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Prediction of Mental Health Treatment Outcome in Asian American College Students

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This research is a product of the graduate program in Clinical Psychology at Eastern Illinois University. Find out more about the program.

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Prediction of Mental Health Treatment Outcome in Asian American College Students

BY

Jamie Michelle Pitzman

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

Master of Arts in Clinical Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
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July 15, 2003
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Prediction of Mental Health Treatment Outcome in Asian American College Students

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Abstract

The current study aimed to examine the relationship between presenting problems and treatment outcome among Asian American college students compared to non-Asian students. The present study also provides information about the relationship between treatment outcome and the following types of demographic and treatment related variables: age, gender, ethnic status, year in school, religion, marital status, parents’ marital status, referral source, previous counseling, medical problems, and family history of medical, emotional, or substance abuse problems. Data for this study were obtained from an existing database from an East Coast university counseling center. The entire sample consisted of 173 males and 271 females. The primary groups of interest in the current study were Asian American students ($n = 63$) and Asian International students ($n = 28$). Students who were presenting for therapy for the first time were required to complete a demographic questionnaire and problem checklist as well as the Behavioral Health Questionnaire (BHQ-14). At every subsequent session, the BHQ-14 was administered to assess client functioning. With respect to severity and presenting issues, non-Asian students expressed less suicidality and had higher initial BHQ means (i.e., better psychological health) than did Asians. Although Asian American and Asian International students did not differ in severity or suicidality, Asian American students expressed greater concerns in four problem areas: academics, feelings of anxiety, problems with a relationship, and depression. With respect to demographic and treatment relevant variables, the most salient results were for class year, religion, and history of family medical, emotional, and substance abuse problems. These results as well as clinical and research implications of the findings are also discussed.
Dedication

I would like to dedicate my thesis to my parents, Herb and Jackie Pitzman, for their constant love, support, and encouragement throughout graduate school and my life. Thank you for always being there for me throughout the good times and the tough times. You two are not only my parents, but two of my best friends.
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Asian Americans have become a rapidly increasing population in the United States due to recent immigration (Maki & Kitano, 2002; Sue, Nakamura, Chung, & Yee-Bradbury, 1994). Since the 1980's the Asian American population has doubled (Maki & Kitano, 2002), and today the population is now greater then ten million (Sue et al., 1994). The largest groups of Asians include the Chinese, the Filipinos, and the Japanese. There are also Asian Indians, Koreans, Pacific Islanders, and Southeast Asians (i.e., Filipino, Malaysian, Vietnamese, Laotians, Cambodians, Indonesian, and Hmong). Asian Americans are considered one of the most ethnically diverse groups "in terms of cultural background, country of origin, and circumstances for coming to the United States" (Sue et al., 1994, p. 62). There are more than 50 ethnic groups within the Asian population and they represent more than half of the world's population (Sue et al., 1994).

Because of a lack of funding, lack of researchers, reluctance of Asian Americans to participate in studies, and problems with research designs and measures, Asians have tended to be understudied (Sue et al., 1994). Previous research has shown that Asian Americans tend to underutilize mental health services as compared to White Americans, Latino Americans, African Americans, and Indian Americans (Leong, 1994; Sue et al., 1994). Asians sometimes tend to avoid using mental health services until their symptoms become too much to handle and other forms of support are not available. This is due to their views that shame and stigma are associated with having a mental illness or making use of mental health services (Sue et al., 1994). Asian Americans are said to possibly have a cultural bias against mental health services as well and "appropriate sources of treatment that are inconsistent with Western views," along with mental health services that are not compatible with Asian cultural or linguistic backgrounds (Sue et al., 1994, p.
Research has shown that Asian Americans are not lacking in mental health service needs, but, in fact, have a high need for such services (1994).

Because of the growing number of Asian Americans in the United States, it is important to research this population to gain insight into their service needs, as well as the extent of mental disorders, in order to change or adapt treatment to fit their needs, increase their utilization of services, prevent premature termination, and increase successful outcomes in therapy. There are many misconceptions regarding Asian Americans’ adjustment and success that need to be addressed before therapists can better tailor their services to the needs of these ethnic groups. The present research will provide some insight into Asian American mental health issues and treatment outcome.

Because participation in mental health services is an important predictor of successful treatment outcome, Asian help-seeking attitudes and mental health treatment must be examined (Flaskerud & Hu, 1994). This cannot be done without an understanding of the cultural context that Asians grow up in. The next section will present research on Asian American help-seeking behaviors, cultural attitudes, and presentation of symptoms.

**Asian American Help-Seeking Behaviors**

Help-seeking behaviors are significantly related to cultural views and attitudes among many Asian Americans. When and how often Asian Americans will seek treatment is governed by their cultural values and attitudes. Help-seeking behavior can be viewed in two ways: how Asian Americans present their mental health problems and where they go to seek help (Zhang, Snowden, & Sue, 1998). Research indicates that Asians usually try to rely on themselves first to deal with any problems, then they go to
family and friends, followed by a community figure, and finally, a mental health professional/counselor (Maki & Kitano, 2002). Americans are more likely to seek therapy sooner than Asians.

These differences between Asians and Americans may be due to differences in cultural beliefs. Cultural values that separate Asian Americans from Europeans include “collectivism, conformity to norms, emotional self-control, and family recognition through achievement, filial piety, and humility” (Kim & Atkinson, 2002, p. 3). That is, Asians values reflect the promotion of harmony, role obligations, hierarchy in family and cultural members, obedience, respect for elders, and maintenance of family rules and traditions (Lau, Jernewall, Zane, and Myers, 2002). Although conflicts will occur between parents and their children as a normal part of the child’s development, this tends to be more distressing for Asian Americans. As cited by Lau et al. (2002), Asians tend to frown on open expression of problems or conflict between children and their parents because in order to keep the peace and harmony, individuals are expected to “avoid confrontation, conform to rules of propriety, and give respect to others” (p. 202). This is in major contrast to the Western views of independence and individuation in which seeking help from therapists or counselors is not seen as losing face. Furthermore, Americans do not seem to frown on open confrontation because it helps a person to express their feelings and emotions, which is not accepted in Asian cultural values.

Using these cultural comparisons, a study conducted by Zhang, Snowden, and Sue (1998), sought to determine differences between Asian Americans and White Americans’ help-seeking and utilization patterns. The study looked at 161 Asian or Pacific Islanders and 1,332 White Americans to determine if there are ethnic differences in disclosing
Asian American College Students

mental health issues and the utilization of mental health services. Participants were interviewed at home using the NIMH Diagnostic Interview Schedule, which is designed for nonprofessional interviewers. Examples of the variables included in this study to which subjects might disclose mental health issues were a friend or relative, a religious figure, a psychiatrist/specialist, or a physician. Examples of mental health services were a psychiatric outpatient clinic at a hospital, a mental health center, an outpatient clinic at a psychiatric hospital or Veterans Administration hospital, an ER unit, self-help groups, spiritualist, or herbalist. The results confirmed previous views that Asian Americans are less willing to talk about their mental health issues and seek treatment in mental health facilities than are White Americans. Results also showed some differences when compared to past research. This study found that Asian Americans did not present with somatic complaints, but those Asian Americans and White Americans who did present with a somatic complaint were more willing to disclose their mental health problems than those who did not present with a somatic complaint. Another finding was that Asians tended to talk to family members or friends about their problems rather than to a professional, but not more than Whites. Whites still talked to their family or friends more often than did Asians. This means that Asians were still more reluctant to talk to even their family or friends about their mental health problems than Whites. Finally, when looking at the type of mental health services used, significantly fewer Asian Americans had ever visited a mental health center, a psychiatric outpatient clinic at a general or university hospital, a self-help group, or therapists as compared to White Americans.

Along these lines another study by Atkinson and Lowe (1995) sought to investigate the relationship between Asian American acculturation, gender, and
willingness to seek personal and academic counseling. Participants were given the Suinn-Lew Asian Self-Identified Acculturation scale and the Willingness to See a Counselor Questionnaire. 123 participants scored in the medium-acculturated range, 51 scored in the high-acculturated range, and 12 in the low-acculturated range. In part one of the Willingness to See a Counselor Questionnaire subjects were asked for demographic information such as age, ethnicity, sex, income, college status, and citizenship status. Part two contained a measure of acculturation level and part three asked subjects to indicated if they have ever seen a therapist.

Results indicated that Asian Americans with a higher acculturation level were not more willing to see a counselor than those lower in acculturation for either an academic or personal problem. This conflicts with previous research that has found a direct relationship between acculturation and willingness to seek counseling. However, Asian Americans were more willing, overall, to seek counseling for an academic concern than for a personal problem. Another finding was that, contrary to what was hypothesized, Asian American women were not more willing to see a counselor than Asian men. Lastly, results showed that Asian Americans with previous counseling experience were more willing to seek counseling for academic as well as personal problems. These results also indicated that when Asians do seek counseling, they find it to be a good experience and tend to seek help again when needed. It also shows that acculturation is not the only variable that can affect whether or not Asians will seek help.

To summarize the above research, Asian Americans are less willing to talk about their mental health issues and seek treatment in mental health facilities. Asians also talked to their family and friends about problems rather than to a mental health
professional, but were still more reluctant to do this than Whites. Also, fewer Asian Americans were likely to have ever visited a mental health facility. Asian American women were not more willing to see a counselor than men. Asian Americans were more willing to seek help for career/academic counseling and those with previous counseling experience were more willing to seek help for academic, as well as personal problems.

Culture-Specific Presentation of Mental Illness

Another potential difference between Asian Americans and White Americans is the culture-specific presentation of mental illness in Asian Americans. Certain cultures tend to promote emotional responses to physical pain and others promote physical responses to emotional pain (Lippincott & Mierzwa, 1995). Research has continuously shown that Asian Americans tend to present more often with somatic complaints for emotional problems as compared to White Americans and Western Europeans (Flaskerud & Hu, 1994; Lippincott & Mierzwa, 1995; Zhang, Snowden, & Sue, 1998). Presenting with somatic complaints rather than emotional ones may represent an acceptable response to emotional problems for Asian Americans. For example, an Asian American who is depressed will describe symptoms of insomnia and lethargy more often than feelings of hopelessness or isolation. This relates to help-seeking behavior because “the culturally influenced conceptualization of one’s own emotional disorder tends to show a correlation with the type of help-seeking behavior in which one engages” (Lippincott & Mierzwa, 1995, p. 202).

A study conducted by Lapidus, Shin, and Hutton (2001) examined Korean Americans’ attitudes towards mental health issues. It was found that Koreans rely more on “indirect and nonverbal forms of communication” and tend to “refrain from open
expressions of emotion" (Lapidus, Shin, & Hutton, 2001, p. 1386). Furthermore, Koreans view emotional disorders as the “result of irrational thoughts about the self and the external world” and view the therapist as an authority figure and expert and want the therapist to give them tangible advice (p.1386).

When seeking help, previous research has found that Asian American students tend to present with different problems than do White students. A study conducted by Tracey, Leong, and Glidden (1986) found that Asian American students tend to seek counseling for academic help as opposed to personal problems. The participants consisted of all the clients seen at the student development center at the University of Hawaii at Manoa (i.e. 3,515 students). White students were found to seek counseling for interpersonal or emotional help as opposed to academic help. This could be due to the emphasis on the importance of academics and career as opposed to expressing feelings in some Asian cultures. The stigma that is associated with expressing feelings could also cause the Asian American students to focus their issues in the area of academics because it may be easier or more acceptable. One difference was that Filipino-Americans and mixed Asian-White clients were more likely to express interpersonal/emotional concerns than the other Asian Americans. This could be due to the Western influence on their culture or their long history in Hawaii. It should be mentioned that the data was collected in Hawaii, where Asian Americans made up more than 50% of the sample size. Asian Americans are not a minority in Hawaii. This could make the results of this study less generalizable to most other colleges.

