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Acculturation in Relation to Somatization and Mental Health Attitudes Among Asian Americans

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Acculturation in Relation to Somatization
and Mental Health Attitudes Among Asian Americans

by

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Approval

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Abstract

A total of 98 Asian Americans completed surveys which consisted of a demographic questionnaire, the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA), the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), and the Symptom Checklist-90-Revised (SCL-90-R). Pearson correlations were conducted between acculturation and the four subscales of the ATSPPHS, acculturation and somatization as indicated by the somatic items on the SCL-90-R, and somatization and the four subscales of the ATSPPHS. Significant negative correlations were found between acculturation and somatization, and somatization and the interpersonal openness subscale of the
Acculturation, Somatization, Attitudes

ATSPPHS. A significant positive correlation was also found between acculturation and the interpersonal openness subscale of the ATSPPHS. These findings suggest that more highly acculturated Asian Americans tend to be more open in discussing interpersonal problems with a mental health professional and tend to report less somatic complaints. Less acculturated Asian Americans, however, do not tend to be as open in discussing interpersonal problems with a mental health professional and report higher numbers of somatic complaints.
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Chapter 1

Introduction

The terms "Asian/Pacific Islander American" and "Asian American" refer to members of over 25 distinct subgroups (Uba, 1994, p.1). According to Uba (1994), these members have been categorized in a group of their own as a result of their "common ethnic origins in Asia and the Pacific Islands, similar physical appearance, and similar cultural values" (1994, p.1). The Asian American population is reportedly the fastest growing minority group in the United States both from increasing numbers of immigrants coming to the United States, and from births by current residents. In a 1994 census, 3% or 8.8 million of the U.S. population were of Asian or Pacific Island descent. This comprises a 1.5 million increase since 1990. It is estimated that since 1990, this population has grown 4.5% per annum with 86% of this growth accounted by immigrants to the United States (Bennett & Martin, 1997).

With such rapid growth of the Asian American population in the United States, Sue & Sue (1987) stated that problems can be anticipated with "socioemotional stress, language skills, unemployment, and education" (1987, p.479). It is thus necessary that subcultural background, demographic factors, and
degree of acculturation be considered when studying this population (Sue & Sue, 1987).

The present study explored the relationship of acculturation to somatization and attitudes toward seeking professional help among Asian Americans. Few studies have researched this area of concern with the Asian American population. Of the few studies that have been done, mixed results were reported. For example, in one study on Asian American cultural identity and attitudes towards mental health services, it was found that more highly acculturated Asian American students were better able than less acculturated Asian American students in identifying their own personal needs for psychological services, more tolerant and accepting of the stigma that is often attached to psychological help, and were more open to receiving psychological help. Less acculturated Asian Americans were however, less willing to seek out psychological services owing to the stigma associated with mental health and mental disorders (Atkinson & Gim, 1989). In another study on acculturation and somatic symptom reporting done with a Canadian Asian and Caucasian student population, it was found that the Canadian Asian students reported approximately the same number of somatic symptoms than Caucasian students (Lai & Linden, 1993). Among Hmong refugees, somatization was found to relate to the demographic variables of age, education, employment, and language as predictors of acculturation success (Westermeyer, Bouafuely, Neider, & Callies, 1989). In conducting a review of recently published literature, the current author
found no recent studies that have evaluated acculturation, mental health
attitudes, and somatization together. It is to be noted that in this study, the terms
"somatization" and "somatic complaints" are used synonymously in accordance
with the symptoms provided on the somatic scale of the Symptom Checklist-90-
Revised (Derogatis, 1993).

Somatization

The term somatization was originally coined by Steckel. He viewed
somatization as being synonymous with Freud's concept of conversion (Steckel, 1943). Even today there is still disagreement among authors in regard to the
definition of somatization. The myriad of definitions all appear to center around
the idea that somatization is an expression of psychological and emotional
distress which is manifested through bodily symptoms (Barsky & Kleinman, 1983;
Katon, Kleinman, & Rosen, 1982; Lipowski, 1987). According to the Diagnostic
and Statistical Manual of Mental Disorders (Fourth Edition), the diagnosis of
somatization disorder requires that the individual have a history of physical
complaints beginning before the age of 30 that occur over a period of several
years (American Psychiatric Association, 1994). During this period, treatment
had been sought or there was significant impairment in social, occupational, or
other important areas of functioning. Four criteria must also be met. These
include four pain symptoms involving a history of pain related to at least four
different sites or functions. The sites include the head, abdomen, back, joints,
extremities, chest, or rectum. The functions include menstruation, sexual
intercourse, or urination. Additionally, two gastrointestinal symptoms, one sexual or reproductive symptom, and a history of a neurological condition other than pain must all be met (American Psychiatric Association, 1994).

According to Katon (1987) and Lipowski (1990), major depression and anxiety are commonly associated with individuals who possess medically unexplainable symptoms. In Lipowski's view (1990), depressed patients who somatize have the tendency to either deny their depression or admit experiencing depression but blame it on the perceived somatic distress. Among the most common symptoms reported are fatigue, pain, palpitations, dizziness, weakness, dyspnea, gastrointestinal complaints, paresthesias, tinnitus, and sexual dysfunction. Nguyen (1982) also found that depression, anxiety, and somatization were the most prevalent problems among Southeast Asian refugees who resettled in Canada. Similarly, Westermeyer et al. (1989) found that acculturation factors such as inability to speak English and social and cultural isolation from the dominant culture may bring about somatization. He further added that somatization could serve as a "face-saving" manifestation of psychopathology even in more acculturated refugees, and that such psychological symptoms as depression and anxiety may also affect the individual's ability to acculturate (Westermeyer et al., p. 42). Cheung (1993) reported that Cambodian refugees presented with a mixture of somatization, anxiety and post-traumatic stress disorder as a manifestation of depression. Older age was also found to be more highly associated with somatization among
Vietnamese refugees (Westermeyer et al., 1989). According to Westermeyer (1989), this may be due to poorer acculturation, lower education, increased psychopathology, and social maladjustment. Grau and Padgett (1988) also found somatization to be common in the elderly. It was also found that depressed older women were more likely to somatize (Berry, Storandt & Coyne, 1984).

It is reported that over 60% of individuals with full or subsyndromal somatization disorder have had a past history of major depression or anxiety (Escobar, 1989). Katon, Vitaliano, Russo, Jones and Anderson (1987) stated that nearly all patients who suffer from major depression or anxiety disorders have somatic complaints which often include pain or other vegetative symptoms. Escobar (1989) additionally reported that such individuals tend to utilize both medical and mental health services, and, have presented primary care providers with both psychological and somatic complaints when compared to individuals who do not somatize.

**Somatization Among Asians**

It has been suggested that Asian Americans are less likely than Caucasian Americans to seek out mental health services (Sue & Morishima, 1982). Root (1985) stated that the very experience of psychological distress may evoke feelings of stigma and shame among Asian Americans. Individuals may feel that they have failed to meet their family's expectations of them (1985). Mental illness in a family member is viewed as a failure of the entire family
system (Sue & Sue, 1987). Additionally, to seek out an “outsider” such as a therapist is also thought to be a shameful reflection on the mother and father’s inability to handle problems within the family system (Shon & Ja, 1982, p. 221). Seeking out mental health services may therefore bring about feelings of shame to oneself and a loss of face or disgrace to the whole family (Root, 1985).

Mental illness has been said to reflect a faulty hereditary characteristic in the family, punishment for past wrongs of the family, and poor guidance and discipline from the family head (Shon & Ja, 1982, p. 222). Consequently, Asian Americans may try to resolve their own problems believing that mental health can be maintained by ignoring bad thoughts and exercising will power (Sue & Morishima, 1982). Mental disorders are also associated with “erratic emotions and behaviors, illogical thinking and irrational ideas,” and “muddle-headedness” (Yu, 1996, p. 10).

Typical ways of coping with mental illness may initially begin with an extended period of coping within the family system. Friends, elders, neighbors, consultation with herbal specialists, herbalists, religious healers, or general physicians may be the next to be consulted. Finally, as a last resort, Western specialists may be sought (Kuo & Kavanagh, 1994). University students from Hong Kong also reported that they would initially attempt to manage their interpersonal problems themselves or seek out friends for advice. Should professional help be needed, medical doctors as opposed to mental health professionals would be consulted (Cheung, Lee, & Chan, 1983).
According to Root (1985), Asian Americans may internalize their stress and express their symptoms through somatic complaints. They may therefore have a greater tendency to seek help from medical services rather than mental health services with the assumption that they have a physical as opposed to a psychological problem. Similarly Sue and Sue (1987) and Sue and Morishima (1982) suggested that Asian Americans are more likely to associate mental illness with somatic or organic variables. Medical services as opposed to mental health services may therefore be a more likely mode of treatment.

Unlike Caucasians, Asians generally make little distinction between the mind and body. Lin (1981) stated that traditional Chinese medicine views psychological and physiological functions as being interrelated. When a group of Chinese participants were asked about possible sources of psychological problems, references were made to the nervous system, unpleasant working environments, genetic weakness, malignant bacteria, and supernatural beings (Bond, 1991). According to Bond, the Chinese view most problems as being attributed to an imbalance of the body. Emotions are seen as being directly affected by the functioning of corresponding bodily organs and are related to the circulation of vital air or qi within the body. For example, happiness is related to the heart, anger to the liver, worry to the lungs, fear to the kidneys, and desire to the spleen. Everything in the human body and nature belongs to, and is affected by, one of the five elements (fire, wood, water, earth, metal), the five viscera (liver, heart, spleen, kidneys, lungs), five emotions (anger, joy, worry, sorrow,
fear), and five climatic conditions (wind, heat, humidity, dryness, cold). Illnesses are attributed to imbalances between these elements.

