Comparisons of Psychological Help Seeking between Asian American and Caucasian College Students

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By

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Dedication

This research project is dedicated to my husband, my puppies, my family, and my friends. I thank you for your love and support throughout my academic career, allowing me to be my true self—a nerd in fabulous heels. This project is also dedicated to individuals who have lofty goals and dreams. I am proudly the daughter of a grocer and a waitress. Through hard work, support, and countless applications, I have been able to continually satisfy my thirst for knowledge, and work towards my goals of helping others and promoting mental health in the community.

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Table of Contents

List of Tables

List of Figures

Abstract

COMPARISONS OF PSYCHOLOGICAL HELP SEEKING BETWEEN ASIAN AMERICAN AND CAUCASIAN COLLEGE STUDENTS

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The current study aimed to examine a) the relationships among demographic and psychological variables and help seeking intentions and behaviors among Caucasians and Asian Americans, noting inter- and intra-ethnic comparisons of predictor and outcome variables; and b) specific factors that may contribute to help seeking intentions and behaviors among Asian Americans. The total sample consisted of 216 (108 Asian Americans, 108 Caucasians) college students who met study requirements. The participants completed an online survey that included questions about demographic information, psychological symptoms, attributions about mental illness, attitudes toward seeking professional psychological help, self-, family, and cultural stigma related to seeking psychological help, enculturation, help-seeking intentions, and help-seeking behaviors. Asian Americans reported lower levels of anxiety than Caucasians. Among Asian Americans, reported symptoms of depression were positively associated with recent and lifetime help seeking behaviors, and symptoms were positively correlated with informal help seeking. Asian Americans also reported less favorable attitudes towards psychological help seeking than Caucasians. Among Asian Americans, more favorable attitudes towards seeking psychological help were significantly predictive of help seeking intentions. However, only perceived need for treatment was predictive of help seeking behaviors. Asian Americans were less likely than Caucasians to make a biological or psychological attribution for an individual with a depressive disorder. However, Asian Americans who conceptualized a mental health issue as biological were more likely to seek psychological services during their lifetime. As predicted, Asian Americans were more likely to report self-, family, and cultural stigma for seeking psychological services than Caucasians, but less likely to intend to seek psychological services and engage in actual help seeking behaviors. Stigma was not related to help seeking intentions and

behaviors. Asian Americans' reports of enculturation were significantly related to perceived stigma for seeking psychological services and lifetime help seeking behavior, but not related to attitudes towards seeking psychological help or recent help seeking behaviors. The current study adds to our understanding of factors that may influence or discourage Asian American college students from seeking psychological services.

Introduction

There is a wide array of effective mental health services available to individuals who are suffering from a range of mental disorders. However, the majority of individuals in need of formal psychological services do not seek treatment (Kessler, et al., 2006). Large epidemiological studies, such as the National Co-morbidity Survey-Replication (NCS-R) Study (Kessler et al., 2006), indicated that in a 12-month period, approximately one-fifth of individuals who met the diagnostic criteria for a mental disorder, according to the *Diagnostic Statistical Manual--Fourth Edition--Text Revised (DSM-IV*; APA, 2000) sought professional psychological help. Ethnic minorities may use mental health services the least. The National Latino and Asian American Study (NLAAS) examined prevalence rates of mental disorders and help seeking patterns among a nationally representative community sample of Asian Americans (Alegria et al., 2004). The data indicated that overall lifetime prevalence of depressive, anxiety, or substance use disorders among Asian Americans were 17.3% (Takeuchi, et al., 2007), and the 12-month prevalence rate was 9.9%. There was a disparity between individuals who met the diagnostic criteria for mental disorders and those who used mental health services. The NLASS survey indicated that in a 12-month period, only 3.1% of Asian Americans sought help from mental health providers (Abe-Kim et al., 2007). Among individuals with diagnosable mental disorders, 34.1% sought services within the 12-month period. This is lower than the 41.1% of individuals in the general population, including other

English-speaking ethnic minorities with probable mental disorders, who sought out services (NCS-R; Wang et al., 2005).

