and the first question on Interview/Research Question (see Appendix A) presented. This process continued until the last question. The interview lasted from 45 minutes to 1 hour and 15 minutes.

Analysis of Data

The researcher listened to the audio tapes of the interview as soon as possible after the interview and made preliminary notes while at the same time transcribing the detailed taped interview. Only one interview was completed in Chinese language. With the help of a graduate student who was an expert in the Chinese language, the researcher carefully ensured that the transcription was done correctly. The transcription was reread in an attempt to analyze for content themes and/or recurring patterns. The demographic variables also were analyzed for background significance. The variables considered were age, sex, place or country of residency, country of birth, languages used in therapy, treatment history, source of referral for treatment, race of the therapist, and occupation.

The recurring patterns and content themes were coded. The materials were placed in different groupings in conjunction with the research questions. The groupings include the length of treatment, modes of treatment, positive and negative aspects of treatment, the goal of therapy and other themes. The copies were then cut and placed in appropriate files. From these groupings, an analysis of the research was completed.

Protection of Human Subjects

The following steps were taken to protect subjects' rights in this research study.

1. Data were collected upon approval given by the Texas Woman's University Graduate School and the Human Subjects Review Committee.

2. All participants were informed of their rights and were instructed that they could withdraw from the study at any time.

3. Participants were asked to sign a consent form allowing the information generated from the interview to be used in future books and journal publications (see Appendix D).

Summary

This research used demographic questionnaires and indepth interviews to elicit data from participating subject who had been in therapy. A pilot study was conducted to refine procedures and finalize the data collecting procedures. Data were collected and analyzed to determine any emerging themes or patterns.

CHAPTER IV

FINDINGS OF THE STUDY

Findings are discussed in detail according to data analyzed from demographic characteristics. In addition, the analysis of the three research questions with the subjects concerning the length of treatment, their experience in therapy, and expectation of treatment outcomes are discussed.

Demographic Characteristics

A total of 18 individual subjects of Chinese descent participated in the study. The subjects ranged in age from 20 to 55 years. Of the subjects, 56% were males while 42% were females.

Approximately 78% of the subjects were United States citizens with only 3 subjects born in the United States. An additional 22% were permanent residents of the United States. The length of stay in the United States ranged from a minimum of 10 years with a mean of 17.9 to a maximum of 25 years. Table 1 lists the categories.

The subjects were mostly immigrants from Far East Asian Countries. A total of 28% of the subjects came from Taiwan,

Table 1

Demographic Characteristics

Variables	N	Percent
Sex		
Male	10	56
Female	8	45
Age		
18 - 25	3	17
26 - 35	3	17
36 - 45	8	44
46 - 55	4	22
56 - 65	0	00
Countries of Birth		
United States	3	16
Taiwan	5	28
Vietnam	1	05
China	2	11
Malaysia	2	11
Hong Kong	3	17
The Philippines	1	06
Singapore	1	06

17% from Hong Kong, and the rest from Vietnam, Singapore, Malaysia, China, and the Philippines. About 68% of the subjects spoke and read more than one language (English). Those subjects who spoke only English were second and third generation Chinese Americans born in the United States. Mandarin was spoken by all the subjects who spoke more than one language. Cantonese dialect was the second most widely

spoken Chinese language used by the subjects, followed by Teochow, Hakka, and the Toisan dialects.

In the category of treatment, approximately 94% were in outpatient treatment. Outpatient treatment ranged from once a week therapy to once every 2 weeks. Only 6% of the subjects had inpatient treatment.

The source of referral for therapy came from family physicians (29%), friends (22%), and the balance came from Employee Assistance Program, church staff, school, and advertisement. Subjects offered various reasons for seeking therapy. The most common presenting problem was depression followed by family problems, social adjustment, death of a loved one, divorce and separation, somatic complaints, and parent-child relationship conflict.