It is evident from the Asian mindset that emotions are viewed as pathogenic factors that cause disturbances to the organs. Consequently, somatic complaints may be more commonplace than expression of emotions among Asians (Tabora & Flaskerud, 1994).

Acculturation

Acculturation has been defined by Redfield, Linton, and Herskovitis (1936) as a culture change resulting from continuous first-hand contact between two different cultural groups. Rosenthal and Feldman (1989) also addressed this culture change but added that acculturation is the process of both adapting to a new cultural setting and learning to function normally in this new setting where norms may differ significantly from the immigrant's original culture. Such resocialization may include changes in identity, social skills, values, attitudes, and behavioral norms. Other research on acculturation which offer similar definitions of acculturation are proposed by Linton (1940), the Social Science Research Council (SSRC) Summer Seminar (1954), and Triandis, Kashima, Hui, and Liansky (1982). Acculturation may also be understood from a psychological level. Graves (1967) proposed that psychological acculturation includes the behavioral changes and changes of the individual's attitudes, beliefs, and personal identity as the individual's cultural group attempts to adapt to a new cultural environment.
Research on acculturation. Berry (1980) identified four modes of acculturation. These include assimilation, integration, separation, and marginalization. Assimilation suggests that an individual may lose his or her original cultural identity and acquire a new cultural identity in the second culture. As this individual faces this new culture, he or she may feel a sense of alienation and isolation from others. It is not until he or she perceives acceptance in that second culture, however, that the individual will experience less alienation and isolation (Johnston, 1976; Sung, 1985). Consequently, anxiety and stress may also lower as the individual becomes more assimilated in the second culture. In the view of LaFromboise, Hardin, and Gerton (1993), the acquiring of this new cultural identity may imply that the individual will lose awareness and loyalty to the original culture. They stated that there are three "dangers" associated with assimilation. These include the possibility of rejection from one's original culture as well as the possibility of rejection from the second culture, the experience of severe stress as the individual learns the new behaviors associated with the new culture, and the discarding of old behaviors that are no longer functional in the second culture.

Unlike assimilation, integration suggests that even though the individual moves to a second culture, he or she will still identify with his or her original cultural heritage. Thus, according to Berry and Kim, the individual may retain his or her original cultural identity and interact with other groups in the second culture (Berry & Kim, 1988).
In the process of separation, the individual may still retain his or her original cultural identity but will withdraw from participating with groups from the second culture (Berry & Kim, 1988). According to Berry and Kim, such individuals may lead a separate or independent existence from the second culture (Berry & Kim, 1988).

Finally, in marginalization, the individual may suffer from a loss of cultural identity as he or she is not only alienated from the original culture, but also the second culture. In Berry’s and Kim’s view, this does not imply that the individual possesses no culture, but is instead at a point in the acculturation process where he or she may be experiencing disorganization (Berry & Kim, 1988). In a study done by Berry and Kim (1988), it was found that immigrants who scored high on Separation and Marginalization scales experienced a greater amount of stress than those immigrants who scored higher on the Integration scale.

Padilla also proposed a model of acculturation which centers around two main elements: cultural awareness and ethnic loyalty (Padilla, 1980). Cultural awareness refers to the extent of which an individual is aware of his or her cultural heritage, the cultural heritage of his or her spouse and parents, preference of language use, cultural orientation and preference, and social behavior orientation (Padilla). Ethnic loyalty refers to the preference of the individual’s cultural orientation. It includes such factors as the individual's cultural pride and affiliation, perceived discrimination against the individual's culture of origin, and the individuals social orientation (Padilla). It is in Padilla’s view that
the less acculturated an individual is, the more he or she will adhere to his or her original cultural orientation.

Asian American Acculturation And Biculturation

With the rising influx of Asians to the United States, comes with it severe acculturative stress. Underlying acculturative stress lie key cultural differences between Asian culture and American culture. Some key differences are noted:
a) Where U.S. culture strongly adheres to a focus on the "self" (individualism), the individual in accordance to Asian culture is defined in context of the extended family unit which serves as his/her fundamental social and economic unit (collectivism). The self in accordance to Chinese culture is considered a "mass person" whose interests in the family/group take priority over the self (Sue & Morishima, 1982). There is thus a focus on interdependence in the Asian culture as opposed to an individualistic focus in the U.S. culture; b) time orientation of Asian culture emphasizes the past, whilst the U.S. culture emphasizes the future; c) relational orientations in Asian culture is toward lineal ties, whilst U.S. culture tends to promote individualism; d) Asian culture emphasizes a man-nature orientation with focus on being in harmony with nature whereas U.S. culture stresses a man-master over nature orientation with greater emphasis on doing, accomplishing, and succeeding rather than harmonious co-existence (Kluckholn, 1958); e) the tendency to suppress strong feelings is consistent with the value of balance that is critical to Asian worldviews and social systems. Appropriate behaviors most often dictate withdrawal, silence, and watchfulness for correct
harmony promoting cues (Shon & Ja, 1982). The role of acculturative stress was noted in a study done by Baron, Thacker, Gorelkin, Vernon, Taylor, and Choi (1983), which associated acculturative stress with 51 cases of unexpected and unexplained nocturnal deaths of Laotian, Vietnamese, and Cambodian refugees. These deaths occurred between July, 1977, and March, 1982 from 15 different states in the United States. When compared to matched controls of the same ethnic background, it was reported that those who died suddenly were more likely to have stayed for a shorter periods of time in the U.S, possessed less job training, spent the majority of their income on housing and other possessions, and have experienced an illness in a refugee camp.

It is evident from the almost dichotomous differences between the two cultural frameworks that the Asian immigrant is faced with a myriad of both practical and personal issues which inevitably affect one's mental health. Westermeyer, Vang and Neider (1983) found that amongst Hmong refugees in Minnesota that depression scores were higher in older age groups (age 45+) than in younger groups. It was also reported that there was less psychological disturbance with an absence of primary and tertiary migration in the United States. In a follow-up study of the same sample (Westermeyer, Neider & Vang, 1984), it was reported that higher symptom scores on the Symptom Checklist – 90 were correlated with language difficulties (low English-proficiency) and socioeconomic issues (low socioeconomic status i.e., welfare status). Similarly in an interview done by Nicassio (1983) on 460 household heads, language
difficulties, socioeconomic status, and a negative self-perception all significantly contributed to feelings of increased alienation from American culture. Nicassio and Pate (1984) reported that those who were employed and lived for a longer time period in the U.S. experienced less feelings of alienation. Higher education, income, and current employment were additionally correlated with a greater sense of social interaction with Americans and a better comprehension of language and culture.

The above studies also point out the importance for immigrants to acquire the host culture's language. Tran (1990) stated that English proficiency is one of the most important factors in the process of adjustment for newly arrived Vietnamese refugees (and immigrants). Gardner (1979, p. 194) defined language as a "symbolic representation of culture and...a primary means of maintaining interaction between individuals." Interestingly, there still remain some immigrants who do not choose to learn the English language as evidenced by those who live in such Asian communities as Chinatown in the United States. Young and Gardner (1990) suggested that some minority groups may deliberately choose not to assimilate because it may imply losing their own ethnic identity. This is congruent with Taylor, Meynard, and Rheault's (1977) concept that for some individuals, it is more preferable to not learn the second culture's language as this would pose too great a threat to the loss of ethnic or cultural identity.
It is evident that the stress of acculturation is due to conflict between norms, behaviors, and values of one's host culture in relation to another culture (Tabora & Flaskeurd, 1994). Rahe (1975) added that such acculturative stress could lead to negative physical and mental health. The general stigma against seeking out mental health services often prevents the Asian individual from seeking assistance for psychological disorders (Tabora & Flaskeurd, 1994). Yamamoto (1978) suggested that even Asians who are more highly acculturated may still maintain a strong stigma against psychiatric care. Owing to this stigma, clinical manifestations of psychological disorders may appear through somatic complaints which are generally viewed to be more acceptable than admission of disturbances in affect or cognition (Ngyuen, 1982).

**Asian American acculturation models.** Various acculturation models have also been proposed specifically for the Asian American population. The "Asian American Acculturation and Adjustment Matrix" developed by Moy (1992, p. 361) proposed six basic ways in which Asian Americans handle cultural differences between Asian and Western cultures. It is Moy's belief that the Asian American's level of acculturation is often an accurate measure of the individual's level of adjustment and psychological well-being. The six means of acculturation include a) the Conflicted Nonacculturated individual, b) the Competent Acculturated Individual, c) the Conflicted Acculturated Individual, d) the Competent Bicultural Individual, and e) the Conflicted Bicultural individual.
According to Moy (1992), the Competent Nonacculturated individual maintains traditional Asian worldviews and values and often refuses, or does not see, the need to acculturate. An example would be first generation Asian Americans who live in the confines of a Chinatown community. Since the social support system is able to maintain the traditional Asian culture and lifestyle, there is thus little need to acculturate. These persons would therefore be able to function adaptively and would unlikely seek psychological services.

The Conflicted Nonacculturated individual also primarily maintains the Asian culture but, unlike the Competent Acculturated individual, is not able to adaptively function in a different culture. He or she may often lack a social support system with the added complexity of not being proficient in the English language (Moy, 1992).

