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RESEARCH ARTICLE

Culture matters: Chinese mental health professionals' fear of losing face in routine outcome monitoring

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Abstract
Objective: The culturally salient fear of losing face might influence Chinese therapists' attitudes toward and use of routine outcome monitoring (ROM). We tested a model wherein self-face concern is associated with ROM use by way of attitudes toward ROM, and whether this process is weakened when therapists report high counseling self-efficacy and perspective-taking.
Method: A national sample of Chinese mental health professionals ($N = 371$) completed questionnaires on their fear of losing face, attitudes toward ROM, ROM use, counseling self-efficacy, and perspective-taking.
Results: Regression-based analyses showed that fear of losing face was linked to greater negative attitudes toward ROM and lower ROM use. Greater negative attitudes mediated the relationship between fear of losing face and ROM use. However, neither counseling self-efficacy nor perspective-taking mitigated the relationship between self-face concern and ROM use; instead, they exacerbated this relationship through different paths. In the mediated pathway, counseling self-efficacy in coping with clients with difficult problems interacted with self-face concern to predict negative attitudes toward ROM. Perspective-taking served as a moderator that exacerbated the direct relationship between self-face concern and ROM use.
Conclusions: Findings suggest the importance of considering culturally salient factors in implementing ROM in China and other non-Western contexts.

Keywords: routine outcome monitoring; fear of losing face; ROM implementation; self-efficacy; perspective-taking; culture

Clinical or methodological significance of this article: This study is the first to demonstrate that culturally salient factors (e.g., fear of losing face) influence mental health professionals' attitudes toward ROM and its use in non-Western contexts. This study also revealed an underlying process and moderators of this relationship. These findings deepen our understanding of how and when self-face concern is related to the use of ROM in the Chinese context. The findings can be used to inform and tailor future ROM training and implementation in China.

Routine outcome monitoring (ROM) is the systematic collection of client feedback using standardized outcome instruments to track client progress, facilitate therapy adjustments, and prevent treatment failure. Multiple meta-analyses have demonstrated the positive effects of ROM on treatment outcomes and dropout rates (e.g., de Jong et al., 2021; Lambert et al., 2018). ROM appears to be especially

effective for clients who were not progressing well in therapy (Lambert et al., 2018). Given the strong empirical support for this method, ROM has been called the most noteworthy advance in psychotherapy in recent years (Wampold, 2015).

However, the practical applications of ROM in clinical work differ greatly between Eastern and Western cultures. According to a recent review on ROM (de Jong et al., 2021), nearly all existing studies on ROM were completed in Western countries (52% in Europe and 45% in the U.S.); and only one was conducted in Asia, specifically China (She et al., 2018). Such a cross-cultural difference is attributable to a variety of reasons, but one of the most important factors probably concerns cross-cultural differences in ROM attitudes. More specifically, the potential utility and issues of using ROM might be perceived differently across different cultures.

Cultural Characteristics, ROM Attitudes, and ROM Use

Research on factors associated with therapist perceptions of ROM has focused on characteristics of the therapist, their organization with regards to ROM, and the chosen feedback measure (de Jong & De Goede, 2015; Duncan & Murray, 2012; Ionita et al., 2016). However, only one study has investigated the link between cultural factors and attitudes toward ROM. Rodriguez et al. (2020) examined the associations between therapist cultural identity and attitudes toward ROM in a sample of therapists who were ethnic minorities (e.g., Latin-American, Asian, and Pacific Islander) in their community. They found that stronger identification with the culture of origin (i.e., non-Western culture of origin) was associated with greater perceived harm in using ROM. Authors argued that ethnic minority therapists might be more concerned about ROM's cultural misfit, thus perceiving it as more harmful (Rodriguez et al., 2020). Although limited, the evidence suggests that a non-Western cultural context might be negatively related to therapists' attitudes toward ROM and its use.

No study has investigated what and how cultural factors were related to the use of ROM. Identifying potential cultural barriers can be helpful in addressing therapists' concerns about this method. This line of research is particularly needed given that most of the research on ROM use has been in the US and Europe, and because existing ROM-promoting strategies are mainly based on the Western context without consideration of potential cultural effects. To this end, the current study examined a culturally salient characteristic in Chinese culture, namely fear of losing face, also called self-face concern. We examined the relationships among therapists' self-face concern, attitudes toward ROM, and use of ROM. We were also interested in whether therapists' counseling self-efficacy and perspective-taking moderated these relationships.

Face Concern, ROM Attitudes, and ROM Use

Face concern, a concept rooted in Chinese tradition, refers to a desire to maintain or preserve one's social image or prestige based on the performance of specific social roles in an interpersonal context (Ho, 1976; Mak et al., 2009). While face concern has been found across Eastern and Western cultures, it is generally considered more salient in collectivist societies like China (Ho, 1976; Mak et al., 2009; Oetzel et al., 2001). Face concern is essential in collectivist cultures because it has the function of maintaining group integrity and harmonious relationships between in-group members; avoiding face-loss interactions thus enhances smooth relations among group members and helps minimize disruptions to the social order (Zane & Yeh, 2002).