Approximately 72% of the therapists were Caucasians who do not speak any Chinese language. The Chinese speaking therapists (28%) were all bilingual and some were even trilingual. A total of 52% of the therapists were males and 42% were females. The most widely used language in therapy was English (77%), followed by a mixture of English and Chinese (22%), and only 11% of the therapists used only Chinese in therapy.

In the types of treatment, 44% of the subjects participated in individual therapy. The same percentage

also participated in individual mixed with family therapy. Only 5% of the subjects participated in group therapy. Approximately 61% of the subjects sought treatment with licensed mental health therapists and 22% with social workers. Only 11% of the subjects consulted a psychiatrist or psychologist for treatment.

Content Analysis

Data were analyzed by examining the themes of the research questions. The results of the findings were discussed with reference to the 3 themes: (a) the expectation on the length of treatment, (b) the experience in therapy, and (c) the expectation on treatment outcomes.

The Expectation on the Length of Treatment

The first research question addressed the expectation on the length of treatment. Through content analysis, the researcher found that the length of treatment experienced by the subjects varied from a minimum of 2 months to as long as 2 years. Approximately 66% (n=12) of the subjects expressed that they sought therapy once a week for the first and second months and was titrated to once every 2 weeks after that. Only 1 subject was in inpatient treatment where the milieu of treatment was more intense. Most short-term treatment (from 2 to 3 months) were done in individual and family therapy. Treatment that was longer term (beyond 3

months) was mostly in group therapy. A total of 80% (n=16) disclosed that before they came to therapy they had very vague expectations on the length of treatment.

> I had no idea. The length of treatment was not important to me. I wanted therapy to save my marriage. I wanted to do all I could to make things work.
>
> No one knew how long it would take to deal with our problems. We were concerned about our daughter, and we wanted her to get well.
>
> It all depends. I have no idea on how long it will take to help me and what length of time involved in treatment.
>
> I had no expectation before I started therapy. I just wanted some help.
>
> I did not have any expectation. I had some problems, and I wanted to deal with it.
>
> The length of treatment was not an issue with me. I had some visits, and I used them.
>
> I really did not have any expectations. I was very depressed, and I needed help.
>
> It did not occur to me how long I wanted to be in therapy. I went to therapy after a friend referred me.

Analysis on the determination on the length of treatment skewed toward the belief that authority, in this case the therapist, determined the length of treatment. A total of 42% of the subjects (n=8) held strongly that the therapists determined the length of treatment since they are the professionals and know what is best.

> My doctor basically determined the length of treatment, and I felt that I needed it and followed along.
>
> The therapist told me when to come back, and I trusted her.
>
> My therapist informed me that I have a problem, and she will help me to deal with it no matter how long it takes. I just followed along because she was my doctor.

A total of 34% (n=6) of the subjects expressed that their insurance/managed care or financial situation determined the length of treatment.

> Basically, because of our financial situation, we cannot afford therapy after we found out that our insurance was not covering our therapy.
>
> I was in group therapy until my therapist told me that my insurance was not paying for my expenses, and after that I decided not to go to therapy anymore.
>
> Therapy was very expensive. We were able to pay for quite a few sessions, but after that it was impossible for us to pay and we decided to terminate our therapy.

Approximately 17% of the subjects felt that therapy was not effective any more and they expressed a desire to terminate treatment permanently or temporarily.

> We decided to stop therapy because we felt that we have learned some basic skills to deal with our problems.
>
> I just decided to quit. Now that I look back, I thought I made the right decision.

Experience in Therapy

During the interviews, the subjects revealed the different experiences that they had which included the hesitancy to seek treatment because of cultural stigma. Subjects also disclosed the positive and negative aspects of their experiences and what they would like to change. The importance of the different aspects of treatment (i.e., individual, family, and group) also were expressed. The subjects, as the researcher has observed, seemed to be direct, candid, and eager to share their experience in treatment.

Approximately 89% (n:16) of the subjects felt that their overall experience with therapy was helpful, meaningful, and pleasant.

