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Psychotherapy Utilization and Presenting Concerns Among Asian International and Asian  
American Students in a University Counseling Center

Hannah La Shell Stokes

A dissertation submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of  
Doctor of Philosophy

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## ABSTRACT

### Psychotherapy Utilization and Presenting Concerns Among Asian International and Asian American Students in a University Counseling Center

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Department of Counseling Psychology and Special Education, BYU

Doctor of Philosophy

To date, there has not been research that disaggregates the experiences of Asian American and international Asian college students seeking psychotherapy in college campus settings. We examined archival data collected over the course of a 17-year period that focused on experiences of Asian American, international Asian, and European American students at a large university in the intermountain west, US. More specifically, we used archival data to identify differences between the aforementioned groups of students in regard to psychotherapy utilization, presenting concerns, distress levels endorsed at intake, and distress levels endorsed at termination. Results were calculated based on findings from the Family Concerns Survey (FCS), Presenting Problem Checklist (PPC), and Outcome Questionnaire 45 (OQ-45). Results indicate no significant differences between these three groups in terms of the maximum number of psychotherapy sessions attended. Cox Regression analyses showed no significant differences between these groups of students in regard to their likelihood for treatment discontinuance. Odds Ratio analyses yielded little statistical difference between groups in terms of likelihood of attending therapy. We found significant differences between these groups of students on a number of items related to their presenting concerns. Additionally, we found a significant difference between students in these three groups in regard to the severity of their presenting distress (as measured by the Outcome Questionnaire-45), with international Asian students presenting with the most distress followed by Asian American students and finally European American students. We also found a significant difference between these groups of students in treatment improvement as measured by change scores on the Outcome Questionnaire-45 with European American students experiencing the greatest change, followed by Asian American students, followed by international Asian students. Given the nature of these results, practitioners are admonished to attend to initial distress levels upon intake as well as Asian American and international Asian students' experience of racism and discrimination. Practitioners are also encouraged to align treatment recommendations with the specific world view of the client they are meeting with.

Keywords: Asian American students, European American students, International Asian students, counseling centers, psychotherapy outcome

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## Description of Dissertation Structure

Traditionally dissertations have been organized in a five-chapter format. However, this dissertation, *Psychotherapy Utilization and Presenting Concerns among Asian international and Asian American Students in a University Counseling Center*, is organized such that it is ready for publication in a standard peer-reviewed journal. A full literature review is included in Appendix B with other supporting documents after the discussion section concludes.

## Introduction

Since the first college counseling center opened in 1910, such centers have become one of the primary providers of mental health services to college aged students in the US (Brunner, Wallace, Reymann, Sellers, & McCabe, 2014). College counseling centers have been shown to be effective in helping students address a myriad of presenting concerns and have focused on everything from depression to personality disorders (Brunner et al., 2014; Lockard, Hayes, McAleavey, & Locke, 2012; Minami et al., 2009). Between 2001 and 2008, it is estimated that 68% of community colleges and 90% of four-year colleges have seen an increase in the number of students seeking psychological services. It is further estimated that the total number of students on college campuses in the US using psychological services ranges anywhere from 5-40% (Levine & Dean, 2012).

Beyond the increased number of students seeking college counseling center services, there has also been an increase in the severity of pathology with which students present (Brunner et al., 2014; Erdur-Baker, Barrow, Aberson, & Draper, 2006), the chronicity of their presenting concerns (Erdur-Baker et al., 2006), and an increase in the diversity of students using such services (Brunner et al., 2014; Kraft, 2011).

As such, administrative staff in college counseling centers across the US have made efforts to meet the increased needs of diverse students by shifting from long term therapy to brief treatment models, implementing session limits, providing after-hours care services, providing crisis intervention, and focusing on effective and multiculturally competent care (Kraft, 2011; Watkins, Hunt, & Eisenburg, 2012). In short, college counseling centers are seeing evermore demands being placed upon them from increasingly diverse student bodies.

As cultural diversity continues to grow in the US, the use of services provided by college counseling centers to students from ethnic and racial minority groups is increasing (Erdur-Baker et al., 2006). However, students from ethnic and racial minority backgrounds (Boone et al., 2011; Davidson, Yakushka, & Sanford-Martens, 2004) and international backgrounds (Nilsson, Berkel, Flores, & Lucas, 2004; Smith & Khawaja, 2011) continue to utilize services at lower rates than their European American (EA) counterparts.

Many have argued that in order to be a competent therapist or counselor, one must be multiculturally competent (Arredondo et al., 1996; Sue, 1998; Sue, Arredondo, & McDavis, 1992). The notion of multicultural competence is based in the idea that therapists should not only be familiar with the values, beliefs, and cultures of others, but also be able to work effectively with them (Sue, 1998). Some have contended that multicultural ideals should not be imposed on therapists for a variety of reasons including a limited research base (Hwang, 2006; Patterson, 2004; Thomas & Weinrach, 2004; Vontress & Jackson, 2004; Weinrach & Thomas, 2002, 2004). However, in recent years, research regarding the effectiveness of multicultural counseling has swelled (Benish, Quintana, & Wampold, 2011; Smith & Trimble, 2016; Sue, Zane, Hall, & Berger, 2009; Wampold & Imel, 2015) and multicultural ideals are increasingly accepted in mainstream psychology and are endorsed by professional associations (e.g., American Counseling Association, 2015; American Psychological Association, 2014).

Even with increased professional attention to multicultural issues related to mental health concerns, there are still several potential reasons that the utilization rates between EA students and students from racial/ethnic minority backgrounds remain disparate. While it is beyond the scope of this paper to examine all of the potential reasons that students from racial/ethnic

minority backgrounds underutilize mental health services, it is worthy to discuss some of the more salient barriers that are likely faced by these students.

Contemporary psychology and counseling practices continue to reflect the values of Western culture (Benish et al., 2011; Smith, Soto, Griner, & Trimble, 2015). As such, the cultural values of those from ethnic/racial minority groups are often incongruent with traditional mental health practices (Chao & Nath, 2011; Sue, 1988; Sue & Zane, 1987) and students from diverse backgrounds may find traditional counseling services unhelpful (Hall, 2001; Trusty, Davis, & Looby, 2002).

Furthermore, there has been a historical lack of bilingual therapists from ethnic backgrounds similar to their clients (Flaskerud & Hu, 1993; Jacobs, Diamond, & Stevak, 2010) which may dissuade culturally diverse students from seeking services. While therapists are unlikely intentionally harming clients from racial and ethnic backgrounds different than their own, many therapists are likely not familiar with the backgrounds, worldviews, and experiences of such clients with whom they meet. As such, contextual factors such as culture, gender, socioeconomic status, race and ethnicity, sexual orientation, religion, and environment may not be given adequate consideration in the counseling process (Gone & Trimble, 2012; Smith et al., 2015).

Scholars and professional organizations alike have repeatedly emphasized the need to improve counseling utilization, retention, and outcome among clients from historically disadvantaged backgrounds (APA, 2002; Arredondo & Toporek, 2004; Arredondo et al., 1996; Smith et al., 2015; Sue, 1998, 2003). For the purposes of this study, we will focus on disaggregating the experiences of Asian American (AA) and international Asian (IA) university

students, which groups have typically been lumped together in previous research (Meyer, Zane, Cho, & Takeuchi, 2009; Yang, Haydon, & Miller, 2013).

### **Asian American University Students**

The AA minority group is one of the fastest growing racial minority groups in the US (Kalibatseva & Leong, 2011). This group is also enrolling in higher education settings at higher rates than in the past (Hune, 2002). However, in general, AAs tend to utilize traditional therapy less than the general population (Abe-Kim et al., 2007; Boone et al., 2011; Kalibatseva & Leong, 2011; Leong & Lau, 2001; Meyer et al., 2009; Ruzek, Nguyen, & Herzog, 2011). Even when AAs do seek treatment, they typically have premature dropout rates (Kim, Park, La, Chang, & Zane, 2015; Leong & Lau, 2001) and a greater initial severity of distress upon entering therapy than their European American (EA) counterparts (Kim et al., 2015). AA students have even been reported to be overrepresented in completed suicides in campus settings and report lower levels of satisfaction with their overall university experience when compared with other university students (Boone et al., 2011).

One potential explanation for these trends are that many AA students hold to traditional Asian belief systems which often run counter to seeking professional mental health treatment (Shea & Yeh, 2008). AA populations also tend to have a strong attachment to their family and tend to prefer to integrate with their family's ideals rather than following their own ideas in treatment (John, Castro, Martin, Duran, & Takeuchi, 2012; Leong, Lee, & Kalibatseva, 2016). Furthermore, in some Asian cultures it is more socially appropriate to suppress or avoid emotions so as to maintain social harmony (Butler, Lee, & Gross, 2007; Cheung & Park, 2010; Kitayama, Karasawa, & Mesquita, 2004; Markus & Kitayama, 1991). While emotion suppression, from a Western point of view, may seem detrimental, research has shown that

emotion suppression does not necessarily negatively impact everyone the same (Butler et al., 2007; Cheung & Park, 2010). For example, Butler et al. (2007) found that American women from a university who held Western-European values tended to have negative effects when engaged in emotion suppression. However, at this same university, Asian American women who held traditional Asian values, had significantly reduced negative effects of emotional suppression. Similarly, Cheung and Park (2010) found that among EA and AA university students, the results of anger suppression seemed to be moderated by race and level of interdependence.

Varying levels of acculturation have also been shown to have an impact on mental health help seeking behavior among AAs. Kim (2007) and Miller, Yang, Hui, Choi, and Lim (2011) describe acculturation as an individual undergoing the process of enculturation. More specifically, enculturation is the adherence to values and behaviors in one's culture of origin, while at the same time undergoing the process of acculturation, which is the adherence to values and behaviors in the second culture. AAs tend to endorse a greater prevalence toward help seeking behaviors and have better treatment outcomes when acculturation levels are high and enculturation levels are low (Gloria, Castellanos, Park, & Kim, 2008; Kim, 2007; Leong & Lau, 2001; Miller et al., 2011; Ruzek et al., 2011).

Another reason that AAs may not seek mental health services is that they may not identify presenting concerns as psychological problems per se (Ruzek et al., 2011). For example, AAs may experience mental health concerns (anxiety, stress, etc.) as somatic symptoms (stomach aches, headaches, etc.) rather than psychological concerns (Chin, 2007; Smith & Khawaja, 2011). Thus, it is not uncommon for AAs to seek treatment in local health centers rather than in mental health or counseling centers (Leong & Lau, 2001; Leong et al., 2016; Smith

& Khawaja, 2011). Furthermore, AA students tend toward seeking help in roundabout ways (websites, classes, student health centers) rather than directly seeking traditional counseling approaches that are often present in college counseling centers (Ruzek et al., 2011).

Generally speaking, Western culture and traditional psychotherapies tend to value individuality, expression of emotion, and assertiveness. As such, AA students may find it difficult to relate to traditional Western ideals in therapy (Smith & Khawaja, 2011).

Furthermore, research has shown that AA individuals generally prefer a more directive approach to therapy (Chin, 2007; Leong et al., 2016), and tend to exhibit a lower tolerance for ambiguity than their EA counterparts (Wong, Beutler, & Zane, 2007). Thus, the credibility of the therapist as the “expert” appears to be particularly important (Chin, 2007; Leong et al., 2016; Wong et al., 2007). As mentioned earlier, the number of diverse groups on college campus settings has steadily increased over the past several years. One of these diverse groups is made up of international students.