The Competent Acculturated individual maintains more Western than Asian values, and may reject traditional Asian culture. This is common among third and fourth generation American-born Asian Americans who are able to function adaptively to living in the United States (Moy, 1992).

Similar to the Competent Acculturated individual, the Conflicted Acculturated individual also maintains more Western than Asian values. Owing to cultural conflicts however, he or she may maladaptively dissociate and avoid anything related to the Asian culture. This individual may actively or passively "puts down" his or her Asian background in an attempt to handle personal insecurities and conflicts in regard to his or her identity. He or she may not be
able to function as adaptively as he or she would like because of these underlying conflicts. An example of this would be of a second-generation adolescent who deliberately rejects anything Asian including Asian food, people, and language (Moy, 1992).

The Competent Bicultural Individual is able to function in both Asian and Western cultures. He or she may both acknowledge and adopt the values and worldviews of both cultures. In most cases, this individual is bilingual and may be a second generation Asian American who has successfully learned to function in both cultures. Oftentimes, significant social support systems such as parents may accept and even encourage this bicultural lifestyle.

The Conflicted Bicultural Individual experiences tension around his or her personal and cultural identity. He or she is described as "culturally marginal, culturally confused, or culturally ambivalent" (Moy, 1992, p. 363). Cultural and generational differences often exist for example between Asian American children and their traditional Asian parents who fear that their children will become too "Americanized." Consequently, these individuals may adopt more Western values in order to successfully function with peers and society. Moy (1992) further added that complications may arise when language differences exist between the child and the parent where the acculturated child possesses limited ability to speak in the native tongue of his or her parents (Moy, 1992).

In another model, Lin, Masuda, and Tazuma (1982) proposed various patterns of acculturation. In their studies of Vietnamese refugees, they
developed 5 categories of acculturation. These include a) marginality, neurotic type, b) marginality, release type, c) traditionalism, d) overacculturation, and e) biculturalism.

"Marginal" individuals may be described "ambivalent, insecure, self-conscious, and chronically nervous" Lin et al. (1982). Two sub-categories may also emerge from marginality: neurotic and released (deviant). The neurotic type is described as becoming easily "paralyzed" while attempting to follow the norms and expectations of both cultures. They are typically extremely anxious and inhibited (Lin et al., p. 179).

Unlike the neurotic marginal individual, the released (deviant) marginal person chooses to ignore the behavioral norms and expectation from both cultures as he or she resolves that there is no way to live up to either culture's expectations. Lin et al. (1982) concluded that neither of these approaches provides adequate solutions to acculturation. The marginal individual will therefore experience isolation, loneliness, and frustration (p.179).

The "traditional" individual may be described as "prematurely arrested" in the acculturation process (p. 180). These individuals may still possess a great awareness and loyalty to their traditional culture and attempt to maintain it through the preservation of traditions through celebrating traditional festivals, listening to music and reading novels in their language. Lin et al. (1982) stated that these individuals may feel the need to preserve their original culture for the sake of maintaining their psychological well-being.
In contrast to the traditional individual, the “overacculturated” individual all too quickly attempts to become acculturated thereby forsaking his or her original culture in its entirety. Lin et al. (1982) have found that such individuals are usually younger and better educated and have had the experience of living with a supportive host family while going to school abroad. They also tend to be separated from persons of their own ethnicity and more involved with "Westernized" individuals that is, Americanized individuals (p.180).

Finally, biculturation is considered the ideal pattern of acculturation (p. 180). Biculturated individuals tend to be the most successful in bridging two cultures. According to Lin et al. (1982) however, these individuals hold the concern that future generations will not be adequately exposed to the Vietnamese culture and will consequently become overly Westernized.

**Biculturation Models.** Biculturation is heralded as the preferred approach to cross-cultural adaptation (Lin et al., 1982). Taft (1977) argued that biculturalism is the most healthy route in coping with a different culture stating that the "mature bicultural individual may rise above both cultures by following superordinate social prescriptions that serve to integrate the individual's behavior relative to each culture" (p. 146). Lin et al. (1982) described how the biculturated individual seeks both individuation and interrelatedness. As previously stated, there is a strong desire amongst such individuals that their children, to some extent, maintain their culture of origin. With this desire, however, also comes the
fear that this next generation will become over-acculturated by becoming excessively "Americanized," thereby losing all traditional roots (Lin et al., 1982).

Clark, Kaufman, and Pierce (1976) proposed six different styles of biculturalism in a model called "Ethnic Identity Profile Types." This model was developed by combining an existing test called the "Acculturative Balance Scale" which measures a person's knowledge of traditional Asian popular culture with current American popular cultures (Pierce, Clark, Kiefer, 1972), with two ethnic identity terms "Traditional Orientation" and "Anglo Face," derived from a questionnaire on one's attitudes toward one's own ethnic identity (Clark et al., 1976). According to Clark et al., the term "Traditional Orientation" refers to the extent to which an individual fits into his or her traditional society as measured by language, citizenship, literacy, and religious affiliation. The term "Anglo Face" however, refers to the degree to which the individual perceives himself or herself as belonging to and participating in the culture of his or her ethnic group. It also suggests how the person may present himself or herself to others as either "ethnic" or "American" (Clark et al.). Thus, lower scores on the Anglo Face measure for example may indicate more traditionalism and higher scores more acculturation to the major culture.

Another bilculturalism model proposed by LaFromboise, Hardin, & Gerton (1993), called the Alternation Model, suggests that an individual can successfully integrate two different cultures without having to choose between them. According to this model, the individual can maintain a sense of belonging to both
cultures without losing his or her original cultural identity (LaFromboise, Hardin, & Gerton). Ogbu and Matute-Bianchi (1986) agreed that an individual does possess the ability to alternate his or her behavior in accordance to the differences of the two cultures concerned. It has also been suggested by various authors that those individuals who can achieve this bicultural medium tend to demonstrate higher cognitive functioning and higher mental health status than those who have only assimilated or acculturated (Rashid, 1984; Rogier, Cortes & Malgady, 1991). LaFromboise, Hardin, & Gerton (1993) also maintain that the successful acquisition of both the original culture and the second culture will allow the individual to believe that he or she can be biculturally competent or "biculturally efficacious." "Bicultural efficacy" may be defined as the "belief, or confidence, that one can live effectively, and in a satisfying manner, within two groups without compromising one's sense of cultural identity" (LaFromboise, Hardin, & Gerton, p. 404).

A third biculturation model proposed by Szapocznik and Kurtines (1980) stated that acculturation occurs two-dimensionally. The first dimension includes the process of "accommodating" to the host culture whilst the second dimension involves the "retaining" of the culture of origin. According to Szapocznik and Kurtines, it was found that the most pervasive variable which assisted the individual in accommodating to the host culture was the amount of time he or she had been exposed to the host culture. Variables such as the availability and
extent of community support were the most influential in regards to the individual retaining his or her culture of origin.

**Hypotheses**

This study will test three hypotheses: a) level of acculturation will relate to one's attitude toward seeking professional psychological help, b) level of acculturation will relate to the level of somatic complaints reported, and c) level of somatic complaints will relate to one's attitude toward seeking professional psychological help. Although the first hypothesis has been explored in Atkinson and Gim's study (1989), no further studies in recent years have attempted to demonstrate this hypothesis. This study will therefore be a partial replication of Atkinson and Gim's study. Additionally, the second hypothesis has mainly been studied with a refugee population (Westermeyer et al., 1989; Nguyen, 1982). The only other study that has examined the effects of acculturation on somatic complaints was done in a Canadian study (Lai & Linden, 1993). The present study will utilize an Asian American population in examining acculturation as relates to somatization. Finally, no studies appear to have examined the relationship between somatic complaints and attitudes toward seeking professional psychological help. The current study however will however examine the relationship between somatic complaints and attitudes toward seeking professional psychological help.
Chapter 2

Methods

This chapter will consist of four sections. The first section will describe the participants of this study. The second section will describe the three instruments used in this study. These include the Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Rickard-Figueroa, Lew & Vigil 1987), Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) and the Symptom Checklist-90-Revised (Derogatis, 1993). The last two sections will discuss the design and analysis used for this study.

Participants

There were 98 participants in this study. The sample in this study consisted of 32 Chinese Americans, 10 Japanese Americans, 25 Korean Americans, 9 Vietnamese Americans, 14 Filipino Americans, 2 Indian Americans, 3 Thai Americans, 2 Hmong Americans, and 1 Laotian American. Gender distribution according to ethnicity can be seen in Table 1.
Table 1

**Gender Distribution According to Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity &amp; Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Japanese</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Korean</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Filipino</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Thai</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Hmong</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Laotian</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td>69</td>
</tr>
</tbody>
</table>

N=98

Descriptive information is presented in Table 2 and Table 3. Sixty of the 98 participants were enrolled as undergraduates at a major West coast University. The remaining 38 were relatives and friends of students from the American Psychological Association of Graduate Students Ethnic Minority
Internet Discussion Line. Participants' age ranged from 17-77 with an average age of 23.7 and standard deviation of 7.6. Of the 98 participants, 79 participants or 81.6% of the sample were in the process of obtaining or had obtained college level education. Of the 98 participants, 17 participants (or 17.3% of the sample) were in process of obtaining or had obtained graduate level education, and 2 participants (or 2.04% of the sample) provided no response.

