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CHAPTER 9

THE USE OF CULTURALLY-BASED VARIABLES IN ASSESSMENT: STUDIES ON LOSS OF FACE

1. INTRODUCTION

Invariably, clinicians find themselves in the predicament of prescribing what constitutes appropriate assessment for Asian American clients. On the one hand, many culturally sensitive and culturally competent clinicians think and go about doing assessment in certain ways to account for and incorporate the cultural background and experiences of Asian American clients into the diagnostic, case conceptualization, and treatment planning processes. Sometimes certain procedural and stylistic changes are indicated while at other times completely different assessment strategies and approaches are necessary to achieve effective outcomes. We also know with a fair degree of confidence that such changes in the traditional Western therapy regimen have an ameliorative effect, which result in clinically significant improvements in treatment efficacy. On the other hand, when asked to describe the manner by which these clinicians come to select a particular strategy or to implement a certain procedure, we frequently experience difficulty in articulating this process. This difficulty cannot be solely attributed to language problems. American-born, primarily English-speaking Asian American therapists also may find it difficult to explain the process by which they account for and use cultural information to enhance interventions. Rather, the problem results more from the use of a Western-based "therapeutic language" that prevents us from expressing the cultural dynamics involved in a particular case.

2. ORIGINS OF CULTURAL BIAS IN ASSESSMENT AND PSYCHOTHERAPY

It is proposed that a major source of cultural bias in psychotherapy centers on the lack of adequate descriptive and explanatory concepts that can be used to construct a meaningful and valid assessment of an Asian American client's bicultural experiences. In order to formulate effective treatment strategies, therapists must first conceptualize how clients experience and respond to their interpersonal environment. Common conceptual schemata for capturing such experiences have been referred to as worldviews, personal constructs, interpersonal dynamics (e.g. transference, countertransference), coping styles (e.g. sensitization versus

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repression), perceptual sets (e.g. field dependence/independence), and problem-solving strategies. In essence, these various approaches are diverse attempts to describe the salient cognitive, affective, and behavioral aspects of a client's psychological functioning that are operative in his or her efforts to effectively negotiate the interpersonal environment. Case conceptualization (not synonymous with diagnosis) uses certain of these schemata to reconstruct what and how clients are experiencing their problems within the context of their particular cultural milieu. Adequate case conceptualization enhances the formulation of appropriate treatment strategies and goals. In this context, appropriateness refers to the extent to which such interventions are culturally syntonic with client needs, values, and coping styles. Indeed, it can be argued that adequate case conceptualization in part reflects the degree to which the therapist can empathize with the client that, in turn, subsequently affects the development of rapport in therapy.

It is in the process of case conceptualization that cultural information can have its most significant impact. The crucial task is to utilize various constructs that do not violate the phenomenological validity of the client's experience. Previous work on cultural bias in mental health practice tends to focus on such issues as misdiagnosis, over-diagnosis, over-pathologization, over-medication, and the use of treatment approaches that are unfamiliar to Asian American clients. Many of these problems result from inadequate case conceptualization. Cultural bias in psychotherapy may develop less out of therapist neglect or prejudice but out of the use of conceptual frameworks that fail to comprehensively account for the bicultural experiences of the Asian American individual. From a bicultural perspective the descriptive and explanatory constructs proffered by the various schools of Western psychotherapy comprise a valid but incomplete set of conceptual tools for assessment. What is needed are alternative ways of viewing and interpreting human behavior from different cultural vantage points. Such conceptual tools can supplement, complement, and at times completely supplant more Western-based constructs frequently used for such tasks. The purpose of this chapter is to examine one such construct, loss of face, which possesses the potential to lend descriptive and explanatory breadth for understanding the clinical experiences of Asian American individuals. One study investigating the loss of face construct is presented followed by a discussion of how the application of this construct can facilitate effective assessment and treatment with Asian American clients.