### **International Students**

Between the years 2013 and 2014 there was an 8% increase of enrolled international students in US colleges; a 72% increase since the year 2000 (Institute of International Education, 2014). International students face a host of difficulties in adjusting to US college settings. They face acculturation stress (Berry, 2005; Smith & Khawaja, 2011), learning new styles of teaching (Smith & Khawaja, 2011), discrimination (Lee, 2007; Poyrazli & Grahame, 2007; Smith & Khawaja, 2011), performing academically and socially in a second language (Olivas & Li, 2006; Smith & Khawaja, 2011), and numerous practical stressors (work restrictions, greater tuition fees, transportation, distance from family and other social supports,

etc.; Polyrasli & Grahame, 2007). Each of the aforementioned concerns can lead to increased mental health concerns.

Yet, even when faced with these mounting oppositions, most international students underutilize counseling services (Nilsson et al., 2004; Olivas & Li, 2006; Smith & Khawaja, 2011). While there are numerous possibilities as to why this is the case, it has been hypothesized that many international students tend to view the disclosure of problems to be a sign of immaturity and weakness, thus further stigmatizing their views on counseling (Mori, 2000). Other international students might present to a primary care physician with somatic symptoms, and thus not receive the treatment that they need (Mori, 2000). Still, other international students are not informed about how to locate services, nor are they informed about what to expect regarding the basic concepts of therapy, particularly in a Western society (Mori, 2000). In the next section we focus more specifically on the experience of IA students.

**International Asian students.** IA students actually make up a significant proportion of international students within the US, with students from China comprising 31% of all international students (Institute of International Education, 2014; Yan & Berliner, 2013). In fact, when examining college enrollment numbers among international students attending U.S. colleges, students from Asian countries comprise over half of the enrollment numbers for international students in the US (Institute of International Education, 2014). IA students often face all of the barriers previously discussed that both AA and international students encounter when attending US universities.

Research focused on the experiences of IA college students is just now burgeoning (Wong, Tsai, Liu, Zhu, & Wei, 2014) and ranges from perceived racial discrimination and its impact on masculinity (Wong, Tsai, et al., 2014) to the manner in which adherence to traditional

Asian values (such as emotional self-control and humility) impacts mental health seeking attitudes (Wong, Wang, & Maffini, 2014). Some research indicates that IA students endorse a higher willingness to seek counseling when experiencing a significant amount of academic stress (Li, Wong, & Toth, 2013). However, many IA students view counseling as a last resort and then, only for severe mental illness (Constantine, Kindaichi, Okazaki, Gainor, & Baden, 2005; Li et al., 2013).

### **Statement of Purpose**

AA students, having grown up in mainstream American culture, are very likely to have different experiences than IA students both in their expectations of school and therapy (Yang et al., 2013). Research has compared AAs and IAs in regard to parental support (Yang et al., 2013), ethnic identity (Yasuda & Duan, 2002), emotional well-being (Yasuda & Duan, 2002) and acculturation (Yasuda & Duan, 2002). However, to date, there has not been research that partitions differences in treatment utilization, presenting concerns, initial severity of presenting concerns, and mental health treatment outcomes between these two groups in college settings.

For the purposes of this study, we focused on AA and IA students; two minority groups that have historically underutilized mental health services (Abe-Kim et al., 2007; Boone et al., 2011; Nilsson et al., 2004; Olivas & Li, 2006; Ruzek et al., 2011; Smith & Khawaja, 2011). Often, these two groups are lumped together hiding potentially significant and important differences between the two (Meyer et al., 2009; Yang et al., 2013). As Sue (1977, p. 623) suggests, “research should be aimed at teasing out group differences as well as similarities in order to promote psychological well-being.” Leong et al. (2016) emphasize the importance of understanding the potential similarities and differences among Asians in the US and Asians from other nations. In this study, we compare and contrast presenting concerns, patterns of treatment

utilization, treatment outcome, and initial severity of the presenting concerns among AA and IA students at a large, Western, private, religiously oriented university. We compared AA and IA students with EA students as EA students make up the majority population at this university. The nuances associated with treating AA and IA students at U.S. university counseling centers, as well as the potential dangers of lumping these groups together will be discussed.

### **Research Questions**

We hypothesized that there would be statistically significant differences between IA, AA, and EA college students on the following variables:

1. Treatment utilization (as measured by the number of sessions attended)
2. Initial presenting concerns (as measured by the Presenting Problems Checklist; please see description of this measure below)
3. Family concerns (as measured by the Family Concerns Survey; please see description of this measure below)
4. Severity of concerns (as measured by initial OQ-45 scores; please see description of this measure below)
5. Treatment improvement rates (as measured by change from initial to final OQ-45 scores after controlling for initial level of severity)

### **Method**

#### **Participants**

Archival data has been collected at a counseling center from a large, private, religiously oriented, intermountain university in the US over the course of 17 years (1996-2013). This data was analyzed to compare results across AA, IA, and EA students who completed the requisite

measures (see instrument section below). This sample included 19,306 students who filled out intake paperwork and identified as IA, AA, or EA (see Table 1 for demographic information).

As with other counseling centers across the US, there are bound to be issues that arise in collecting and storing data, particularly when such data spans the course of 17 years. Due to the fallibility of human staff in recording data (both clerical and research assistants), the large nature of the counseling center from which this data was obtained, the transition from paper to electronic versions of intake questionnaires and other records of interest, and the premature discontinuance of treatment by some clients, some participants were missing data from one or more of the measures we analyzed. Given the large number of EA students and the relatively smaller numbers of AA and IA students in our sample, coupled with the lack of a conceptually compelling rationale to exclude participants who were missing data, we analyzed each measure using the total number of students in each group who completed the measure of interest. Thus, analyses conducted on each measure of interest have varying sample size numbers for participants.

**Inclusion and exclusion criteria.** Every participant filled out a basic demographic questionnaire in which they were asked about their birth country, citizenship country, and ethnicity. The demographic questionnaire allows students to list up to eight ethnicities with which they identify. In order to determine which students would be placed into the IA and AA groups, we first looked at students' reported ethnicity and identified those who reported their primary or secondary ethnicity as Asian. We excluded those who reported Asian ethnicity at the tertiary level and below in order to better ensure that we captured the experiences of those students from primarily Asian backgrounds. After identifying those students who identified their

primary or secondary ethnicity as Asian, we focused on their country of citizenship to differentiate AA and IA.

In order to be considered an IA student, the individual needed to endorse their citizenship as a country that is typically associated as Asian (i.e., China, Hong Kong, Indonesia, India, Japan, Malaysia, Mongolia, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Thailand, and Vietnam). It should be noted that several participants reported a birth country and citizenship country typically considered Asian, but endorsed their primary or secondary ethnicity as PAC, meaning part of the Pacific islands. Because several Asian countries are in the Pacific Ocean and are typically associated with the classification of PAC, these students were included. Those who endorsed a primary or secondary ethnicity of Asian and reported U.S. citizenship were included in the AA group.

In order to be included in the EA sample, students needed to endorse their ethnicity as Caucasian or White and their citizenship as US on the demographic questionnaire. We included only those EA students who endorsed U.S. citizenship to help rule out international EA students. It should also be noted that individuals who endorsed Caucasian or White ethnicity with Asian Citizenship, Caucasian or White ethnicity with Other Citizenship, or Asian ethnicity with Other Citizenship were not included in the study.

### **Setting**

Over the 17 years that this data was collected, on a yearly basis this counseling center employed a range of 21-28 full-time clinical faculty members, 3-5 pre-doctoral interns, and 16-22 doctoral level practicum students. While we were unable to obtain specific demographic information, the vast majority of therapists in this center in any given year were White.

Students requesting counseling services were assigned to the first available counselor based on availability. Considerations were taken to make sure that students presenting with a high severity in symptoms were assigned to clinicians with the appropriate level of competence. The full and part time clinical faculty, pre-doctoral interns, and doctoral practicum students at this center endorsed a variety of theoretical orientations (e.g., cognitive-behavioral, acceptance and commitment therapy, interpersonal, etc.), and unless the student requested a specific type of treatment or a specific therapist, they were assigned at random to the first available counselor and received services as per that counselors' theoretical orientation. In addition to individual therapy, the counseling center has, on average, twenty different psychotherapy groups available each semester as well as biofeedback services that the student may choose to participate in if applicable.

### **Instruments**

A variety of instruments were included in this study: three of the measures were administered at intake and one instrument measured clients reported levels of distress and was administered prior to each counseling session. Descriptions of the measures follow.

**Demographic Questionnaire (DQ).** This self-report demographic measure asks questions about previous counseling experience, marital status, age, gender, ethnicity, citizenship country, country of birth, and religious affiliation.

**Family Concerns Survey (FCS).** The Family Concerns Survey lists 18 items used to assess a clients' family history of traumatic events and was administered at intake. The participant is asked to endorse items that happened during their childhood or adolescence and are asked to mark "Yes," "Unsure," or "No" on this survey. This survey is used by the clinician on

an item-by-item level and has no subscales. While there is not reliability or validity data available for this measure, the Cronbach's alpha for this study was 0.77.

**The Presenting Problem Checklist (PPC; Draper, Jennings, & Baron, 2003).** The Presenting Problem Checklist was developed by the Counseling and Mental Health Center at the University of Texas at Austin (Draper et al., 2003). Draper et al. (2003) used 12 presenting problem checklists that were already in use in various counseling centers and combined them to make this 42-item measure. This measure was designed to evaluate the level of distress and the duration of said distress on a number of concerns. Students were asked to "indicate the extent to which the problem is currently causing you distress" on a Likert scale of 0 (none) to 4 (extreme) and were then asked "for how long have you had the problem," and were asked to rate this on a Likert scale of 1 (less than a week) to 6 (more than 3 years). Students completed this measure at intake. Clinicians usually look at the results of this measure on an item by item basis to better understand the clients' presenting concerns. We recognize that item-by-item level analysis tends to be less reliable than using a total score, however as most clinicians utilize the PPC on an item-by-item level we chose to use an item-level analytic strategy. The total scale on this measure had a Cronbach alpha of .90 (Draper et al., 2003). The Cronbach's alpha for this study was .94.

**The Outcome Questionnaire-45.** The Outcome Questionnaire-45 (OQ-45) is a measure of client distress that includes 45, five-point Likert scale questions. Participants are asked to endorse each item using a Likert scale with 0 being "never" and 4 being "almost always." Some items are reverse scored, depending on the orientation of the question. The higher the overall score on this measure, the greater the indication of distress, with a score above 63 representing a population in clinical distress (Kadera, Lambert, & Andrews, 1996). If the client moves 14 points in either direction, this is considered indicative of reliable change. Kadera et al. (1996)

found that the OQ-45 has high internal reliability (alpha at .93), a high test-retest reliability (.84), and concurrent validity with other instruments of distress ( $r = .58$  to  $.84$ ). The Cronbach's alpha for the data in this study was .92.

## Results

### Treatment Utilization

Odds Ratio analyses were conducted to determine the likelihood that IA, AA, and EA students would attend therapy compared to the proportion of students on campus in each of the aforementioned groups across 12 years (2002-2013) for which we had both accurate enrollment data at this university and treatment utilization in the counseling center. The university's system for tracking Asian students changed over the years resulting in more accurate record keeping starting in 2002. Over this 12-year period, enrollment data from the university indicated that, on average, around 30,210 students attended the university. Of those roughly 30,210 students on campus in a given year, on average 507 (0.02%) were IA students, approximately 746 (0.03%) were AA students, and approximately 26,348 (87.22%) of students enrolled were EA.

Approximately 1,300 students in a given year completed intake paperwork at this university's counseling center. Of those roughly 1,300 students, on average in any given year, there were roughly 14 (1.07%) IA students, roughly 26 (2%) AA students, and roughly 1092 (84%) EA students.