Face concern is deeply embedded in the daily interpersonal communication among Chinese people (Gao et al., 1996). Naturally, face concern might also shape communication between therapists and clients in the Chinese cultural context. Face concern has been conceived as a two-dimensional construct in the Chinese context (i.e., self-face concern and other-face concern; Mak et al., 2009; Ting-Toomey et al., 1991). Other-face concern involves considering others' face needs (Mak et al., 2009), and is less relevant to professionals considering ROM. This is because treatment progress indicated by ROM more directly signals therapist competency than client adequacy in the Chinese cultural context. Although clients' other-face concern may make the client less willing to give negative feedback, this is beyond the scope of this study. Thus, we only focused on therapists' self-face concern, namely, the Chinese mental health professional's fear of losing face when using ROM in the clinical context.

Self-face concern is likely to be relevant to therapists' attitudes toward and use of ROM because ROM is designed to identify clients who are not progressing as expected and to alert the therapist to discuss with their clients the reasons for the lack of progress (Duncan & Reese, 2015; Lambert & Harmon, 2018) and might generally signal a face-losing situation in the Chinese cultural context. More specifically, Chinese therapists with high self-face concern may fear that ROM would reveal their ineffectiveness, making them lose face in front of their clients due to their own "poor" performance.

This assumption is reasonable, considering China's hierarchical culture and the extensions of hierarchical norms into the therapeutic relationship (Duan et al., 2022). For example, compared with a more collaborative therapeutic relationship in Western countries, Chinese clients typically view therapists as experts or authorities who offer advice and direct the treatment (Duan et al., 2022). Correspondingly, as the higher party in a hierarchical relationship (e.g., therapist to client), Chinese therapists might also want to maintain their professional image by achieving desirable treatment progress through their performance (Duan et al., 2022; Ho, 1976). In other words, while assuming authority in the process, Chinese therapists also assume responsibility for the treatment progress. In this case, receiving negative feedback, and discussing it with clients, would suggest that the therapist has failed to meet the client's expectations and inadequately fulfilled the therapist's role, which could be easily perceived as a face-losing situation in Chinese context (Hu, 1944). According to Face-Negotiation Theory (Ting-Toomey & Kurogi, 1998), people with high face concern will put additional pressure on themselves to escape possible face-losing situations. Thus, we expected that Chinese mental health professionals with stronger self-face concern would likely exhibit more negative attitudes toward ROM and less use of ROM to avoid potential face-losing situations and to maintain their social role.

Moreover, according to the Theory of Planned Behavior (Ajzen, 1991), mental health professionals' attitudes toward ROM can be considered a precursor to whether or not they will adopt ROM (Patel et al., 2022). Thus, we further hypothesized that professionals' ROM attitudes would mediate the relationship between self-face concern and ROM use.

Moderators

Counseling self-efficacy. Although self-face concern is expected to predict ROM attitudes and its use, the activation of the link, as noted previously, might depend on whether therapists in practice anticipate poor progress and an eventual face-losing scenario. Several factors could contribute to this evaluation, one of which is counseling self-efficacy. Counseling self-efficacy refers to a counselor's beliefs about their ability to perform particular professional behaviors (Lent et al., 2003). According to Self-Efficacy Theory (Bandura, 2010), individuals with higher self-efficacy take a more proactive stance towards challenges and difficulties in various stressful circumstances. On the other hand, individuals with lower self-efficacy might give up quickly in the face of difficulties rather than concentrate on performing successfully. Specific to psychotherapy situations, studies have indicated that therapists with higher counseling self-efficacy exhibited more effort in overcoming obstacles that occurred during the counseling process, and more perseverance in the face of challenging counseling tasks (Larson & Daniels, 1998; Lent et al., 2006). In addition, compared to therapists with lower counseling self-efficacy, those with higher counseling self-efficacy displayed less anxiety; they interpreted their anxiety as challenging rather than overwhelming or hindering (Larson & Daniels, 1998).

It was therefore expected that, in the same self-face concern, therapists with higher counseling self-efficacy would have more confidence in handling cases with negative progress feedback, and would view difficult cases (e.g., clients who are off-track) as a challenge to overcome rather than a threat to avoid. In other words, therapists with high counseling self-efficacy might have less concern for face loss. They may thus have a less negative attitude toward ROM and its use. In contrast, therapists with lower counseling self-efficacy would have less confidence in handling difficult cases, would tend to view ROM as a potential face loss threat, and would choose to avoid it. That is, they would hold more negative attitudes toward ROM and use it less. Thus, it could be inferred that both the relation between self-face concern and ROM attitudes as well as the relation between self-face concern and ROM use may be moderated by counseling self-efficacy.