3. AN ALTERNATIVE CONCEPTUAL TOOL: LOSS OF FACE

The development of assessment and treatment approaches that are more culturally-responsive to the mental health needs and issues of ethnic minority clients has been a challenging and, at times, frustrating undertaking. Problems in conducting culturally-sensitive assessments have been attributed to methodological difficulties such as the conceptual non-equivalence of measures (Brislin, Lonner, & Thorndike, 1973), culturally-specific response sets (Kleinman, 1977), cultural differences in handling contextualized versus non-contextualized information (Lynch & Hanson, 1992), clinician bias (López, 1989), and distortions that occur

when clients describe problems using English as their second language (Marcos, Urcuyo, Kesselman, & Alpert, 1973). However, in addition to methodological limitations, there are serious conceptual difficulties that constrain the valid and comprehensive assessment of human behavior as framed from different cultural contexts.

One major conceptual lacuna involves the lack of constructs that characterize and explain certain types of interpersonal dynamics that may be more salient in one culture than in another. In other words, cultures differ in the extent to which certain types of interpersonal dynamics can predict and account for variation in interpersonal relationships.

Tracking and assessment of the attitudes and orientations that people have in and toward their relationships are critical for several reasons. First, relational issues tend to be at the core of many problems that clients present in psychotherapy, and much of the time spent in therapy focuses on how clients can better manage and cope with their interpersonal problems (Horowitz, 1979). Second, change in therapy is primarily mediated through the client-therapist relationship so that it is important to examine certain interpersonal constructs that may be relatively more culturally-salient for different ethnic groups. Such variables may directly affect the relationship between client and therapist or what clinical researchers have called the working alliance between the client and the therapist. Finally, the assessment of a specific psychological dimension such as a particular interpersonal orientation provides for stronger explanatory models by allowing clinicians and researchers to determine *what it is specifically about culture* that accounts for a certain behavior or clinical problem. The deconstruction of culture into specific psychological elements enhances assessment efforts by providing more testable hypotheses (in terms of specific constructs) concerning the influence of culture on the client's behavior, symptoms, and/or psychosocial functioning (Betancourt & López, 1993).

Ho (1976) has noted that East Asian cultures, given their collectivist emphasis, are rich in relational constructs such as *on*, *amae*, filial piety, and "face." Moreover, the lack of emphasis on relational constructs in Western psychology has hindered our understanding of the role of culture in psychotherapy—given its interpersonal nature. One such construct that is definitely more salient in East Asian cultures is face. Face has been identified as a key and often-dominant interpersonal dynamic in Asian social relations (Sue & Morishima, 1982), particularly when the relationship involves seeking help for personal issues (Shon & Ja, 1982).

Based on various accounts of face in both East Asian and Western psychology, it appears that face has the following psychosocial parameters: First, as social beings, people are invested in presenting to others, either implicitly or explicitly, certain claims about their character in terms of traits, attitudes, and values. Others come to recognize and accept the person's "face" or "line" that the person claims for her or himself. This set of claims constitutes that person's face (Ho, 1991). Second, face is not simply prestige or social reputation obtained through success and personal achievements. Rather, according to Hu (1944) face represents the person's social position or prestige gained by performing one or more specific social roles that are well recognized by others or as Goffman (1955) notes, "face is an image of self

delineated in terms of approved social attributes" (p. 213). The line or face that one can claim is constrained or parameterized by the social roles ascribed and assumed by that person. Third, as Ho (1991) has observed, face is very salient in East Asian social relations whereas it has less social significance in more individualistic-oriented societies such as in the United States. The importance of face in East Asian cultures lies in its function as a mechanism that maintains group harmony. Reflecting a collective emphasis, great value is placed on maintaining harmonious relationships among in-group members and protecting the integrity of the group. Face-saving behaviors and the avoidance of face loss interactions enhance smooth relations among group members and help minimize disruptions to the social order. In this way, face concerns (especially for those with East Asian cultural heritage) are tied to *both* individual and group integrity. Thus, face can be defined as essentially a person's set of socially-sanctioned claims concerning one's social character and social integrity in which this set of claims or this "line" is largely defined by certain prescribed roles that one carries out as a member and representative of a group. The fact that face has esteem implications that extend beyond the individual to that individual's reference group is probably the main reason it has such psychological power in certain shame-based societies such as East Asian cultures.