Across all 12 years, the aggregate odds ratio for IA students compared to AA students was 0.77, suggesting that IA students were 23% less likely to attend therapy than AA students across all years calculated (an odds ratio of 1.0 indicates identical likelihood). According to interpretive guidelines by Jacob Cohen (1987), this denotes a relatively small difference. The aggregate odds ratio comparing EA and IA students was 0.72, suggesting that IA students were

28% less likely to attend therapy than EA students across all years calculated. While this difference is even greater than that between AA and IA students, again according to Cohen's interpretive guidelines (1987), this also denotes a relatively small difference. Lastly, the aggregate odds ratio comparing EA and AA groups was 0.94, suggesting very little difference between these two groups in their likelihood of attending therapy. Variations in the year to year data can be seen in Table 2.

### **Discontinuance of Treatment**

One way of analyzing the effectiveness of therapy is to measure the rate at which clients discontinue therapy. We ran a one-way analysis of variance (ANOVA) as well as Cox Regression Analyses to determine differences between AA, IA, and EA groups in terms of discontinuance rates. We determined that no significant difference exists between AA, IA, and EA groups in terms of the maximum number of sessions they attended ( $F=.394$ ;  $p=.674$ ).

The modal number of therapy sessions attended by individuals in all groups was two, with a mean of 11.67 sessions. Because the data was skewed due to some outliers (the highest number being 512), we analyzed the data with a cut off of 28 sessions. We chose this number in part because counseling centers often have session limits that would exclude high usage of services by any one individual, and, secondly because we found that 90% of all students in this sample used 28 sessions or less. In order to explore discontinuance rates across AA, IA, and EA students, we conducted a survival analysis. More specifically we ran Cox Regression analyses (see Table 3) and found no significant differences between these three groups in regard to their discontinuance rates after controlling for ethnicity, gender, initial distress level, and age ( $\text{Exp}(B)=1.001$ ;  $\text{Sig}=.970$ ). However, we found that regardless of ethnicity, the initial OQ-45 score was more indicative of therapy discontinuance rates.

### Initial Presenting Concerns

Given the rank-ordered nature of the data on the PPC, we tested for significant differences between IA, EA, and AA groups of students using the Kruskal-Wallis one-way ANOVA. Participants were analyzed on an item by item level because the PPC is clinically used on an item by item level by practitioners. Due to the number of analyses run, Bonferroni corrections were used and an adjusted  $p$ -value of .001 was needed to reach statistical significance. Post-hoc analyses were conducted to determine which groups differed from one another and significant differences between groups are shown in Table 4.

Given that the comparatively large number of EA participants in our study impacted our analyses in such a way that most analyses would reach statistical significance, in Table 5 we provide both  $p$ -values and their accompanying mean rank effect sizes (Cohen's  $d$ ). The meaning of effect sizes will vary by context, however, an interpretation offered by Cohen (1987), is that 0.2=small, 0.5=moderate, and 0.8 or above indicates a large effect size. Effect sizes that reached the moderate category are considered meaningful. In the following paragraphs, we report only results that reached both statistical significance and meaningful significance (as determined by having a moderate effect size).

When compared to EA students, IA students endorsed significantly greater distress on items related to adjustment to the university ( $p<.001$ ;  $d=0.55$ ), ethnic/racial discrimination ( $p<.001$ ;  $d=1.89$ ), homesickness ( $p<.001$ ;  $d=0.61$ ), irritability/ anger/hostility ( $p<.001$ ;  $d=0.59$ ), and test/speech/performance ( $p<.001$ ;  $d=0.56$ ). In regard to duration of these concerns, IA students endorsed experiencing ethnic/racial discrimination for a significantly longer period of time ( $p<.001$ ;  $d=1.92$ ).

When compared to EA students, AA students endorsed significantly greater distress on the item related to ethnic/racial discrimination ( $p < .001$ ;  $d = 1.04$ ). AA students also experienced distress related to ethnic/racial discrimination for a significantly longer period of time ( $p < .001$ ;  $d = 0.85$ ) when compared to EA students.

Finally, when comparing AA and IA students, there were no differences that were both statistically significant and that reached a moderate effect size. A number of items between these two groups reached statistical significance but had only small effect sizes. Some of these items began to approach moderate effect sizes and can be seen in Table 5.

### **Family Concerns Survey**

Given the categorical nature of the data on the FCS, we tested for disproportional representation between IA, EA, and AA groups of students using the Chi-Square test of independence. Table 6 provides the statistically significant standardized residuals of answers given by individuals responding “yes” or “no” to the questions on the FCS. Again, because of the number of analyses run, we included Bonferroni corrections which resulted in a .003  $p$ -value needed to reach statistical significance. As with the PPC, participants were analyzed on an item by item level because the FCS is clinically used on an item by item level by practitioners.

We found that Asian students in both IA and AA groups responded “no” at a lower rate and “yes” at a higher rate than would be proportionally expected to the question related to frequent/hostile arguing among family members. Conversely, IA and AA students responded “no” at a higher rate and “yes” at a lower rate than would be proportionally expected to the question related to having a family member diagnosed with a mental disorder. Both IA and AA students also responded “yes” at a higher rate than would be proportionally expected to the question regarding having parent(s) with a gambling problem.

IA students responded “yes” at a lower rate and “no” at a higher rate than would be proportionally expected to the question related to having a family member with an eating problem. IA students also reported “yes” at a higher rate than would be proportionally expected to the question regarding parent(s) with a drinking problem. Those from the EA group answered all questions at proportionally expected rates.

### **Severity of Concerns**

In order to analyze the severity of initial distress levels, we examined students’ initial scores on the OQ-45 at intake and conducted a Repeated Measures One Way ANOVA to determine if there was a significant difference between IA, EA, and AA students (see Table 7). We found that there is a significant difference ( $F=51.402$ ;  $p<.001$ ) between these groups regarding distress levels at intake. Post hoc analyses identified a statistically significant difference between IA students ( $\mu=81.44$ ;  $p<.001$ ) when compared to EA students ( $\mu=68.74$ ;  $p<.001$ ), a statistically significant difference between AA students ( $\mu=71.96$ ;  $p<.001$ ) when compared to EA students ( $\mu=68.74$ ;  $p<.001$ ), and a statistically significant difference between IA students ( $\mu=81.44$ ) and AA students ( $\mu=71.96$ ;  $p<.001$ ). That is, IA students experienced the highest levels of initial distress at intake, followed by AA students, and finally EA students.

### **Treatment Improvement Rates**

We analyzed the rate of improvement from treatment within IA, AA, and EA student groups using a Repeated Measures One Way ANCOVA controlling for initial symptom severity as well as age and gender (see Table 7). In doing so, we found that there was a statistically significant change in OQ-45 scores between IA, AA, and EA students ( $F=16.666$ ,  $p<.001$ ). Further post-hoc analyses revealed that EA students showed a greater change in OQ-45 scores than IA students (contrast estimate=3.335,  $p<.001$ ), EA students showed a greater change in OQ-

45 scores than AA students (contrast estimate= 1.284,  $p=.006$ ), and AA students showed a greater change in OQ-45 than IA students (contrast estimate=2.050,  $p=.010$ ). Thus, EA students showed the greatest change in OQ-45 scores ( $\mu =11.21$ ), followed by AA students ( $\mu=9.90$ ), followed by IA students ( $\mu =9.05$ ). Marginal means were recorded for each group in order to adjust for initial OQ-45 distress scores and the same pattern held true after this adjustment. EA students showed the greatest change score ( $\mu=11.29$ ;  $p<.001$ ), followed by AA students ( $\mu=8.79$ ;  $p<.001$ ), followed by IA students ( $\mu=4.14$ ;  $p<.001$ ).

### **Discussion**

More often than not, research regarding Asian populations on college campus settings have lumped AA and IA students together (Meyer et al., 2009; Yang et al., 2013). While research has examined differences between AA and IA college students on a number of variables (parental support, ethnic identity, emotional well-being, acculturation) (Yang et al., 2013; Yasuda & Duan, 2002), to date there has not been research examining potentially important differences among the aforementioned groups in regard to psychotherapy utilization, presenting concerns, and mental health treatment outcomes. This study separated these groups and provides information about treatment utilization, presenting concerns, the severity of those concerns, and improvement rates.

#### **Summary of Treatment Utilization and Therapy Discontinuance Rates**

Results from the odds ratio analysis suggest that IA students were 23% less likely to attend therapy than AA students. In practical terms, this statistic would mean that if an average of 10% of 1000 AA and 1000 IA students had attended therapy in the counseling center, 26 more AA students would have attended therapy than IA students. Although 26 out of 200 total students attending therapy is not a large percentage difference (13%), the fact that IA students

are underrepresented to that degree would clearly impact the IA students who needed mental health treatment but did not receive it. Furthermore, IA students were 28% less likely to attend therapy than EA students across all years calculated. Using the same hypothetical values of 1000 students in each group once again, the odds ratio of 0.72 would be equivalent to 32 more EA than IA students attending therapy among 200 total attendees (16% difference). Again, while not a large percentage difference, IA students are once again shown to be underrepresented. Finally, the aggregate odds ratio comparing EA and AA groups suggested very little difference between these two groups in their likelihood of attending therapy.

In other words, statistically speaking, all three groups of students attended therapy at comparable rates. However, it is again worth noting that while not statistically significant, IA students attended therapy at slightly lower rates than their EA and AA counterparts. The fact that IA students attended therapy at lower rates warrants consideration and counseling centers are urged to develop programs to reach out to IA students in order to increase the likelihood of their attending therapy.

Our analyses further revealed no significant differences between EA, IA, and AA students in terms of the maximum number of sessions attended. We also found no significant difference between these groups of students in terms of discontinuance rates. These findings are surprising given that extensive literature suggests that students categorized as Asian tend to have higher discontinuance rates than their EA counterparts (Kim et al., 2015; Leong & Lau, 2001; Smith & Khawaja, 2011).

Existing literature suggests that AA students face barriers to seeking professional help for a variety of reasons (varying levels of acculturation, identification with somatic symptoms rather than psychological symptoms, adherence to traditional Asian values, etc.; Chin, 2007; Leong et

al., 2016; Miller et al., 2011; Ruzek et al., 2011; Smith & Khawaja, 2011). Similarly, literature suggests that international students also face a number of barriers to seeking mental health treatment (varying levels of acculturation, discrimination, adherence to traditional Asian values, language concerns, etc.; Berry, 2005; Lee, 2007; Olivas & Li, 2006; Smith & Khawaja, 2011).

We can only speculate about potential reasons that these three groups in our study did not differ in statistically significant ways regarding treatment utilization and discontinuance rates. While we attempted to statistically control for the significantly larger proportion of EA students in our study, differences in the sample sizes of these three groups likely impacted the results. Thus, therapy utilization and discontinuance rates would likely look different at a university with a higher proportion of AA and IA students. Furthermore, the vast majority of students (98%) at this university shared the religion of this university's sponsoring church. Thus, values of the predominant religion shared amongst participants in this study may have had a moderating effect.

It is also possible that the IA and AA students who attended therapy at this counseling center had higher levels of acculturation. For example, at this university students are required to pass a language proficiency test which would require significant knowledge regarding Western ideals. If it were true that these students had higher levels of acculturation, then it stands to reason that these students may have had a higher likelihood of seeking out therapy than those with lower levels of acculturation (Leong et al., 2016). Conversely, it is possible that IA and AA students adhering to the more stereotypical Asian values of humility, conformity, obedience, and subordination to authority (Leong et al., 2016) who did seek treatment could have remained in therapy longer than desired in order to please a particular therapist. These hypotheses are purely

speculative as we did not have any means to measure acculturation levels of the students in this sample.