Perspective-taking. While self-face concern is a potential inhibitory motivator for ROM use, there could be a competing, facilitative motivation for ROM use. Perspective-taking, a form of cognitive empathy, has been defined as a deliberate attempt to adopt others' perspectives and to see things from their point of view (Davis, 1980); it involves being able to think from the perspective of others. People who use perspective-taking regularly have also been found to do so in specific situations, especially when there is an explicit or implicit cue to engage in psychological role-taking (Davis et al., 1987). Given that ROM in psychotherapy provides direct access to understanding how clients think and feel in the therapeutic process, it is reasonable to speculate that therapists with higher perspective-taking would be more open to using ROM and also more likely to use it.

Furthermore, previous studies have shown that greater perspective-taking was associated with more significant empathic concern for others, and with fewer feelings of personal unease in the face of others' negative experiences (Davis, 1980; Stocks

et al., 2011). These findings further suggest that perspective-taking might be a moderator in the relationship between self-face concerns and negative responses to ROM. Specifically, ROM reflects a vital source of client perspectives in clinical dyads and reveals clients' potential negative experiences (e.g., not progressing well) during treatment. Thus, compared to therapists with lower perspective-taking, we expected that therapists with higher perspective-taking would be more likely to view ROM positively and use it as a way to understand and help clients during psychotherapy regardless of any related fears, concerns, or pressures related to losing face. Thus, we inferred that both the relation between self-face concern and ROM attitudes and the association between self-face concern and ROM use may be moderated by therapists' levels of perspective-taking.

The Present Study

In the present study, we examined the association between Chinese mental health professionals' attitudes toward ROM (measured by the Monitoring and Feedback Attitudes Scale, MFA; Jensen-Doss et al., 2018), counseling self-efficacy, and perspective-taking, and how these are related to self-face concern and ROM use. Four hypotheses guided our analyses: (a) H_1: Greater fear of losing face will predict more negative attitudes toward and use of ROM; (b) H_2: Attitudes toward ROM will mediate the relationship between self-face concern and ROM use; (c) H_3: Counseling self-efficacy will serve as a moderator that weakens the direct effect and indirect effect (the first leg of the indirect link) of self-face concern on ROM use; (d) H_4:

Perspective-taking will serve as a moderator that weakens the direct effect and indirect effect (the first leg of the indirect link) of self-face concern on ROM use. The proposed model is shown in Figure 1.

Method

Participants

Chinese mental health professionals ($N = 400$) from 28 provinces and municipalities across China volunteered to complete questionnaires online. Participants who provided incomplete data ($n = 29$) were removed from the final analyses. The final sample included 371 mental health professionals (304 women, 67 men). Most participants were psychological counselors (88%), while the remaining 12% included psychotherapists, psychiatrists, clinical/counseling psychologists and social workers. The average age was 39.72 years ($SD = 9.10$; ranging from 22 to 81). Their clinical experience ranged from 0.1–32 years, with an average of 7.37 years ($SD = 5.79$). More information about the sample characteristics can be found in Table I.

Measures

Self-Face concern. The Fear of Losing Face Scale (FLF) was used to assess participants' self-face concern. The scale consists of 5 items. Each item (e.g., I always avoid talking about my weaknesses) is rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), with higher scores reflecting more fear of losing
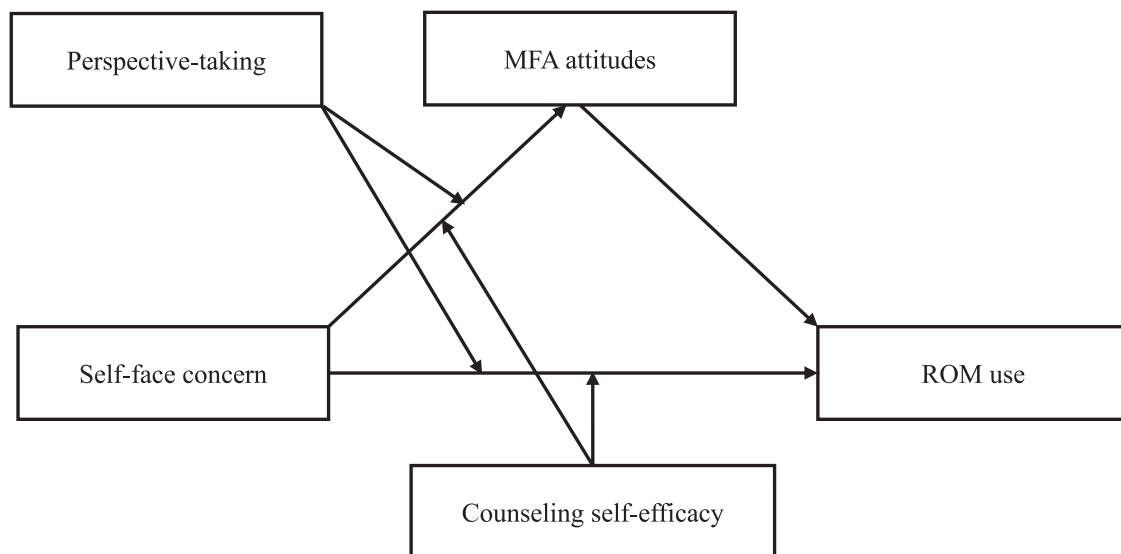

Figure 1. Moderated mediation model.