> I felt that therapy has been very helpful. I did not think that it could resolve all my problems. If you spent 6 months in therapy and thought that all your problems are gone--it will be nice. Realistically, you still have to work on your problems.

> It was a very good experience for me. My therapist understood me very well. He was very supportive and went at my own pace. I had a lot of family problems, and therapy has given me a lot of tools to deal with my issues and my family situation.

> We went through some very difficult times. We have no one to turn to. Therapy was a good experience. It provided the support we desperately need.

> Therapy was a very meaningful experience for me. I received a lot of support. My group therapy was

> my only source of support. I felt that I was not alone; others were having problems similar to mine.

A total 78% (n=16) of the subjects interviewed related specifically that their experience in therapy had been positive.

> It helped me to keep my focus and build my confidence.
>
> It helped me to think positively, to get rid of my negative thoughts which have been a perpetuate problem. It also provided opportunities for me to look at my own issues.
>
> I have learned to communicate more effectively with my spouse and be opened with each other.
>
> My therapy has become a strong support for me. I had no one to turn to after my divorce. I have a lot of adjustment to make and try to deal with own hurtful feelings.

A total of 67% (n=12) of the subjects felt that their cultural backgrounds had created a sense of suspicion and mistrust in their effort in therapy. All of the subjects also revealed that once trust with the therapists (both Chinese and non-Chinese) was established the suspicion seemed to diminish quickly.

> When I was first referred to a psychologist by my family doctor, I was very stressed out. I did not like the idea at all. Chinese keep their problems to themselves. They do not let other people know.
>
> Initially, while in group therapy, I stayed very distant from others. I was the only Chinese in the whole group. Later, I felt very comfortable with the group members and therapist. After the initial stage, I got very involved in the group.

> At first, I was very nervous and frightened. I asked a friend to come with me to therapy for two times. It was very difficult for me to go and tell someone about my problems. As Chinese, we just keep things to ourself rather than to seek help.
>
> I went through some very difficult times in my divorce. My experience with therapy was very helpful. I had not been to therapy before, so I was very nervous, but the therapist was very helpful.

A total of 44% (n=8) of the subjects felt that individual therapy was more helpful that family (27%), couple (17%), or group therapy (11%). Table 2 lists the appropriate categories.

> I was in individual therapy all along. I did not want my parents to be involved, at least not now. I was in therapy myself. It was fine with me if they were not here.
>
> Individual therapy in the beginning was very helpful. I was also involved in some group therapy later on in my treatment. Individual therapy helped me dealt with my depression and hurt. Group therapy provided the support I needed.
>
> My experience with individual therapy has been very helpful. I was also in conjoint therapy, but I preferred individual therapy.
>
> I really enjoyed family therapy. It helped a lot because my parents were thinking that I was the cause of all their problems.

Approximately 28% (n=4) of the subjects felt that their experiences were unpleasant or negative.

Table 2

Types of Treatment and Therapist

Types of Treatment	N	Percent
Individual Therapy	8	44
Family Therapy	8	44
Couple Therapy	1	05
Group Therapy	1	05
Types of Therapist	**N**	**Percent**
Licensed Professional Counselor (LPC)	11	61
Social Workers	4	22
Psychologist	2	11
Psychiatrist	2	11
Others	0	00

My therapy amplified some very trivial problems in our relationship to where it became so huge and at times hard to manage. I felt that it was very unnecessary.

It lacked flexibility. Once, we were not able to go to family therapy and we had to wait for another 2 weeks for the next appointment.

I was not given sufficient information to explore the different options.

I felt that there was no direction in my therapy. The therapist was too laid back, and he was not doing anything. He was very passive.

Only 28% (n=5) of the subjects suggested that certain changes were needed in their experience, while the remaining subjects felt that they were contented with the services offered.

> I would like to contribute and participate more in my own therapy. I think the partnership effort was missing.
>
> I like to see more structure, goals, and assignments given by my therapist.
>
> The individual therapy was okay, but I felt that I needed the experience of group therapy. Unfortunately, I was not placed in group, and I terminated therapy.
>
> I wish I had gone to therapy earlier. I had to work harder now especially my grades are suffering.