The decision was made to focus on loss of face in this chapter because it appears to have more serious effects on one's social behavior. "Basic differences are found between the processes involved in gaining and losing face. While it is not a necessity to strive to gain face, losing face is a serious matter which will in varying degrees affect one's ability to function effectively in society" (Ho, 1974). Face loss is more serious because it tends to disrupt the interpersonal harmony within the group that is often a strong behavioral norm among East Asian societies (Ho, 1991). Moreover, it appears that face loss concerns and shame issues may be especially salient for Asian American clients seeking help for mental health problems that tend to be highly stigmatized issues in their communities and families (Uba, 1994).

In the following study, a measure assessing loss of face was developed and validated. In addition to concurrent and discriminant validity concerns, we also determined if the measure could account for ethnic variance above and beyond that accounted for by existing personality measures of more person-centered constructs.

4. DEVELOPMENT AND VALIDATION OF THE LOSS OF FACE MEASURE

4.1 Scale development

Using the rational development approach, a 21-item, 7-point Likert scale measure assessing loss of face (LOF) was constructed. An item pool was generated following an extensive review of available literature on the concept of loss of face, resulting in a list of 45 face-related behaviors and face-threatening situations. A research team of five persons including one clinical psychologist, one social psychologist, and three research assistants, using the following criteria, evaluated these items: (a) The item must involve a face-threatening behavior in one of the following four areas which have been suggested by the literature to be the most

common face-threatening situations (Hu, 1944; Ho, 1976; Hwang, 1987), and these are social status, ethical behavior, social propriety, or self-discipline; (b) the item must not be highly related to maladjustment; and (c) the item must be easily translated into Japaese and Chinese for cross-national research purposes. Decisions on the items using these criteria were reached by the unanimous agreement of all five researchers. Consequently, 21 items (for example, "I am more affected when someone criticizes me in public than when someone criticizes me in private") were selected for inclusion in the Loss of Face Scale (see Appendix A). Each statement was rated on a 7-point Likert scale, from 1 (*Strongly Disagree*) to 7 (*Strongly Agree*). All items were scored in the direction of face loss concern.

4.2 Sample

The participants were 158 undergraduate students at a major research university in California. There were 77 Caucasian Americans (42 males, 35 females) and 81 Asian Americans (37 males, 44 females) in this sample. The Asian American sample consisted of 34 Chinese (42%), 10 Filipino (12%), 7 Japanese (7%), 22 Korean (22%), and 8 Vietnamese (8%). Because there were no significant differences between Chinese, Korean, and other Asian American groups on the variables of interest (described below), the Asian American groups were combined for the subsequent analyses. There were no significant differences between males and females on all variables so that the groups were combined for all analyses. There were 29 Asian Americans (35.8%) born in the United States and 52 foreign-born Asian Americans (64.2%). For the foreign-born Asian Americans, the average number of years living in the United States was 12.5 ($SD = 3.9$).

4.3 Validation Study Design

The Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975), the Self-Monitoring Scale (Snyder, 1974), the Social Desirability Scale (Edwards, 1957), and an acculturation scale were chosen for inclusion in the validation study with the expectation that they would be related to the Loss of Face measure.

4.4 Concurrent Validity

Yang (1945) has suggested that there are several factors that influence face loss concerns. These include the degree of equality or inequality of status between the persons involved, the presence of another individual, the type of social relationship, social sanctions, age of the interactants, and sensibility. Therefore, it is expected that face loss concerns would involve awareness of one's own feelings, actions, and social status, indicated by a high level of self-consciousness. In addition, the control of self that an individual must exhibit to maintain and avoid losing face necessitates

a degree of self-monitoring. Thus, the Self-Consciousness Scale and the Self-Monitoring Scale were chosen to test concurrent validity.