Table 2

Demographic Information

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-19 years</td>
<td>13</td>
</tr>
<tr>
<td>20-23 years</td>
<td>57</td>
</tr>
<tr>
<td>24-27 years</td>
<td>16</td>
</tr>
<tr>
<td>28-38 years</td>
<td>9</td>
</tr>
<tr>
<td>41-56 years</td>
<td>2</td>
</tr>
<tr>
<td>77 years</td>
<td>1</td>
</tr>
</tbody>
</table>

Marital Status

<table>
<thead>
<tr>
<th>Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>83</td>
</tr>
<tr>
<td>Married</td>
<td>14</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 2 (cont)

Education

<table>
<thead>
<tr>
<th>Education</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
<td>79</td>
</tr>
<tr>
<td>Graduate School</td>
<td>17</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
</tr>
</tbody>
</table>

N=98

Table 3

Asian American Acculturation Demographics

<table>
<thead>
<tr>
<th>Born in United States</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>53</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of Residence in United States</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>6</td>
</tr>
<tr>
<td>6-10 years</td>
<td>5</td>
</tr>
<tr>
<td>11-15 years</td>
<td>6</td>
</tr>
<tr>
<td>16-20 years</td>
<td>37</td>
</tr>
<tr>
<td>21-25 years</td>
<td>21</td>
</tr>
<tr>
<td>26-30 years</td>
<td>11</td>
</tr>
<tr>
<td>Age Group</td>
<td>Count</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>31-57 years</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>10</td>
</tr>
</tbody>
</table>

**Acculturation Level**

<table>
<thead>
<tr>
<th>Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>3</td>
</tr>
<tr>
<td>Medium (bicultural)</td>
<td>89</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
</tr>
</tbody>
</table>

**English as Preferred Language**

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>48</td>
</tr>
</tbody>
</table>

**Importance of Maintaining Asian Roots**

<table>
<thead>
<tr>
<th>Importance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0</td>
</tr>
<tr>
<td>Medium</td>
<td>10</td>
</tr>
<tr>
<td>High</td>
<td>88</td>
</tr>
</tbody>
</table>

**Family Importance of Maintaining Asian Roots**

<table>
<thead>
<tr>
<th>Importance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>2</td>
</tr>
<tr>
<td>Medium</td>
<td>16</td>
</tr>
<tr>
<td>High</td>
<td>80</td>
</tr>
</tbody>
</table>

**N=98**
Instruments

**Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA).** The SL-ASIA (Suinn et al., 1987) was used for the purposes of measuring level of acculturation. It is comprised of 26 items which covers the four areas of language (4 items), identity (4 items), friendship choice (4 items), behaviors (5 items), generation/geographic history (3 questions), attitudes (1 item), and values (4 items). The items are scored from a range of 1-5 with lower scores implying low acculturation (or high Asian identity), high scores as high acculturation or (high Western/American identity), and average scores (score of "3") implying medium acculturation or "biculturality."

The SL-ASIA was patterned after the Acculturation Rating Scale for Mexican-Americans (Cuellar, Harris & Hasso, 1980). The SL-ASIA has been used in eight studies related to Asian American concerns. These studies examine how level of acculturation relates to a) attitudes toward mental health services among Asian American students (Atkinson & Gim, 1989); b) severity of concerns, and willingness to see a counselor among Asian American students (Gim, Atkinson & Whiteley, 1990); c) occupational values among Chinese American children (Leong & TaTa, 1990); d) psychological characteristics of Chinese American students (Sue & Kirk, 1972); e) career decisions among Asian American students (Suinn, Khoo & Ahuna, 1985); f) cross-cultural information between Asian American students and Singaporean individuals (Suinn et al., 1995); g) attitudes toward seeking professional help among Chinese American
students (TaTa & Leong, 1994); and h) eating disorders among Asian American females (Yoshimura, 1995). Cronbach's alpha for the SL-ASIA was reported to be .91 (Suinn, Ahuna & Khoo, 1992), compared to the internal-consistency estimates of .88 in a prior study done by Suinn et al. (1987), and .89 (Atkinson and Gim, 1989). Correlations between demographic information and SL-ASIA scores all yielded significant results with p < .001. These included total years attending school in the U.S. (r = .61), age upon attending school in the U.S. (r = .60), years living in the U.S. (r = .56), age upon arriving in the U.S. (r = .49), years lived in a non-Asian neighborhood, (r = .41), and, self-rating of acculturation, (r = .62) (Suinn et al. (1992).

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). The ATSPPHS (Fischer & Turner, 1970) is comprised of 29 items with 4 subscales measuring recognition of need for psychotherapeutic help, stigma tolerance (tolerance of stigma associated with psychological help), interpersonal openness with a mental health professional, and confidence in a mental health practitioner (Fischer & Turner, 1970). Scores range from 1-4, with 1 implying strongly disagree and 4, strongly agree. Fischer and Turner (1970) reported that the ATSPPHS was able to differentiate mental health facility users from nonusers and has a test-retest reliability of .83. The ATSPPHS has been used to show how level of acculturation relates to attitude toward mental health services among Asian American students (Atkinson & Gim, 1989). It has also been used to measure attitudes toward counseling of Vietnamese and Anglo-
Acculturation, Somatization, Attitudes

American students (Atkinson, Ponterotto, & Sanchez, 1984), and, Asian international and native Caucasian students (Tedeschi & Willis, 1993). In other studies, the ATSPPHS has been used to determine help-seeking attitudes from variables such as individualism-collectivism, social-network orientation, and acculturation (TaTa & Leong, 1994).

**Symptom Checklist-90-Revised (SCL-90-R).** The SCL-90-R is a 90 item symptom checklist measuring psychological distress. The items are rated on a 5-point scale of distress ranging from “Not at all” (0) to “Extremely” (5) during a 7-day period. Although the entire SCL-90-R was administered, only three scales were utilized for the purposes of this study. These include the somatization scale, anxiety scale, and depression scale (see Appendix A). For purposes of this study, the term “somatization” is used synonymously with the term “somatic symptoms/complaints” as defined by the symptoms described on the SCL-90-R. Although the SCL-90 and SCL-90-R have been used to research psychological distress in chronic pain patients (Hendler, 1981; Schwartz & DeGood, 1983; Shutty, DeGood & Schwartz, 1986), somatization; depression, and anxiety with an outpatient population (Kirmayer, Robbins, Dworkind & Yaffe, 1993); neurotic symptoms with an inpatient population (Peveler & Fairburn, 1990); psychiatric symptomology with a psychiatric outpatients (Derogatis & Cleary, 1977); only one study was found that used the SCL-90-R on an Asian American population (Takeuchi, Kuo, Kim & Leaf, 1989). The SCL-90, however, has been utilized to assess symptom reporting among Hmong refugees (Westermeyer, Vang &
Neider, 1983), and a Korean version of the SCL-90 was used to assess psychopathology among Korean immigrants in Canada (Noh & Avison, 1992). Internal consistency and test-retest reliability for the somatization scale ranged from .86 to .88 and .68 to .86; for the anxiety scale, .85 to .88 and .80; and for the depression scale, .90 and .75 to .82 respectively. These were derived from studies done by Derogatis, Rickels and Rock (1976) and Horowitz, Rosenberth, Baer, Ureno and Villasenor (1988). Construct validation for the somatization, anxiety, and depression scales were .40 to .66, .31 to .63, and .44 to .71 respectively (Derogatis & Cleary, 1977).

**Design and Procedure**

A total of 188 testing packets were compiled and sent via priority mail to the participants with a total of 98 packets or 52% returned. Out of the 100 packets sent to the West Coast University, 60 or 60% of the packets were returned. Out of the 88 packets sent to remaining participants, 38 or 43% were returned. The packets consisted of an informed consent, a demographic questionnaire, the SL-ASIA (Suinn et al., 1987), the ATSPPHS (Fischer & Turner, 1970), the SCL-90-R (Derogatis, 1993), and a stamped return addressed envelope. The demographic questionnaire comprised of questions regarding gender, age, marital status, ethnicity, occupation, years lived in the U.S., whether participant was born in the U.S., age upon arriving in the U.S. if not born in the U.S., age attending school in the U.S., educational level, where their degree was completed, which state they currently reside, whether English was their first
language, language spoken at home and at workplace or school, how they would rate the importance of maintaining their Asian roots, and how they would rate the importance of their family's view for them to maintain their Asian roots. The last two questions were rated on a five point Likert scale, with “1” implying “not important” and “5” as “extremely important.”
Chapter 3

Results

This chapter will present the results of this study in three sections. First, each of the three hypotheses will be restated and examined in relation to the results. Tables and graphs will be used to illustrate the findings. Finally, additional analyses will be reported.

Hypothesis One: Acculturation and Attitudes Toward Seeking Professional Psychological Help

Hypothesis One stated that the level of acculturation will relate to one's attitude toward seeking professional psychological help. Using the SL-ASIA (Suinn et al., 1987) and the ATSPPHS (Fischer & Turner, 1970), it was hypothesized that Asian Americans who have a higher level of acculturation to the American culture or increased Western-identification would be more likely to seek professional psychological help from a mental health professional. Asian Americans, however, who are less acculturated to the American culture or who are Asian-Identified would be less likely to seek professional psychological help from a mental health professional.