Expectation on Treatment Outcomes

This part of the interview dealt with the subjects expectations before therapy as well as their perceptions after therapy. Some subjects (n=13) disclosed very general expectations to very specific expectations before therapy. While other subjects (n=5) had no reported expectation.

Subjects also revealed what therapy had done for them and the specific aspects of therapy that had been most helpful. The perception of therapy also was disclosed in length. Most subjects contributed to the general comments concerning their overall perception in therapy and they were generous with their recommendations and concerns.

Approximately 89% (n=16) of the subjects felt that therapy had helped a lot. Therapy helped them put things in perspective, enhanced self-esteem, to be autonomous and self reliant, deal with family of origin issues, and express feelings appropriately. About 67% (n=12) of the subjects stated that certain interventions were very helpful ranging from reading a book, home work assignments, suggestions on changing certain habits, taking time out when feeling out of control, and reframing certain thought processes. Approximately 22% (n=4) of the subjects felt that therapy was not effective.

> It helped me to put things in perspective. I had a lot of stress and adjustment to make coming to America. Therapy helped me to understand the way I am and the types of adjustment I need to make.
>
> Therapy was a very good vehicle for me to deal with my personal issues. Group therapy helped me to developed my social skills and other related issues.
>
> Therapy provided a form of support for me and I felt very safe. It also helped me to be positive and offered me hope and strength to move on. It made me a stronger person.
>
> I have to learn to let go. The recommended books were very helpful. I was also challenged to make small changes on my attitude and to admit my fault.
>
> The problem-solving technique was very helpful to me. It was very practical and effective. Even today, I kept using what I learnt from therapy.
>
> Therapy has helped me to remove negative thinking and to think positively. I felt so trapped by my negative thinking and anger.

About 50% (n=9) of the subjects expressed very general to no expectations before seeking therapy. They also expressed that their primary concern was to get help, reduce their symptoms, deal with their relationship conflict, get support, and work on personal issues.

> In a way, I do not have any expectation. I was having a lot of personal problems and I needed help. I was very nervous about going to therapy.
>
> My expectation was very minimal. I wanted to understand myself and what was happening to me, especially after my divorce.
>
> We were very suspicious of therapy in the beginning. After a while, we were more accepting of therapy. We did not have high expectations. We agreed with a lot of the therapist's evaluation of our family problems.
>
> I expected therapy to provide me with a sense of hope and to move on with my life and nothing else.

A total of 50% (n=9) of the subjects were very specific in their expectations before therapy. They revealed that they wanted to deal with their depression, grief related to divorce, family of origin issues, parent-child relationship, and communication problems.

> I was very depressed and getting no where. I expected therapy to help me not to be depressed and also help with my self-esteem.
>
> My expectation and reason for going to therapy was to deal with my divorce. I felt very hurt and angry at my ex-husband.
>
> I specifically needed to deal with some stresses in my life. I expected therapy to be short term and deal directly with my presenting problems. I

> knew what my needs are and hoped to get them met through therapy.
>
> My daughter and I were having a lot of problems. we decided to go to therapy recommended by a friend. My friend told me that she was a very good therapist. I expected therapy to help our relationship and help us to get along with each other.

Subjects differed in their response in revealing their subjective perception of therapy. A total of 44% (n=8) of the subjects felt that they perceived therapy to very helpful. Approximately 34% (n=6) of the subjects perceived therapy to be somewhat helpful, while 22% (n=4) perceived therapy to be of minimal help.

> Therapy, the way I see it, has been very helpful to me. It practically saved my life. I will continue with group 'til I am very comfortable with my self. I was not sure of therapy, but after I went through it, it was very helpful.
>
> I have learned a lot from therapy. Now that I look back I feel that therapy has started my process of growth. Now the responsibility rested on me to move on with my life. I will continue to deal with my parents and to learn how to adjust to this country.
>
> I have completed therapy, my perception is that therapy helped me somewhat. A lot of the work still has to be done by me. I cannot stay in therapy for the rest of my life. I have to move on and deal with things on my own.