It is also possible that therapists at this center had higher levels of experience and/or skills in working with individuals from multicultural backgrounds, thus increasing the likelihood of students from AA and IA groups to continue in therapy. Many of the therapists in this counseling center have lived abroad and learned a foreign language for either a year and a half or two years, while serving as missionaries for the church sponsoring this school. The experience of learning a foreign language and living outside of the US may have increased their abilities to effectively interact with culturally different others. Again, as we had no means to examine therapists' levels of multicultural competence, this hypothesis remains purely speculative as well.

Considering the larger body of literature that suggests higher levels of treatment discontinuance among Asian populations, further research in this domain seems warranted. Furthermore, given the likelihood that the shared religious values of those in this study may have moderated our results, research is needed that examines potential differences and similarities in treatment utilization amongst IA and AA students at other more secular university settings.

### **Summary of Initial Distress Level as Measured by the OQ-45**

While we did not find statistically significant differences in treatment utilization and discontinuance rates, we did find significant differences in the level of distress at intake between IA, AA, and EA groups of students as measured by the OQ-45. IA students reported the highest level of distress, followed by AA students, and finally EA students. This finding seems to support the hypothesis that both IA and AA students tend to utilize therapy as a last resort, and only when their distress levels are significantly high (Kim et al., 2015; Lee, 2007; Li et al.,

2013). Previous research has compared initial levels of distress between EA and Asian (IA and AA combined) college students (Lambert et al., 2006). However, to our knowledge, comparisons on initial OQ-45 scores between IA and AA students has not been examined.

One potential explanation for the lower levels of distress reported by AA students, when compared to IA students, is that AA students have likely had more exposure to Western culture. Thus, AA students may have a lower threshold for distress before seeking professional help as they may be more familiar with values and ideas commonly espoused in traditional psychotherapy.

This increased exposure to Western culture may further serve as a bridge of sorts between traditional Asian and Western cultures for AA students. That is, AA students' increased exposure to Western culture may lead to lower levels of distress than their IA counterparts, but higher levels of distress than their EA counterparts. Further research regarding differences between AA and IA students on symptom distress is warranted.

### **Summary of Differences in Distress and Duration of Presenting Problems as Measured by the PPC**

In this section, we focus on differences between IA, AA, and EA groups of students' responses on the PPC that reached statistical significance and had at least moderate effect sizes. We found that both IA and AA students experienced significantly greater levels of distress related to ethnic/racial discrimination when compared to EA students. This finding is in line with other research that shows that racial discrimination negatively impacts both international (Lee, 2007; Poyrazli & Grahame, 2007; Smith & Khawaja, 2011; Wadsworth, Hecht, & Jung, 2008) and AA students (Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013; Wei, Yeh, Chao, Carrera, & Su, 2013).

There are numerous potential reasons that IA and AA students in this sample experienced increased stress related to ethnic/racial discrimination. While it may be popular to believe that racism on college campuses is an artifact of the past, students from minority backgrounds in university settings across the US continue to face racial prejudice (Miville & Ferguson, 2014; Yosso, Smith, Ceja, & Solorzano, 2009). Given the proportionally smaller number of IA and AA students on this particular campus, it is highly likely that these students stood out and could have easily become the target of overt or covert discrimination. While students from minority backgrounds may not be exposed as frequently to overt racism, they are no less likely to encounter more subtle, innocuous, and covert forms of racism known as microaggressions (Huber & Solorzano, 2015; Miville & Ferguson, 2104). Furthermore, while seemingly not as detrimental as overt racism, microaggressions have an additive effect which impacts the mental well-being of those who encounter them. Given the nature of our data, there is no way to determine whether such issues were discussed in therapy and this hypothesis remains speculative. Further research would benefit by examining presenting concerns related to racism for IA and AA students and how these concerns play out in therapy.

Interestingly, both IA and AA students experienced more distress related to ethnic/racial discrimination than EA students, but did not differ in statistically meaningful ways from one another in this distress. This seems to indicate that regardless of international status, both groups of students from Asian backgrounds experienced racism that reached statistically significant and meaningful levels.

When compared to both their EA and AA counterparts, IA students reported significantly and meaningfully higher levels of distress at intake regarding adjustment to university, homesickness, and test/speech/academic performance. These results seem to support what others

have found in that IA students face more practical stressors than those who are familiar with not only traditional Western culture, but also the U.S. educational system (Polyrazli & Grahme, 2007). IA students are typically further from home than their AA and EA counterparts and are less able to talk with their parents about their adjustment concerns. Prior research also suggests that international university students experience greater levels of stress related to acquiring English as a second language (Chin, 2007; Hung & Hyun, 2010; Leong & Lau, 2001; Meyer et al., 2009).

We found that IA students further reported significantly and meaningfully higher levels of distress related to irritability/anger/hostility than AA and EA students. Given that IA students often face many additional challenges above and beyond typical college stress (language acquisition, learning U.S. education system, visa status, employment rules/regulations, etc.) it is not surprising that this area of concern would be endorsed at a higher rate by this group of students.

As discussed previously, in some Asian cultures it is more socially appropriate to suppress or avoid emotions so as to maintain social harmony (Kitayama et al., 2004; Markus & Kitayama, 1991). To our knowledge, there have not been studies that examine potential similarities and/or differences between IA and AA students in regard to emotion suppression. This seems to be an area that would benefit from future research as well.

### **Summary of Family Concerns as Measured by FCS**

We examined respondents' answers to "yes" and "no" questions regarding familial difficulties on the FCS and found that several themes emerged. Interestingly, EA students answered all questions on this survey at proportionally expected rates, while IA and AA students did not. We encourage caution in interpreting the responses of IA and AA students on this

measure so as to avoid viewing such responses through a Westernized worldview that may stigmatize their responses.

Both IA and AA students responded “no” at a lower rate and “yes” at a higher rate than would be proportionally expected to the question related to frequent/hostile arguing among family members. While we cannot ascertain from our data why this may be the case, it is not uncommon for Asian American students to attribute psychological distress to relationships within the family (Lee, 1997; Lee, Choe, Kim, & Ngo, 2000; Uba, 1994).

One potential explanation for the difference in response rates on this question may be related to differences in levels of acculturation between parent and child. Perhaps parents of AA and IA students who adhere to traditional Asian values want their child to adhere to more traditional values and lifestyles as well. As these students drift from traditional Asian values toward more Westernized ideas, the acculturation mismatch may cause friction among family members to occur (Lee et al., 2000). It is also likely that the FCS was designed without taking into account potential cultural differences that may occur amongst various minority groups. Perhaps the manner in which this question is perceived by those from IA and AA backgrounds, may be different than what the question was intended to ask.

We also found that IA and AA students responded “no” at a higher rate and “yes” at a lower rate than would be proportionally expected to the question related to having a family member diagnosed with a mental disorder. There are potentially numerous reasons for the differences in endorsement of family members diagnosed with mental health disorders. One such possible explanation is that the concept of Western mental health and the idea of Western mental health treatment are emerging fields in many Asian countries (Minas & Lewis, 2017). Hence, because of different values regarding mental health and treatment of mental health, many

IA and AA students that adhere to more traditional Asian worldviews may have a family member who suffers from a mental illness, but may not be formally diagnosed.

Both IA and AA students also reported a higher than proportionally expected response to parents with a gambling problem. In the US gambling is only legal in a handful of states and there is no legal gambling in the state where this university resides. It may be that gambling occurs at a higher rate in some Asian countries and as a result more parents of these students may have been involved in this activity. Furthermore, those from Asian backgrounds tend to have greater stigma surrounding gambling than do EA individuals (Dhillon, Horch, & Hodgins, 2011) and may be more sensitive to this question than those more accepting of gambling.

IA students responded “yes” at a lower rate and “no” at a higher rate than would be proportionally expected to the question related to having a family member with an eating problem. This may be due to differing cross-cultural views on eating. A study by Tsai, Hoerr, and Song (1998) showed that among college-aged women, EA individuals were more likely to report eating disordered behavior than IA counterparts. It may be that IA individuals who have historically be stereotyped as “thin” (Tsai et al., 1998), may receive more validation from their EA counterparts. It may also be that the standards for judging ideal eating habits is different in IA students’ countries of origin. In contrast, a dissertation by Howard (2012) showed that there was no significant difference among eating disordered behavior between EA and IA students. All interpretations made as to why IA students in this study responded the way they did to this question are speculative.

IA students also reported “yes” at a higher rate than would be proportionally expected to the question related to having parent(s) with a drinking problem. The university from which this data gathered is consistently ranked as one of the most stone cold sober universities in the nation

(Richmond, 2016). It is also true that in order to remain at the university all students sign a code of conduct that prohibits alcohol use. It may be that both IA students experience a contrast between the drinking habits of their parents and the dry campus in which they now live. Several studies have discussed the effect of ethnic drinking cultures on the behaviors of immigrants and Asian Americans and have found that the level of drinking amongst these groups of people may be affected by acculturation as well as the manner in which drinking is incorporated into particular cultures (Cook, Mulia, & Karriker-Jaffe, 2012). IA students may also have experienced a contrast in their parents drinking behavior and the behavior of the parents of their friends in the US.

### **Summary of Treatment Improvement Rates as Measured by the OQ-45**

As previously mentioned, IA students showed the highest level of initial distress on the OQ-45, followed by AA students, followed by EA students. After controlling for initial distress levels, we compared improvement rates (change from initial to final OQ-45 scores) and found that IA students had the lowest level of improvement in therapy, followed by AA students, followed by EA students. While there are again several reasons why this may be the case, it seems a strong possibility that traditional forms of psychotherapy were used in this center. Such approaches to psychotherapy tend to be better suited for EA populations with Western worldviews (Minas & Lewis, 2017). Again, this is not surprising given the historical roots of Western traditional psychotherapy having colonized more traditional Eastern psychotherapy approaches (Minas & Lewis, 2017). It also seems likely that IA students have the least exposure to Western ideals associated with traditional psychotherapy, whereas AA students are likely to be more familiar with such ideals given that they have lived in the US. While the majority of practicing clinicians have likely received training in multicultural issues, we encourage clinicians

to continue to seek additional trainings. We further encourage clinicians to seek training in issues faced by international students as multicultural trainings often do not disaggregate such students from aggregated ethnic minority groups (Latino/a, Asian, Black, etc).

### **Implications for Practice**

Traditionally, an intake session is utilized to gather extensive information about the client. However, given the higher levels of initial distress experienced among IA and AA student groups, practitioners are encouraged to be aware that some initial crisis work done during the first session may serve to reduce symptom distress, as well as help to establish therapy in a positive light.

Therapists are further encouraged to be aware of and seek to understand the experiences of racism that AA and IA students are likely to encounter. More specifically, therapists are encouraged to explore with IA and AA students the subtle, and not-so-subtle, nuances associated with racism and discrimination that they may face on campus. Therapists may need to broach this topic as it may be uncomfortable for students to talk about racism without an invitation to do so.

In addition to helping IA and AA students unpack experiences of racism and discrimination, it may also be important for clinicians to monitor IA and AA students' family of origin concerns. It may be shameful for IA or AA students to talk about family concerns due to a sense of duty toward one's family. Subsequently, concerns like hostile arguing, family members diagnosed with mental disorders, drinking problems, etc. may be difficult topics for IA and AA students to talk about. Additionally, given that IA students are likely to experience significant feelings of homesickness, it may be helpful for clinicians to talk with IA students about their particular experience adjusting to university life away from their home culture.