Similar results were also found by Sue and Kirk (1975) when they looked at use of counseling and psychiatric services on a college campus on the West Coast. Records
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were looked at to determine what services were utilized. From these records 1,761 men and 1,292 women were identified of which 220 were Chinese Americans and 106 were Japanese Americans. Results indicated that Asian Americans tended to overutilize the campus counseling services, but underutilized the psychiatric services as compared to non-Asian subjects. The authors explain this by stating that the counseling center provides less stigmatized services such as academic and career counseling, whereas the psychiatric clinic provides mental health counseling services that are considered more stigmatizing to Asians.

Kim and Atkinson (2002) examined Asian American client adherence to Asian cultural values, counselor expression of cultural values, counselor ethnicity, and the career counseling process. They hypothesized that Asian American clients with a high adherence to Asian cultural values would evaluate the counseling process more positively when the counselor expressed similar cultural values and when exposed to an Asian American counselor rather than a European American counselor. The participants in this study were 112 undergraduate volunteer subjects from Asian American studies classes at a large West Coast University. Participants were given the Asian Values Scale to determine adherence to Asian cultural values, the Counselor Effectiveness Rating Scale to measure perceived counselor credibility, the Cross-Cultural Counseling Inventory to measure cross-cultural counseling competency, the Session Evaluation Questionnaire to measure session depth and positivity of the sessions, and the Empathic Understanding Subscale of the Relationship Inventory to measure counselor empathy. Results did not support their hypotheses, which is in contrast to past studies that did find positive results. The authors conclude that this might be due to the fact that they used actual counseling
sessions with real clients and problems, rather than laboratory settings where most variables can be controlled and might not be able to generalize to the outside population. Also, clients who seek career counseling might not care if the counselor is of the same ethnicity or has the same values as they do because it is irrelevant to their goals. Lastly, the results may be due to the fact that only one counseling session was used in the study so the client-counselor relationship may not have been formed well enough. It takes longer than one session for the client and therapist to develop the trusting relationship needed for effective counseling.

With respect to Asian Americans presentation of mental illness, results show that they tend to present with culture-specific attitudes and complaints. Asian Americans will present more often with somatic complaints than their White counterparts. Results show that Koreans rely more on “indirect and nonverbal forms of communication” and “tend to refrain from open expression of emotions.” Koreans also see the therapist as an expert and expect them to give them advice. Asian Americans seek counseling more often for academic help than personal problems, whereas the reverse is true for Whites. Asian Americans were found to overutilize academic assistance services, but underutilize the psychiatric services. Also, Asian Americans with high adherence to Asian cultural values do not evaluate the counseling process more positively when their counselor expresses similar cultural values.

_Treatment Outcome Among Asians in Community Mental Health_

There are many variables that can affect treatment outcome. Some of these variables include a difference in ethnicity, gender, socioeconomic status, premorbid adjustment, expectations for an immediate solution, and therapists’ attitudes formed early
in treatment towards their client (Flasketrud & Hu, 1994; Zane, Enomoto, & Chun, 1994). Furthermore, given the difference between Asian Americans and White Americans, it can also be hypothesized that there will be a difference between recently immigrated Asian Americans and those that have been in the United States for awhile, which can, in turn, affect their help-seeking behavior, presenting issues, and treatment outcomes. It can be said that recently immigrated Asian Americans will keep their own cultural values and beliefs to a greater extent than those who have been here longer, for example, third generation Asian Americans (Kim & Atkinson, 2002). Many studies have been conducted to determine what effects these variables can have on treatment outcomes in the Asian American population.

Zane, Enomoto, and Chun (1994) compared short-term treatment outcomes among Asian American and White American clients in outpatient therapy. 85 subjects participated in the study, 20 Asians and 65 White clients. Only Asians who could speak English were included in the study. Data was collected from a community mental health center on the West Coast. One-half of clients in this center are Asians so the center has developed services to meet the needs of an area with many ethnicities and cultures. The study examined ethnic variations in short-term outcomes and assessed client-rated outcomes (i.e., experiences of symptoms such as anxiety and evaluations of well-being such as happiness) and therapist-rated outcomes (i.e., judgments of symptoms such as adjustment problems and depression and evaluations of the client’s overall level of psychosocial functioning). Expectations for therapy along with initial reactions of the therapists’ to the client were also examined to determine why clients might terminate their counseling early on.
Measures utilized included a demographic questionnaire, the Client Expectation Questionnaire to assess expectations and attitudes toward therapy, the Therapist Evaluation Questionnaire to assess for therapists' attitudes towards clients, which was administered after the first session just like the CEQ, the Symptom Check List to assess the amount of symptom presentation and distress, the Brief Rating Scale to measure therapists' evaluations of their clients' symptoms and functioning, and the Global Assessment Scale to determine the clients' general level of functioning in everyday life. The GAS represents a level of functioning from generally good mental health to mental illness. The BRS and GAS were completed after the first and fourth sessions.

Results on outcome showed that Asian Americans reported feeling angrier, sadder, and more worried after four sessions of treatment than White-American clients. Worse outcomes in treatment were related to lower socioeconomic status, client expectations of immediate solutions, and more severe symptoms at the beginning of treatment. Asian American clients also reported being less satisfied with all areas of services and treatment than White clients. The most important predictor of satisfaction was client ethnicity. Results also indicated that there was a tendency for the therapists' to give Asians a lower score on their functioning as compared to White clients. Asian clients experienced worse outcomes in therapy, even after controlling for SES, initial attitudes of both therapists and clients, and pretreatment severity. Results indicate that certain aspects that occur early on in treatment contribute to the worse outcomes in Asian clients. Results also showed that Asian clients did not differ in their initial expectations about therapy.
Two similar studies conducted by Flaskerud and Hu (1990, 1991) sought to
determine if there was a relationship for Asian American clients, when matched with
their therapist on ethnicity, gender, and language, on utilization measures and treatment
outcomes in therapy. The first study examined 543 adult (18 years or older) Southeast
Asian clients (Vietnamese and Cambodian) seen in all Los Angeles County mental health
facilities and therapists matched by ethnicity and language. The second study assessed
1,746 Asian American clients of Chinese, Korean, Filipino, and Japanese decent. As
cited by the authors, previous studies, although limited in nature, have found support for
client-therapist match in language and ethnicity. Having a therapist who can speak their
clients language and share ethnicity could help the clients feel more comfortable when
entering therapy, along with helping keep them in therapy. The outcome measures
employed were number of sessions with the primary therapist, dropout from therapy, and
differences in the Global Assessment Scale (GAS) scores from admission to discharge.
Global Assessment Scores relate to how well the client is functioning, based on the
therapist’s belief after talking with the client, from the very first session to the last
session. If a score has increased from the first to the last session, the client is considered
to have had successful treatment. Results from these studies found that a client-therapist
match for ethnicity and language was found to significantly increase the number of
sessions the clients spent with their therapist. This match also had an effect on dropout
from treatment, but it was a negative effect and actually was related to an increased
dropout rate. No other significant results were found. Perhaps, since the therapist shares
the same cultural attitudes (discussed earlier in the paper) as the client, they could be
“communicating disapproval of the clients’ behavior to the client and family” and have the effect of inhibiting the therapy leading to premature termination (p. 27).

Along these lines, another study conducted by Fujino, Okazaki, and Young (1994) sought to examine the relationship between ethnic and gender match among Asian American women. Results found that ethnicity and gender match were associated with fewer premature termination rates and more time in therapy, which was related to client satisfaction. Also, ethnic and gender match and ethnic match alone were significantly associated with a higher overall functioning score at the beginning of treatment.

Finally, Ying and Hu (1994) examined the mental health service use and outcome for 1,731 Asian Americans in the Los Angeles County area. As found in previous research, they found that a client-therapist ethnic match predicted an increased use of services in Koreans, Chinese, Japanese, and Filipinos, but not in Southeast Asians.

Flaskerud and Hu (1994) sought to examine participation in and outcomes of treatment for Asian Americans with diagnoses of depression. The four variables studied were treatment with medication or with no medication, therapist of the same ethnicity or different ethnicity as the client, an Asian ethnic-specific agency or non-Asian ethnic-specific agency, and a therapist with a professional degree or non-professional degree such as a licensed psychiatric technician and licensed or nonlicensed mental health workers. Results show that all of these variables were associated with an increase in the number of sessions for Asian Americans with major depression.

To summarize the above, for Asian Americans, worse treatment outcomes were associated with lower SES, client expectations for immediate solutions, and more severe symptoms at the beginning of treatment. Also they report less satisfaction with all areas
of treatment and services than Whites. Therapists have also been found to give Asians lower scores in functioning than White clients. Results also found that Asian clients did not differ in their initial expectations for therapy. Results from these studies also found that a client-therapist ethnic and language match significantly increases the number of sessions that Asians will spend with their therapist. Finally, treatment with medication and with no medication, therapist of the same ethnicity and of a different ethnicity, an Asian ethnic-specific or non-Asian ethnic-specific agency, and a therapist with a professional degree or non-professional degree were all associated with an increase in number of sessions for Asian Americans with depression.

*Mental Health Treatment of Asian American College Students*

Related to the previous studies on variables associated with treatment outcome are issues concerning mental health treatment and treatment outcomes among Asian American college students. As discussed earlier, minority students may avoid using university counseling centers for personal or emotional issues because of the shame and stigma associated with mental illness. Asian students who are also recent immigrants must also deal with the stress of adjusting to a new and unfamiliar culture, including mastering a different language, different norms and customs, differences in academics, financial issues, discrimination, learning to rely on themselves rather than family, and loneliness. Another problem typically encountered by Asian American college students is the “model minority” myth (Pang, 1995, p. 171). They are usually associated with higher achievement in classes and are believed to make it more difficult to get a good grade for other students. This can result in feelings of pressure and contribute to interpersonal problems. Asian Americans might also avoid university counseling centers
due to a perception of these services possibly being biased and racist, lacking counselors similar to them in ethnicity and race, and that the counselors will not share their perceptions of the world (Constantine and Chen, 1997).

These issues were examined by addressing intake concerns of minority students at a university counseling center to help develop relevant treatment programs (Constantine and Chen, 1997). Participants included 157 Asian Americans, Hispanic Americans, African Americans, and Native Americans. Results show that there were 4 main overlapping concerns among all the minority groups. These included problems in family and romantic relationships, academic problems or concerns, and depression. One limitation of this study was that the small sample size in some groups and the large number of presenting problems resulted in difficulty conducting some analyses of intergroup differences. Also, intake concerns were based on the clients' self-report, and some may not have reported accurate concerns.

A similar study sought to determine Asian American and White American perceptions of the effectiveness of their counseling experience (Lee & Mixon, 1995). Participants included 255 Caucasian students and 73 Asian American students who were from a West Coast university and had attended at least one counseling session. Variables examined included perceived helpfulness, perceptions of counselor characteristics, reactions to the experience, and service use. An individual questionnaire was mailed out to the students. Results indicated that Asian American clients rated their counselors as "significantly lower in competence, were less favorable toward returning to their counselors, and rated the effectiveness of counseling lower for personal-social-emotional concerns than did Caucasians" (Lee & Mixon, 1995, p. 3). Consistent with previous
research, Asian American students were more likely to seek help for academic or career concerns, rather than White students who sought help for personal-social-emotional problems. Asian American clients also attended fewer sessions than Caucasian students.