In the United States, ethnic minorities have used professional mental health services less than Caucasians, and this is markedly evident among Asian Americans (Kessler, 2006). For example, data from the Epidemiological Catchment Area (ECA) study indicated that among a representative sample of Asian Americans and Caucasians in the greater Los Angeles area, Asian Americans (4%) were less likely than Caucasians (26%) to visit a psychiatrist or mental health specialist (Zhang, Snowden, & Sue, 1998). The results were significant even after controlling for other socio-demographic and psychological variables, such as gender, age, education, socio-economic status, number of children, and lifetime DSM-III diagnoses. In a study that pooled data from three national surveys of Asian Americans, Latinos, African Americans, and non-Latino Whites that compared rates of treatment for depression in the 12 months prior to the study, Alegria et al. (2008) found that 69% of Asian Americans did not receive mental health services as compared to 40% of non-Latino Whites.

The documented need for psychological services among Asian Americans leads to the question: if Asian Americans are not seeking help for mental health problems from specialists, with whom are they consulting about their psychological distress? While Asian Americans (11%) are less likely to talk to their family and friends about mental health problems than are Caucasians (25%), Asian Americans are more likely to discuss these issues with friends and family (11%) than with a mental health specialist (4%; Zhang, Snowden, & Sue, 1998). Asian Americans that seek professional help for

psychological problems tend to consult with family friends, medical health services, social services, and religious leaders (Akutsu, Snowden, & Organista, 1996; Abe-Kim, Takeuchi, & Hwang, 2002). These consultations prior to seeking mental health services are more culturally accepted (Akutsu, Snowden, & Organista, 1996).

There are many potential barriers to mental health care among Asian Americans, including a lack of culturally and linguistically responsive mental health services, strong personal and familial distrust of the mental health system, stigma regarding the use of mental health services, and low awareness of available services (Abe-Kim, Takeuchi, & Hwang, 2002). There is minimal research that links processes and outcomes with evidence based approaches to mental health care among Asian Americans (Chen, Kramer, Chen, & Chung, 2005). Some programs that have attempted to address the mental health needs of Asian Americans appear promising. For instance, the Bridge Program sought to strengthen the link between medical and psychiatric services to better serve low-income Chinese Americans (Yeung, et al., 2004). Professionals in both fields underwent extensive cultural sensitivity training. Results indicated that of the Chinese-Americans referred for psychiatric services by primary care physicians within the 12-month program, 80% attended their psychiatric evaluations compared to 53% of individuals in the 12-months prior to the program. Despite recent efforts to provide culturally competent care to Asian Americans, they still underuse mental health services. Therefore, it is important to examine factors that may influence Asian Americans help-seeking.

The present study examined factors related to psychological help-seeking among Asian American college students. As a group, Asian Americans have demonstrated high

educational achievement (Kim, 1993). Further, Asian Americans are "over-represented" in professions such as engineering, medicine, technology, and education, relative to their percentage of the general population (Sodowsky, Kwan, & Pannu, 1995). Despite their success and increasing enrollment in colleges, Asian Americans may face perceived and actual racism (Sodowsky, Kwan, & Pannu, 1995), unfair expectations of flawless academic performance (Sue, 1994), and incongruence between native values and mainstream values. For example, Asian values indicate that professors are authority figures that should be obeyed, and therefore, Asian Americans may fear approaching or challenging a professor.

The barriers that Asian Americans face in the educational arena are deeply rooted in social, historical, and political factors (Han, 2006). In the 19th century, Chinese workers were "imported" to work on the railroads and other large-scale construction projects, and the racial slur "coolie" was born along with other stereotypes (Takaki, 1998). The immigration laws passed during the 1960's led to an increase of Asian immigrants in the United States (Sodowsky, Kwan, & Pannu, 1995). More stereotypes arose in society such as the Western ideals of "orientalism" (Han, 2006). Asians were viewed as exotic, foreign, and inferior. Further, Asian Americans were quickly categorized as "the other," and had to overcome the popularized images of Miss Saigon, geishas, and "gooks," or individuals who looked physically "different" and could not speak English (Sodowsky, Kwan, & Pannu, 1995). As a result of these stereotypes, Asian Americans were forced in to unskilled work, such as dishwashers, cooks, and laundry-mat employees.