Table I. Sample Characteristics (*N* = 371).

Variable	*N*	(%)
Age (years)		
Mean (SD)	39.72 (9.10)	—
Range	22–81	—
Missing	2 (0.5%)	—
Gender		
Women	304	81.9%
Men	67	(18.1%)
Education		
Associate degree	22	5.9%
Bachelor degree	143	38.5%
Master degree	173	46.6%
Doctoral degree	30	8.0%
Missing	3	0.8%
Clinical experience (years)		
Mean (SD)	7.37 (5.79)	—
Range	0.1–32	—
Working settings		
Education system	162	43.7%
Mental health system	39	10.5%
Private practice	163	43.9%
Judicial system	7	1.9%
Principal therapeutic orientation		
Humanistic/client-centered	88	23.7%
Psychoanalytic/psychodynamic	133	35.9%
Cognitive/cognitive–behavioral	88	23.7%
Other	62	16.7%
Professional role		
Counselor	327	88.1%
Psychotherapist	19	5.1%
Psychiatrist	6	1.6%
Counseling/Clinical psychologist	4	1.1%
Others	15	4.1%

face. The Chinese version of the FLF has demonstrated good reliability and validity in Chinese samples (Zhang et al., 2011). Its internal consistency in the present sample was .85.

ROM attitude. The Monitoring and Feedback Attitudes Scale (MFA; Jensen-Doss et al., 2018) was used to assess mental health professionals' attitudes toward ROM. The original English version was translated into Chinese by the first author and two other counseling psychologists, and back-translated by an independent researcher with a Ph.D. in counseling psychology. Participants were given definitions of routine progress monitoring and feedback in the MFA instructions. The scale includes 14 items corresponding to two dimensions: MFA benefit (e.g., "Providing clients with feedback about treatment progress can increase their insight") and MFA harm (e.g., "Providing clients with negative feedback about their progress would make them think their therapist is incompetent"). Each item is rated on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores on the MFA benefit indicating more positive attitudes and higher scores on the MFA harm indicating more negative attitudes toward ROM. In the present study, the internal consistency was .91 for the MFA benefit subscale and .81 for the MFA harm subscale.

Perspective-taking. The Perspective-Taking subscale from the Interpersonal Reactivity Index (Davis, 1980) was used to assess therapists' tendency to consider another person's point of view. The perspective-taking subscale consists of 7 items. Each item (e.g., "Try to look at everybody's argument") is rated on a 5-point Likert scale ranging from 0 (does not describe me well) to 4 (describes me very well), with higher scores indicating a greater tendency to consider the perspectives of others. The Chinese version of the full scale has been shown to have good reliability and validity (Zhang et al., 2010). Its internal consistency in the present sample was .66.

Counseling self-efficacy. The Counseling Challenges Self-Efficacy subscale (CCSES) from the Counselor Activities Self-Efficacy Scale (Lent et al., 2003) was used to assess therapists' self-efficacy in handling challenging counseling situations. The CCSES includes 16 items corresponding to two factors: Relationship Conflict (CCSES-RC, 10 items) and Client Distress (CCSES-CD, 6 items). CCSES-RC items reflect interpersonal tensions or potential conflicts between the client and counselor. CCSES-CD items reflect difficult presenting problems. Each item is rated on a 10-point Likert scale ranging from 0 (no confidence) to 9 (complete confidence), with higher scores indicating greater counseling self-efficacy in each domain. The Chinese version of the scale has been validated with a Chinese sample of therapists (Li et al., 2022). In the present study, the internal consistency was .90 for the Relationship Conflict and .92 for the Client Distress; the internal consistency for the global CCSES was .93.

ROM use. Participants indicated how often they administer standardized progress measures on average in their clinical practice, using a one-item 4-point Likert scale (0 = never, 1 = sometimes, 2 = regularly, but not every session, 3 = almost every session; Jensen-Doss et al., 2018).

Control Variables

Extant research indicates that the use of ROM is more common among therapists who are women, have a CBT orientation, and have less clinical experience (Jensen-Doss et al., 2018; Rye et al., 2019);

however, the ROM use is lower for therapists working in private practice (Jensen-Doss et al., 2018). Thus, our analyses controlled for these variables as potential confounds. Theoretical orientation (CBT vs. other) and work setting (private practice vs. other) were coded as dummy variables.