The authors cite several possible explanations for these differences. First, Asian students may want different things from their counselors in the areas of counseling and treatment. Also, some of the personal-social-emotional problems were different for Asians such as racial identity and cultural conflict. The results indicated that counselors need to research different cultures to learn how to work effectively with different minority groups. Some limitations of this study included not enough ethnic information to determine subgroup differences within the Asian groups, or within the Caucasian groups. Also, gender differences were not examined, so the results may not be generalizable to all male and female populations. Lastly, subjects were college students and their attitudes and perceptions may not be generalizable to other Asian populations.

Another study examined the role of previous counseling experience, gender, and ethnicity among Asian American college students and how these variables relate to the severity of problems and willingness to seek counseling (Solberg, Ritsma, Davis, Tata, and Jolly, 1994). 596 Asian American college students participated in this study. Variables of interest included academic, interpersonal, and substance abuse concerns. Results showed that previous counseling experience was related to the severity of substance abuse problems and participants' willingness to seek help from a counseling center for academic, interpersonal problems, and substance abuse problems. Furthermore, women reported higher ratings of severity for academic problems than men.
However, ethnicity was not related to severity of problems or willingness to seek help from counseling centers.

Along these lines, another study conducted by Tedeschi and Willis (1993) sought to determine Asian International and Native Caucasian students' attitudes toward counseling. The participants consisted of 30 Asian international women, 36 Asian international men, 26 Caucasian women, and 22 Caucasian men who were students at a Missouri university. Participants responded to a questionnaire about demographic information, preferred sources of help for personal issues (e.g. emotional, family, or relationship problems), preferred characteristics of a counselor, and attitudes towards professional help for personal issues. Participants rank ordered sources of help they would seek (e.g. university counseling center counselor, academic/foreign student advisor, faculty member, private practitioner, community mental health center, religious figure, parent, friend, or no one) and rated counselors on same ethnicity, has a university degree, older than the client, and same gender on a scale from very unimportant to very important. Participants also completed the Fischer and Turner scale of Attitudes Toward Seeking Professional Psychological Help. This measure consists of four subscales: Need, Stigma, Openness, and Confidence.

Results showed that Asian international students thought that having a counselor that was older and of the same ethnicity was more important than the Caucasian students. Caucasian women reported more positive attitudes towards counseling and were more tolerant of the stigma attached to seeking counseling than all other groups. Also both groups of women reported the need for help more often than the men.
Another study conducted by Gim, Atkinson, and Whiteley (1990) looked at Asian American acculturation, severity of concerns, and willingness to see a counselor. Subjects consisted of 399 male and 417 female Asian American students from a West Coast university. The subjects completed a questionnaire consisting of three parts: a demographic part, the Suinn-Lew Asian Self-Identity Acculturation Scale, and the modified Personal Problems Inventory. The PPI consists of fifteen problems that are of concern to college students, along with five problems that minority students might face (e.g. adjustment to college, academic performance, financial concerns, feelings of isolation and loneliness, and feelings of not belonging). Five more concerns of Asian American students on the campus were added to the list for this study (e.g. trouble studying, ethnic or racial discrimination, roommate problems, ethnic identity confusion, and general health problems).

Results showed that acculturation and ethnicity were related to the severity of problems experienced by Asian Americans. Also acculturation and gender were related to willingness to see a counselor. Asian Americans were found to view financial and career concerns to be their biggest problems. The results also show that acculturation may be inversely related to severity of concerns. The authors explain this by saying that less acculturated Asians may experience more stress than more acculturated Asians. More acculturated Asian Americans may not experience as much stress due to cultural conflict because they have adopted the American culture more than less acculturated Asian Americans. Results also indicate that Asian Americans were more willing to see a counselor for academic, career, or financial counseling. Also women were more willing than men to see a counselor for all concerns in the study.
A study conducted by Chang (2002) sought to determine reasons for distress in Asian Americans. Using Beck's cognitive model that states certain types of cognitions are associated with many psychological problems (e.g. depression, anxiety, stress, hopelessness), their main goal was to determine the relationship between measures of outcome expectancies (i.e. optimism and pessimism), affectivity (i.e. positive and negative), and a few measures of psychological distress (i.e. anxiety, depression, hopelessness, stress) among Asians and White Americans. The second goal was to determine if there were any ethnic differences on the outcome measures of expectancies, affectivity, and psychological stress. And, finally, their last goal was to examine the role of cognitions and affective states in predicting psychological stress/distress.

The participants included 92 Asian Americans and 252 Caucasian Americans from a large Northeastern university. Measures used in the study included: the Life Orientation Test (to measure optimism and pessimism), the Positive and Negative Affect Schedule, the State-Trait Anxiety Inventory-State Form, the Beck Depression Inventory, the Hopelessness Scale, the Derogatis Stress Profile, and the Symptom Checklist-90-Revised. All measures were given in small groups. Results showed that Asian Americans had higher levels of pessimism when compared to Whites, but groups did not differ in their levels of optimism. Asian Americans were also found to express higher negative affectivity, whereas White Americans expressed higher positive affectivity. Finally, scores from the STAIS-S, BDI, DSP, and SCL-90-R indicated that Asian Americans had a higher level of psychological distress and disturbance.

A study conducted by Nguyen and Peterson (1993) looked at depressive symptoms among Asian American college students. Specifically, they looked at the level
of acculturation and how it is associated with depression. Results indicated that being female and being younger were associated with more depressive symptoms. Also acculturation to American culture and experiencing stressful life events were associated with more depressive symptoms.

Little previous research has examined session-to-session treatment outcome for Asian American clients. One study conducted by Haas, Hill, Lambert, and Morrell (2002) sought to determine if early responders to treatment maintain their treatment gains after termination of therapy. 147 subjects from a private Western university participated in the study. Included in these subjects were Caucasian, Latino, Asian/Pacific Islander, and mixed ethnicity participants. Subjects were given the Outcome Questionnaire, which was used to measure symptoms during treatment and after treatment. The OQ measures three areas of functioning: discomfort, interpersonal functioning, and social role performance. Calculating a difference score between expected change and actual change identified early responders. Results showed that response rate predicted treatment outcome. Early positive responses to treatment were associated with fewer psychological symptoms at termination. Early responders to treatment responded better to treatment and kept their gains up to two years after treatment, even if they received less treatment. Even those who were slower responders to treatment showed eventual response to treatment and gains after therapy. The authors explain this by stating that early responders may just be ready for treatment and more receptive than the other groups with a higher motivation to change things.

With respect to Asian American college students, results from the previous studies found that there were four main overlapping concerns among Asian Americans:
problems in family and romantic relationships, academic problems, and depression. Asian American students rated their counselors as “significantly lower in competence, were less favorable toward returning to their counselors, and rated the effectiveness of counseling lower for personal-social-emotional concerns than White students.

Results also show that, for Asian American students, previous counseling experience is related to severity of substance abuse problems and clients’ willingness to seek help from a counseling center. Acculturation, stressful life events, and ethnicity were also related to severity of problems experienced by Asian Americans. Caucasian women reported more positive attitudes towards counseling and were more tolerant of the mental health stigma than Asian women and both groups of women reported the need for help more than men. Finally, Asian Americans were found to have higher levels of pessimism and expressed higher negative affectivity. Early positive responses to treatment were also associated with fewer psychological symptoms at termination.

The Present Study

Little research has been conducted on treatment outcome of Asian Americans. The current study focused on the relationship between presenting problems and treatment outcome among Asian American college students compared to non-Asian students. The present study also provides information about the relationship between treatment outcome and the following types of pretreatment variables: demographic variables (e.g., age, gender, ethnic status), academic variables (e.g., academic major, standing, year in school), and treatment history variables (e.g., previous counseling, history of medical, emotional, or substance abuse problems, presenting complaint).
Data were collected from 444 undergraduate and graduate clients from an East Coast university counseling center. Questionnaires were completed at intake and at every subsequent therapy session. These data were analyzed in the current study. There were six primary questions of interest and related hypotheses, which are delineated below:

1. Are there treatment outcome differences between Asians and non-Asians? My hypothesis was that Asians would not improve as much in treatment, unless they had previous counseling experience. This is consistent with previous research findings. This is also due to their acculturation level. It was assumed that Asian students would be less acculturated to the American culture and more to their own cultural values and norms, which would result in less positive treatment outcomes. Finally, it was hypothesized that, overall, Asians would present for fewer treatment sessions than non-Asians (Kim & Atkinson, 2002; Lee & Mixon, 1995).

2. Are there treatment outcome differences between Asian Americans and Asian International students? Consistent with previous research, it was hypothesized that Asian International students would have less positive treatment outcomes than would Asian American students because they would be less acculturated to the American culture and they may wait to seek treatment until their symptoms are more severe. Also, Asian International students would perceive the counseling process as a violation of their own cultural values and norms (Kim & Atkinson, 2002; Lee & Mixon, 1995).

3. Are there differences in the severity of presenting complaints/disorders (e.g., emergency visits, hospitalizations, or suicidality) between a) Asians and non-Asians and b) Asian Americans and Asian Internationals? Based on previous research, it was hypothesized that Asian international students would be more likely to have negative
feelings about the counseling experience, unless they had previous counseling experience, due to the stigma associated with the open expression of problems among the Asian culture (Kim & Atkinson, 2002; Lee & Mixon, 1995). This would lead to Asian students seeking services only when their issues are more severe. Therefore, they would be more likely to be involved in emergencies, be hospitalized, and have suicidal ideation (Gim, Atkinson, & Whiteley, 1990; Solberg et al., 1994; Sue et al., 1994). In the current study, emergency visits and hospitalizations were not looked at due to the fact that the data did not include this information. All that was known was if the first visit to the counseling center was an emergency visit and only one Asian met the criteria. Severity was defined by looking at the clients' level of suicidality and the BHQ initial mean. If these scores were higher, that meant a greater level of severity.

4. Are there differences in content of presenting complaints between Asian Americans, Asian Internationals, and non-Asians? It was hypothesized that, consistent with previous research, Asian international students would be more likely to seek career/academic counseling as opposed to interpersonal counseling because they see the latter as a violation of family expectations/norms and are less acculturated to American culture than Asian-American and non-Asian students (Gim, Atkinson, & Whiteley, 1990; Kim & Atkinson, 2002; Lee & Mixon, 1995; Tracey, Leong, & Glidden, 1986).

5. Will there be gender differences in content of presenting complaints and treatment outcome? It was assumed that, based on previous research, Asian American, Asian International, and non-Asian women would have more positive treatment outcomes and would be more likely to admit to interpersonal problems than Asian American, Asian International, and non-Asian men (Tedeschi & Willis, 1993). Asian American, Asian
International, and non-Asian women would also report higher levels of severity than men (Gim, Atkinson, & Whiteley, 1990; Solberg et al., 1994).

6. Will other demographic differences or treatment-related variables influence presenting complaints and treatment outcome? For many of these variables there has been little to no research done, so no conclusive hypotheses can be made. The current study explored these variables (i.e., age, year in school, students’ and parents’ marital status, religion, referral source, history of previous counseling, history of medical problems, and history of medical, emotional, and alcohol or substance abuse problems in the family).

Method

Client Sample

Data for this study were obtained from an existing database from an East Coast university counseling center. The database consists of information obtained from 444 students who were presenting for therapy at this clinic for the first time during the 2000-2001 academic year. Data were analyzed for the following student demographic variables: age, gender, ethnic status, year in school, religion, marital status, parents’ marital status, and international student status. The overall sample consisted of 173 males (38.7%) and 271 females (60.6%) with ages ranging from 17 to 46 ($M = 22.27$). Of this sample, 17 were African American (3.8%), 91 were Asian (20.5%), 19 were Latino (4.3%), 1 was Native American (.2%), 283 were Caucasian (63.7%), 22 marked Other (5.0%), and 11 were Missing (2.5%). 78 of the participants were freshmen (17.4%), 69 were sophomores (15.4%), 89 were juniors (19.9%), 80 were seniors (17.9%), 106 were graduate students (23.7%), and 18 were in other groups. The majority
of the clients were single (85.2%), followed by married/committed relationship (10.7%).