Using a Pearson correlation between scores from the SL-ASIA and scores from the ATSPPHS, a significant correlation was found between acculturation
and the interpersonal openness scale on the ATSPPHS with $r (90)= .23$, $p<.01$. On the SL-ASIA, a score of one indicates low acculturation to American culture, a score of 3 indicates biculturality, and a score of 5 indicates a high level of acculturation. On the ATSPPHS, scores are measured in accordance to 4 subscales measuring recognition of need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in a mental health practitioner. It was found that Asian Americans with higher levels of acculturation or higher Western-identification tended to be more open about discussing interpersonal problems with a mental health professional. Asian Americans who were less acculturated or more highly Asian-identified tended to be less open about discussing interpersonal problems with a mental health professional.

Table 4 presents the correlations for acculturation levels from the SL-ASIA in relation to the four ATSPPHS subscales. Figure 1 illustrates these findings. Table 5 presents the means and standard deviations for the different acculturation groups and the four subscales of the ATSPPHS.
Table 4

Correlation Between SL-ASIA and ATSPPHS

<table>
<thead>
<tr>
<th>Attitudes Toward Professional Help</th>
<th>Acculturation Correlation (r)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of need for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychotherapeutic help</td>
<td>.15</td>
<td>.16</td>
</tr>
<tr>
<td>Stigma Tolerance</td>
<td>.09</td>
<td>.36</td>
</tr>
<tr>
<td>Interpersonal Openness</td>
<td>.23</td>
<td>.02</td>
</tr>
<tr>
<td>Confidence in a Mental Health Practitioner</td>
<td>.09</td>
<td>.41</td>
</tr>
</tbody>
</table>

N=98
Figure 1. Correlation illustrating positive relationship between level of acculturation and degree of interpersonal openness with a mental health professional.
Table 5

Means and Standard Deviations for Acculturation Groups on Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)

<table>
<thead>
<tr>
<th>Attitude Toward</th>
<th>Acculturation Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Help</td>
<td>Very Low&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Recognize Need For Psychotherapy</td>
<td>Mean</td>
</tr>
<tr>
<td>20.3</td>
<td>1.53</td>
</tr>
<tr>
<td>Stigma Tolerance</td>
<td>Mean</td>
</tr>
<tr>
<td>13.0</td>
<td>2.65</td>
</tr>
<tr>
<td>Interpersonal Openness with Mental Health Professional</td>
<td>Mean</td>
</tr>
<tr>
<td>17.3</td>
<td>2.08</td>
</tr>
<tr>
<td>Confidence in a Mental Health Professional</td>
<td>Mean</td>
</tr>
<tr>
<td>25.3</td>
<td>4.93</td>
</tr>
</tbody>
</table>

Note. Acculturation groups are differentiated by acculturation scores on the SL-ASIA

<sup>a</sup>n=3 <sup>b</sup>n=36 <sup>c</sup>n=53 <sup>d</sup>n=6

Hypothesis One was partially confirmed on one of the four subscales of the ATSPPHS. It appears that acculturation is inversely related to interpersonal
openness. Thus, more highly acculturated Asian Americans who are more Western-identified tend to be more interpersonally open than less acculturated or Asian-identified Asian Americans.

**Hypothesis Two: Acculturation and Somatization**

Hypothesis Two stated that level of acculturation will relate to level of somatic complaints reported. Using the SL-ASIA (Suinn et al., 1987) and the SCL-90-R (Derogatis, 1993), it was hypothesized that Asian Americans who have a higher level of acculturation to the American culture or increased Western-identification tend to have a lower level of somatic complaints. Asian Americans, however, who are less acculturated to the American culture or who are Asian-Identified would report an increased number of somatic complaints.

Using a Pearson correlation between the scores from the SL-ASIA and scores from the somatization scale of the SCL-90-R, a significant negative correlation was found with \( r(81) = -0.31, p < .01 \). Again, on the SL-ASIA, a score of 1 indicates low acculturation to American culture, a score of 3 indicates biculturality, and a score of 5 indicates a high level of acculturation. On the SCL-90-R, scores are measured on a 5-point scale of distress with 0 as “not at all” to 5 as “extremely.” It was found that Asian Americans with higher levels of acculturation or higher Western-identification reported less somatic complaints than lesser acculturated or Asian-identified Asian Americans. Table 6 presents the correlations for acculturation and somatization. Figure 2 illustrates these findings. Table 7 presents the means and standard deviations for the different
acculturation groups in relation to the somatization, depression, and anxiety subscales of the SCL-90-R.

Table 6

Correlation Between SL-ASIA and SCL-90-R

<table>
<thead>
<tr>
<th>SCL-90-R subscale</th>
<th>Acculturation Correlation (r)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization</td>
<td>-.31</td>
<td>.006</td>
</tr>
<tr>
<td>Depression</td>
<td>-.21</td>
<td>.056</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.12</td>
<td>.077</td>
</tr>
</tbody>
</table>

N= 98
Figure 2. Correlation illustrating inverse relationship between level of acculturation and somatization.
Table 7

Means and Standard Deviations for Acculturation Groups and SCL-90-R

<table>
<thead>
<tr>
<th>SCL-90-R Subscales</th>
<th>Very Low(^a)</th>
<th>Low(^b)</th>
<th>Medium(^c)</th>
<th>High(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Somatization</td>
<td>10.3</td>
<td>11.93</td>
<td>9.2</td>
<td>9.07</td>
</tr>
<tr>
<td>Depression</td>
<td>18.3</td>
<td>8.62</td>
<td>12.6</td>
<td>9.89</td>
</tr>
<tr>
<td>Anxiety</td>
<td>10.0</td>
<td>8.72</td>
<td>6.9</td>
<td>7.80</td>
</tr>
</tbody>
</table>

Note. Acculturation Groups are differentiated by acculturation scores on the SL-ASIA.

\(^a\) n=3, \(^b\) n=36, \(^c\) n=53, \(^d\) n=6

Hypothesis Two was confirmed as indicated by the inverse relationship of acculturation and somatic complaints. Thus more highly acculturated or Western-identified Asian Americans presented with fewer somatic complaints than less acculturated or Asian-identified Asian Americans. Correlations were also found between the somatization and the depression subscales on the SCL-90-R with \(r(79) = .72, p = .001\), somatization and anxiety subscales with \(r(80) = .79, p = .001\), and, depression and anxiety subscales with \(r(80) = .85, p = .001\).
Hypothesis Three: Somatization and Attitudes Toward Seeking Professional Psychological Help

Hypothesis Three stated that level of somatic complaints will relate to one's attitude toward seeking professional psychological help. Using the SCL-90-R and the ATSPPHS, it was hypothesized that Asian Americans who present with higher levels of somatic complaints will show less of a desire to seek professional psychological help. Asian Americans who present with less somatic complaints will be more prone to seek professional psychological help.

Using a Pearson correlation between scores the somatization subscale of the SCL-90-R and scores from the four subscales of the ATSPPHS, a significant negative correlation was found between somatization and the interpersonal openness subscale with $r (81) = -0.33$, $p < .01$. On the SCL-90-R, scores are measured on a 5-point scale of distress with 0 as "not at all" to 5 as "extremely." On the ATSPPHS, scores are measured in accordance to 4 subscales measuring recognition of need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in a mental health practitioner. It was found that Asian Americans who presented with higher levels of somatic complaints had a tendency to be less open about discussing their interpersonal problems with a mental health professional. Those who presented with less somatic complaints had a tendency to be more open about discussing their interpersonal problems with a mental health professional. Table 8 presents the
correlations for somatization scores on the SCL-90-R in relation to the ATSPPHS subscales. Figure 3 illustrates these findings.

Table 8

Correlation between SCL-90-R Somatization Subscale and ATSPPHS Subscales

<table>
<thead>
<tr>
<th>Attitudes Toward Professional Help</th>
<th>Somatization Correlation (r)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of need for Psychotherapy</td>
<td>-.13</td>
<td>.25</td>
</tr>
<tr>
<td>Stigma Tolerance</td>
<td>.08</td>
<td>.50</td>
</tr>
<tr>
<td>Interpersonal Openness with a Mental Health Professional</td>
<td>-.33</td>
<td>.002</td>
</tr>
<tr>
<td>Confidence in a Mental Health Professional</td>
<td>-.17</td>
<td>.13</td>
</tr>
</tbody>
</table>

N=98
Figure 3. Correlation illustrating inverse relationship between somatization and interpersonal openness with a mental health professional.
Hypothesis Three was partially confirmed with somatization items on the SCL-90-R negatively correlating with one of the four subscales of the ATSPPHS. It was found that Asian Americans who presented with higher levels of somatic complaints tended to be less open about their interpersonal problems. Asian Americans who presented with lower levels of somatic complaints tended to be more open about their interpersonal problems.