Procedure

The study was approved by the Research Ethics Committee at the first author's institution (HR1-0002-2022). This study was not preregistered. A cross-sectional online survey was designed to collect data from mental health professionals across China. Multiple recruitment channels were used to maximize the representativeness of our sample, including posting notices on social media platforms used by professional groups and sending emails to professionals in the mental health field in different provinces of Mainland China. Participants were informed about the research aim, the estimated completion time, and confidentiality. All participants who completed the study received a gift of five yuan (about US $0.80).

Statistical Analysis

Descriptive statistics and correlation analyses were performed with SPSS 21.0. The SPSS macro PROCESS (Hayes, 2013) was used to test the predicted indirect effect (mediating effect) from self-face concern to ROM use through ROM attitudes (Model 4), and the moderating effect of counseling self-efficacy and perspective-taking in the relationship (both the direct link and the first part of the indirect link) between self-face concern and ROM use (Model 8). All study variables were standardized. Bootstrapping was applied with 5,000 samples, and bias-corrected 95% confidence intervals (*CI*) were used to test the mediation and moderated mediation

effects. Effects are considered statistically significant if the 95% CI does not include zero (Hayes, 2013). The dataset generated and analyzed in the current study is available from the corresponding author on reasonable request.

Results

Preliminary Analyses

Means, standard deviations, and zero-order correlations among the variables are presented in Table II. The fear of losing face was associated with MFA harm and ROM use, but not with MFA benefit. Because self-face concern was not significantly associated with MFA benefit ($r = -.08$, $p > .05$), we only processed the following mediation and moderated mediation analyses with MFA harm as a mediator. However, we conducted two separate moderated analyses (PROCESS macro model 1) to test whether CCSES and perspective-taking moderated the relationship between self-concern and MFA benefit after controlling for the control variables. Results indicated that perspective-taking ($\beta = -.11$, $p < .05$) but not CCSES (either subscale) showed a moderating effect ($p > .05$). To further evaluate the moderation of perspective-taking, we utilized the Johnson-Neyman method in PROCESS. The results showed that self-face concern had a significant inverse relationship with MFA benefit for professionals above the 99th percentile of perspective-taking and a positive relationship with MFA benefit for those below the 1st percentile of perspective-taking. However, we found no significant correlation between self-face concern and MFA benefit for those with perspective-taking levels between the 1st and 99th percentile. These results together with the nonsignificant moderation of CCSES-CD further showed that self-face concern was hardly related to MFA benefits.

Table II. Descriptive statistics and zero-order correlations for study variables.

	M	*SD*	1	2	3	4	5	6	7	8
1. Self-face concern	2.96	1.07	—							
2. MFA benefit	4.01	0.50	−.09	—						
3. MFA harm	2.75	0.74	.15**	−.23**	—					
4. CCSES−RC	5.27	1.44	−.20***	.08	−.16**	—				
5. CCSES−CD	5.25	1.81	−.16**	.15**	−.18**	.67***	—			
6. Global CCSES	5.26	1.45	−.20***	.12*	−.18***	.94***	.89***	—		
7. Perspective-taking	2.76	0.47	−.29***	.28***	−.04	.23***	.19***	.23***	—	
8. ROM use	0.72	0.82	−.16**	.22***	−.23***	.09	.17**	.14**	.17**	—

Note. N = 371.
**p < .05. **p < .01. ***p < .001.

Test of the Mediation Model

The mediation analyses tested MFA harm as a mediator of the association between self-face concern and ROM use after controlling for therapist gender, work settings, theoretical orientations, and years of clinical experience (PROCESS macro Model 4). The results showed that self-face concern positively predicted MFA harm ($\beta = .12$, $p < .01$) and negatively predicted ROM use ($\beta = -.19$, $p < .001$). These results provided support for H_1.

A bias-corrected bootstrap with 5000 samples estimated two effects: direct effect (effect of self-face concern on ROM use) and mediation effect (effect of MFA harm as a mediator in the relationship between self-face concern and ROM use). The direct effect was significant *(direct effect = −.13, SE = .05, 95% CI [−.23, −.03])*. The mediation effect was also significant *(indirect effect = −.02, SE = .01, 95% CI [−.06, −.01])*. The mediation effect explained 13.33% of the variance in the total effect. These results provided support for H_2.

Test of the Moderated Mediation Models

Next, we conducted moderated mediation analyses in which the first part of the mediated pathway (self-face concern → MFA harm) and the direct pathway (self-face concern → ROM use) would be moderated by counseling self-efficacy and perspective-taking, after controlling for therapist gender, theoretical orientation, work setting, and years of clinical experience. In the tested models, each included counseling self-efficacy or perspective-taking as an independent moderator (PROCESS macro Model 8).

We first included the global CCSES score as a moderator. The results showed that the global CCSES score did not moderate the association between self-face concern and MFA harm or the associate between self-face concern and ROM use. Because the global CCSES score did not show a moderating effect, we then conducted exploratory analyses to test the two subscales of this measure (CCSES-RC and CCSES-CD) as independent moderators and re-ran the same model. The CCSES-RC did not show a moderating effect, whereas the CCSES-CD did show a moderating effect (see below). For simplicity, we only report the results for tests of CCSES-CD as a moderator.