Most students came from homes where their parents were in a married/committed relationship (69.4%), divorced homes (18.8%), separated (3.6%), and widowed (3.4%).

Most students identified their religious preference as Catholic (22.8%) followed by Protestant (17.0%), Jewish (10.3%), Other (9.6%), Buddhist (4.3%), Hindu (3.8%), and Moslem (3.6%). 24.4% identified with no religion.

With respect to treatment relevant variables, most of the clients were self-referred to the counseling center (43.2%), followed by those that were referred by university professional staff (28.9%), and a friend (16.6%); had never received any previous counseling or therapy (54.6%), and most did not have any medical problems (72.7%).

With regards to family history of medical, emotional, and substance abuse problems, most reported no history of medical problems (49.4%), followed by 31.1% with a family history of medical problems, and 14.5% that were unsure; no history of emotional problems (42.1%), followed by 32.4% with a family history of emotional problems, and 21.0% that were unsure; and, finally, no substance abuse history (63.1%), followed by 24.2% with a family history of substance abuse, and 8.3% who were unsure.

The primary groups of interest in the current study were Asian American students and Asian International students. Preliminary review of data indicated that there were 63 Asian American students (14.1%) and 28 Asian International students (6.3%) in the database. The data from these groups were compared with all non-Asian students \( n = 356; 79.6\% \). With regards to Asian Americans, there were 25 males (39.7%) and 38 females (60.3%) with ages ranging from 17 to 27 \( M = 19.79 \). 15 Asian Americans were freshmen (23.8%) followed by 17 sophomores (27.0%), 14 juniors, 14 seniors (22.2%
each), and 3 graduate/post-graduate students. The majority were not in a relationship (98.4%) and came from homes where their parents were in a married/committed relationship (88.9%). Most of the Asian Americans were of the Hindu religion (23.8%) followed by Buddhist (15.9%) and Protestant (15.9%) (see Table 1).

With respect to Asian International clients, 13 were male (46.4%) and 15 were female (53.6%) with ages ranging from 18 to 40 \((M = 22.96)\). There were 9 freshmen (32.1%), 3 juniors (10.7%), 4 seniors (14.3%), 11 graduate students (39.3%), and 1 other. The majority were single (85.7%) and came from homes where their parents were in a married/committed relationship (85.7%). Finally, the majority of Asian International students were of Catholic and Buddhist religion (17.9% each) followed by Moslem and Protestant (14.3% each) (see Table 1).

Most Asian Americans were self-referred to the counseling center (38.1%) as were Asian International students (35.7%). The majority of Asian Americans had never had any previous counseling experience (77.8%) along with Asian Internationals (78.6%). Most Asian Americans (77.8%) and Asian Internationals (82.1%) did not report having any medical problems. With respect to having a family history of medical, emotional, or substance abuse problems, Asian Americans reported no medical (49.2%), unsure of medical (22.2%), and a history of family medical problems (25.4%); no emotional (52.4%), unsure of emotional (25.4%), and a history of family emotional problems (19.0%); and no substance abuse (81.0%), unsure of substance abuse problems (11.1%), and a family history of substance abuse problems (4.8%). Asian International students also reported no medical problems (75.0%), unsure of medical problems (14.3%) and a family history of medical problems (7.1%); no emotional problems (75.0%), unsure
of family history of emotional problems (10.7%), and a family history of emotional
problems (10.7%); no substance abuse problems (92.9%), and unsure of substance abuse
problems (3.6%) (see Table 2).

Measures

Personal Information Form (PIF). The PIF was developed by Michael Mond,
Ph.D., director of the university counseling center, based on over 20 years of experience
as a university counseling center director (Mond, personal communication, 2003). The
PIF is a questionnaire designed to obtain background information about prospective
clients who are presenting to the counseling center for treatment and their specific
reasons for seeking counseling (see Appendix A). The client is first asked to state the
main reason for coming into the center at that time and how "troubled" they are by the
presenting issue [ranging from 1 (hardly at all) to 4 (severely)]. The PIF is divided into
three primary sections: demographic questions, treatment relevant questions, and a
problem checklist.

The PIF's demographic questions assess the client's affiliated school on campus
[i.e., Homewood (primary undergraduate campus), Nursing, Peabody Institute (school of
music), Other], age, gender, ethnic status [i.e., African American, Asian, Latino, Native
American, Caucasian, Other], religion [i.e., Buddhist, Catholic, Hindu, Jewish, Moslem,
Protestant, Other], year in school [i.e., freshman, sophomore, junior, senior, grad. student,
graduated, post graduate], marital status and parents marital status [i.e., single,
marrried/committed relationship, separated, divorced, other], academic standing [i.e., in
good academic standing, academically dismissed, reinstated, on probation], academic
The PIF also includes treatment relevant questions. The primary variables of interest are: referral source [i.e., self, friend, relative, residential life staff, faculty, staff, student health and wellness, career planning and development, other, academic advising, dean of students], if they have had any counseling experience before coming to the center [i.e., never, previously, currently], history of medical problems, current medication use, and history of medical, emotional, and alcohol or substance abuse problems in the family.

The final page of the PIF includes a problem checklist to assess presenting complaints. These are rated on a Likert type scale: 0 (not a problem at all), 1 (slight problem), 2 (moderate problem), 3 (serious problem), and 4 (severe problem). Presenting complaints are assessed from 13 categories of issues. These include career issues, academic issues, relationship issues, self-esteem issues, anxiety issues, existential issues (i.e., generally unhappy, gay/lesbian issue, concern about being a member of a minority, and confusion over religious issues), depression, eating disorder issues, substance abuse issues, sexual abuse or harassment issues, stress and psychosomatic symptoms, sexual dysfunction issues, and unusual thoughts or behavior (i.e., irritable, angry, or hostile feelings; thinking is very confused; fear of loss of contact with reality; violent thoughts, feelings, or behaviors, etc.) The final question on the PIF asks the client to indicate their overall risk of suicide (i.e., extremely low risk, low risk, moderate risk, high risk, extremely high risk).
Reliability and validity data on the PIF have not been computed due to the PIF being continually revised. The PIF does have significant face validity and there is evidence for criterion related validity and construct validity, based on client report, therapist report, and the relationship of items endorsed on the PIF with other measures (i.e., BHQ, Suicide Status Form) (Mond, personal communication, 2003).

Behavioral Health Questionnaire-20. The BHQ-20 is a brief client-rated measure of treatment outcome (Kopta & Lowry, 2002). The BHQ assesses 5 areas of functioning: well-being (i.e., distress, life satisfaction, and motivation); psychological symptoms (i.e., depression or anxiety); life functioning (i.e., intimate or social relationships); drug and alcohol abuse; and personal risk (i.e., suicidal thoughts or violence). The BHQ-20 was not available at the time of the current study in 2000-2001, so an earlier version, the BHQ-14, was used (Mond, personal communication, 2003) (see Appendix B).

The BHQ-14 measures the same areas as the BHQ-20. It was administered at intake and after each counseling session. Students were instructed to rate how they had been feeling over the past two weeks. The first two questions measure remoralization (e.g., subjective well-being). Questions 3 through 10 measure remediation (e.g., alleviation of symptoms). Questions 11 through 14 measure rehabilitation (e.g., changes in life functioning). The first question asked students to rate on a Likert-type scale ranging from 0 (not satisfied at all) to 4 (very satisfied) how satisfied they had been with their life. The second question asked students to rate on a Likert-type scale ranging from 0 (not at all energetic) to 4 (very energetic) how energetic and motivated they have been feeling. Questions 3-10 asked the students to rate on a Likert-type scale ranging from 0 (almost always) to 4 (never) how distressed they have been in the past two weeks by the
following: not liking themselves, difficulty concentrating, feeling sad, feeling fearful, feeling hopeless about the future, intense mood swings, difficulty making decisions, and feeling nervous. Questions 11-14 asked students to rate on a Likert-type scale ranging from 4 (very well) to 0 (terribly) how well they have been getting along in the following areas: work/school, intimate relationships, nonfamily social relationships, and life enjoyment. Two additional questions were added to the BHQ-14 that were not a part of the original measure to assess functioning at every therapy visit after intake (Mond, personal communication, 2003). These were question #15 ("How much have you benefited so far from being in psychotherapy/counseling?") and question #16 ("How much have you benefited from taking medication if you are receiving medication from the center?") Answers were rated on a Likert-type scale ranging from 0 (I’ve gotten much worse) to 4 (I’m much better).

In order for the BHQ-14 to be valid, the following conditions must be met: (1) questions 1 and 2 must be answered, (2) no more than 2 answers can be missing in questions 3-10, (3) no more than 1 answer can be missing from questions 11-14, and (4) no more than 3 total questions on the entire questionnaire can be missing (Mond, personal communication, 2003).

Data on the psychometric properties of the BHQ-14 are not available, however, research has been conducted on the BHQ-20. A study conducted by Kopta and Lowry (2002) sought to determine the psychometric properties of the Behavioral Health Questionnaire-20. Participants included 380 community adults, 465 undergraduate college students, 208 undergraduate college students in counseling, and 211 adults in outpatient psychotherapy. The BHQ-20 was given with the Behavior and Symptom
Identification Scale-32 (BASIS-32), the COMPASS Treatment Assessment System (COMPASS), the Outcome Questionnaire-45.2 (OQ), and the Symptom Checklist-90-Revised (SCL-90-R). These measures all assess the same areas as the BHQ-20 (well-being, symptomatic distress, and life/interpersonal functioning). The BASIS-32 is a self-report measure that looks at 5 main areas of functioning and psychological symptoms: relation to self and others, depression and anxiety, daily living and functioning, impulsive and addictive behavior, and psychosis. The COMPASS is a scale that measures therapist rating, need for treatment, presenting problems, current well-being, current symptoms, and current life functioning. The OQ is also a self-report measure that assesses a person’s symptom distress, interpersonal relations, and social role performance. Finally, the SCL-90-R is a self-report measure that assesses three global indices of distress and nine areas of symptoms: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Results found that the BHQ-20 is a reliable and valid outcome measure that measures symptoms that may be common to psychotherapy outpatients such as well-being, and major areas of life functioning, such as relationships, work, and enjoyment. Internal consistency coefficients for Global Mental Health ranged from .89 to .90; for Well-Being it ranged from .65 to .74; for Symptoms it ranged from .85 to .86; and for Life Functioning it ranged from .72 to .77. To assess concurrent validity each of the BHQ-20 scales were compared to their counterparts on each other measure. The correlations between the scales were moderately high. Higher correlations were found between the BHQ-20 and the nonanalogous scales of the other measures. To determine independence of the BHQ-20 scales Pearson Product-Moment correlations were
conducted. Results showed that the correlations were all high and significant which means that the scales are not independent from each other.

Procedure

Students who were presenting for therapy at the counseling center for the first time were required to complete the PIF and the BHQ-14. All clients selected for the current study had not previously been seen at this counseling center. At every subsequent session, the BHQ-14 was administered to assess client functioning. This was continued until: (1) therapist-client mutually agreed on termination (2) the client dropped out of treatment or (3) the end of the 2000-2001 academic year (at which time clients’ data was entered into the 2001-2002 database).

All client BHQ and PIF data was entered into the counseling center database by trained undergraduate work-study students. No personally identifiable information was made available at this time (clients were identified by code only).

Results

Data were primarily analyzed with a combination of t-tests, one-way ANOVAs, and chi-square tests. The study questions were analyzed as follows:

1) Will there be treatment outcome differences between Asians and non-Asians?