It was expected that the public self-consciousness and private self-consciousness factors of the Self-Consciousness Scale and the other-directedness factor of the Self-Monitoring Scale would positively correlate with the Loss of Face Scale. It has been noted that face serves both the function of "a social sanction for enforcing moral standards" as well as that of "an internalized social sanction" (Hu, 1944, p. 62). Hwang (1987) has also indicated that face loss concern involves awareness of norms, the structure of social relationship networks within the society, and social obligations that are "incurred through a self-conscious manipulation of face and related symbols." As stated earlier, interactions of face include awareness of one's own social prestige, social relationship, and the social status of others as compared to the self (Yang, 1945). Thus, awareness of one's role in society, as measured by the public self-consciousness and other-directedness scales, and an awareness of one's internal state, as indicated by the private self-consciousness scale, would be expected to correlate with the face concerns.

Although a concern for face exists in every culture (Hu, 1944), the salience of face in the social interactions individuals from East Asian cultures has been well-documented (Chen-Louie, 1981; Goffman, 1955; Yang, 1945; Zane, Enomoto, & Chun, 1994). However, Chen-Louie (1981) has noted that face is important in "traditional Chinese culture, but esteemed in varying degrees by generations [in the United States] less steeped in the old ways" (p. 232). Thus, it is expected that high cultural identification with Asian American cultures would correlate positively with face loss concerns while high identification with White American culture would correlate negatively with loss of face.

4.5 Discriminant Validity

Loss of Face involves both an awareness of social norms as well as a consciousness of one's own internal state (Hu, 1944). We would expect that face loss would be distinguishable from simple conformity to social norms, namely, social desirability. It was expected that the Loss of Face measure would correlate somewhat with both the Social Anxiety subscale of the Self-Consciousness Scale and the Social Desirability Scale. As indicated by Yang (1945), the age of the persons involved, the presence of another individual, and the social status of the participants are all factors that influence face interactions. Face loss concern includes responsiveness to the status of the persons involved in the interaction beyond that of behaving in a strictly socially desirable manner. Thus, it was expected that although social desirability and social anxiety would correlate to some extent with loss of face, these relationships would not be so strong as to suggest that the constructs would be indistinguishable. Because all the items in the Loss of Face Scale are worded in the direction of face loss, a Response Acquiescence scale was also included in this study to control for this tendency. Finally, as noted earlier, items were selected so that they would not reflect a maladjusted, insecure behavioral style associated with individuals who are simply too concerned about what others

think or feel about them. To determine if the Loss of Face measure assessed individual tendencies independent of poor psychological functioning, a measure of maladjustment was included.

4.6 Incremental Validity

If indeed the Loss of Face Scale measures a salient construct that reflects important ethnic and cultural differences, ethnic differences on face loss should be evident beyond that which are registered by existing personality measures. First, ethnic comparisons between Asian and Caucasian American groups were conducted on all the personality variables assessed in the study including face loss. Second, to determine if face loss contributed to ethnic variance above and beyond what was accounted for by other personality variables, ethnic differences on face loss were examined after controlling for all other personality variables for which significant Asian-White differences were found.

4.7 Instruments

4.7.1 Self-Consciousness Scale

The Self-Consciousness Scale consists of 23 items designed to measure individual tendencies of self-attention (Fenigstein et al., 1975). The Self-Consciousness construct involves 3 factors: private self-consciousness, public self-consciousness, and social anxiety (Fenigstein, et al., 1975). Private self-consciousness measures attention to one's internal state of thoughts and feelings (e.g., "I'm constantly examining my motives"), while public self-consciousness concerns awareness of oneself as a social object, which affects others (e.g., "I'm concerned about what other people think of me"). Social anxiety refers to discomfort in the presence of others that may result from focusing attention on one's self through private self-consciousness or public self-consciousness (e.g., "I have trouble working when someone is watching me"). Items are rated on a 5-point Likert scale from 0 (*Extremely uncharacteristic*) to 4 (*Extremely characteristic*). Substantial evidence for the construct, convergent, and discriminant validity of the public and private self-consciousness scales has been found (Fenigstein et al., 1975; Carver & Glass, 1976; Carver & Scheier, 1978; Turner, Scheier, Carver, & Ickes, 1978). Previous studies on the Self-Consciousness Scale have found 4 of the 23 items to be "conceptually inconsistent with the underlying dimensions and/or did not load onto the identified factors" (Abe & Zane, 1990). Thus, these four items were omitted in the study, resulting in the administration of a 19-item scale.