**Additional Analyses**

Using t-tests, demographic questionnaire items addressing language preferences and place of birth were examined in relation to somatization items on the SCL-90-R and the four subscales of the ATSPPHS. See Table 9 for results. Demographic items addressing language produced a significant difference with the somatization scale of the SCL-90-R with $t (79) = -2.8, p < .01$; and, with the interpersonal openness scale of the ATSPPHS with $t (94) = 2.5, p < .01$. This indicates that the ability to speak American/English in the United States plays an inverse role in the level of somatic complaints reported by Asian Americans. Ability to speak American/English in the United States is also positively related to the level of interpersonal openness manifested by Asian Americans. Additionally, the demographic item addressing place of birth produced a significant difference with the somatization scale of the SCL-90-R with $t (78) = -2.4, p < .02$. This indicates that Asian Americans who were born in the United States have a tendency to report less somatic complaints than those who were born in a country other than the United States.
Table 9

T-test Results Relating Language Items on Demographic Questionnaire With ATSPPHS

<table>
<thead>
<tr>
<th>ATSPPHS subscales</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of Need for Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>48</td>
<td>23.5</td>
<td>3.81</td>
<td>1.81</td>
<td>.07</td>
</tr>
<tr>
<td>Non-English</td>
<td>47</td>
<td>21.9</td>
<td>4.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma Tolerance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>49</td>
<td>14.6</td>
<td>2.85</td>
<td>1.34</td>
<td>.18</td>
</tr>
<tr>
<td>Non-English</td>
<td>46</td>
<td>13.8</td>
<td>2.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Openness With a Mental Health Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>49</td>
<td>20.7</td>
<td>3.74</td>
<td>2.49</td>
<td>.02</td>
</tr>
<tr>
<td>Non-English</td>
<td>47</td>
<td>19.0</td>
<td>2.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence in a Mental Health Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>48</td>
<td>26.0</td>
<td>4.10</td>
<td>.26</td>
<td>.79</td>
</tr>
<tr>
<td>Non-English</td>
<td>46</td>
<td>25.8</td>
<td>4.07</td>
<td></td>
<td></td>
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</tbody>
</table>

N=98

*Numbers in subgroups do not equal 98 because of non-responses.
Chapter 4

Discussion

This chapter will discuss the results of this study in three sections. The first section will address each of the hypotheses in relation to past research findings. Second, limitations of this study will be discussed. Finally, recommendations for future research will be presented.

Hypothesis One: Acculturation and Attitudes Toward Seeking Professional Psychological Help

Hypothesis One stated that the level of acculturation will relate to one’s attitude toward seeking professional psychological help. Acculturation has been defined as a culture change resulting from first-hand contact between two different cultural groups (Redfield et al., 1936). It also involves the learning of new social norms involving changes in identity, social skills, values, attitudes, and behavioral norms (Rosenthal & Feldman, 1989).

Attitudes toward seeking professional psychological help among Asian Americans tend to center around medical services as opposed to mental health services. Asian Americans are generally less likely than Caucasians to seek outside help for emotional problems (Lin et al., 1978). According to Root (1985), Asian Americans tend to internalize their stress and express their symptoms
through somatic complaints. Such somatic complaints may therefore be interpreted as physical illness as opposed to possible psychological distress. Root (1985) also reported that Asian Americans are more likely not to discuss problems with a mental health professional as this may be viewed as bringing disgrace and shame onto the entire family system.

Hypothesis One was tested with the SL-ASIA (Suinn et al., 1987), and the ATSPPHS (Fischer & Turner, 1970). It was found in this study that Asian Americans with higher levels of acculturation or higher Western-identification had a tendency to be more open about discussing interpersonal issues with a mental health professional. Asian Americans who were less acculturated or more highly Asian-identified had a tendency to be less open about discussing interpersonal problems with a mental health professional. Root's findings (1985), therefore, that Asian Americans are more likely to resolve their own problems and avoid talking to mental health professionals, may apply more specifically to lesser acculturated Asian Americans. No significant correlations were found for acculturation and recognition of need for psychotherapeutic help, stigma tolerance, and confidence in a mental health practitioner. This may be due to the restricted range of acculturation scores in this study as most of the sample scored in the bicultural range. The sample's views therefore tended not to lean as heavily toward either Asian-identification or Western identification. In light of Lin's (1983) statement that Asians tend to stigmatize mental illness, it could be said that if there had been higher numbers of participants scoring in the low
Acculturation range in this study, significance would more likely have been found between acculturation and the ATSPPHS subscale measuring stigma tolerance. The same may have held true for the areas of recognition of need for psychotherapeutic help and confidence in a mental health practitioner.

The findings for hypothesis one are thus partially congruent with Atkinson and Gim's findings that the higher acculturated Asian American tends to be more open about discussing interpersonal issues with a mental health professional (Atkinson & Gim, 1989).

**Hypothesis Two: Acculturation and Somatization**

Hypothesis Two stated that level of acculturation will relate to the level of somatic complaints reported. Acculturation, as previously discussed, involves the process of both adapting to a new cultural setting and learning to function in the new setting where norms may differ significantly from the immigrant’s original culture (Rosenthal & Feldman, 1989). Language has been shown to play a significant role in acculturation. Gardner (1979) states that language is a “symbolic representation of culture and ... a primary means of maintaining interaction between individuals” (p.194). The findings of this study indicate that language abilities, that is, the ability to speak American/English is an accurate predictor of acculturation to the United States. Thus, the more fluent the participant was in speaking the English language, the lower the level of somatic complaints reported. It is evident from this finding that fluency in the language of the dominant culture indicates a higher level of adaptation. Tran (1990) stated
that English proficiency is one of the most important factors in the process of adjustment for newly arrived Vietnamese refugees and immigrants. It was additionally found that Asian Americans who were born in the United States tended to report less somatic complaints. It may be said, therefore, that ability to speak the language of one's dominant culture, and being born in the country of one's dominant culture, suggests a lessening of acculturative stress which may affect the number of somatic complaints reported.

Sue and Sue (1987) reported that Asian Americans are more likely to associate mental illness with somatic or organic variables. Mental illness is related to the loss of will power, morbid thoughts, and to environmental factors. These beliefs may contribute to the finding that Asian Americans are more likely to discuss somatic complaints during psychotherapy (Sue & Sue, 1974). According to Beiser and Fleming (1986), Asian Americans may somatize mental health problems as a means of expressing psychological distress. It is also a reflection of Asian cultural values that emphasize avoiding shame and maintaining honor of the family. Sue and Morishima (1982) also suggested that somatization may be an unconscious reflection of the holistic view of the mind and body adopted in Asian cultures.

The SL-ASIA (Suinn et al., 1987) and the SCL-90-R (Derogatis, 1993) were used to test Hypothesis Two. It was found that Asian Americans with higher levels of acculturation or higher Western-identification reported less somatic complaints than lesser acculturated or Asian-identified Asian Americans.
Although depression and anxiety did not significantly correlate with acculturation, depression did show a closer probability of a correlation with acculturation than anxiety. This lack of significance may be due to the restricted range of acculturation scores in this study as most of the sample scored in the bicultural range. The sample’s views therefore tended not to lean as heavily toward either Asian-identification or Western identification.

The findings of this study do indicate relationships between somatization, depression, and anxiety which are congruent with the research done in these areas (Cheung, 1993; Cheung, Lau & Waldmann, 1981; Westermeyer et al., 1989; Smith, 1992). The findings of this study suggest that with increasing levels of somatic complaints, both depression and anxiety are also both likely to rise. Anxiety is also likely to heighten with increasing levels of depression.

Hypothesis Three: Somatization and Attitudes Toward Seeking Professional Psychological Help

Hypothesis Three stated that level of somatic complaints will relate to one’s attitude toward seeking professional psychological help. As discussed, Asian Americans tend to somatize mental illness as a means of expressing psychological distress (Beiser & Fleming, 1986). Asian Americans are also less likely that Caucasians to seek outside help for emotional problems (Lin et al., 1978).

Using the SCL-90-R and the ATSPPHS, it was found that Asian Americans who presented with higher levels of somatic complaints tended to be
less open about their interpersonal problems with a mental health professional. Asian Americans who presented with lower levels of somatic complaints tended to be more open about their interpersonal problems with a mental health professional. This finding may suggest that more acculturated Asian Americans who are willing to discuss interpersonal issues with a mental health professional may consequently report less somatic complaints. No significant relationships were found for somatic complaints in relation to recognition of need for psychotherapeutic help, stigma tolerance, and confidence in a mental health practitioner. This may be attributed to a higher functioning, well-adjusted, and educated bicultural sample in this study.

Limitations of the Study

A limitation of this study is the lack of generalizability of the results to other general populations. With the sample consisting in its majority of University students, findings of this study may not be generalizable to other Asian American populations.

Suinn also stated that the SL-ASIA (Suinn et al., 1987) is unable to differentiate between the ethnicities of each of the Asian American groups. It may therefore be difficult to generalize the findings of this study to specific Asian American ethnic groups though Chinese and Korean Americans represented the two majority groups in this study.

Finally, the ranges of scores for acculturation, attitudes toward seeking professional psychological help, and symptom reporting may have been
narrowed due to the fact that the majority of the sample consisted of well-adjusted, high functioning, and educated bicultural individuals.

Recommendations for Future Research

Future research is recommended with populations other than University populations to allow for greater generalizability to other Asian American populations. This will also allow for more diversity in regards to variables such as age and education level. It may additionally be helpful if future studies researched specific Asian American groups to see if differences exist between the varying Asian groups.

Owing to the restricted ranges of scores obtained for this study, it would be beneficial if there was a greater distribution of acculturation levels. This would provide a more accurate picture of the experiences and views of Asian Americans from varying acculturation levels.

Finally, an evaluation of gender differences and an examination of psychological symptoms other than somatization with acculturation may also prove beneficial in future research studies with Asian Americans.
References


Appendix A

SCL-90-R Somatization, Anxiety and Depression Scale Items
Owing to copyright laws, the items on the SCL-90-R could not be reprinted. The somatic scale on the SCL-90-R consists of items 1, 4, 12, 27, 40, 42, 48, 49, 52, 53, 56, and 58. The anxiety scale consists of items 2, 17, 23, 33, 39, 57, 72, 78, 80, and 86. The depression scale consists of items 5, 14, 15, 20, 22, 26, 29, 30, 31, 32, 4, 71, and 79. The SCL-90-R may be obtained through NCS Assessments, PO Box 1416, Minneapolis, MN 55440-9050.
Appendix B

Informed Consent for Participation Form
INFORMED CONSENT FOR PARTICIPATION

You are asked to participate in a survey. It involves four questionnaires and will require a total of about 15 minutes. Your participation in this survey is voluntary and you may stop at any time. This survey is completely anonymous. Please do not write your name on any of these pages. By completing the survey, you are giving your consent to participate.