The final part of the interview offered an open-ended question to the subjects. The subjects seemed to be candid in offering their concerns and opinions in issues related to their perception in therapy with Chinese Americans. About

56% (n=10) of the subjects disclosed the need for therapists to speak Chinese language and understand the culture. Table 3 illustrates these data. A total of 78% (n=14) of the subjects revealed that they would recommend peers and family members to therapy if needed. Approximately 83% (n=15) felt that they would return to therapy if necessary.

Table 3

Languages and Race of Therapists

Languages	N	Percent
English	14	78
Chinese	2	11
English & Chinese	2	11
Race of the Therapists	**N**	**Percent**
Caucasian	12	67
Chinese	5	28
Black	1	05

> I wish to see more Chinese therapists doing therapy. My folks do not speak a lot of English, and, at times, communication was extremely difficult with our therapist who did not speak Chinese.
>
> I feel that there is a need for therapy to be done by therapists who are very knowledgeable with the culture. I feel that the therapist will miss a lot by not understanding the culture of the client.

> After been to therapy myself, I would recommend therapy to any one who needs it. I regret that I have not gone to conjoint therapy before my divorce. It may have saved my marriage.

Table 4 summaries the different themes drawn for the interviews.

Table 4

Different themes drawn from the Interviews

Expectation on the length of Treatment	N	Percent
Unspecified expectations	16	80
Length of treatment determined by therapist	8	84
Length of treatment determined by financial reasons	6	34
Experience as meaningful, pleasant, helpful, and positive	16	89
Cultural backgrounds created mistrust and suspicion	12	67
Suggest changes in treatment	5	28
Treatment was not helpful	4	29

Expectation on treatment outcomes	N	Percent
Will return to therapy if needed	15	83
Recommend others to therapy	14	78
Prefer therapists that speak and understand Chinese	10	56

Table 4 (continued)

Expectation on treatment outcomes	N	Percent
Has very specific expectations	9	50
Has very general expectations	9	50
Therapy considered not as helpful	4	22

Summary

The purpose of this study was to focus on the perception of therapy by clients of Chinese descent. This was done by exploring the client's assessment on the length of treatment, experience in therapy, and their expectation of treatment outcomes. The demographic characteristics as well as each of the interview questions were carefully analyzed for recurring patterns and themes.

CHAPTER V

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This chapter reviews the study and presents a discussion of the findings. The conclusions are noted and certain recommendations are suggested for further research.

Summary of the Findings

This study used a qualitative method to explore the subject's evaluation of the length of therapy, their subjective perceptions of their therapeutic experience, and expectation on treatment outcomes. This study had its roots in the functional theory which emphasized the importance of cohesion, role definition, and a sense of duty to family and society at large.

The research sample consisted of 18 volunteer adults, who are of Chinese descent. The subjects had been to at least 5 sessions in therapy. Personal interviews were conducted with each subjects in which they provided personal information on a demographic questionnaire and answered about 13 questions from 3 major research questions.

Following a pilot study to test the feasibility of such a research study and the applicability of the demographic

questionnaire and the interview questions, a qualitative process of in-depth interview was conducted. All interviews were taped and transcribed for coding purposes and assessment reliability. A content analysis was done on the taped materials by the researcher to analyze the interview materials for recurring patterns and themes in the areas on the length of treatment, experience in therapy, and the expectation on treatment outcomes.

The subjects interviewed seemed to be very interested and open to getting therapy. The length of treatment varied from 3 months to 2 years. Most of the subjects started with once a week individual therapy to once every 2 weeks. Some subjects were in therapy once a month.