As with any group of individuals, the amount of within group variance is as significant as the amount of variation between groups. As such, therapists are encouraged to respectfully engage in the process of using knowledge of another's culture without succumbing to broad stereotypes associated with a particular group, a process coined "dynamic sizing" (Sue, 1998).

The manner in which IA and AA students perceive psychotherapy and other help-seeking behaviors will likely differ from client to client. These perceptions will likely depend on a number of variables (language ability, SES, adherence to a particular set of values, acculturation levels, etc.). Given the numerous ways that mental health concerns could be viewed and conceptualized according to various worldviews, special care should be taken by the therapist in evaluating the client's perceptions of therapy and determining what the client wants in treatment. Therapists are encouraged to better align their treatment to align with the goals and worldview of the client with whom they meet.

### **Limitations**

One potential limitation is that while the mean age for AA and IA students (21.9 and 25.7 respectively) certainly falls within the average age of college aged individuals, extrapolating these results to other populations would not be appropriate. Individuals in an older age cohort may have different presenting concerns and different struggles associated with their time of life. While we were unable to ascertain the socioeconomic status (SES) of students in this sample, it can be assumed that the majority of college students have higher a higher SES level which may have impacted our results (Pascarella & Terenzini, 2005).

Another limitation is that all participants in our sample come from one large, private, religiously oriented, university. Most students who attend this university (98%) are members of the common faith, and several scholarship opportunities exist to appeal to international students

of this same faith. Thus, despite considerable cultural differences between AA, IA, and EA students in terms of lifestyle, there may be a common religious cultural factor that provides more “sameness” that may not exist in other universities. That is, participants in this study may have similar worldviews based on their common membership in the dominant religion that may mask differences that would be found in a more diverse sample.

There is also a strong emphasis at this university for language learning. Many students at this university defer school to engage in missionary service where second languages are often learned. Hence, IA and AA participants in our study may have encountered many other students on campus who not only share their religious beliefs, but speak their language as well, which again, could have impacted results.

Another limitation is that this research used archival data which did not include direct information regarding the international status of students. As such, we determined criteria which we felt would best capture AA and IA students, but we may have missed some cases based on the stringent criteria we set.

There was also no way to gather additional information regarding the level of multicultural training of therapists or therapists’ specific treatment interventions. Furthermore, we were unable to measure for levels of acculturation among the AA and IA groups.

Also, because of the archival nature of the data we were able to examine only the measures used in this counseling center during the 17-year period. While the internal reliability of these measures tends to be high, there may have been some compounding factors in completing these measures (limited English proficiency among some students). Furthermore, the measures used were likely developed without specific consideration for AA and IA populations’

unique worldviews and may not have accurately captured the experiences of IA and AA students.

## **Conclusion**

Previous literature examining the experiences of Asian groups has tended to lump together individuals from Asian backgrounds, potentially concealing important differences between IA and AA groups. While there has been some research examining differences between IA and AA college students in regard to emotional well-being (Yasuda & Duan, 2002) and parental support (Yang et al., 2013), to date there has not been research examining differences between IA and AA college students in regard to treatment utilization, therapy discontinuance rates, treatment outcome, and presenting concerns. This research was designed to better understand potential similarities and differences between IA and AA students regarding treatment concerns.

We analyzed archival data from the year 1996 to 2013 on demographic information, family concerns, presenting problems, initial level of distress, and treatment improvement rates using the Family Concerns Survey, Presenting Problem Checklist, and Outcome Questionnaire-45.

There were no significant differences in discontinuance rates between EA, IA, and AA students which is contrary to much literature already in circulation. IA students reported the highest level of distress, followed by AA students, and lastly EA students. This would suggest that IA students may present in therapy when their distress levels are significantly higher than other students. IA students also reported higher levels of concerns with test/speech/performance anxiety, adjustment to the university, homesickness, and ethnic/racial discrimination. IA students also endorsed lower levels of family members being diagnosed with a mental disorder

and frequent/hostile arguing among family members than either AA or EA counterparts. While IA students' initial level of distress were statistically the highest, they also showed the least amount of change in therapy.

Our research adds to the growing body of literature suggesting that there are important nuanced differences between IA, AA, and EA students in therapy. It is important for clinicians to be mindful of the higher levels of distress with which IA and AA students present upon entering therapy. Further research is needed to tease apart further nuances between these groups, particularly in a variety of university settings.

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## APPENDIX A

## Tables

Table 1

*Demographic Information*

Racial Group	Mean Age	% Female	% Male	% Married	% Single	% Divorced
International Asian	25.7	62.5	37.5	30.6	68.4	.009
Asian American	21.9	61.6	38.4	34.2	64.4	1.4
European American	22.4	58.8	41.2	45.6	52.9	.015
Total	22.5	58.9	41.1	45.1	53.3	.01

*Note.* Some percentages do not add to 100% as several of those who participated in this study did not provide information regarding some of the demographic information above.

Table 2

*Odds Ratios by Year Comparing Therapy Utilization Rates Among Asian American (AA) Students, European American (EA) Students, and International Asian (IA) Students*

Year	Comparing EA and AA		Comparing EA and IA		Comparing AA and IA	
	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE
2002	1.02	0.30	0.84	0.27	0.83	0.40
2003	0.65	0.31	0.72	0.26	1.09	0.40
2004	1.13	0.21	0.51	0.31	0.45	0.37
2005	1.31	0.18	0.38	0.34	0.29	0.38
2006	0.83	0.20	0.59	0.29	0.71	0.35
2007	1.16	0.17	0.91	0.23	0.79	0.28
2008	0.73	0.19	0.65	0.27	0.89	0.33
2009	0.88	0.18	1.02	0.20	1.17	0.26
2010	0.74	0.17	0.59	0.26	0.79	0.31
2011	0.90	0.16	0.90	0.20	1.06	0.25
2012	0.95	0.15	0.89	0.22	0.94	0.26
2013	1.04	0.18	0.60	0.26	0.57	0.31
Total	.94		.72		0.77	

*Note.* The Odds Ratio data was reported from 2002-2013 due to inadequate university data. An aggregate examining utilization rates over the course of the 11 years is provided. When comparing each group, an odds ratio greater than 1 indicates a greater treatment utilization rate among the second group being compared (AA, IA, and IA respectively) and is based on the proportion of students from each group attending therapy compared to the proportion of the total number of students from each group attending this university.

Table 3

*Cox Regression Analysis Comparing the Likelihood of Discontinuance of Therapy Between European American (EA), International Asian (IA), and Asian American (AA) Students When Controlling for Number of Sessions (28)*

<u>Category</u>	<u>Sig.</u>	<u>Exp(B)</u>	<u>SE</u>	<u>95% around CI</u>
European American	p=.987	.999	.051	.904-1.104
International Asian	p=.962	1.004	.087	.847-1.190
Asian American	p=.987	1.001	.051	.906-1.106
Gender OQ	p=.699	.994	.016	.963-1.026
Initial OQ	p=.002*	.999	.000	.998-1.000
Age	p=.340	1.000	.000	1.000-1.000

\*Significance was measured at the p=.05 level.

*Note.* The n values are as follows for each group: EA n=18328; IA n=231; AA n=439.



family, parents, or siblings								
28. Relationships with friends, roommates, or peers								
29. Relationship with romantic partner or spouse								
30. Religious or spiritual concerns								
31. Self-esteem or self- confidence								
32. Sexual concerns	.001	.40 <sub>a</sub>	.66 <sub>b</sub>	.52 <sub>a,b</sub>				
33. Sexual identity or orientation issues								
34. Sexually transmitted disease(s)								
35. Shyness, being ill at ease with people								
36. Sleeping problems	<.001	1.37 <sub>a</sub>	.98 <sub>b</sub>	1.02 <sub>b</sub>				
37. Stress management	<.001	1.96 <sub>a</sub>	1.40 <sub>b</sub>	1.63 <sub>a,b</sub>				
38. Suicidal feelings or thoughts	<.001	.75 <sub>a</sub>	.43 <sub>b</sub>	.51 <sub>a,b</sub>				
39. Test, speech, or performance anxiety	<.001	1.46 <sub>a</sub>	.73 <sub>b</sub>	.90 <sub>b</sub>	<.001	.81 <sub>d</sub>	.40 <sub>e</sub>	.48 <sub>e</sub>
40. Time management	<.001	1.89 <sub>a</sub>	1.21 <sub>b</sub>	1.42 <sub>b</sub>				
41. Uncertain about future or life after college	<.001	2.04 <sub>a</sub>	1.38 <sub>b</sub>	1.64 <sub>a</sub>				
42. Weight problems or body image								

*Note.* PPC Distress and Duration subscales are reported. Differences between these three groups were analyzed using a One-way ANOVA and the Sig. column indicates p-values that reached statistical significance between groups at the .001 level. Each difference in subscript letters denotes significant differences (at the .001 level) between the different groups of interest. If all groups have the same subscript within each question category, there was not a statistically significant difference. Distress and duration categories were not compared to one another. Thus, the column examining differences in distress responses uses the subscripts a, b, and c. The column examining differences in duration responses uses the subscripts d, e, and f.

Table 5

*Cohen's d Effect Sizes on the Presenting Problems Checklist Between International Asian (IA) (n = 220), European American (EA) (n = 17,530), and Asian American (AA) (n = 403) Students*

	Distress		Duration			
	<u>IA compared with EA</u>	<u>AA compared with EA</u>	<u>IA compared with AA</u>	<u>IA compared with EA</u>	<u>AA compared with EA</u>	<u>IA compared with AA</u>
1. Academics or school work or grades	p<.001; .03	p<.001; 0.28				
2. Adjustment to the university	p<.001; 0.55*	p<.001; 0.24	p<.001; 0.26	p<.001; 0.37	p<.004; 0.13	p<.043; 0.21
3. Alcohol or drugs						
4. Anxiety, fear, worries, or nervousness						
5. Assertiveness						
6. Breakup/loss of a relationship	p<.001; 0.26					
7. Concentration	p<.001; 0.31	p<.001; 0.26				
8. Confusion about beliefs or values	p<.001; 0.48	p<.001; 0.22	p<.033; 0.22			
9. Dating concerns						
10. Death or impending death of a significant person						
11. Decisions about career or major	p<.001; 0.40	p<.001; 0.22			p<.001; 0.20	
12. Depression	p<.001; 0.32		p<.001; 0.33			
13. Developing independence from family	p<.001; 0.32					
14. Ethnic/racial discrimination	p<.001; 1.89**	p<.001; 1.04**	p<.001; 0.28	p<.001; 1.92**	p<.001; 0.85**	p<.001; 0.29
15. Eating: binging, vomiting, dieting, laxatives, etc.						
16. Fasting or avoiding food						
17. Finances						
18. Homesickness	p<.001; 0.61*		p<.001; 0.46	p<.001; 0.38		p<.002; 0.28
19. Irritability, anger, or hostility	p<.001; 0.59*	p<.001; 0.35				
20. Making friends						

21. Perfectionism					
22. Physical health problems (ie: headaches, etc.)					
23. Problem pregnancy					
24. Procrastination or getting motivated		p<.001; 0.19			
25. Rape, sexual assault, or unwanted sex					
26. Reading or study skills problems	p<.001; 0.48		p<.001; 0.22		
27. Relationship with family, parents, or siblings					
28. Relationships with friends, roommates, or peers					
29. Relationship with romantic partner or spouse					
30. Religious or spiritual concerns					
31. Self-esteem or self-confidence					
32. Sexual concerns	p<.032; -0.21				
33. Sexual identity or orientation issues					
34. Sexually transmitted disease(s)					
35. Shyness, being ill at ease with people					
36. Sleeping problems	p<.001; 0.29			p<.018; 0.25	
37. Stress management	p<.001; 0.38		p<.002; 0.16		
38. Suicidal feelings or thoughts	p<.001; 0.35			p<.011; 0.23	
39. Test, speech, or performance anxiety	p<.001; 0.56*	p<.019; 0.14	p<.001; 0.20	p<.001; 0.39	p<.001; 0.26
40. Time management	p<.001; 0.49	p<.014; 0.15	p<.001; 0.31		
41. Uncertain about future or	p<.001; 0.44	p<.003; 0.17	p<.014; 0.25		

life after college  
42. Weight  
problems or body  
image

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*Note.* Given the likelihood that the large n for European American (EA) students impacted levels of significance, p-values for each pairwise comparison that reach statistical significance and their accompanying Cohen's d effect sizes are reported for comparisons between groups on the Presenting Problems Checklist between International Asian (IA) (n = 220), European American (EA) (n = 17,530), and Asian American (AA) (n = 403) students. Values marked with a \* indicate a Cohen d value of .5 which is qualified as a moderate effect size. Values marked with a \*\* indicate a Cohen d of .8 or greater which is qualified as large effect size.



a debilitating illness,  
injury, or handicap.