4.7.2 Self-Monitoring Scale

The Self-Monitoring Scale is a 25-item, true-false measure developed to assess "self-observation and self-control guided by situational cues to social

appropriateness" (Snyder, 1974, p. 526). The Self-Monitoring Scale has been found to have at least three factors (Briggs, Check, & Buss, 1980) that include: other-directedness (11 items), acting (5 items), and extraversion (6 items). Other-directedness refers to changing one's behavior to please other people (e.g., "In order to get along and be liked, I tend to be what people expect me to be rather than anything else"); acting involves the ability to do and enjoyment of speaking and entertaining (e.g., "I have considered being an entertainer"); and extraversion deals with being the center of attention and confidence in social skills (e.g., "At a party I let others keep the jokes and stories going"). Nunnally (1978) found alpha coefficients for the subscales of the Self-Monitoring Scale as well as for the full scale itself that meet acceptable standards of internal consistency. The Kuder-Richardson reliability of the whole scale has ranged from .63 to .70 (Snyder, 1974), and the test-retest reliability after one month was found to be .83.

4.7.3 Cultural Identification

Two measures of cultural identification were used in this study, one of which was designed to assess identification with White American culture and the other which measured identification with Asian American cultures (Oetting & Beauvais, 1991). Each measure includes four questions involving adherence and an attachment to a particular cultural lifestyle and orientation (e.g., "Do you live by or follow the White-American way of life?" "Does your family live or follow the Japanese American way of life?"). Respondents indicate on a 4-point Likert scale the extent to which they have been involved in a particular cultural lifestyle varying from 1 (*Not at all*) to 4 (*Most of the time*). It was hypothesized that the Loss of Face measure would be correlated negatively with White cultural identification and positively with Asian American identification.

4.7.4 Social Desirability

The Social Desirability Scale (Edwards, 1957) is a 39-item, true-false inventory drawn from the Minnosota Multiphasic Personality Inventory, which is designed to assess "the tendency to endorse statements on the basis of their implicit social desirability rather than their actual explicit content" (e.g., "I dream frequently about things that are best kept to myself"). A corrected split-half reliability of .83 was reported and this measure has been correlated with other measures of social desirability such as the Marlow-Crowne Scale (Edwards, 1957).

4.7.5 Response Acquiescence and Maladjustment

The Minnesota Multiphasic Personality Inventory (MMPI) contains 79 true-false items designed to assess personality styles that can be factored into what Welsh and Dahlstrom (1956) have called the A and R scales. The R scale (40 items) has been shown to measure response acquiescence (e.g., "Sometimes, when embarrassed, I break out in a sweat which annoys me greatly"). The A scale (39 items) contains statements that generally have socially undesirable attributes (e.g., "I feel anxiety

about something or someone almost all the time"). The A scale generally correlates negatively with the Social Desirability Scale from -0.81 to -0.91 (Edwards, 1957).

4.8 Procedure

Subjects were scheduled in groups of 2 to 12, and the time for survey completion was generally 15 to 40 minutes. The surveys were administered by one of four female Asian American research assistants. Subjects were instructed to respond to each question and were permitted to leave after completing the survey. Explanations of the purpose of the survey were offered and given on request after the completion of the questionnaire.