_____ Please check here if you would be interested in receiving a summary of the results. Please write your mailing address or email address on the line below so the results can be sent to you when they become available.

Address: ____________________________________________________________

**Please do NOT write your name or any other information that is asked on the front cover of the SCL-90-R survey. You may also use a pen to fill in the circles for this survey rather than a pencil.

**Please return the surveys and informed consent no later than January 20, 1997.
Appendix C

Demographic Questionnaire
DEMOGRAPHIC QUESTIONNAIRE

Please complete all items. Circle or write your response where appropriate.

1). Gender: Male
   Female

2). Age: _____

3). Marital Status: Single
   Married
   a). If you are married, what is the ethnicity of your spouse?
      Chinese
      Japanese
      Korean
      Vietnamese
      Filipino
      Indian
      Caucasian
      Other: _______________________

4). What is your ethnicity?
   Chinese
   Japanese
   Korean
   Vietnamese
   Filipino
   Indian
   Other: _______________________

5). What is your occupation? ________________________________

6). Were you born in the United States?
   Yes
   No  If not born in the United States:
       Age upon arriving to the United States? ______

7). How many years have you been living in the United States? ______

8). In which state do you live? _____________________________

9). At what age did you attend school in the United States? ______

10). What is your highest degree obtained/ or in process of obtaining?
    High School
    College/ University
    Graduate School
    Area of study? _______________________

   a). If Graduate School, what is your highest degree obtained/ or in process of obtaining
      (if applicable):
      Masters Degree
      Doctoral Degree

   b). In which country did you complete your degree? ____________________________

   c). How many years did you take to complete this degree? _______
11). Is English your first language?
   Yes
   No   If not, what is your first language? _______________________

12). What language do you speak at home? _______________________

a). What language do you speak at your workplace/school? _______________________

13). How important is it for you to maintain your Asian roots?

   1  2  3  4  5
   Not important  _______ Extremely important  _______

14). How important is it for your family that you maintain your Asian roots?

   1  2  3  4  5
   Not important  _______ Extremely important  _______
Appendix D

Suinn-Lew Asian Self-Identity Acculturation Scale
Instructions: The questions which follow are for the purpose of collecting information about your historical background as well as more recent behaviors which may be related to your cultural identity. Choose the one answer which best describes you.

1). What language can you speak?
A. Asian only (for example: Chinese, Japanese, Korean, Vietnamese etc.)
B. Mostly Asian, some English
C. Asian and English about equally well (bilingual)
D. Mostly English, some Asian
E. Only English

2). What language do you prefer?
A. Asian only (for example: Chinese, Japanese, Korean, Vietnamese etc.)
B. Mostly Asian, some English
C. Asian and English about equally well (bilingual)
D. Mostly English, some Asian
E. Only English

3). How do you identify yourself?
A. Oriental
B. Asian
C. Asian-American
D. Chinese-American, Japanese-American, Korean-American, etc.
E. American

4). Which identification does (did) your mother use?
A. Oriental
B. Asian
C. Asian-American
D. Chinese-American, Japanese-American, Korean-American, etc.
E. American

5). Which identification does (did) your father use?
A. Oriental
B. Asian
C. Asian-American
D. Chinese-American, Japanese-American, Korean-American, etc.
E. American

6). What was the ethnic origin of the friends and peers you had as a child up to age 6?
A. Almost exclusively Asians, Asian-Americans, Orientals
B. Mostly Asians, Asian-Americans, Orientals
C. About equally Asian groups and Anglo groups
D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
E. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
7). What was the ethnic origin of the friends and peers you had as a child from age 6 to 18?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

8). Whom do you now associate with in the community?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

9). If you could pick, whom would you prefer to associate with in the community?
   A. Almost exclusively Asians, Asian-Americans, Orientals
   B. Mostly Asians, Asian-Americans, Orientals
   C. About equally Asian groups and Anglo groups
   D. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   E. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

10). What is your music preference?
   A. Only Asian music (for example: Chinese, Japanese, Korean, Vietnamese etc.)
   B. Mostly Asian
   C. Equally Asian and English
   D. Mostly English
   E. English only

11). What is your movie preference?
   A. Asian-language movies only
   B. Asian-language movies mostly
   C. Equally Asian/ English
   D. English-language movies mostly
   E. English-language movies only

12). Where were you born?
   A. United States
   B. Asia
   C. Other? If so, where? __________________________
   D. Don't know

12a). Where was your father born?
   A. United States
   B. Asia
   C. Other? If so, where? __________________________
   D. Don't know
12b) Where was your mother born?
A. United States
B. Asia
C. Other? If so, where? _______________________
D. Don't know

12c) Where was your father's father born?
A. United States
B. Asia
C. Other? If so, where? _______________________
D. Don't know

12d) Where was your father's mother born?
A. United States
B. Asia
C. Other? If so, where? _______________________
D. Don't know

12e) Where was your mother's father born?
A. United States
B. Asia
C. Other? If so, where? _______________________
D. Don't know

12f) Where was your mother's mother born?
A. United States
B. Asia
C. Other? If so, where? _______________________
D. Don't know

12g) On the basis of the above answers, circle the generation that best applies to you:
A. 1st Generation= I was born in Asia or other
B. 2nd Generation= I was born in U.S., either parent was born in Asia or other
C. 3rd Generation= I was born in U.S., both parents were born in U.S., and all grandparents
   born in Asia or other
D. 4th Generation= I was born in U.S., both parents born in U.S., and at least one grandparent
   born in Asia or other and one grandparent born in U.S.
E. 5th Generation= I was born in the U.S., both parents and all grandparents also born in U.S.
F. Don't know what generation best fits since I lack some information

13) Where were you raised?
A. In Asia only
B. Mostly in Asia, some in U.S.
C. Equally in Asia and U.S.
D. Mostly in U.S., some in Asia
E. In U.S. only
14). What contact have you had with Asia?
A. Raised one year or more in Asia
B. Lived for less than one year in Asia
C. Occasional visits to Asia
D. Occasional communications (letters, phone calls etc.) with people in Asia
E. No exposure or communications with people in Asia

15). What is your food preference at home?
A. Exclusively Asian food
B. Mostly Asian food, some American
C. About equally Asian and American
D. Mostly American food
E. Exclusively American food

16). What is your food preference in restaurants?
A. Exclusively Asian food
B. Mostly Asian food, some American
C. About equally Asian and American
D. Mostly American food
E. Exclusively American food

17). Do you...
A. read only an Asian language
B. read an Asian language better than English
C. read both Asian and English equally well
D. read English better than an Asian language
E. read only English

18). Do you...
A. write only an Asian language
B. write an Asian language better than English
C. write both Asian and English equally well
D. write English better than an Asian language
E. write only English

19). If you consider yourself a member of the Asian group (Oriental, Asian, Asian-American, Chinese-American etc...whatever term you prefer), how much pride do you have in this group?
A. Extremely proud
B. Moderately proud
C. Little pride
D. No pride but do not feel negative toward group
E. No pride but feel negative toward group

20). How would your rate yourself?
A. Very Asian
B. Mostly Asian
C. Bicultural
D. Mostly Westernized
E. Very Westernized
21). Do you participate in Asian occasions, holidays, traditions etc.? 
A. Nearly all 
B. Most of them 
C. Some of them 
D. A few of them 
E. None at all 

22). Rate yourself on how much you believe in Asian values (e.g., about marriage, families, education, work):

1 2 3 4 5
(Do not believe) (Strongly believe in Asian values)

23). Rate yourself on how much you believe in American (Western) values:

1 2 3 4 5
(Do not believe) (Strongly believe in American values)

24). Rate yourself on how well you fit when with other Asians of the same ethnicity:

1 2 3 4 5
(Do not fit) (Fit very well)

25). Rate yourself on how well you fit when with other Americans who are non-Asian (Westerners):

1 2 3 4 5
(Do not fit) (Fit very well)

26). There are many different ways in which people think of themselves. Which ONE of the following most closely describes how you view yourself?