When adding the CCSES-CD score as a moderator (see Table III), the interaction between self-face concern and CCSES-CD was positively associated with MFA harm ($\beta = .10$, $p < .05$), but not with ROM use ($\beta = -.02$, $p > .05$). The results suggested

Table III. Moderation and moderated mediation effects in predicting MFA harm and ROM use.

	Outcome: MFA harm				Outcome: ROM use			
	β	SE	t	[95% CI]	β	SE	t	[95% CI]
Moderator: CCSES-CD								
Constant	.22	.27	.82	[−.31, .75]	−.45	.27	1.71	[−.07, .98]
Gender	.01	.13	.07	[−.25, .27]	−.28	.13	−2.18*	[−.54, −.03]
Work setting	−.18	.11	−1.69	[−.38, .03]	−.23	.10	−2.19*	[−.43, −.02]
Years of clinical experience	−.02	.01	−2.59**	[−.04, −.01]	.01	.01	1.57	[−.01, .03]
Theoretical orientation	.09	.12	.76	[−.14, .33]	.13	.12	1.12	[−.10, .36]
Fear of losing face (FLF)	.11	.05	2.05*	[.01, .21]	−.12	.05	−2.45*	[−.22, −.02]
Client distress	−.12	.05	−2.33**	[−.23, −.02]	.07	.05	1.39	[−.03, .18]
CCSES-CD × FLF	.10	.05	2.06*	[.01, .19]	−.02	.05	−.41	[−.11, .07]
MFA harm					−.18	.05	−3.53***	[−.28, −.08]
Moderator: Perspective-Taking								
Constant	.21	.28	.74	[−.34, .75]	.39	.26	1.46	[−.13, .91]
Gender[a]	.04	.13	.32	[−.22, .31]	−.28	.13	−2.17*	[−.53, −.03]
Work setting[b]	−.20	.11	−1.82	[−.41, .02]	−.23	.10	−2.23*	[−.43, −.03]
Years of clinical experience	−.03	.01	−3.70***	[−.05, −.02]	.02	.01	1.81	[−.01, .03]
Theoretical orientation[c]	.08	.12	.67	[−.16, .32]	.14	.12	1.19	[−.09, .37]
Fear of losing face (FLF)	.13	.05	2.35*	[.02, .23]	−.08	.05	−1.63	[−.19, .02]
Perspective-taking	.002	.06	.04	[−.11, .11]	.10	.05	1.87	[−.01, .21]
Perspective-taking × FLF	−.07	.05	−1.42	[−.17, .03]	−.16	.05	−3.41***	[−.25, −.07]
MFA harm					−.21	.05	−4.12***	[−.31, −.11]

Note. $N = 371$. Standardized regression coefficients are reported. Each column is a regression model that predicts the criterion at the top of the column. CCSES-CD = Counseling Challenges Self-Efficacy Client Distress subscale; [a]0 = men, 1 = women. [b]0 = other, 1 = private practice. [c]0 = other, 1 = CBT.
*$p < .01$. **$p < .01$. ***$p < .001$.

that CCSES-CD moderated the indirect effect of self-face concern on ROM use (via MFA harm), but not the direct effect of self-face concern on ROM. We probed the interaction by analyzing the simple slopes, with CCSES-CD scores categorized as high (1SD above the mean) or low (1SD below the mean). The indirect effect of self-face concern on ROM use through MFA harm was significant for the high CCSES-CD group (effect size = −.04, 95% CI [−.08, −.01]), but was not significant for the low CCSES-CD group (effect size = −.001, 95% CI [−.03, .03]). See Table IV. These results were contrary to the hypothesis (H_3). That is, higher CCSES-CD did not weaken but exacerbated the correlation between self-face concern and MFA harm.

Similarly, we tested H_4 using PROCESS macro Model 8. Again see Table III. The interaction between self-face concern and perspective-taking was negatively associated with ROM use (β = −.16, p < .001) but not with MFA harm (β = −.07, p > .05). These results suggested that perspective-taking moderated the direct effect of self-face concern on ROM use, but not the indirect effect (via MFA harm) of self-face concern on ROM use. We further examined the interaction by analyzing the simple slopes at ±1 SD of perspective-taking. The conditional direct effect of self-face concern on ROM use was significant in the high perspective-taking group (effect size = −.25, 95% CI [−.38, −.11]) but not in the low perspective-taking group (effect size = −.06, 95% CI [−.08, .19]), see Table IV. These results were contrary to the hypothesis (H_4). That is, higher perspective-taking did not weaken but exacerbated the correlation between self-face concern and ROM use.