Table 1. Reliability Alphas for Loss of Face Questionnaire for Total Sample

Subscales	α (n = 231)
Acting	.64
Other-directedness	.63
Extraversion	.63
Loss of Face	.83
Private Self-Consciousness	.72
Public Self-Consciousness	.77
Social Anxiety	.77
White-American Cultural Identity	.83
Asian Ethnic Cultural Identity	.87
Social Desirability	.78
Response Acquiescence	.60
Maladjustment	.81

4.9 Results and Discussion

The LOF measure was internally consistent with an alpha of .83. Table 1 shows that all validation measures demonstrated adequate internal consistency so that estimates of validity could be made without being compromised by differential reliability among the measures. The LOF measure demonstrated both concurrent and discriminant validity (see Table 2). As predicted, face loss correlated positively with other-directedness, private self-consciousness, public self-consciousness, and negatively with extraversion, acting (the desire to perform before others), and White cultural identity. Face loss was only correlated moderately with social anxiety and social desirability. However, it was not significantly related to response acquiescence, and more importantly, it was not related to maladjustment. Similar results were found when Asians and Whites were analyzed separately. Factor analysis of the LOF measure yielded one factor that accounted for 26 percent of the variance. These results suggest that the measure is unidimensional. Table 3 shows

the item loadings by ethnic group and total sample. An inspection of these loadings indicates that the LOF factor structure is similar for both Asians and Whites.

The only discrepant finding involved the non-significant relationship between Asian cultural identification and face loss. This may have been due to technical problems with the Asian identity measure, itself. Unlike the White cultural identification measure in which respondents simply respond to standard items, the Asian identity measure requires respondents to fill in their specific Asian ethnicity so that the item can reflect adherence to a specific ethnic Asian culture. Many respondents either did not comply with the instructions or reportedly found them to be somewhat confusing.

Table 2. Correlations of Loss of Face with Each Validation Measure for Asian Americans and Whites

Measures	Asians	Caucasians	Total
Acting	.01	- .24*	- .18**
Other-directedness	.44***	.33**	.37***
Extraversion	- .28**	- .23*	- .32***
Private Self-Consciousness	.22*	.15	.20**
Public Self-Consciousness	.42***	.56***	.51***
Social Anxiety	.54***	.54***	.58***
White-American Cultural Identity	- .10	- .03	- .13*
Asian Ethnic Cultural Identity	.16	- .28**	- .03
Social Desirability	- .49***	- .35**	- .47***
Response Acquiescence	.03	.11	.08
Maladjustment	.10	.13	.11

*p<.05 **p<.01 ***p<.001

Finally, a critical question is whether face loss can account for ethnic variance in addition to what has been accounted for by personality variables already established in Western psychology. Asians (M = 91.8, SD = 16.9) scored significantly higher on face loss than Whites (M = 80.4, SD = 16.3), t (156) = 4.32, p < .001. Consistent with previous studies, ethnic differences between Asians and Whites were also found on social anxiety, acting, other-directedness, and White cultural identification (see Table 4). However, the Asian–White difference on face loss persisted even after controlling for ethnic differences on these other personality variables, F (1, 150) = 7.42, p < .01, (adjusted means of 89.7 and 82.7 for Asians and Whites, respectively). An effect size analysis provides another way of examining the sensitivity of the LOF measure to ethnic differences. The effect sizes associated with the ethnic comparisons include the following: acting = .31, other-directedness = .27, social anxiety = .38, Asian cultural identity = .83, and face loss = .64. The effect sizes associated with ethnic differences on most of the other personality variables are somewhat larger than what Cohen (1992) considers to be a small effect size, whereas the effect size associated with ethnic differences on face loss is somewhat larger

than a moderate effect size. These results strongly suggest that face loss was an important ethnic discriminator. In fact, the only effect size larger than the face loss effect size is the one involving Asian cultural identity that is a large effect size, according to Cohen. However, this would be expected since little overlap would be expected in the cultural identities of Whites and Asian Americans on Asian cultural identity.

Table 3. Means, Standard Deviations, and t-values of Measures by Ethnic Group

	Ethnic Group		
Measure	Asian	White	*t*-value
Acting			
M	2.0	2.5	- 2.16*
SD	1.6	1.6	
Other-directedness			
M	5.4	4.8	1.90*
SD	2.0	2.2	
Extraversion			
M	3.0	3.4	- 1.44
SD	1.4	1.5	
Loss of Face			
M	91.8	80.4	4.32***
SD	16.9	16.3	
Private Self Consciousness			
M	21.0	20.4	0.82
SD	4.7	4.6	
Public Self Consciousness			
M	20.4	19.5	1.39
SD	4.1	4.1	
Social Anxiety			
M	10.0	8.6	2.28*
SD	3.7	3.6	
Acculturation (White)			
M	12.2	14.2	- 5.35***
SD	2.3	2.4	
Acculturation (Ethnic)	12.5	9.9	5.62***
M	2.2	3.6	
SD			
Response Acquiescence			
M	15.0	14.5	0.79
SD	3.9	3.9	