The length of therapy was not the subjects' major concern. Their major concern was to deal with the presenting problem that brought them to therapy. True to traditional Chinese beliefs, the subjects have a lot of respect for the therapist, similar to the ways they were taught to respect those in authority. In most cases, the therapist was perceived as the one who was in authority and the one who determined the type and length of treatment.

The subjects generally reported their experience in therapy to be very pleasant, helpful, and meaningful. A majority of the subjects disclosed that they were very reluctant to go to therapy due to the fact that seeking help

from mental health professionals has yet to be accepted by the Chinese culture. Subjects suggested some very positive as well as negative aspects of their experience.

Individual therapy seemed to be the most common mode of treatment followed by family and couple therapy. Group therapy was the least popular mode of treatment, largely due to the passive nature of the Chinese clients. Most subjects felt that therapy has substantially helped them. A vast majority of the subjects reported take home assignments given by the therapists to be very helpful. Subjects fell into different categories when expressing their subjective perception in therapy. The subjects disclosed that therapy was highly helpful, helpful, and mildly helpful.

A large percentage of the subjects expressed the need for therapists to speak Chinese language and understand the culture. Most of the subjects indicated that they would be willing to return to therapy if the need arose. Others were open to recommending peers and family members to therapy.

Limitations

The findings of this research is limited to the clients who are of Chinese descent. Subjects had to be either permanent residents or born in the United States.

Discussion of Findings

Of the 18 subjects who participated in this study, slightly more than 50% were males. This came as a surprise since traditionally females are more prone to seek help in the Chinese culture than males. Males were taught to be strong from early age and to take care of the females in the family. They were the breadwinners while females worked at home raising the family. This would be an area for further research on the types of adjustments and role definitions for Chinese males.

The age of the subjects ranged from 20 to 55 years. A total of 42% were between the age of 36 to 45 which was the major age bracket. Even though 78% of the subjects were United States citizens, only 3 subjects were born in the United States. Those who were not born in the United States came from various South East Asian Countries, with the majority coming from Taiwan (27%). This supported the demographic thesis that the majority of the Chinese immigrants originally came as graduate students and decided to stay in the United States after their graduate work. They worked hard for the next generation to have a better education and higher standards of living.

Approximately 72% of the therapists were Caucasians who did not speak Chinese. The Chinese-speaking therapists were

all bilingual and some trilingual. The findings supported past researcher's effort (Leong, 1986; Sue & Morishima, 1982) to recruit more Chinese-speaking therapists. In most cases, as expressed by the subjects, they had to resort to non-Chinese speaking therapists referred by some one they knew and trusted. Given a choice, most subjects would prefer to have therapists that understand and speak Chinese (Doi, Lin, & Vohran-Sahu, 1981; Shon, 1980).

The subjects in the study preferred individual therapy more than any other form of therapy followed by family therapy. Group therapy was least utilized. Subjects felt that they were brought up not to disclose their problems outside the family. Subjects expressed that initially it was difficult to disclose their problems in therapy and even more difficult to reveal personal problems in a group setting.

One of the most common reasons for seeking therapy expressed by the subjects was depression related to adjusting to living in the United States. This included looking for new jobs, communication and language issues, discrimination, child schooling and upbringing, and financial security. Past research (Lin & Lin 1978; Shon, 1980) found that these are common stressors that affect the Chinese immigrants resulting in depression and marital breakup.

Subjects reported that family physicians provided the most referrals to therapy. This was followed by friends and church staff. This correlated significantly to the cultural beliefs that professionals especially physicians are perceived to be the experts and they are fully respected and trusted most by the Chinese community.

The content analysis findings confirmed some of the important constructs expressed by subjects especially the client's experience and perception in therapy. Functional theory emphasized the differentiation of roles and the cohesion and solidarity of society. It also further stated that human institutions are defined by the roles with a strong sense of interconnectedness. This theory firmly supports the researcher's findings that clients of Chinese descent expressed a strong support for structure and role definition in their therapeutic experiences. Subjects also disclosed a strong sense of interdependence in other family members to deal with stress.