Discussion

To our knowledge, this is the first study to investigate how and when a cultural characteristic is related to mental health professionals' use of ROM. Face-Negotiation Theory and the Theory of Planned Behavior provided the conceptual framework for the hypotheses. The results showed that greater fear of losing face (a salient cultural characteristic in China) was associated with more negative attitudes toward ROM and less ROM use. Greater negative attitudes toward ROM mediated the relationship between fear of losing face and ROM use, and this indirect effect was strengthened by professionals' self-efficacy in coping with challenging cases. In addition, mental health professionals' tendency to take others' perspectives strengthened the direct relationship between fear of losing face and ROM use.

Relationship Among Self-face Concern, ROM Attitude, and its Use

As expected, self-face concern significantly predicted higher perceived MFA harm and lower ROM use—even when controlling for participant gender, theoretical orientation, work setting, and years of clinical experience. This result is consistent with evidence that therapists' stronger identification with their ethnic culture of origin predicted more perceived harm of using ROM (Rodriguez et al., 2020). According to Rodriguez et al. (2020), non-Western therapists' more negative responses to ROM may be due to Western-developed evidence-based practices being unaligned with the values and norms of non-Western cultures. Our results support this assumption and suggest that fear of losing face would be such a culturally salient barrier to ROM use in the Chinese context.

A greater negative attitude toward ROM mediated the relationship between self-face concern and ROM use. The result was consistent with the Face-Negotiation Theory (Ting-Toomey & Kurogi, 1998) that high face-conscious persons are more likely to avoid potentially face-losing situations (e.g., a more negative attitude toward ROM), and with the Theory of Planned Behavior's assertion that attitude is an essential antecedent to behavior (Ajzen, 1991). Notably, positive attitudes toward ROM did not mediate the relationship between self-face concern and ROM use, as the association between self-face concern and

Table IV. Significance testing of the conditional indirect effects.

Moderator		Counseling self-efficacy (Client Distress)			Perspective-taking		
		β	SE	[95% CI]	β	SE	[95% CI]
Level of moderator	*M-SD*	−.001	.01	[−.03, .03]	.06	.07	[−.08, .19]
	M	−.02	.01	[−.05, −.01]	−.10	.05	[−.20, .01]
	M + SD	−.04	.02	[−.08, −.01]	−.25	.07	[−.38, −.11]

Note. M = the means of moderator, *SD* = standard deviation of moderator.

perceived positive attitudes toward ROM was non-significant. These findings indicated that self-face concern might influence ROM use by strengthening negative attitudes rather than by lowering positive attitudes toward ROM. Our results thus suggest a theoretical mechanism explaining how therapists' self-face concern affects ROM use in a Chinese cultural context. Specifically, those who reported greater fear of losing face were more likely to perceive harm in ROM and, in turn, to report less ROM use.

Counseling Self-efficacy as a Moderator

Contrary to our expectations, having higher counseling efficacy to cope with complex problems did not weaken the direct relationship between self-face concern and ROM use. This result was not consistent with our hypothesis. One possible explanation is that, in the Chinese context, counseling self-efficacy might not be enough to promote ROM use directly or as a moderator of another effect. More studies are needed to investigate the role of counseling self-efficacy in the link between self-face concern and ROM use.

The mediation analyses showed that self-face concern was associated with more negative attitudes about ROM, and in turn, lower ROM use. We hypothesized that the first part of this process (the association between self-face concern and MFA harm) would be weaker for therapists who reported self-efficacy about working with clients' difficult problems. However, self-efficacy did not weaken this relationship; instead, it exacerbated the relationship. Specifically, the association between self-face concern and negative ROM attitudes was stronger in the group with a high level of counseling self-efficacy to handle challenging clinical situations.

One possible explanation that CCSES-CD did not weaken the first leg of the mediation process is that Chinese therapists with higher scores on the CCSES-CD may trust themselves and use their internal resources (e.g., previous experience and clinical judgment) rather than external client feedback to address challenging cases. In addition, greater confidence in addressing complex client problems has been shown to be correlated with years of clinical experience (Lent et al., 2003; Morrison & Lent, 2018). Confident/experienced therapists in China might be even more defensive about potential face-losing situations or are more likely to perceive negative feedback as face-losing situations. In other words, they might not believe that negative feedback will happen but might be still concerned about this potential. They might thus show more negative attitudes toward ROM.

Perspective-taking as a Moderator

Contrary to our expectations, the Chinese professionals' level of perspective-taking failed to weaken the first leg of the mediation process (the association between self-face concern and MFA harm). Specifically, the professionals' greater tendency to take others' perspectives into consideration did not mitigate the effect of self-face concern on their negative attitudes toward ROM. According to Tuller et al. (2015), perspective-taking might change an individual's negative attitudes when there is actual contact with targets (Tuller et al., 2015). Given that most mental health professionals in this survey (83.8%) had never/seldom used ROM with their clients, in other words, most participants might have no meaningful contact with ROM when working with clients; it is understandable that perspective-taking did not substantially reduce the effect of self-face concern on negative attitudes toward ROM.