*$p<.05$ **$p<.01$ ***$p<.001$

The results support the reliability and construct validity of the LOF measure. Moreover, they also strongly suggest that the measure is especially sensitive to ethnic/cultural differences involving Asian Americans and Whites.

5. CONCLUSION AND IMPLICATIONS

Mental health practitioners and researchers continue to be perplexed by the problem of how to increase the effectiveness of mental health services to culturally diverse groups. A major but often overlooked difficulty that hinders progress in this area is the lack of appropriate "conceptual tools" to understand the interpersonal relationships of people from different cultures. In other words, cultures often differ in the extent to which certain interpersonal dynamics such as autonomy, dependence, loss of face, etc. govern or affect social interactions. Given that therapy tends to focus on the amelioration of interpersonal problems and that change in therapy is mediated through the client-therapist relationship, it is important that *assessment practices incorporate certain interpersonal constructs that may be relatively more culturally salient for different ethnic groups.*

The study presented demonstrates the potential utility of expanding the domain of assessment constructs to include loss of face issues. It appears that, consistent with accounts of Asian American clinicians, face loss is an important interpersonal issue that may hold the key to better understanding the dynamics involved in interpersonal problems of Asian American clients, as well as the treatment process and problems in establishing the working alliance between therapists and these clients. The assessment of face loss concerns opens up a number of potentially useful avenues for clinicians and researchers to pursue. First, knowing that face loss concerns may be paramount from the client's perspective may suggest the need to do "face work" in one's relationship or in treatment itself. Goffman (1955) has delineated the strategies that people often take to avoid loss of face and the usual steps that are necessary to conduct face work once face loss has actually occurred. These steps are necessary for a person who has lost face to re-claim it. By not knowing the essentials of face work, clinicians may be inadvertently impeding progress in therapy for clients who are more shame-oriented.

Second, attention to face issues may assist in understanding why Asian American clients tend to have the highest premature termination rates and shortest treatment stays in mental health systems (Sue, Zane, & Young, 1994). Therapists are often trained to elicit extensive self-disclosure and cathartic release especially in the early stages of therapy. Murase (1977) views this procedural tendency as reflecting the confessional nature of psychotherapy that reflects its Judeo-Christian roots as a healing practice. This process, while often effective, may also generate great face loss for certain clients, especially those who are unfamiliar with sharing their most private thoughts and feelings with a stranger, albeit a professional one. It is possible that by allowing such disclosures and catharses to go unabated, great face loss may be experienced as a client realizes, following these initial sessions, that she has caused face loss to not only herself but to those with whom she is closest. Such experiences would be expected to be more poignant for clients from shame-based,

collectivistic cultures. These predicaments may become exacerbated when clinicians unaware of face issues and dynamics perceive such disclosures as signs of therapeutic progress and fail to engage in face work. It is unclear if these problems actually occur and contribute to the early termination of Asian American clients. However, a face analysis strongly suggests that these should be investigated both empirically and clinically. Lastly, the assessment of face loss concerns provides clinicians with a tangible outcropping of that fuzzy construct of culture (Triandis, 1996). In this case, cultural variations map onto a specific psychological element that may affect social behavior. Moreover, since face loss issues may be intertwined with a client's interpersonal problems as well as with the process between client and therapist, this culturally-based construct is proximal to psychotherapy processes and outcomes (cf. Sue & Zane, 1987).