A difference score was computed which was the BHQ initial mean subtracted from the BHQ final mean. This provided an index of overall treatment outcome. For those clients who had only a single session, the difference score was set at zero ($n = 114$).

An independent samples t-test was conducted to compare outcome differences with the independent variable (IV) being ethnicity (Asians and non-Asians) and the dependent variable (DV) being the BHQ difference score. Results indicated there were
no significant treatment outcome differences between Asian students \((M = .34, SD = .65)\) and non-Asian students \((M = .30, SD = .62)\), \(t(418) = .48, p = .63\) (see Table 3).

Treatment outcome was also assessed by examining the final BHQ mean itself. An independent samples \(t\)-test was conducted in which the IV was ethnicity (Asians and non-Asians) and the DV was the BHQ final mean. Results indicated that Asian students \((M = 2.42, SD = .82)\) had significantly lower BHQ scores at their final session than did non-Asian students \((M = 2.64, SD = .71)\), \(t(429) = -2.49, p < .05\) (see Table 3).

To assess differences in number of sessions, an independent samples \(t\)-test was conducted in which the IV was ethnicity (Asians and non-Asians) and the DV was the number of total sessions. Results indicated that Asian American students \((M = 4.15, SD = 3.93)\) attended significantly fewer treatment sessions than non-Asian students \((M = 5.42, SD = 5.56)\), \(t(429) = -2.03, p < .05\).

2) Will there be treatment outcome differences between Asian Americans and Asian Internationals?

An independent samples \(t\)-test was conducted with the IV being Asian group (Asian Americans and Asian Internationals) and the DV being the BHQ difference score. There were no significant differences in BHQ difference scores when comparing Asian American students \((M = .30, SD = .62)\) and Asian International students \((M = .41, SD = .72)\), \(t(85) = -.70, p = .48\) (see Table 3).

An independent samples \(t\)-test was also conducted in which Asian group (Asian Americans and Asian Internationals) was the IV and the BHQ final mean was the DV. Results indicated that there were no significant differences in BHQ final mean scores for
Asian Americans ($M = 2.37, SD = .82$) and Asian Internationals ($M = 2.53, SD = .81$), $t (87) = -.86, p = .39$ (see Table 3).

Finally, an independent samples $t$-test was conducted with Asian group (Asian Americans and Asian Internationals) as the IV and the number of sessions as the DV. Although the analysis approached significance, results indicated that there were no significant differences in the number of sessions attended by Asian American students ($M = 3.63, SD = 2.85$) and Asian International students ($M = 5.33, SD = 5.56$), $t (87) = -1.91, p = .06$.

3) Will there be differences in level of severity (suicidality and BHQ initial scores)?

Severity was operationalized by looking at the clients’ level of suicidality (PIF question 28) and initial BHQ mean. The level of suicidality was assessed by looking at the client’s response to PIF question 28, which asked for the level of suicidal thoughts, feelings, and behaviors. If this score was higher, that meant a greater level of severity. For initial BHQ mean, lower scores indicated a greater level of severity. Two independent samples $t$-tests were conducted in which the IV was ethnicity (Asian vs. non-Asian) and the DV were the severity variables (suicidality and BHQ initial mean).

Results indicated that non-Asian students ($M = .36, SD = .83$) expressed significantly less suicidal thoughts, feelings, and behaviors than did Asian students ($M = .62, SD = 1.17$), $t (421) = 2.40, p < .05$. Results also indicated that Asian students ($M = 2.06, SD = .83$) had significantly lower initial BHQ mean scores than did non-Asian students ($M = 2.34, SD = .74$) $t (418) = -3.03, p < .01$. 
Two independent samples t-tests were also conducted in which Asian group (Asian Americans and Asian Internationals) was the IV and the two severity variables (suicidality and BHQ initial mean) were the DV. Results indicated that Asian American students \((M = .71, SD = 1.30)\) did not significantly differ in severity of suicidal ideation, and behavior from the Asian International students \((M = .43, SD = .84)\), \(t(85) = 1.05, p = .30\). Results also indicated that there were no significant differences in initial BHQ mean scores between Asian American students \((M = 2.06, SD = .84)\) and Asian International students \((M = 2.07, SD = .82)\), \(t(85) = -.05, p = .96\) (see Table 4).

Emergency visits and hospitalizations were not examined because the data did not include this information. All that was known was whether or not the first visit to the counseling center was an emergency and as only one Asian met this criteria, no analyses on this variable were conducted.

4) Will there be differences in content of presenting complaints?

Ratings from the questions for the 13 presenting complaints categories on the PIF were summed. 13 analyses of variance (ANOVAs) were conducted in which the IV was ethnicity (Asian Americans, Asian Internationals or non-Asians) and the DV was each of the summed ratings for the 13 categories. Results indicated that Asian American students had greater concerns in four problem areas: academic concerns, \(F(2, 415) = 11.93, p < .001\); anxiety concerns, \(F(2, 417) = 4.58, p < .01\); relationship concerns, \(F(2, 415) = 4.18, p < .05\); and depression issues, \(F(2, 412) = 3.53, p < .05\).

Using the Bonferroni Correction, the significance value was set at .004 (.05/13). Post hoc analyses indicated that Asian Americans reported more concerns than did non-Asians, as follows: academic issues \((M_{AA} = 14.85, SD_{AA} = 8.45; M_{NA} = 10.05, SD_{NA} =\)
6.74); anxiety issues ($M_{AA} = 7.27$, $SD_{AA} = 4.46$; $M_{NA} = 5.64$, $SD_{NA} = 3.67$); relationship issues ($M_{AA} = 7.32$, $SD_{AA} = 5.59$; $M_{NA} = 5.41$, $SD_{NA} = 4.57$); and depression ($M_{AA} = 4.45$, $SD_{AA} = 4.19$; $M_{NA} = 3.22$, $SD_{NA} = 3.13$).

A crosstabulation and chi-square analysis was conducted to determine if Asians present with more career/academic complaints than interpersonal complaints. The two factors were ethnic status (Asian Americans, Asian Internationals, and non-Asians) and primary presenting complaint (career/academic concerns, psychological/interpersonal concerns, and “personal and career” concerns). Results from the chi-square, $X^2 (4, N = 404) = 13.73, p < .01$, indicated a relationship between ethnic status and type of presenting problem. Results indicated that 58.9% of Asian Americans presented with personal problems only, as compared to 92.3% of Asian Internationals, and 78.0% of non-Asians. 7.1% of the Asian American students presented with career problems only, as compared to none of the Asian International students, and 4.3% of non-Asian students. Finally, 33.9% of the Asian American students presented with a combination of personal and career problems, compared to 7.7% of Asian Internationals who presented with this combination, and 17.7% of non-Asians.

5) Will there be gender differences in treatment outcome and content of presenting complaint?

To assess treatment outcome differences, 2 independent samples $t$-tests were conducted with the IV being gender and the DV being the BHQ outcome score and BHQ final mean score. Results indicated that there were no gender differences within each group (Asian Americans, Asian Internationals, non-Asians) on the BHQ final mean score or the BHQ outcome score.
To assess gender differences in presenting complaints, 2 (male vs. female) x 3 (Asian American, Asian International, non-Asian) ANOVAs were conducted in which the DV were the sum ratings of the 13 presenting complaint areas. No main effect for gender and no interaction effects for ethnicity x gender were found for the 13 PIF problem areas.

To assess severity of presenting complaint (i.e., suicidality and BHQ initial mean), 2 independent samples t-tests were conducted with the IV being gender and the DV being suicidality and BHQ initial mean score. The results of these analyses were not significant.

6) As per the above: a combination of correlational analyses and ANOVAs were conducted to assess the relationship between demographic variables and a) presenting complaints and b) treatment outcome. Due to the number of analyses, the significance level was set at $p \leq .01$.

The following sections will look at the relationship between demographic variables and treatment related variables and the 13 PIF problem areas and treatment outcome for the entire client population seeking counseling.

**Demographic Variables**

In order to examine the impact of age on the final BHQ mean, a Pearson correlation analysis was conducted. It was found that age was positively correlated with final BHQ mean, $r = .16$, $p < .001$, but not with BHQ treatment outcome, indicating that older clients had higher final BHQ mean scores. Pearson correlations were also conducted to determine the relationship between age and the 13 presenting concerns. Results showed that age was negatively correlated with 8 of the presenting complaints:
academic concerns ($r = -.20, p < .01$), anxiety concerns ($r = -.14, p < .01$), relationship concerns ($r = -.17, p < .01$), adjustment issues ($r = -.22, p < .01$), self-esteem ($r = -.17, p < .01$), depression ($r = -.21, p < .01$), eating disorder concerns ($r = -.12, p < .05$), and career issues ($r = -.21, p < .01$).

A series of ANOVAs were conducted with the IV being demographic variables and the DV being the PIF problem areas. The main significant findings were for religion and class year. Results of one-way ANOVAs found significant differences between religion and the presenting complaint area of academic concerns, $F(7, 399) = 3.43, p < .01$. Post hoc tests revealed, specifically, that Hindu students ($M = 16.44, SD = 8.31$) expressed more concerns with academic issues than Jewish students ($M = 9.05, SD = 6.95$) or those who did not identify with any religion ($M = 9.13, SD = 6.81$) (see Table 5).

Significant differences were found for class year and the following presenting complaint areas: academic concerns, $F(7, 406) = 4.24, p < .001$, anxiety concerns, $F(7, 408) = 2.75, p < .01$, adjustment issues, $F(7, 409) = 6.78, p < .001$, self-esteem, $F(7, 413) = 2.86, p < .01$, depression, $F(7, 403) = 3.67, p < .001$, and career issues, $F(7, 411) = 2.95, p < .01$. Post hoc analyses were conducted to determine specific differences for these areas. As can be seen in Table 6, graduate students were less likely to express academic concerns than freshmen or sophomores. Freshmen were more likely to express adjustment concerns than juniors, seniors, or graduate students. Freshmen were also more likely to express greater concerns with self-esteem than graduate students. Finally, graduate students were less likely to express concerns with depression than were freshmen or sophomores. Post hoc analyses did not reveal significant differences between class year and presenting complaints for anxiety concerns and career issues.
Significant differences were also found for marital status and the presenting complaint areas of: adjustment issues, \( F(4, 414) = 4.49, p < .01 \); self-esteem, \( F(4, 418) = 4.49, p < .01 \); and depression, \( F(4, 408) = 3.82, p < .01 \). These data should be approached with caution, as there were very few clients in some of the groups, with the result that post hoc analyses could not be conducted.

No significant differences were found for referral source, previous history of counseling, or parent's marital status and the 13 PIF presenting complaints.

One-way ANOVAs were also conducted to determine the relationship between demographic variables and treatment outcome (i.e., final BHQ mean, BHQ treatment outcome). Significant differences were found for religion and final BHQ mean, \( F(7, 409) = 3.12, p < .01 \). As can be seen in Table 5, post hoc tests revealed that Hindu students \((M = 2.06, SD = .88)\) were more likely to have lower final BHQ mean scores than either Jewish students \((M = 2.72, SD = .78)\) or those with no religion \((M = 2.78, SD = .69)\).

Class year of students was also significant for final BHQ mean, \( F(7, 419) = 3.63, p < .001 \). Post hoc analyses were conducted to determine the specific differences for the class years. It was found that freshmen \((M = 2.33, SD = .89)\) were more likely to have lower final BHQ scores than were seniors \((M = 2.74, SD = .67)\) or graduate students \((M = 2.68, SD = .70)\) (see Table 6).