17. Family member  
prosecuted for criminal  
activity.

18. Family member with an eating problem.	42.23	<.001	3.1	-.5	.8	-4.7	.7	-1.3
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Values above 1.9 or below -1.9 denote a significant difference in levels than would be proportionally expected.

Table 7

*Repeated Measures One Way Analysis of Variance Comparing Initial OQ-45 and Final OQ-45 Means Between International Asian (IA) (n = 201), European American (EA) (n = 16,448), and Asian American (AA) (n = 400) Students. One Way Analysis of Co-Variance Compared Change Scores of the OQ-45 Controlling for Initial OQ Scores Between International Asian (IA) (n = 201), European American (EA) (n = 16,448), and Asian American (AA) (n = 400) Students*

Variable	Sig.	<u>IA</u>		<u>EA</u>		<u>AA</u>	
		Mean	SD	Mean	SD	Mean	SD
Initial OQ	<.001	81.44 <sub>a</sub>	25.84	68.74 <sub>b</sub>	22.74	71.96 <sub>c</sub>	23.48
OQ Change	<.001	9.05 <sub>a</sub>	22.42	11.21 <sub>b</sub>	20.32	9.90 <sub>c</sub>	20.11
Marginal Means OQ Change	<.001	4.138 <sub>a</sub>		11.293 <sub>b</sub>		8.791 <sub>c</sub>	

Each difference in subscript letters denotes a significant difference (at the .05 level) between the different ethnic groups of interest.

## APPENDIX B

### Review of the Literature

#### **Introduction**

College counseling centers are a short-term treatment modality for college students (Kraft, 2011). These centers treat many disorders including depression, anxiety, PTSD, and personality disorders (Brunner, Wallace, Reymann, Sellers, & McCabe, 2014). A recent study by Minami and colleagues (2009) showed the effectiveness of college counseling centers in psychological treatment. The researchers compared therapy outcomes of college students treated at a university counseling center against clinical trials of adults who presented with major depression. In this study, Minami and colleagues (2009) used the Outcome Questionnaire-45 (OQ-45; please see description of this measure in instrument section) and other outcome measures to assess the levels of distress of clients. Minami and colleagues (2009) found that treatment received by clients with significant distress in a university counseling center was as effective in reducing that distress as the treatment of individuals who presented with depression in the clinical trial. Minami and colleagues (2009) also found that when compared to a waitlist control, 80% of college student treated at a university counseling center experienced a reduction of distress as measured by the OQ-45. Others have found similar results. For example, Lockard, Hayes, McAleavey, and Locke (2012) measured academic distress on a subscale of the larger Counseling Center Assessment of Psychological Symptoms assessment (CCAPS) and found a decrease in academic distress between a clinical sample who received treatment at a university counseling center and a non-clinical sample.

While many college counseling centers have been shown to be effective in their treatment of students, these centers are reporting an increase in the number of students seeking

psychological help as well as an increased severity of the pathology (Brunner et al., 2014; Erdur-Baker, Barrow, Aberson, & Draper, 2006) and an increase in the chronicity of the presenting illnesses (Erdur-Baker et al., 2006). Erdur-Baker and colleagues (2006) have speculated about the nature of the claim that college counseling centers are seeing an increase in presenting concern severity and chronicity, however they note that regardless of the truthfulness of the claim, many counseling center staff are concerned with the issue of increased severity and chronicity.

In order to help meet these increasing demands, counseling center staff have been encouraged to shift to brief treatment models, session limits, after-hours care services, crisis intervention, and effective multicultural care (Kraft, 2011; Watkins, Hunt, & Eisenburg, 2012). Despite these efforts, it would seem that as societal problems increase in complexity, the problems of college-aged students have become increasingly complex as well (Erdur-Baker et al., 2006).

The traditional college student currently attending university comes from what has been termed the Millennial Generation (Brunner et al., 2014). This generation is the most ethnically diverse, with about one-third of this population identifying as ethnic minorities (Brunner et al., 2014). Among the ethnic minority group is international students; international students have increased in total number by 8% from the 2013 to the 2014 school year (Institute of International Education [IIE], 2014). Interestingly, students from ethnic minority backgrounds (Boone et al., 2011; Davidson, Yakushka, & Sanford-Martens, 2004) and international students (Nilsson, Berkel, Flores, & Lucas, 2004; Smith & Khawaja, 2011) still utilize services at lower rates than their White counterparts. Erdur-Baker and colleagues (2006) reported that minority groups are increasing in their usage of counseling centers, however they are still underrepresented.

In order to increase utilization rates among ethnic minority student groups, many have argued for multiculturally competent therapists (Arredondo et al., 1996; Sue, 1998; Sue, Arredondo, & McDavis, 1992). Multicultural ideals have become increasingly accepted and are endorsed by professional associations (American Counseling Association, 2015; American Psychological Association, 2014). Sue (1998) describes multicultural competency as the therapist's ability to work effectively with the values, beliefs, and cultures of others. Many researchers have shown the effectiveness of multicultural counseling (Benish, Quintana, & Wampold, 2011; Smith & Trimble, 2016; Sue, Zane, Hall, & Berger, 2009; Wampold & Imel, 2015).

Despite this increase in multicultural competency, students of minority groups tend to underutilize treatment (Erdur-Baker et al., 2006). Nam, Choi, Lee, Lee, Kim, & Lee (2013) conducted a recent meta-analysis and examined the factors behind underutilization of counseling center services by college students. They found that help seeking attitudes are not static and that there are many complex factors that effect the decision to attend counseling. If the student endorsed a high anticipated benefit, a high level of self-disclosure, and a high level of social support, she or he is more likely to seek professional help (Nam et al., 2013). If, however, the student endorsed a high stigma associated with mental health help seeking, if the anticipated risks were high, or if they preferred to self-conceal she or he was more likely to use other methods of treatment (Nam et al., 2013). Olivas and Li (2006) found that international students tend to reach out to family and friends for support rather than a therapist. This is likely because international students are often unfamiliar with counseling services and prefer less formal methods of treatment (Olivas & Li, 2006). Cornell University founded an outreach program that deemphasized traditional counseling and focused more on informal meeting time/length. Several

clients are even meeting with counselors anonymously (Boone et al., 2011). Anecdotally, Boone and colleagues (2011) state that the program has seen significantly more ethnic minority individuals as well as international students, however they note the difficulty in providing outcome research on a less formal method of treatment.

Two minority groups that have been historically underrepresented in mental health services are Asian Americans (AA; Abe-Kim et al., 2007; Boone et al., 2011; Ruzek, Nguyen, & Herzog, 2011) and international students (Nilsson et al., 2004; Olivas & Li, 2006; Smith & Khawaja, 2011). This research is designed to provide information about AA and international Asian (IA) students in therapy. Most research lumps together these two groups, but several researchers have noted there are potential dangers in doing so (Meyer, Zane, Cho, & Takeuchi, 2009; Yang, Haydon, & Miller, 2013). The nuances associated with treating AA and IA students at U.S. university counseling centers will be discussed in the review of the literature.

### **Asian Americans**

One of the fastest growing minority groups in the US are AAs (Kalibatseva & Leong, 2011). In spite of the fast growth amongst this population, it is important to note that AAs tend to use therapy less than the general population (Abe-Kim et al., 2007; Boone et al., 2011; Kalibatseva & Leong, 2011; Leong & Lau, 2001; Meyer et al., 2009; Ruzek et al., 2011) and even when AAs do seek treatment, they typically have premature dropout rates (Kim, Park, La, Chang, & Zane, 2015; Leong & Lau, 2001) and a greater initial severity of distress upon entering therapy than their European American (EA) counterparts (Kim et al., 2015). Even more tragic is the overrepresentation of AAs in completed suicides in campus settings (Boone et al., 2011).

Several researchers have speculated as to the reason for these alarming trends. Shea and Yeh (2008) explained that seeking professional help tends to be contrary to traditional Asian

belief systems. Shea and Yeh (2008) further suggest that in order to bridge the gap between traditional Asian belief systems and western therapy, outreach efforts should be taken to collaborate with outside community resources familiar to AAs such as local churches and other organizations. Gloria, Castellanos, Park, and Kim (2008) describe their work in collaborating with the Kuyok Yebae, a church district meeting for Korean Americans, and counselors. The Kuyok Yebae is a resource where many Korean Americans tend to seek treatment; this informal setting for social interaction appears to reduce some of the stigma associated with a more formal counseling meeting. In fact, several participants in this study endorsed that they felt safer talking about issues in an informal setting rather than a formal one (Gloria et al., 2008). In order to better serve AAs, it is important that counseling center staff receive additional training on several issues that are particularly salient to AA individuals.

Counseling centers need staff with specialized skills to meet the increasing demands placed on them (Erdur-Baker et al., 2006). Griner and Smith (2006) found that tailoring treatment to the specific culture of the client is optimally effective. Thus, training counseling center staff to better understand particular nuances of these Asian groups could be a first step in providing more effective treatment. Indeed, Olivas and Li (2006) found that treating clients with a cultural universality has been shown to be ineffective among ethnic minorities. In an effort to more effectively treat AAs there are some particularly salient issues that need to be addressed: acculturation, racial discrimination, differing expectations of therapy between AAs and EAs, differing worldviews between AAs and EAs, and English language concerns.

**Acculturation.** In the Handbook of Asian American Psychology Sue, Mak, and Sue (2007) define acculturation generally as the “changes in cultural attitudes, values, and behaviors due to contact between two cultures” (Sue et al., 2007, p. 292). They then further describe the

difference between a linear model of acculturation and a bilinear model of acculturation. In a linear model, the AA individual adapts to mainstream culture with the change coming, for the most part, from the AA individual. However, in a bilinear model, the individual exerts a change on the larger mainstream society as well as the larger mainstream society exerting a change upon her or him (Sue et al., 2007). Berry (2005) defines this bilinear model of the acculturative process in terms of assimilation, separation, marginalization, integration, multiculturalism, melting pot, segregation, and exclusion. For example, an AA engaging in assimilation would immerse themselves in the dominant culture with little retention of her or his own cultural identity; an AA engaging in separation would attempt to hold on to his or her own cultural identity with as little interaction as possible with the dominant mainstream culture; when the individual has little investment in keeping her or his own cultural identity or engaging with the mainstream culture, the individual is engaging in marginalization. Integration appears to bring the most overall well-being. This is defined as “maintaining one’s heritage culture while in daily interactions with other groups” (Berry, 2005, p. 705). Berry further acknowledges that the level at which an AA individual, or any other ethnically diverse individual can engage in integration is affected by the host culture. Thus, assimilation in the context of the larger society is called the melting pot; segregation comes when the mainstream culture forces a separation between the dominant group and the less dominant group; when the dominant group imposes marginalization it is called exclusion. The ideal, then, is multiculturalism which is “when diversity is an accepted feature of the society as a whole” (Berry, 2005, p. 704).