Although perspective-taking moderated the relationship between self-face concern and MFA benefit, the Johnson-Neyman analysis showed that self-face concern had a significant relationship with MFA benefit only at values below the 1st or above the 99th percentile of perspective-taking. That is, self-face concern showed an inverse relationship with MFA benefit for professionals with extremely high levels of perspective-taking, or a positive relationship with MFA benefit for professionals with extremely low levels of perspective-taking. One possible explanation is that Chinese professionals with extremely high perspective-taking might be particularly vulnerable to external feedback (including feedback potentially hurting face), which could enhance the negative relation of self-face concerns to MFA benefit. On the other hand, Chinese professionals with extremely low perspective-taking may struggle to comprehend their clients' progress independently. As a result, they may place more value on external client feedback, and their self-face concerns could stimulate the motivation for feedback and cultivate a more favorable attitude towards ROM. However, we should be cautious in making a conclusive decision because the perspective-taking in predicting the relationship between self-face concern and a positive attitude toward ROM is limited by a very narrow range of significance. This limitation could be attributed to a limited sample size or a generally weak association between self-face concern and the benefits of MFA. Future studies with a larger sample may confirm the role of perspective-taking in the relationship between self-face concern and a positive attitude towards ROM.

Furthermore, our findings found that perspective-taking moderated the direct association between

self-face concern and ROM use. However, contrary to our expectation, perspective-taking did not weaken the relationship between self-face concern and ROM use; instead, it exacerbated this relationship. Specifically, the negative effect of self-face concern on ROM use was stronger in professionals with a high level of perspective-taking. Although perspective-taking indicates a tendency to adopt the views of others spontaneously, professionals with higher levels of perspective-taking tended to use less ROM. This result seems inconsistent with previous notions indicating that individuals with a higher level of perspective-taking are more willing to adopt others' views in specific situations (Davis et al., 1987), as well as findings that other-oriented empathy (an indicator of perspective-taking) may reduce the clinician's perceptions of the personal costs of helping (e.g., the risk of losing face in the present study) (Siem, 2022).

We tried to draw from the literature to interpret this unexpected finding. In the study of Vorauer and Sucharyna (2013), they found the potential adverse effects of perspective-taking in close relationships. Their findings suggest that perspective-taking in contexts involving the potential for evaluation might prompt individuals to focus on how they appear to their evaluators (e.g., a partner). Specifically, perspective-taking increases individuals' tendency to consider themselves as objects of evaluation and to draw conclusions about how they are perceived; they might thus focus more on how their partners see them (Vorauer & Sucharyna, 2013). In other words, in a close relationship (therapeutic relationship is the focus of the current study), people with higher levels of perspective-taking might care more about their self-image and performance. Similarly, in the current case, while perspective-taking alone is positively associated with ROM use, it may also sensitize professionals to face-related information, resulting in self-face concern becoming a more influential factor. This could potentially decrease professionals' ROM use in their practice.

Limitations and Future Work

A number of limitations should be noted in this study. First, the cross-sectional design precludes us from making causal inferences about the associations among variables. Second, we used only the Counseling Challenges Self-Efficacy subscale to assess counseling self-efficacy; it might not capture all domains of counseling self-efficacy, such as helping skill self-efficacy and session management self-efficacy (Lent et al., 2003). Third, we studied a limited sample of professionals in a Chinese context, and more

studies are needed to replicate these findings and test their generalizability to other groups of therapists. Fourth, the sample in the current research is quite diverse. Professionals' clinical experience (e.g., the severity of their clients' issues) might contribute to the unexpected results. More homogenous samples would be needed to replicate our findings.

Clinical Implications

These results have several implications for ROM training and implementation. The findings suggest that fear of losing face may interfere with the potential benefits of ROM use in the Chinese context (She et al., 2018). Thus, trainers in ROM should take into account Chinese and other Asian mental health professionals' specific cultural values related to self-face concern. Training programs should also address the connection between self-face concern and negative attitudes toward ROM. For example, the ROM standard format/wording could be adapted to the Chinese context in order to reduce the risk of self-face concern. In addition, our findings suggest that Chinese mental health professionals with high counseling-self efficacy (especially handling clients with challenging issues) or perspective-taking tend to show less ROM use. Targeted training that emphasizes the values of external client feedback might be useful to improve this situation in China. For example, Chinese mental health professionals can be encouraged to collect some external progress feedback from clients to supplement what they know from other sources.

Conclusions

This study is the first to demonstrate a connection between a culture-specific characteristic (self-face concern) and Chinese mental health professionals' attitudes toward and use of ROM, and the circumstances wherein this connection is most potent. The results deepen the understanding of Chinese mental health professionals' responses to ROM and inform future ROM training and practice in Chinese culture. Furthermore, this study highlights the impact of cultural factors on ROM use, an issue largely ignored in previous ROM studies. We hope this study will encourage more research that will inform the adoption of ROM in non-Western cultures.

Author Note

This study was not preregistered. The datasets generated during and/or analyzed during the current study

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Disclosure Statement

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