From a pan-cultural perspective, the results suggest that assessment research on loss of face issues can enrich the general study of interpersonal processes. Loss of face was found to be a valid individual difference variable for Whites as well as Asian Americans such that the Loss of Face measure showed similar psychometric properties for both ethnic groups. This lends empirical support to the notion that face concerns are universal but may be more salient in certain cultures (Ho, 1976). Needless to say, face loss concern is but one of many relation-oriented personality constructs that may be important for clinical assessment purposes. For example, constructs such as *personalisimo* in Latino culture, *amae* in Japanese culture, and *jen* in Chinese culture constitute some of these alternative "conceptual tools" that may greatly facilitate the development of more culturally-responsive assessment and treatment approaches for ethnic minority clients.

What distinguishes these constructs from other personality variables often used in assessment is their greater emphasis on the relational aspects of social behavior among individuals in contrast to the person-centered characteristics of individuals (Ho, 1982). Historically, assessment research and practices have tended to focus on variables that characterize individually oriented dispositions. Constructs such as self-esteem, locus of control, dependence, extraversion-introversion, and anxiety tend to refer to dispositions and attitudes that reflect how the individual perceives and experiences the world from his or her own personal perspective. While such constructs may at times point to or have implications with respect to the individual's relations with others, the major orientation is toward the person's experience and consciousness as an autonomous, independent functioning entity. In contrast, constructs often emphasized in Asian social sciences tend to be more relation-centered in that they more directly map onto the relational and reciprocal aspects of the social dynamics between people. For constructs such as face, *amae*, and *jen*, the focus is on the social relationship or the social behavior as the major unit of analysis, thereby, directly situating the person's experience within a more social rather than more person-oriented matrix.

As aptly noted by Ho (1982), the difference between relation-centered constructs and individual-centered constructs is relative in nature reflecting the frame of analysis that tends to be more salient. However, since the constructs employed affect

the way in which practitioners and clinicians organize and interpret the experiences of clients, the predominant application of Western, person-centered constructs may be a major contributor to error and/or bias involved in the assessment of individuals from collectivistic cultures and societies. Relation-centered constructs tend to be more salient for individuals who have been socialized from a more collectivistic cultural milieu. Consequently, the use of such constructs may make assessment practices and measures more effective in capturing the life circumstances and worldviews of these clients. Equally important, the inclusion of relation-centered constructs simply provides psychology, in general, and the assessment field, in particular, with a more comprehensive array of conceptual tools that can be used to account for human behavior.

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Appendix A. Loss of Face Questionnaire

Developed by Nolan Zane, University of California, Santa Barbara

Instructions: Use the scale below to indicate the extent to which you agree with each statement as it applies to you.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Mildly Disagree
4 = Neither Agree or Disagree
5 = Mildly Agree
6 = Moderately Agree
7 = Strongly Agree

_____ 1. I am more affected when someone criticizes me in public than when someone criticizes me in private.
_____ 2. During a discussion, I try not to ask questions because I may appear ignorant to others.
_____ 3. I maintain a low profile because I do not want to make mistakes in front of other people.
_____ 4. Before I make comments in the presence of other people, I qualify my remarks.
_____ 5. I downplay my abilities and achievements so that others do not have unrealistically high expectations of me.
_____ 6. I carefully plan what I am going to say or do to minimize mistakes.
_____ 7. I say I may be in error before commenting on something.
_____ 8. When I meet other people, I am concerned about their expectations of me.
_____ 9. I hesitate asking for help because I think my request will be an inconvenience to others.
_____ 10. I try not to do things which call attention to myself.
_____ 11. I do not criticize others because this may embarrass them.
_____ 12. I carefully watch others' actions before I do anything.
_____ 13. I will not complain publicly even when I have been treated unfairly.
_____ 14. I try to act like others to be consistent with social norms.
_____ 15. Before I do anything in public, I prepare myself for any possible consequence.
_____ 16. I prefer to use a third party to help resolve our differences between another person and me.
_____ 17. When discussing a problem, I make an effort to let the person know that I am not blaming him or her.
_____ 18. When someone criticizes me, I try to avoid that person.
_____ 19. When I make a mistake in front of others, I try to prevent them from noticing it.
_____ 20. Even when I know another person is at fault, I am careful not to criticize that person.
_____ 21. When someone embarrasses me, I try to forget it.

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