Kim (2007) and Miller, Yang, Hui, Choi, and Lim (2011) describe acculturation in terms of enculturation and acculturation. Enculturation focuses specifically on behaviors and values of one’s culture of origin while acculturation focuses on behaviors and values of the second culture.

This process of negotiating one's own culture and the second culture falls under the blanket term of acculturation. Not only did Miller and colleagues (2011) expound upon the difference between acculturation and enculturation, they also highlighted the idea that there is a behavioral dimension to acculturation/enculturation and that there is a value-based dimension to acculturation/enculturation; meaning that AAs adjust to the new mainstream culture in both values and behaviors. They found that in regards to help seeking, AAs endorse a greater prevalence toward help seeking when they showed an increase in values acculturation and a decrease in values enculturation. They also found that the more an AA endorsed the values associated with acculturation, the greater their outcomes in mental health. Thus, it would seem that when AAs make an attempt to align their values with the mainstream culture, and decrease affiliations with the AAs' Asian culture, they are predicted to endorse more help seeking behaviors and have better outcomes in mental health (Miller et al., 2011).

Contrary to the above mentioned results, Kim (2007) found that when an AA endorsed acculturation to EA culture it had little effect on help-seeking attitudes. He did, however, find that AAs that endorsed high enculturation with an Asian culture were less likely to have a positive attitude toward help seeking. This suggests that enculturation, rather than acculturation, is especially salient for AAs in regards to help seeking attitudes (Kim, 2007).

Leong and Lau (2001) support the claim that the more acculturated a client is into the mainstream culture, the more likely they are to seek help. Indeed in a recent study, Korean American women were more likely to endorse help seeking behavior if they had less adherence to traditional Asian values (Gloria et al., 2008). It has been reported that a failure to embrace European values can result in an increase in psychological distress among AA students, and an AA that engages in more culturally Asian behaviors is at risk for increased anxiety (Ruzek et al.,

2011). It would seem that the more acculturated an AA student is to the mainstream culture, the better their outcomes will be in regard to mental health concerns (Ruzek et al., 2011).

Yoon, Hacker, Hewitt, Abrams, and Cleary (2012) discuss social connectedness as a mediator of acculturation or enculturation and subjective well-being. They found that AAs endorsed a higher level of subjective well-being when moving toward one cultural orientation did not entail losing the other cultural orientation. For example, an AA individual that engages with the mainstream culture while maintaining their own Asian culture (integration) is more likely to report higher subjective levels of well-being. This would suggest the importance of a bicultural identity and the ability to shift between AAs' Asian culture as well as their American culture. Yoon and colleagues (2012) also found that AAs endorsed higher levels of subjective well-being when they were socially connected to both AAs' Asian group and American group, again supporting the benefits of bicultural identity.

**Racial discrimination.** Despite several ideas that AAs are the “model minority,” Ong, Burrow, Fuller-Rowell, Ja, and Sue (2013) found that AAs are continually experiencing discrimination. They provide information on three types of racial microaggressions encountered by AAs: “microassaults (explicit racial derogations)... microinvalidations (actions that nullify the experiential reality of racial minorities, such as regarding AAs as perpetual foreigners), and microinsults (subtle behaviors or communication styles that debase or minimize an individual's racial heritage)” (Ong et al., 2013, p. 189). Of the three, microinvalidations are the most common and result in the highest levels of psychological distress. Indeed, individuals endorsed poorer psychological adjustment and an increase in somatic symptoms as they experienced an increased level in microinvalidations (Ong et al., 2013). Since therapy has traditionally been

performed by EA individuals, AAs may be less likely to attend if they experience severe racial discrimination.

**Differing expectations of psychology.** It has long been acknowledged that AAs tend to prefer a more directive approach to therapy (Chin, 2007; Leong, Lee, & Kalibatseva, 2016), and AAs tend to exhibit a lower tolerance for ambiguity than their EA counterparts (Wong, Beutler, & Zane, 2007). Chin (2007) explains that for many AAs, psychotherapy may be unfamiliar. The credibility of the therapist as the “expert” appears to be especially salient for AA individuals (Chin, 2007; Leong et al., 2016; Wong et al., 2007).

A study conducted by Wong et al. (2007) found that when compared with their EA counterparts, AA individuals endorsed counselors as difficult to understand which lead to a lower rating of working alliance with their counselor. AA and EA clients in this study were not ethnically matched, however all therapists did receive some multicultural training. Wong et al. (2007) hypothesize that these results could be explained by AAs’ limited understanding of what therapy entails and that AAs could benefit from psycho-education on what the therapy process will entail. They also explain that when an AA individual has a high expectation for a directive approach, this individual tends to endorse the therapist as less credible if they are using a nondirective approach (Wong et al., 2007).

A recent study by Nam and colleagues (2013) found that individuals with a high level of self-stigma had a more negative attitude toward help seeking. Thus, in order to maintain a positive image of themselves they choose not to engage in help seeking behaviors (Nam et al., 2013). They also found that individuals who were more willing to self-disclose endorsed a greater help seeking attitude (Nam et al., 2013). Because AA groups tend toward higher levels on self-stigma and have lower levels of self-disclosure this might cause them to seek help less.

AA groups tend to be highly concerned with saving face and generally disclose less about themselves. Nam and colleagues (2013) also found that among those individuals diagnosed with depression, only about one third sought psychological help. Thus it would seem that the diminished interest, indecisiveness, and an overall lack on interest that comes with depression is negatively affecting people who otherwise need psychological help (Nam et al., 2013).

**Different worldviews.** Some common cultural beliefs that are particularly salient for AAs are filial piety, extended family relationships, harmony, cooperation, and shame (Chin, 2007). Because AA populations have a strong attachment towards their family, they tend to prefer to integrate with their family's ideals rather than following their own ideas in treatment (John, Castro, Martin, Duran, & Takeuchi, 2012; Leong et al., 2016). Thus, it becomes important to involve the family system in the dialogue about the student's distress. Western culture tends to value individuality and assertiveness; AAs may find it difficult to relate to those ideals in therapy as their culture tends to value one's relationship to the group as more important (Smith & Khawaja, 2011).

Despite their experience of significant distress, often times AAs do not identify their issues as problems and thus do not seek mental health services (Ruzek et al., 2011). Many AAs complain of somatic symptoms (stomach aches, headaches, etc) rather than psychological concerns (anxiety, stress, etc) (Chin, 2007; Smith & Khawaja, 2011). Rather than experiencing the shame associated with seeking treatment from a mental health counseling center, many AAs will seek help from a physician in a health center (Leong & Lau 2001; Leong et al., 2016; Smith & Khawaja, 2011). A recent study by Ruzek et al. (2011) suggests that AAs tend to prefer to seek help in roundabout ways rather than directly seeking traditional counseling center approaches. For example, they reported that AA students are more likely to pursue mental health

help through means such as classes on mental health, websites, and visits to a student health center.

**English language proficiency.** Meyer et al. (2009) found that non-English proficient individuals, regardless of immigration status, were less likely to use alternative healing methods as a gateway toward more formal mental health utilization. One alternative method of treatment is the Kuyok Yebae (Gloria et al., 2008). This church district meeting provides community assistance to Korean individuals (Gloria et al., 2008), which could then be used as a platform for seeing professional counseling help. AAs who were proficient in the English language tended to use alternative forms of healing as a gateway into mental health utilization (Meyer et al., 2009). It is well documented that communicating in a second language (in this case English) can be much more difficult than communicating in one's primary language (in this case native Asian languages; Leong & Lau, 2001). Thus, given that the majority of counseling centers in the US conduct the majority of therapy in English, the better the client can speak English the greater their success in therapy. Special consideration should be given to immigrant families as they could have more problems with communicating in English than their AA counterparts (Leong et al., 2016).

Griner and Smith (2006) found that culturally adapting treatment is helpful when working with minority clients. One of their recommendations to culturally adapt psychotherapeutic services involves conducting interventions in the client's native tongue. Chin (2007) found that, while using interpreters is an important modification, the use of an interpreter tends to foster a less reliable therapeutic relationship, thus suggesting that when treatment can be directly delivered in the client's native language it is more effective. Yu, Clark, Chandra, Dias, and Lai (2009) found that outreach provided to AA individuals who were at risk for substance abuse was

more successful when screening tools and educational material were translated into the specific Asian language of the population with whom they worked (Yu et al., 2009). They also found that when a client needed a direct intervention, speaking with a staff member that was fluent in the client's native tongue was more effective than performing the intervention in English.

In light of the aforementioned considerations it important to note that, in spite of the tendency to lump all Asians together when discussing mental health treatment and treatment efficacy, AAs are a heterogeneous group (Leong & Lau, 2001) with unique differences. Furthermore, there are considerable differences between AAs and Asians who grew up in countries outside of the US. Indeed, many studies do not distinguish between AA and IA student groups (Meyer et al., 2009; Yang et al., 2013). One study that did make that distinction discussed intergenerational cultural conflict and social support in female AA students as well as female IA students (Yang et al., 2013).

Yang et al. (2013) found that female IA students endorsed higher levels of social support from their parents than did their female AA counterparts (Yang et al., 2013). These researchers defined higher levels of social support as “the help and care that others can provide and the effects of that care on coping, health, and psychological well-being” (Yang et al., 2013, p. 194). Yang and colleagues (2013) hypothesized that parents may feel more inclined to provide social support to a daughter that has left their home country (US) for study rather than a daughter that remains in their home country and that the ways that parents provide support is different between AA students and IA students. AA students, having grown up in mainstream American culture, could be expecting parental support that is closer to traditional styles that American parents provide, whereas IA students' expectation of their parental support is in line with the support their parents are giving based in their own cultural backgrounds (Yang et al., 2013).

Another study examined the relationship between ethnic identity and acculturation and the effect these had on emotional well-being in both AA and IA students. Yasuda and Duan (2002) found that AAs endorse higher levels of acculturation toward Western American culture than their IA student counterparts. They also found that ethnic identity tends to be a particularly salient issue only for AAs, as AA students have lived in a multiethnic society and IA students tend to come from a cultural context that tends to be more homogenous. They found that both groups endorsed a high level of emotional well-being and that only ethnic identity predicted emotional well-being in AA students. Acculturation did not appear to predict emotional well-being in either the IA student population or the AA population and ethnic identity was only salient in the context of emotional well-being for AA students (Yasuda & Duan, 2002).

In summary, research has examined comparisons between AA students with their IA student counterparts in the areas of parental support, ethnic identity, and acculturation. While these issues are valuable and relevant, there is currently no research that partitions differences in presenting concerns and mental health treatment outcomes for AA and IA students. There is, however, a body of literature that does discuss issues that are particularly salient in Asian immigrant mental health.

### **Asian Immigrant Populations**

Individuals who were born in the US tend to utilize therapy services at a higher rate than their immigrant counterparts (Abe-Kim et. al., 2007; Meyer et al., 2009). Individuals born outside of the US tend to use therapy less and English proficiency level is a good indicator for seeking therapy (Meyer et al., 2009). Those individuals that have a great level of English language proficiency tend to seek help more often. Takeuchi and colleagues (2007) found that

among Asian men, those who spoke English well tended to have lower rates of lifetime disorders.