\emph{Treatment Related Variables}

A series of ANOVAs were conducted in which the IV was treatment related variables and the DV was PIF problem areas. The most significant results were found for a family history of medical, emotional, and substance abuse problems. An independent
A samples t-test was conducted in which history of medical problems (yes, no) was the IV and the 13 PIF presenting problems were the DV. Results found no significant differences between those with a history of medical problems and those with no history for presenting problem.

ANOVAAs were conducted with the IV being family history of medical problems and the DV being PIF problem areas. Results were significant for: anger issues, \( F(2, 406) = 5.05, p < .01 \); unusual behaviors, \( F(2, 410) = 4.52, p < .01 \); somatic issues, \( F(2, 406) = 11.03, p < .01 \); academic concerns, \( F(2, 403) = 8.57, p < .01 \); anxiety concerns, \( F(2, 405) = 6.01, p < .01 \); relationship concerns, \( F(2, 403) = 5.10, p < .01 \); and eating disorder issues, \( F(2, 409) = 4.77, p < .01 \). Post hoc analyses revealed that for anger concerns, those that had a family history of medical problems were more likely to express concerns in this area (\( M = 1.39, SD = 1.91 \)) than those who did not (\( M = .88, SD = 1.40 \)). Those with a family history of medical problems were also more likely to express concerns with unusual behaviors (\( M = 1.60, SD = 2.22 \)) than those with no family history (\( M = 1.03, SD = 1.78 \)). Finally, those with no family history of medical problems were less likely to express concerns in the following 5 presenting complaint areas than those with a history or those who were unsure: somatic concerns, academic concerns, anxiety concerns, relationship concerns, and eating disorder issues (see Table 7).

ANOVAAs were also conducted with the IV being family history of emotional problems and the DV being the PIF problem areas. For family history of emotional problems, results were significant for, anger, \( F(2, 408) = 5.16, p < .01 \); somatic issues, \( F(2, 408) = 8.69, p < .01 \); relationship concerns, \( F(2, 405) = 10.94, p < .01 \); adjustment issues, \( F(2, 408) = 4.47, p < .01 \); self-esteem, \( F(2, 411) = 9.76, p < .01 \); depression, \( F
Asian American College Students 41

(2, 401) = 6.81, \( p < .01 \); eating disorder issues, \( F(2, 411) = 5.32, p < .01 \); substance abuse issues, \( F(2, 408) = 9.93, p < .01 \), and physical/emotional/sexual abuse issues, \( F(2, 409) = 13.11, p < .01 \). Post hoc analyses were conducted to determine specific differences within groups. Results showed that those students with a history of family emotional problems were more likely to express more concerns with anger issues, somatic issues, adjustment issues, substance abuse issues, and physical/emotional/sexual abuse issues than those with no family history of emotional problems. Students with no family history of emotional abuse expressed fewer concerns with relationship issues, self-esteem, depression, and eating disorder concerns than those who have a family history or are unsure if they have a family history of emotional problems (see Table 7).

It was also found that students who have a family history of alcohol or substance abuse problems were more likely to have greater concerns about anger issues \( [F(2, 407) = 4.66, p < .01; (M = 1.43, M = .95, SDy = 1.97, SDn = 1.46)] \) somatic concerns \( [F(2, 407) = 5.07, p < .01; (M = 3.79, M = 2.80, SDy = 3.00, SDn = 2.82)] \), and substance abuse issues \( [F(2, 407) = 28.60, p < .01; (M = 0.99, M = 0.15, SDy = 1.54, SDn = 0.59)] \) than those with no family history of substance abuse (see Table 7).

One-way ANOVAs were also conducted on medical problems and final BHQ mean and BHQ treatment outcome. Final BHQ mean and BHQ treatment outcome was not significant for medical problems.

Finally, one-way ANOVAs revealed significant differences for history of family emotional problems and final BHQ mean, \( F(2, 416) = 5.06, p < .01 \). Post hoc analyses showed that those students who reported a family history of emotional problems (\( M = \) \( \ldots \) \)
Asian American College Students

2.49, $SD = .73$) had lower final BHQ scores than those with no family history of emotional problems ($M = 2.72, SD = .70$).

No significant differences were found for marital status, parent’s marital status, referral source, previous counseling, history of family medical problems, or history of family substance abuse on final BHQ mean and BHQ treatment outcome scores.

Discussion

The current study sought to investigate the relationship between presenting complaints and treatment outcome among Asian American and Asian International college students compared to non-Asian college students. The current study also aimed to provide information about the relationship between treatment outcome and the following types of demographic and treatment variables: age, gender, ethnic status, year in school, religion, marital status, and parent’s marital status, referral source, history of medical problems, and history of family medical, emotional, and substance abuse problems. The primary hypotheses of this study were that 1) Asians would not improve in treatment as much unless they had previous counseling and would present for fewer treatment sessions compared to non-Asians; 2) Asian International students would have more negative treatment outcomes/not improve as much as Asian American students; 3) Asian International students would have a greater level of severity when presenting for counseling (i.e., higher initial BHQ scores and higher levels of suicidality) than Asian Americans or non-Asians; 4) Asian International students would seek career/academic counseling more often than personal counseling as compared to Asian American and non-Asian students; 5) women in all groups would have more positive treatment outcomes and would be more likely to admit to greater levels of severity than men.
Treatment Outcome

The present study found that there were no significant differences in treatment outcome (i.e., BHQ difference score) between Asian and non-Asian students. This was contrary to what was hypothesized, and could be due to the fact that a large percentage of individuals (25.68%) had a difference score of 0 as they only presented for one session. However, it was found that Asians had lower BHQ scores at their final session (i.e., higher psychological maladjustment) and attended fewer treatment sessions than did non-Asians. This was consistent with previous research findings (Lee & Mixon, 1995) that Asians report feeling more angry, sad, and worried after four sessions of treatment than do Whites (Zane, Enomoto, & Chun, 1994). Research has also found that, with Asian clients, more negative outcomes were associated with lower socioeconomic status, client expectations of immediate solutions, and more severe symptoms at the beginning of treatment. Also Asians have been found to report being less satisfied with all aspects of services and treatment than White clients (Zane, Enomoto, & Chun, 1994). These findings could be due to something occurring in the client-therapist relationship, such as lack of collaboration, that made Asians feel less comfortable or confident with their treatment, causing them to terminate early and feel less positive about treatment.

When Asians were separated into Asian American and Asian International students, results showed that there were no differences in treatment outcome between these two groups. There were also no differences in final BHQ scores and how many sessions attended for Asian American and Asian International students. This is not consistent with previous research that has found that Asian International students are less acculturated to the American culture and see the counseling process as a violation of their
own cultural norms and values (Kim & Atkinson, 2002; Lee & Mixon, 1995). This could be due to the fact that there were not enough Asian International students in the sample.

Initial Severity and Presenting Issues

With respect to severity and presenting issues, non-Asian students expressed less suicidal thoughts, feelings, and behaviors than Asians. Non-Asians also had higher initial BHQ means (i.e., better psychological health) than Asians. This could be due to the fact that Asians tend to avoid seeking services until their symptoms are more severe (Gim, Atkinson, & Whiteley, 1990; Solberg et al., 1994; Sue et al., 1994). Additionally, acculturation and ethnicity have been found to be related to the severity of problems experienced by Asian Americans (Gim, Atkinson, & Whiteley, 1990). Specifically, less acculturated Asians may experience more stress than those that are more acculturated to the U.S. culture (Gim, Atkinson, & Whiteley, 1990).

Although Asian American and Asian International students did not differ in severity or suicidality, they did differ in area of presenting concern. Contrary to what was hypothesized, Asian International students did not present with increased suicidal ideation, and also had no differences in initial BHQ mean scores, when compared to Asian American students. This means that there were no differences between Asian American and Asian International students in their level of severity when entering treatment. The reasons for these findings are unclear, but the general consensus would be that there are differences.

When looking at presenting issues, Asian American students in the present study were found to express greater concerns in four problem areas when compared to non-Asians: academic concerns, feelings of anxiety, problems with a relationship, and
Asian American College Students

Having more concerns with academic problems is consistent with previous research for Asian Americans (Atkinson & Lowe, 1995; Lee & Mixon, 1995; Tracey, Leong, & Glidden, 1986). This may be due to the greater emphasis Asian families place on academics or the shame and stigma that the Asian culture places on open expression of problems (Lau et al., 2002). Families place a greater emphasis on academics in the Asian culture so it may be more acceptable to express issues concerning academics (Kim & Atkinson, 2002). Previous research has found that Asian Americans with previous counseling experience are more willing to seek counseling for academic as well as for personal reasons, and when they do seek counseling, they find it to be a good experience and seek help again when needed (Atkinson & Lowe, 1995). Furthermore, previous research has found Asian clients to have four main concerns that overlap with other minorities: problems in the family and romantic relationships, academic concerns, and depression (Constantine and Chen, 1997). It could be that since the campus counseling center provides academic and career counseling as opposed to only mental health counseling, Asians feel less threatened because they can tell people they are seeking academic/career counseling, even if they are seeking personal counseling.

**Gender and Demographic Differences**

The data from this study indicate that there were no gender differences for any of the groups for treatment outcome, presenting issues, or suicidality. This supports previous research that has found that Asian American women are not more willing to seek counseling, even with previous counseling experience (Atkinson & Lowe, 1995). However, these findings also contradict previous research, which has found that Asian American women report higher levels of severity for academic problems (Solberg et al.,
1994). The reason for these findings is not clear. It may be that the measure of psychological health used in the present study measured different aspects of health. Predictors of treatment outcome may be more complex than gender alone.

Demographic Variables. This study also examined other non-ethnic demographic variables and treatment related variables and how they may relate to treatment outcome. With regards to demographic variables, it was found that older students tended to have greater positive health, along with fewer complaints in the following areas: academics, feelings of anxiety, concerns with relationships, problems adjusting, self-esteem issues, depression, eating disorders, and career concerns. This seems to be consistent with most college populations because as you evolve throughout your educational years, you tend to make career and life decisions so concerns with these areas tend to decrease. Younger students may have more concerns in these areas due to being away from home for the first time. Younger students tend to be away from home for the first time and may experience more problems adjusting to life on their own, deciding on a career, coping with increased academic loads, and new relationships, which can also lead to feelings of depression and isolation from family back home.

With respect to class year, it was found that graduate students had more concerns with academic issues than freshmen or sophomores, freshmen expressed more concerns with adjustment issues than juniors, seniors, or graduate students, and freshmen expressed more concerns with self-esteem issues than graduate students. Finally, graduate students did not express as much concerns with depression than freshmen and sophomores. This may be due to the fact that graduate students are more mature and have more developed coping skills, which may lessen their feelings of depression. Also,
graduate students may have more concerns with academics because being in a higher level of education places greater emphasis on doing well for their careers after they graduate and graduate students may take their schooling more seriously than younger students. These results are consistent with the findings for age.

For the demographic variable, religion, it was found that Hindu students expressed more concerns with academic issues than Jewish students or students with no religion. Also, Hindu students did not improve as much in counseling as Jewish students or students with no religion. Since all the Hindu students were likely Asian, this finding seems to be consistent with the general findings in the literature that Asians tend to present with more academic complaints (Lau et al., 2002).

Treatment Related Variables. With respect to treatment related variables, the most salient factors seemed to be a personal history of medical problems and a family history of medical, emotional, or substance abuse problems. It was found that students with a personal history of medical problems had more concerns with somatic issues. This finding seems to be consistent with what would be expected of those with somatic complaints. It is logical that students with a medical history would worry about physical complaints more often than those with no medical history.