In this study, the subjects developed an isomorphic relationship with their therapists similar to that of the elders in the traditional Chinese family. This relationship is very defined and structured in that the therapist is the expert and ultimately determines the length of therapy and final treatment plan. The subjects had a lot of respect for the therapist and followed instructions carefully.

Subjects in this study were very concerned about the problems they had. They focused on getting problems resolved regardless of the length of treatment. Therapy was the last resort in dealing with the presenting problems. Culturally, it took courage for the subjects to seek help since sharing one's problems with outsiders is considered by the Chinese traditions to be a shameful act (Sue, 1981).

The subjects felt that their family structure and bond could be restored through therapy. Parents, in most cases, will go to family therapy with their children to maintain the family homeostasis, interdependency, and connectedness which was the basic assumption of the functional theory. Functional theory emphasized the importance of equilibrium. This study showed that clients who are of Chinese descent are very committed to understanding and accepting their defined roles within the Chinese family and the American society. This is especially true of those who were born in the United States.

Implications

Several challenges are presented from the findings of this study. These challenges include training for professionals regarding the dynamics of the Chinese family system and the acculturation process for the immigrants.

As members of the mental health profession become more exposed to the increasing Chinese clients, therapists should receive more training in evaluating and diagnosing clients from this population. Additionally, this education must challenge the myth suggesting that all clients of Chinese descent have the same presenting problem. This study suggests that the presenting problems are as diverse as the clients themselves.

Societal adjustments, cultural shame, and language problems often have been cited as reasons why clients of Chinese descent have not utilized mental health services. Creating new services or expanding existing services in the Chinese community can provide the information and support needed by the Chinese clients, who have traditionally relied on the community for support. Future research should examine the therapist's role as well as the types of theoretical approach that are most helpful for this population.

Conclusions

Based on the findings of this study, the following conclusions seem warranted:

1. When clients of Chinese descent seek therapy, they generally are committed to change, since therapy, in most

cases, is the last resort for them to deal with their problems.

2. Chinese clients tend to respond more effectively to therapy that requires active assignments given by the therapist.

3. Chinese clients often choose individual and family therapy more than group therapy partly due to the fact that Chinese clients prefer to keep their problems in private.

4. Chinese clients have a lot of respect for the therapist. Therapists are highly regarded as experts like other professionals.

5. Chinese clients prefer to see a Chinese-speaking therapist or a therapist who has extensive understanding of the Chinese culture.

6. Chinese clients consider depression and issues related to adjusting to living in the United States as reasons why they seek therapy.

Recommendations

As a result of this study, this researcher recommends that mental health professionals who plan to work with clients of Chinese descent need improved understanding of the Chinese culture. This should include the difference between the Chinese immigrants and those who were born in

the United States, commonly labeled as Oversees-born Chinese (OBC) or American-born Chinese (ABC).

Other recommendations include the theories of therapy used to work with this population. A few studies (Leong, 1986) have concluded that there are some theories that are not helpful in working with clients of Chinese descent, but there is hardly any conclusive study that supports the theories that are helpful to this population.

This research indicates that there is a need to look at further roles a therapist needs to play in terms of helping the Chinese immigrants to sensitively acculturate into the mainstream of American society. Adjusting to life in the United States has been the key concern for all Chinese immigrants.

Due to the severe lack of Chinese therapists, future research needs to pay attention to effectively enhancing the quantity as well as the quality training of Chinese therapists.