Hong, Walton, Tamaki, and Sabin (2014) further found that immigrants have lower lifetime prevalence rates of any mental disorder. They found that immigrant men are more susceptible to substance use and that immigrant men and women are similar in their prevalence rates of anxiety, mood, and other mental disorders. Among US born AA men, however, the greatest prevalence of mental health related concerns is for substance use. Among immigrant Asian women, the greatest prevalence of mental health concerns was found for anxiety, mood, and other mental disorders. This idea that immigrants tend to have better mental health outcomes is known as the “immigrant paradox,” and comes from the idea that there is a protective effect against mental health concerns for foreign-born individuals (John et al., 2012).

Typically immigrant individuals tend to be associated with a strong minority group, and are thus able to ethnically identify with these individuals providing a supportive network. John et al. (2012) suggest that this idea should be used with caution as they found some protective effects associated with immigrant status, but not a vast number of protective effects. They found that generalizing good mental health to all immigrants may be damaging as many individuals suffer severely due to multiple concerns related to their immigrant status (John et al., 2012).

While it is valuable to understand the experiences of Asian immigrants, it is beyond the current scope of this research to explore this issue fully. The current research focuses on aspects unique to IA students attending universities within the US. International students have a unique experience in that they usually return to their host country after their time studying in the U.S (Yan & Berliner, 2013). The following review of the literature focuses on experiences unique to international student populations.

## **International Students**

The number of international students in the US has increased by 8% during the 2013/2014 school year which is a 72% overall increase since the year 2000 (IIE, 2014). Also of note is that students from China make up 31% of all international students in the US, and Chinese students are the leaders in international study in the US (IIE, 2014; Yan & Berliner, 2013). The US, and particularly U.S. universities, receive several benefits from hosting international students including an increase in cultural diversity which fosters diverse ways of thinking as well as economic advantages (IIE, 2014; Olivas & Li, 2006). It is estimated that international students add more than \$30 billion to the economy of the US in addition to fostering international business relationship between students host countries and the US (IIE, 2014). Despite limited research in this area, several individuals from the IIE (2014) suggest that the global problems facing today's society can be solved with the help of international relationships. International students help Americans to increase in global competency, self-awareness, and resiliency (IIE, 2014). J.J. Lee (2007, p. 28) wrote that "positive exchanges are essential to improving diplomatic relations, increasing international awareness, and furthering multiculturalism, all critical components of a thriving global society." Not only do international students bring an opportunity for increased international relationships, but they also increase the intellectual capital of the US (Lee, 2007). Even though international students are bringing a wealth of benefits by studying in the US, they are facing some difficult challenges (Lee, 2007). The following is an effort to discuss issues that are particularly salient for international students and include: acculturation, academic difficulties, discrimination, English as a second language, practical stressors, and differing experiences in therapy.

**Acculturation.** As previously mentioned, acculturation is defined as a bi-dimensional process in which two cultural groups (an international student and their host mainstream culture) come into contact thus resulting in psychological and cultural changes (Berry, 2005; Smith & Khawaja, 2011). Berry (2005) explains the acculturation process in terms of the relationships between the international individual's culture and the larger society. It seems that the most healthy relationship option for the ethnocultural group is integration; which is the ability to hold onto the individual's cultural heritage while interacting with the larger society (Berry, 2005). It seems that the healthiest option for the larger society is integration or multiculturalism in which "diversity is an accepted feature of the society as a whole, including all the various ethnocultural groups" (Berry, 2005, p. 706). However, in order to reach this point of integration or multiculturalism, both the international individual and the society at large must engage the acculturative process on a psychological as well as sociocultural level (Berry, 2005). Hirai, Frazier, and Syed (2015) support Berry's claim that international students experience psychological as well as sociocultural adjustment when they come to the US to study. It is beyond the current scope of this research to focus on society at large, thus we turn our attention to international students' experiences of acculturation within the university setting.

**Psychological acculturation.** It is natural that international students experience stress due to acculturation (Berry, 2005). However, when the individual becomes overwhelmed with acculturative stress it can become clinically distressing and progress to becoming a significant mental health issue (Smith & Khawaja, 2011). Acculturative stress has several consequences inasmuch as it "can result in international students reporting somatic complaints such as sleep and appetite disturbance, fatigue, headaches, increases in blood pressure, and gastrointestinal problems... [it] can lead also to psychological symptoms such as isolation, helplessness,

hopelessness, sadness, feelings of loss, anger, disappointment, a sense of inferiority, and... depression” (Smith & Khawaja, 2011, p. 706).

Hirai et al. (2015) discuss the trajectory that most international students take in their adjustment to the first year of living and studying in the US. The majority of international students report high levels of psychological distress, as measured by Depression Anxiety Stress Scale, at the beginning of their American educational experiences followed by a slight decrease in symptoms over a 6-month period (Hirai et al., 2015). Hirai et al. (2015) used the Psychological Well-Being Scale, which measures concepts such as self-acceptance and personal growth, to assess positive psychological adjustment. They found that most students decreased in positive psychological adjustment, suggesting the psychological acculturative period temporarily lowers the positive view of self that a student may have had in their host country. Indeed, only the students with the healthiest sense of self at the beginning of their transition to university in the US seem to have the best outcome in psychological adjustment (Hirai et al., 2015).

**Sociocultural acculturation.** Sociocultural adjustment is defined as a change in a person’s behaviors due to contact with the society in which they now live (Berry, 2005). A recent study by Hirai et al. (2015) found that, initially, international students tend to report sociocultural adjustment as the most difficult aspect of their adjustment, however these difficulties decreased for almost all students over time. Berry (2005) argues that behavioral changes are usually easier and less problematic than psychological changes. There are a number of aspects relevant to an international students’ sociocultural adjustment experience that will be discussed below.

**Academic difficulties.** International students may find the American style of teaching difficult to adjust to (Smith & Khawaja, 2011) even though students’ perceived control over

academic stress is regarded as the most important factor to a positive trajectory of acculturation adjustment (Hirai et al., 2015). Specifically international students tend to struggle with class participation, group work, and an expectation of oral presentations (Olivas & Li, 2006). A recent study found that a large predictor of satisfaction in the classroom, as measured by a classroom experiences satisfaction survey, was dependent upon communication (Wadsworth, Hecht, & Jung, 2008). “Structuring classroom experiences so that international students may communicate in ways that do not disconfirm their personal identities seems to play an important role in determining the quality of their classroom experiences” (Wadsworth et al., 2008, p. 81). For example, a student that expects a lecture-based classroom might struggle to participate in a classroom based on open discussion, especially when that discussion involves a direct challenge to a teacher.

**Discrimination.** Many international students suffer from discrimination (Lee, 2007; Poyrazli & Grahame, 2007; Smith & Khawaja, 2011). J. J. Lee (2007, p. 29) included a particularly poignant comment from an international student, “Yeah, we generally walk back home from campus, and it was not a big deal, but people threw bottles at us. Being international students, you get used to it.” Wadsworth et al. (2008) studied discrimination among international students in American classrooms. Individuals that had an increase in perceived discrimination were less likely to communicate, thus ranking their classroom experience less satisfactory (Wadsworth et al., 2008). Over the course of several focus groups conducted by Poyrazli and Grahame (2007) with international students, a theme of subtle discrimination came to light. They found that many international students found it difficult to perform in class when they perceived that other students did not appreciate their unique background or their accent.

**English as a second language.** In addition to adjusting to the new style of teaching, this new style of teaching is performed in a second language. International students may have difficulties as they try to perform academically and socially in a second language (Olivas & Li, 2006; Smith & Khawaja, 2011). One English for Academic Purposes (EAP) practitioner wrote about her experience with two graduate level students as she helped them with the thesis writing process (Strauss, 2012). While the two students in question had completed graduate work in their country of origin, upon receiving initial drafts of their theses from these students, this practitioner recalled that these students struggled in basic grammar concepts (i.e., use of articles and prepositions) and sentence structure (Strauss, 2012). These two students reported that it had become incredibly difficult to communicate with their immediate supervisor because the disparity in expectations was so great (Strauss, 2012). These students, despite their obvious capabilities, reported a low sense of worth simply because they could not communicate effectively in English (Strauss, 2012).

Stephanie Vandrick (2015) writes a stirring article highlighting the unearned and often invisible privilege of studying in the US as a native English speaker; her list of invisible privileges is based on the 2003 list by Peggy McIntosh (Vandrick, 2015). This list serves to help put a voice to underrepresented international students such as the two mentioned above. Among the most poignant statements that she writes are: “Professors... do not immediately see me as a possible problem in their classes as soon as my language identity becomes apparent” and “I can expect that my professors and fellow students will hear what I say and not just how I say it” (Vandrick, 2015, p. 57). It would seem that several international students struggle to be understood in their new language.

**Practical stressors.** Many international students suffer from practical stressors such as finances (i.e., work restrictions and greater tuition fees) and transportation (Poyrazli & Grahame, 2007; Smith & Khawaja, 2011). Poyrazli and Grahame (2007) conducted focus groups with various groups of international students and found that many of the international students reported how difficult it was financially and otherwise, especially for the first few months (Poyrazli & Grahame, 2007). Several reported difficulty obtaining a Social Security Card, and thus not being eligible for purchasing a vehicle (Poyrazli & Grahame, 2007). The public transportation system was difficult and cumbersome for many of the international students to use (Poyrazli & Grahame, 2007). Several international students also mentioned that the cost of tuition and living was heightened and there was little support from the government (e.g., student loans or grants; Poyrazli & Grahame, 2007).

**International students' experience in therapy.** Despite the higher than average level of distress reported by international students (Lee, 2007), underutilization of counseling services is common in international students (Nilsson et al., 2004; Olivas & Li, 2006; Smith & Khawaja, 2011). Among those who did utilize counseling services, only two thirds returned after the first session (Nilsson et al., 2004). Mori (2000) speculates as to why these underutilization rates are so high. Part of the stigma associated with counseling for international students is the view that talking about their problems to “strangers” is a sign of immaturity and weakness. These individuals may have a strong stigma associated with what to expect regarding the basic concepts of therapy and how to locate services. Also, often times, primary care physicians treat somatic symptoms not understanding the underlying mental health causes (Mori, 2000).

Among international students, “students from English speaking and Westernized countries may have less difficulty adjusting to the US compared to students from other

countries” (Nilsson et al., 2004, p. 50). Poyrazli & Grahame (2007) explored this theme as they spoke with various international students in their focus groups. They found that often times White international students (Germans, Australians, Canadians, etc.) had an easier time making American friends and adjusting to American culture than did their counterpart Asian or Middle Eastern international students (Poyrazli & Grahame, 2007). The current research seeks to expound upon the experiences of individuals of Asian descent studying in the US.

### **International Asian Students**

IA students tend to have similar experiences to those of both AA and international students that were discussed above. However, academic distress seems to be particularly prevalent amongst IA students. Li, Wong, and Toth (2013) found that IA students endorsed a higher willingness to seek counseling when experiencing a significant amount of academic stress. They also found that many IA students viewed counseling a last resort and then, only for severe mental illness (Li et al., 2013).

The current research aims to provide information about patterns of treatment utilization, treatment outcome, and initial severity of the presenting concerns among AA, IA, and EA students at a large, Western, private, religiously oriented university. We plan to compare AA and IA students to EA students as EA students make up the majority population at this university. While there has been some research conducted in regards to the differences in AA and IA individuals in the areas of intergenerational cultural conflict, social support, ethnic identity, acculturation, and emotional well-being, research concerning treatment utilization, treatment outcome, and initial severity of presenting concerns among AA and IA university students have not yet been examined. The information gathered could then be useful in assisting

mental health workers in bettering mental health treatment for AAs and IA students within university counseling centers.

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