Furthermore, students with a family history of medical problems, emotional problems, and substance abuse problems had more concerns in the following areas: anger, somatic issues, problems with adjustment, substance abuse concerns, and physical/emotional/sexual abuse problems. These findings seem to make sense that having some kind of family dysfunction would be related to current psychological problems for college students. For example, children who were raised in households
where there was some form of family dysfunction would be more apt to recognize and worry about these problems than those who were not exposed to these problems. If there is a family history of medical problems, family members would be more likely to worry about preexisting conditions and symptoms in themselves. Likewise, children who grow up in a home where one of their parents or family members is a substance abuser, they are more likely to worry about becoming one as well. Additionally, children with a family history of medical, emotional, or substance abuse problems may be more likely to worry about these concerns because they are more likely to inherit these traits due to genetics.

Finally, looking at treatment related variables and treatment outcome it was found that those students with a family history of emotional problems did not improve in their psychological health as much as those with no history. This may be due to the fact that they may not have had as much guidance in dealing with their problems or expressing themselves appropriately as those with no family history of emotional problems. You would expect that growing up in a family with emotional problems would create a lot of chaos and emotional turmoil that may take longer to resolve in treatment.

Limitations

There are some caveats to the present findings. First, the data was collected from a university counseling center and all clients were college students; therefore, their attitudes and perceptions may not be generalizable to other Asian populations. College students experience different life events than the general population, which can cause their attitudes to be different from other Asians.
A second limitation was that the intake concerns/presenting problems were based on the students' self-report and some may not have reported accurate concerns. Also, retrospective evaluation of the data could confound the results. Self-report measures may not include all possible information that is needed to understand the client's problems. Also, general attitudes about mental illness, time away from home, and poor memory may skew the results. Additional research should focus, not only on the clients' perspective, but also the therapists' perspective. Furthermore, research has found that Asians have higher levels of pessimism and express higher negative affectivity (Chang, 2002), so this might have created response bias patterns that may have affected the results, causing lower BHQ scores.

A third limitation was that the only outcome measure used was the Behavioral Health Questionnaire. Additionally, the PIF is not a standardized instrument and reliability and validity have not been established. Not a lot of research has been done with the BHQ as the only outcome measure so the results may not cover all aspects of how well the student is functioning at the end of each session. Furthermore, instead of computing a difference score, it may have been useful to examine a session-by-session comparison to see how well clients were doing in treatment.

Finally, the sample consisted of college students who were all mainly self-referred to the counseling center. Students may not report their accurate concerns. Additionally, the present study only focused on students who were presenting for therapy for the first time and not those who had been in treatment for a longer duration.
Implications and Suggestions for Future Research

Despite these limitations, these findings have clear implications for future research as well as clinical practice. In order to understand and work effectively with Asians, research needs to be conducted on treatment of minorities. Much of the research on Asians has tended to focus on the client-therapist ethnic and gender match (Flaskerud & Hu, 1990, 1991; Fujino, Okazaki, & Young, 1994; Ying & Hu, 1994). The present study adds to the body of research about mental health treatment of Asian college students in that treatment outcome was examined not only for Asians versus non-Asians, but also for Asian Americans and Asian International students, an understudied group in the literature. Important implications were found for understanding and treatment of Asian college students. Due to the growing number of Asian Americans in the United States (Maki & Kitano, 2002; Sue, Nakamura, Chung, & Yee-Bradbury, 1994), it is important to research this population to gain insight into their service needs and the their presentation of mental illness so we can change and adapt treatment to fit their needs, increase their utilization of services, prevent early dropout of treatment, and increase successful outcomes in therapy.

The present study contradicts some of the previous research on Asians and lets researchers know not to assume certain things about this population based on previous research alone. Previous research indicated that Asians tend to present with somatic, career, or academic complaints rather than personal complaints (Atkinson & Lowe, 1995; Flaskerud & Hu, 1994; Lippincott & Mierzwa, 1995; Tracey, Leong, & Glidden, 1986; Zhang, Snowden, & Sue, 1998). The present study found that Asian American and Asian International students presented more often with personal or a combination of personal
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and career complaints. This may be due to the fact that Asians are usually grouped in research studies, even though there are different subgroups among Asians. The present study divided the Asian students into Asian Americans and Asian Internationals. This may have resulted in the different pattern of findings from past research, and may also have resulted in more clarification of inconsistencies in previous research (e.g., treatment outcome). It is important for future researchers to split up Asians into their subgroups in order to really gain true insight into their culture and presentation of mental illness. Also, the variables from the present study should be examined for non-college Asians as well to see if the findings hold true for this population. If they do not, treatment can be tailored to each population of Asians, hopefully increasing more positive treatment outcomes.

Most previous research has also been conducted in areas that have more extensive Asian populations (e.g., Hawaii, California). This could make the results less generalizable to most other colleges or Asians in the general population. Research should be conducted in other areas of the U.S. in order to get a more true representation of their cultural beliefs and mental health needs.

Another important area to look at for Asians is early dropout from treatment. Why do Asians not do as well in treatment and what happens to cause them to have lower treatment outcome scores? The present study found that Asians tend to have lower BHQ scores. More research is needed to determine if this is due to pessimistic attitudes and possible response-bias patterns. Furthermore, when Asians come into treatment with a family history of certain problems, the therapist should be more sensitive to these issues and concerns. It is important to have more dialogue early on in treatment on what issues Asians are seeking help for to ensure that the therapist periodically reassesses how Asians
are doing. To put it simply, there should be more collaboration in the relationship between therapist and client. Also, personal/social/emotional concerns may be different for Asians and may include racial identity and cultural conflict (Lee & Mixon, 1995), so this area needs to be defined more clearly.

Finally, there were no gender differences found in the present study, which contradicts previous research that has found gender differences. This is in need of further study to determine differences needed in treatment to decrease dropout rate and increase successful treatment outcomes for Asian men and women.

With more than 50 ethnic groups in the Asian population, it is important to have counselors research their different cultures to learn how to work effectively with Asians. Different cultures have different beliefs about mental health treatment and seeking help for problems. The belief that shame and stigma are attached with having a mental illness or making use of mental health services influences Asian beliefs on mental health issues. Even though this is true, counselors should not assume anything about any minority group. Due to the growing population of Asians in the United States, we must research this minority group to help in the determination of their service needs. The present study is a first step to understanding clinical issues to working with Asian college students.
References


Table 1
Demographic Variables for Asian Americans, Asian Internationals, and non-Asians

<table>
<thead>
<tr>
<th>Variables</th>
<th>Asian American</th>
<th>Asian International</th>
<th>non-Asian</th>
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<tbody>
<tr>
<td><strong>Frequency n (%)</strong></td>
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<td><strong>Gender</strong></td>
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<td>Male</td>
<td>25 (39.7)</td>
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<td>38 (60.3)</td>
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</tr>
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<td><strong>Religion</strong></td>
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</tr>
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<td>Buddhist</td>
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Table 2
*Treatment Related Variables for Asian Americans, Asian Internationals, and non-Asians*

<table>
<thead>
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<th>Variables</th>
<th>Asian American</th>
<th>Asian International</th>
<th>non-Asian</th>
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<td>159 (44.7)</td>
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<td>Previously</td>
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<td>5 (17.9)</td>
<td>148 (41.6)</td>
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*BHQ*<sup>a</sup> Mean Scores by Ethnic Group: Asian American, Asian International, and non-Asian

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Note. BHQ was administered at the first session and every subsequent session thereafter. Higher scores denote greater psychological health.

<sup>a</sup> BHQ = Behavioral Health Questionnaire.
Table 4
Means of Treatment Related Variables for Asian Americans, Asian Internationals, and non-Asians

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\(a\) Suicidal ideation was rated on a Likert-type scale ranging from 1 to 4. Higher scores denote greater suicidal thoughts.

\(^b\) PIF = Personal Information Form. Higher scores denote greater maladjustment.
### Table 5
*Means of Treatment Related Variables by Client Religion*

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**Note.** PIF = Personal Information Form. Higher scores denote greater concern.

**Note.** BHQ = Behavioral Health Questionnaire. Higher scores denote more positive psychological health.
Table 6

Means of Treatment Related Variables by Class Year

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Note. PIF = Personal Information Form. Higher scores denote greater concern.

Note. BHQ = Behavioral Health Questionnaire. Higher scores denote more positive psychological health.
Table 7
*Means of Treatment Related Variables by Family History*

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a. PIF = Personal Information Form. Higher scores denote greater maladjustment.
PERSONAL INFORMATION FORM: 2000-01 (PIF00)

Welcome to the Counseling & Student Development Center! Please fill out the information requested below. All the information on this form will be kept strictly confidential and will be used only to assist us in providing you with the best help. Thank You!

2) Name: __________ __ __________
   Last First M.I.

3) Today’s Date: ______/_____/_____

4a) Local Address: ________________________________
    (street or dorm)

4b) ____________________________
    (City) ____________________________
    (State) ____________________________
    (Zip)

4c) Local Phone Number: ________________________________

4d) E-mail Address: ________________________________

5a) Permanent Address: ________________________________
    (street )

5b) ____________________________
    (City) ____________________________
    (State) ____________________________
    (Zip)

5c) Perm. Phone Number: ________________________________

6) Soc. Sec. No.: _____-____-___________

7) Birth date: _____/_____/_____

8a) Please indicate your reason for coming to the Counseling Center. Describe below in a sentence or two, the MAIN ISSUE OR PROBLEM, which brought you in today:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

8b) At this time, how much does this issue trouble you? (Mark the number which best represents your present feelings).

Hardly at all
Mildly
Moderately
Severely

8c) Are there any other ISSUES or CONCERNS that you might also want to discuss?

_________________________________________________________________________

_________________________________________________________________________

9) Mark the type of service you are interested in receiving: Mark all that apply:

☐ Help with personal issues
☐ Help with career issues
☐ Other (explain if you wish):

FOR CC USE ONLY

- 2) No Answer/Missing
  1) 1+2
  2) 1
  3) 1+3
  4) 2+2
  5) 1+3
Available Schedule. To help us arrange a regular appointment for you please circle each hour that you are available. Circle as many hours as possible.

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The Counseling Center offers a number of GROUPS each semester. Listed below are groups typically offered. If you are interested in participating in or want more information about any of these groups please check below. Also, feel free to suggest any additional groups which interest you.