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APPENDICES

Appendix A

Demographic Questionnaire

Subject's Number _____

DEMOGRAPHIC CHARACTERISTICS

1. Male _____ Female _____

2. Age
   18-25 _____
   26-35 _____
   36-45 _____
   46-55 _____
   56-65 _____

3. Years (in the United States) _____

4. U.S. Citizen _____ Permanent Resident _____

5. Country of Birth _____

6. Language/s Spoken _____, _____,
   _____, _____,

7. Language/s Read _____, _____,
   _____, _____,

8. Occupation _____

9. Treatment History
   _____ Outpatient
   _____ Day Treatment
   _____ Inpatient
   _____ Others

10. Source of Referral _____

11. Numbers of Sessions _____

12. Reason/s for Therapy _____

13. Race of the Therapist _____

14. Sex of the Therapist _____ Male _____ Female

15. Language/s Used in Therapy _____, _____

16. Types of Particpation:

_____ Individual _____ Marital

_____ Family _____ Group

17. Types of Therapist

_____ Psychiatrist _____ Psychologist

_____ Social Worker _____ LPC

_____ Others

Appendix B

Research/Interview Questions

Research/Interview Questions

Research Questions:	Interview Questions:
1. What length of treatment are expected by Chinese-American clients?	1. What was your length of of treatment? 2. Who determines the length of treatment? 3. What expectations did you have with the length of treatment before therapy?
2. What is your experience in therapy?	1. Can you explain your personal experience in therapy? 2. What are some of the positive aspects? 3. What are some of the negative aspects? 4. What would you like to change in this experience? 5. Which aspects of the involvement in therapy was most helpful in terms of individual, couple, and family therapy, please explain?

3. What expectations do you you have toward treatment outcomes?

1. What expectation did have before therapy?

2. What do you think therapy has done for you?

3. Which aspect of therapy has been most helpful to you?

4. What was your perception after therapy?

5. Is there anything more you would like to share with me about your expectations/perception?

Appendix C

Letter of Introduction

June 4, 1994

Dear:

I am writing to introduce myself and ask your help in a special study on persons of Chinese descent and their experience and perception in therapy.

I am conducting this research project to learn more about the experience of persons from Chinese descent in therapy. Since, traditionally seeking therapy has not been utilized by most Chinese-Americans, I hope to discover more information to facilitate a better understanding of the process of therapy within the Chinese community. This research also will help to dispense the fear of therapy.

Any men and women from Chinese descent, above the age of 18 and are either a permanent resident or citizen are eligible to participate in this study. Participants will also need to be in therapy for at least five visits. I will personally talk with you for about an hour at a convenient time and place about your experience in therapy.

This study is strictly confidential. There will be no names mentioned in this study. The material shared in the interview will be given a number which will be the only means of identification. I will be very glad to share the findings with you either by mail or verbally upon your request.

Sincerely,

Kit S. Ng, M.Ed.
Licensed Professional Counselor
Licensed Marriage and Family Therapist

Appendix D

Consent Form

CONSENT TO ACT AS A SUBJECT FOR RESEARCH

TITLE OF STUDY: "CHINESE-AMERICAN'S PERCEPTION OF THERAPY: A QUALITATIVE STUDY"

I, _____ certify that I am voluntarily agreeing to participate in this study conducted by Kit S. Ng, M.Ed. The purpose of this study research is to investigate the perception of therapy experienced by Chinese clients and the information will be obtained by completing a questionaire and an oral interview.

I understand that that the information discussed in the interview and the information given in the questionaire is confidential. The audio tapes will be stored at the researcher's office and will be kept until the study is completed (for about 6 months), after in which all, information will be deleted mechanically.

A description of the possible subjects discomfort and risks resonable to expect have been discussed with me. I understand that I may withdraw my participation at any time for any reason.

I understand that no medical service or compensation is provided to the subjects by the university as a result of injury from particiaption in research.

I understand that all interviews will be audio tape recorded and are subject to the confidentiality clause stated above. The recording may last from 25 to 40 minutes.

I understand that I am entitled to a written and/or verbal summary of the results of this study. I am aware that I will be referred back to my therapist or another therapist if I need therapy resulting from this study.

For any further concerns about the way this research has been conducted, contact Texas Woman's University Office of Research and Grants at (817) 898-3375.

DATE: _____ SIGNATURE:_____

RESEARCHER: Kit S. Ng, M.Ed.,LPC,LMFT.
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