A. I consider myself basically an Asian person (e.g., Chinese, Japanese, Korean, Vietnamese, etc.). Even though I live and work in America, I still view myself basically as an Asian person.
B. I consider myself basically an American. Even though I have an Asian background and characteristics, I still view myself basically as an American.
C. I consider myself an Asian-American, although deep down, I always know I am an Asian
D. I consider myself an Asian-American, although deep down, I view myself as an American first
E. I consider myself an Asian-American. I have both Asian and American characteristics, and I view myself as a blend of both.
Appendix E

Attitudes Toward Seeking Professional Psychological Help Scale
Instructions: Below are a number of statements. Read each statement carefully and indicate your degree of agreement or disagreement. Please express your honest opinion in rating the statement. There are no "wrong" answers, and the only "right" ones are whatever you honestly feel or believe. It is important that you answer every item. Please check ONE appropriate line (i.e., strongly agree, disagree somewhat, agree somewhat, or strongly agree) for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree Somewhat</th>
<th>Agree Somewhat</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Although there are clinics for people with mental troubles, I would not have much faith in them.</td>
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<td>2. If a good friend asked my advice about a mental problem, I might recommend that he/she see a counselor.</td>
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<tr>
<td>3. I would feel uneasy going to a counselor because of what some people would think.</td>
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<td>4. A person with a strong character can get over mental conflicts by himself/herself, and would have little need of a counselor.</td>
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<tr>
<td>5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.</td>
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<td>6. Considering the time and expense involved in psychotherapy, it would not be very valuable for me.</td>
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<td>7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
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<td>8. I would rather live with certain mental conflicts than go through the difficulty of getting counseling help.</td>
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<td>9. Emotional difficulties, like many things, tend to work out by themselves.</td>
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<td>10. There are certain problems which should not be discussed outside of one's immediate family.</td>
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<tr>
<td>11). A person with a serious emotional disturbance would probably feel most secure in a mental hospital.</td>
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<tr>
<td>12). If I believed I was having a mental breakdown, my first inclination would be to get professional help.</td>
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<tr>
<td>13). Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.</td>
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<tr>
<td>14). Having been a counseling patient is a blot on a person's life.</td>
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<tr>
<td>15). I would rather be advised by a close friend than by a psychologist even for an emotional problem.</td>
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<tr>
<td>16). A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.</td>
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<tr>
<td>17). I resent a person, professionally trained or not, who wants to know about my personal conflicts.</td>
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<tr>
<td>18). I would want to get counseling attention if I were worried or upset for a long period of time.</td>
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<td>19). The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
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<td>20). Having been mentally ill carries with it a burden of shame.</td>
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<tr>
<td>21). There are experiences in my life I would not discuss with anyone.</td>
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<td>22). It is probably best not to know everything about oneself.</td>
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23). If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in counseling.

24). There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help.

25). At some future time I might want to have psychological counseling.

26). A person should work out his/her own problems; getting psychological counseling would be a last resort.

27). Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."

28). If I thought I needed counseling help, I would get it no matter who knew about it.

29). It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Appendix F

VITA
Vita

Natasha A. E. Wong Stokem
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EDUCATION

George Fox University, Graduate School of Clinical Psychology, Newberg, OR, 9/93-present
Masters of Arts in Clinical Psychology, 1996
Dissertation Title: Acculturation in Relation to Somatization and Mental Health Attitudes among Asian Americans.

George Fox University, Newberg, OR, 9/92-5/93
Completion of 30 credit hours in psychology in preparation for graduate work. G.P.A. 3.80

Middlebury College, Middlebury, VT, 9/86-5/90
B. A. in East Asian Studies.
Graduation Honors: Cum laude with Honors in Major and Senior Dissertation.
College Scholar: Spring 88, Spring 89. Dean's List: Fall 87, Fall 89.

German Swiss International School, Hong Kong, 9/77-6/86
High School Diploma.

INTERNSHIP

Pacific University School of Professional Psychology, Psychological Service Center, Portland, OR, 8/97-present.

Portland State University Psychological and Testing Services, Portland, OR, 8/97-present.

CLINICAL EXPERIENCE

Assessment Specialist: Newberg School District, Newberg, OR, 8/96-6/97
Responsibilities include: Administration of intellectual and achievement tests to children and adolescents; and Report Writing.
Weekly group supervision.

Family Therapist: Chehalem Youth and Family Services, Intensive Family Services Division, Newberg, OR, 7/96-6/97
Responsibilities include: Therapy with families, couples, and children referred by Yamhill County Services to Children and Families Division; Administration of personality, intellectual, neuropsychological assessments and, achievement tests; Psychological Evaluations and Case Presentations.
Weekly group supervision.
Group Process Leader: George Fox University, Newberg, OR, 9/96-4/97
Responsibilities include: Leading Process groups and supervising dyad work for beginning and advanced undergraduate Counseling and Introductory Psychology courses. Weekly group supervision.

Oregon State Hospital- Head Injured Adult Ward, Salem, OR, 1/96-7/96
Clinical Psychology Practicum Student.
Responsibilities include: Individual, group, and milieu therapy to an acute, chronically mentally ill, and head-injured adult population; Administration of personality, intellectual, neuropsychological assessments; Psychological Reports; and Case Presentations. Weekly individual supervision.

Oregon State Hospital- Geriatric Ward, Salem, OR, 1/96-7/96
Clinical Psychology Practicum Student.
Responsibilities include: Group and milieu therapy to an acute and chronically mentally ill adult population; Administration of personality and neuropsychological assessments; Psychological Reports and Case Presentations. Weekly individual supervision.

Oregon State Hospital- Male Forensics Ward, Salem, OR, 9/95-12/95
Clinical Psychology Practicum Student.
Responsibilities include: Individual, group, and milieu therapy to an acute and chronically mentally ill adult population; Administration of personality and intellectual assessments; Psychological Evaluations; and Case Presentations. Weekly individual supervision.

Student Supervisor: George Fox University, Newberg, OR, 9/95-6/96
Supervision of graduate pre-practicum and practicum students in clinical psychology. Weekly group supervision.

Tualatin Valley Mental Health Center- Adolescent Day Treatment, Tigard, OR, 7/94-6/95
Clinical Psychology Practicum Student.
Responsibilities include: Individual therapy, co-leading in group therapy, and milieu therapy to severely emotionally disturbed adolescents; and achievement testing. Weekly individual and group supervision.

TEACHING EXPERIENCE

George Fox University, Newberg, OR, 9/95-12/95
Graduate Teaching Assistant and Group Discussion leader for an undergraduate general psychology class.

EMPLOYMENT

The First Step, Newberg, OR, 1/93-4/93
Daycare provider for children.

The Chase Manhattan Private Bank, Hong Kong, 7/90-1/92
Assistant Marketing Officer.
Middlebury College, Middlebury, VT, 9/89-12/89
Drill Instructor and Tutor for first year Chinese students.

Standard Chartered Bank, Hong Kong, 6/87-8/87
Research Assistant in Advertising and Public Relations Department.
Data research in Retail Marketing Department.

PROFESSIONAL AFFILIATIONS AND MEMBERSHIPS

Asian American Psychological Association (AAPA)
Member

American Psychological Association (APA)
Student Affiliate

American Psychological Association, Division 45: Society for the Psychological Study of Ethnic Minority Issues
Student Affiliate

American Psychological Association, Division 12: Clinical Psychology
Student Affiliate

Oregon Psychological Association
Student Member

Northwest China Council
Member

PRESENTATIONS


AWARDS

ASSESSMENT EXPERIENCE

Personality Tests

- Beck Depression Inventory
- Beck Suicide Inventory
- Draw-A-Person Test
- Dyadic Adjustment Scale
- Family Adaptation and Cohesion Scale
- House-Tree-Person Test
- Meyers-Briggs Type Indicator
- Minnesota Multiphasic Personality Inventory 1 & 2
- Rorschach Ink Blot Test (Exner System)
- Rotter Incomplete Sentences Blank
- Thematic Apperception Test
- Self-Report Family Inventory
- Sixteen Personality Factor Questionnaire
- Symptom Checklist 90-Revised
- Symptom Questionnaire

Intelligence Tests

- Stanford Binet, Fourth Edition
- Wechsler Adult Intelligence Scale-Revised
- Wechsler Intelligence Scale for Children-Revised
- Wechsler Intelligence Scale for Children-III
- Wechsler Memory Scale-Revised
- Wide Range Achievement Test-3

Neuropsychological Tests

- Bender Visual Motor Gestalt Test
- California Verbal Learning Test (CVLT)
- Draw a Bicycle Test
- Kaufman Short Neuropsychological Assessment Procedure
- Mini-Mental Status Exam
- Rey Auditory-Verbal Learning Test
- Rey 15-item
- Test of Nonverbal Intelligence -2
- Trail Making Test- Parts A & B
- Rey-Osterrieth Complex Figure Test
- Symbol Digit Modalities Test
- Wechsler Memory Scale-Revised
SEMINARS/ WORKSHOPS

**Issues in Intervention with Latino Adolescents, Children and Families**, OR, 3/97
Joseph M. Cervantes, Ph.D., A. B. P. P.

Albert Ellis, Ph.D.

**The Lasting Scars of Sexual Abuse: Child Sexual Abuse and It's Aftermath**, OR, 1/97
Adena Lee Banks, C. M. S. W., N. C. A. D. C.

**Life and Loss: Living and Grieving in the Family System Seminar**, OR, 10/96
Jackson P. Rainer, Ph.D.

**Attention Deficit Hyperactivity Disorder in Children and Adults Workshop**, OR, 9/96
Russell Barkley, Ph.D.

**Object Relations Seminar**, OR, 3/96
N. Gregory Hamilton, M.D.

**Multicultural Assessment Workshop**, OR, 3/96
Richard Dana, Ph. D.

**Virginia Satir 5-Day Workshop**, Hong Kong, 7/92
Jane Gerber, M.A.

COMMUNITY WORK

**Mother’s Choice**, Hong Kong, 5/90-8/90
Caregiver for abandoned babies and children.

**Alliance Youth Fellowship**, Hong Kong, 7/89
Group leader and counselor for youth summer camp.

**Vietnamese Refugee Camps**, Hong Kong, 9/85-1/86
Volunteer teacher for children.

**Welfare Handicrafts Shop**, Hong Kong, 3/85-6/85
Volunteer worker in sales benefiting the physically and mentally handicapped.