**GROUPS**

- Dissertation Support Group
- Eating Awareness Group
- First Steps: Discovering Careers That Fit
- Family Relations Group
- Freshman Support Group
- General Therapy Group
- Graduate Womens Support Group
- International Students Discussion Group
- Long-Distance Relationships Group
- Nursing Students Support Group
- Stress Management/Relaxation Techniques
- Substance Abuse Education & Recovery Group
- Surviving Loss Group
- Survivors of Sexual Abuse/Assault
- Understanding Your Emotional Intelligence

**INTEREST IN OTHER POSSIBLE GROUPS:**

- Anger Management/Assertiveness Training
- Becoming A Master Student
- Performance Anxiety/Stage Fright Group
- Coping With Depression Group
- Couples Group
- Family Problems Group
- Interpersonal Relationships Group
- Surviving A Break-up Support Group
- Smoking Cessation
- Gay, Lesbian & Bisexual Students Support Group
- Students with ADD Support Group
- Test Anxiety/Performance Anxiety Group
- Time Management

**OTHER SUGGESTIONS- PLEASE DESCRIBE:**
## Asian American College Students

### Student Information Form

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<td>1c)</td>
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<td>1d)</td>
<td>Intake Code: (New Intake=1, 1V or 1E; Returning Intake=2, 2V or 2E)</td>
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<td>Item Rating (from previous page)</td>
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<td>9)</td>
<td>Type of help (from previous page)</td>
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**PLEASE FILL IN THE INFORMATION BELOW:**

10) Affiliated schools:
- [ ] Homewood Campus
- [ ] Nursing School
- [ ] Peabody Institute
- [ ] Other (Name): __________

11) Your age: __________

12) Gender: [ ] Male [ ] Female

13) Marital status:
- [ ] Single
- [ ] Married/committed relationship
- [ ] Separated
- [ ] Divorced
- [ ] Other: __________

14) Parents' marital status:
- [ ] Married/committed relationship
- [ ] Separated
- [ ] Divorced
- [ ] Widowed
- [ ] Other: __________

15) Specify ethnic status:
- [ ] African-American
- [ ] Asian: Specify __________
- [ ] Latino
- [ ] Native-American
- [ ] Caucasian
- [ ] Other: __________

16) Religion:
- [ ] Buddhist
- [ ] Catholic
- [ ] Hindu
- [ ] Jewish
- [ ] Moslem
- [ ] Protestant
- [ ] Other: __________
- [ ] None

17) Are you a transfer student?
- [ ] No [ ] Yes

18) Are you an international student?
- [ ] No [ ] Yes

19) Are you a physically challenged student?
- [ ] No [ ] Yes

20) Do you have any concerns about possible Attention Deficit Disorder?
- [ ] No [ ] Yes

21) Class year:
- [ ] Freshman
- [ ] Sophomore
- [ ] Junior
- [ ] Senior
- [ ] Grad. stud.
- [ ] Graduated
- [ ] Post Graduate
- [ ] Other: __________

22) Number of credits registered for this semester?
- [ ] None
- [ ] 1-6 credits
- [ ] 7-11 credits
- [ ] 12-16 credits
- [ ] 17-18 credits
- [ ] 19 or more credits

23) Current academic status?
- [ ] In good academic standing
- [ ] Academically dismissed
- [ ] Reinstated
- [ ] On probation

24) Where do you live?
- [ ] 1__ AMRI
- [ ] 2__ AMRI I
- [ ] 3__ Building A
- [ ] 4__ Building B
- [ ] 5__ Bradford Apts
- [ ] 6__ Homewood Apts
- [ ] 7__ Ivy Apt
- [ ] 8__ McCoy Hall
- [ ] 9__ Peabody Residence Hall
- [ ] 10__ Rogers House
- [ ] 11__ Wolman Hall
- [ ] 12__ Other off-campus


- [ ] a) Live Alone
- [ ] b) Live with roommates(s)
- [ ] c) Live with spouse
- [ ] d) Live with child(ren)
- [ ] e) Live with romantic partner
- [ ] f) Live with parent(s)
- [ ] g) Live with other relative
- [ ] h) Other: __________
26) What is your academic major or program?
01. Undeclared at present

Arts & Sciences
02. Anthropology
03. Biology
04. Biophysics
05. Chemistry
06. Classics
07. Cognitive Science
08. Earth & Planetary Science
09. Economics
10. English
11. Environ. Earth Science
12. French
13. German
14. Hispanic & Italian Studies
15. History
16. History of Art
17. History of Science, Medicine, & Technology
18. Humanities Center
19. International Studies
20. Latin American Studies
21. Mathematics
22. Music
23. Near Eastern Studies
24. Philosophy
25. Physics & Astronomy
26. Public Health
27. Policy Studies
28. Political Science
29. Psychology
30. Sociology
31. Writing Seminars
32. Other Arts & Science

Area Majors
33. Humanistic Studies
34. Natural Sciences
35. Social & Behavioral Sc.
36. Other Area:________________

Engineering
37. Biomedical Engineering
38. Chemical Engineering
39. Civil Engineering
40. Computer Science
41. Electrical & Computer Eng.
42. Geography & Envir. Eng.
43. Materials Science & Eng.
44. Mathematical Sciences
45. Mechanical Engineering
46. Other Engineering

Nursing: Affiliated School
47. Regular Program
48. Accelerated Program
49. Other

27) Who referred you to the Counseling Center?
01. Myself
02. Friend
03. Relative
04. Residential Life Staff
05. Faculty
06. Staff
07. Student Health & Wellness
08. Career Planning & Devel.
09. Other: please specify
10. Academic Advising
11. Dean of Students
12. Other: please specify

28) How did you first learn or hear about the Counseling Center?
01. Brochure
02. Career Planning & Develop.
03. Faculty
04. Flyer
05. Friend/Relative
06. Residence Hall Staff
07. Contact w/Counseling Staff
08. Newsletter
09. Saw location
10. Student Health & Wellness
11. JHU Publication
12. Peabody Publication
13. Word of mouth
14. Dean of Students
15. Other: please specify

29) Have you ever used our services before?
□ No
□ Yes (please give name of counselor below)

29a) Names: ____________________________

30) Have you received any personal counseling elsewhere?
□ Never □ Previously □ Currently

30a) Counselor: ____________________________

Dates: ____________________________

31) Any medical problems?
□ No □ Yes (List problems below):

31a)

32) Are you currently using any medication(s)?
□ No □ Yes (List below):

32a)

33) Do you have insurance for mental health services?
□ No □ Not sure □ Yes

34) If yes to question #33 mark one below:
□ through Johns Hopkins University.
□ from a company independent of Johns Hopkins University.
□ I am covered under my parents’ insurance policy.

35) If you marked option #2 or #3 in question #34, please give name of company: ____________________________

36) Is there a history of medical problems in your family?
□ No □ Yes □ Unsure

37) Is there a history of emotional problem in your family?
□ No □ Yes □ Unsure

38) Is there a history of Alcoholism or substance abuse in your family?
□ No □ Yes □ Unsure

39) Are you adopted?
□ No □ Yes □ Unsure

40) Does anyone in your family own a gun?
□ No □ Yes □ Unsure
# PROBLEM CHECKLIST

The following information will help us learn about issues that are problematic for you. Please take the time to mark each of the following items with either a A0, A1, A2, A3, or A4 indicating the degree to which that issue is a problem for you at the present time. This list is not exhaustive, but covers many of the common problem areas seen by our Counseling Center staff. Thank you!

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<th>0 Not a Problem (Or not Applicable)</th>
<th>1 Slight Problem</th>
<th>2 Moderate Problem</th>
<th>3 Serious Problem</th>
<th>4 Severe Problem</th>
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<td><strong>Pr 02)</strong> Test anxiety</td>
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<td><strong>Pr 03)</strong> Time management, procrastination, getting motivated</td>
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<td><strong>Pr 05)</strong> Overly high academic standards for self</td>
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<td><strong>Pr 07)</strong> Pressures from family for success</td>
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<tr>
<td><strong>Pr 22)</strong> Confusion over personal or religious beliefs and values</td>
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<tr>
<td><strong>Pr 23)</strong> Concerns related to being a member of a minority</td>
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<tr>
<td><strong>Pr 24)</strong> Issues related to gay/lesbian identity</td>
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<tr>
<td><strong>Pr 25)</strong> General lack of motivation, interest in life; growing sense of detachment&amp; hopelessness</td>
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<tr>
<td><strong>Pr 26)</strong> Depression</td>
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<tr>
<td><strong>Pr 27)</strong> Grief over death or loss</td>
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<tr>
<td><strong>Pr 28)</strong> Suicidal thoughts, feelings, behaviors</td>
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<tr>
<td><strong>Pr 29)</strong> Eating problem (overeating, not eating, or excessive dieting)</td>
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<tr>
<td><strong>Pr 30)</strong> Alcohol and/or drug problem</td>
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<tr>
<td><strong>Pr 31)</strong> Alcohol/drug problem in family</td>
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<tr>
<td><strong>Pr 32)</strong> Sexually abused or assaulted, as a child or adult</td>
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<tr>
<td><strong>Pr 33)</strong> Physically or emotionally abused, as a child or adult</td>
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<tr>
<td><strong>Pr 34)</strong> Concerns about health; physical illness</td>
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<tr>
<td><strong>Pr 35)</strong> Physical stress (headaches, stomach pains, muscle tension, etc...)</td>
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<tr>
<td><strong>Pr 36)</strong> Sleep problems (can't sleep, sleep too much, nightmares)</td>
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<td><strong>Pr 37)</strong> Sexual matters</td>
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<td><strong>Pr 38)</strong> Problem pregnancy</td>
<td></td>
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<tr>
<td><strong>Pr 39)</strong> Irritable, angry, hostile feelings; Difficulty in expressing anger appropriately</td>
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<tr>
<td><strong>Pr 40)</strong> Concern that thinking is very confused</td>
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<tr>
<td><strong>Pr 41)</strong> Fear that someone is out to get me</td>
<td></td>
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<tr>
<td><strong>Pr 42)</strong> Fear of loss of contact with reality</td>
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<tr>
<td><strong>Pr 43)</strong> Violent thoughts, feelings, or behaviors</td>
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<tr>
<td><strong>Pr 44)</strong> Have been considering dropping out or leaving school</td>
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<tr>
<td><strong>Pr 45)</strong> Feel that someone is stalking or harassing me (e.g., by phone, letter, or email)</td>
<td></td>
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</tr>
</tbody>
</table>

| Pr 46)** If you answered 1-4 on question Pr 28 above, please check (□) below to indicate your overall risk of suicide: | | | | |
| | Extremely low risk, Low risk, Moderate risk, High risk, Extremely high risk (will not kill self): |

PIFOO_revised 9-18-00_form
BEHAVIORAL HEALTH QUESTIONAIRE (Follow Up)

Please answer these questions as they relate to the past two weeks.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>How satisfied have you been with your life?</td>
<td>0</td>
</tr>
<tr>
<td>2)</td>
<td>How energetic and motivated have you been feeling?</td>
<td>0</td>
</tr>
</tbody>
</table>

Please use the following rating scale for questions #3 to #10.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3)</td>
<td>Not liking yourself.</td>
<td>0</td>
</tr>
<tr>
<td>4)</td>
<td>Difficulty concentrating.</td>
<td>0</td>
</tr>
<tr>
<td>5)</td>
<td>Feeling sad most of the time.</td>
<td>0</td>
</tr>
<tr>
<td>6)</td>
<td>Feeling fearful, scared.</td>
<td>0</td>
</tr>
<tr>
<td>7)</td>
<td>Feeling hopeless about the future.</td>
<td>0</td>
</tr>
<tr>
<td>8)</td>
<td>Powerful, Intense mood swings (highs and lows).</td>
<td>0</td>
</tr>
<tr>
<td>9)</td>
<td>Difficulty making decisions.</td>
<td>0</td>
</tr>
<tr>
<td>10)</td>
<td>Feeling nervous.</td>
<td>0</td>
</tr>
</tbody>
</table>

Please use the following rating scale for questions #11 to #14. How have you been getting along in the following areas of your life over the past two weeks?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>11)</td>
<td>Work/School (for example, performance, attendance).</td>
<td>0</td>
</tr>
<tr>
<td>12)</td>
<td>Intimate Relationships (for example, support, communication, closeness).</td>
<td>0</td>
</tr>
<tr>
<td>13)</td>
<td>Nonfamily Social Relationships, (for example, communication, closeness, level of activity).</td>
<td>0</td>
</tr>
<tr>
<td>14)</td>
<td>Life Enjoyment (for example, recreation, life appreciation, leisure activities).</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GRAND TOTAL SCORE</th>
<th>MEAN SCORE</th>
<th>CORRECTED TOTAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Questions 1 - 14)</td>
<td>(Questions 1 - 14)</td>
<td></td>
</tr>
</tbody>
</table>

15) How much have you benefitted so far from being in psychotherapy or counselling?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>16)</td>
<td>Please answer the following question if you are also receiving medication from the Center. How much have you benefitted so far from taking medication?</td>
<td>0</td>
</tr>
</tbody>
</table>

BHQ (Follow Up) (POAMS) revised 1-9-01 forms