These aforementioned stereotypes of Asian Americans are still present, and the "model minority" stereotype has recently become one of the more pronounced stereotypes (Sue, 1994). This stereotype posits that Asian Americans are high achievers in educational and occupational settings, despite the discrimination and racism they have experienced throughout American history. Embedded in this stereotype is the notion that Asian Americans are immune to negative events, and that they will complete their work with minimal or no complaint. The danger in this stereotype is that it implies that all Asian Americans: a) have overcome forms of racial/ethnic discrimination; b) are successful professionally and economically; and c) are mentally healthy.

In addition to dealing with racial/ethnic stereotypes, Asian Americans have had to negotiate their integration into Western culture (assimilation), and the degree to which they should adhere to their own cultural values (enculturation). In educational settings, these issues may create stress since Western ideals of individualism are widespread. It is important to understand and examine a variety of cultural, social, language, and service barriers that influence Asian Americans' help-seeking attitudes and use of mental health services (Leong, Wagner, & Tata, 1995). The present study will examine variables related to intentions to seek psychological services and actual help-seeking behaviors. These variables will include enculturation, psychological symptoms (e.g., depression, anxiety, and somatization), stigma, professional psychological help seeking attitudes, and conceptualization of psychological problems. Further, the study will examine differences along these dimensions between Asian American and Caucasian college students.

Acculturation

An ethnic minority member's level of acculturation to American culture may influence the decision to seek professional help for a mental disorder. While some studies have supported the link between the acculturation of ethnic minorities and help-seeking (e.g., Atkinson & Gim, 1989), others have not (e.g., Atkinson & Lowe, 1995). The difficulty in the measurement of acculturation is related to the operationalization of the construct. For instance, should the construct be defined as an ethnic minority group evolving in order to "adapt to the mores, behaviors, and values of the dominant group" (Roysircar-Sodowsky & Maestas, 2002; p. 77)? Alternatively, should acculturation be defined as an ethnic minority's attempt to negotiate between adhering to one's native cultural values and identity, and assimilating into the dominant culture through interactions with individuals from the dominant culture?

Despite methodological issues in the measurement of the construct, many studies have emphasized the importance of acculturation to Asian Americans' help-seeking behaviors. For instance, more acculturated Chinese American students (Tata & Leong, 1994) and Asian international students (Zhang & Dixon, 2003) tend to have positive attitudes towards counseling, which may inform their help seeking intentions and behaviors. In a study of beliefs about the likely causes of 24 typical counseling problems, Mallinckrodt, Shigeoka, and Suzuki (2005) found that higher levels of acculturation among Asian Americans was significantly related to a greater willingness to seek mental health services, and greater similarity between counselors' and students' beliefs of the causes of counseling problems. In addition, congruence between counselors and students etiological beliefs of counseling problems was significantly

associated with greater willingness to see a counselor and more favorable ratings of a counselor.

A component of acculturation is *enculturation*, or an individual's adherence to native values (Kim, Atkinson, & Yang, 1999). Enculturation is distinct from behavior-based acculturation (e.g., food preferences), which has been the focus of more commonly used acculturation measures (e.g., *Suinn-Lew Acculturation Scale (SL-ASIA)*; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). While research on the relationship between acculturation and help seeking attitudes and behaviors has produced inconsistent findings, research suggests that enculturation may be more predictive than acculturation of help seeking attitudes and behaviors (e.g., Liao, Rounds, & Klein, 2005).

Health Related Attitudes and Beliefs

The literature has indicated that racial/ethnic minorities' attitudes and beliefs towards seeking help, especially seeking treatment within the mental healthcare system, are less favorable than are those of Caucasians. According to Sue et al. (1998), many Asian Americans believe that mental health services are irrelevant to their needs because mental health professionals may lack an understanding of language, ethnicity, and cross-cultural factors (Zhang, Snowden, & Sue, 1998). Based on the cultural values that are deeply embedded in Confucian and Taoist ideologies, Asian Americans are prone to believe that problems should not be discussed outside of the family (Lockery, 1991; Tata & Leong, 1994; Akutsu & Chu, 2006).

Although the majority of the research indicates that ethnic minorities are less likely to hold positive attitudes towards counseling than are Caucasians, Sue et al. (1991)

found that once Asian American become involved in community outpatient services, they are more likely to stay in treatment than are Caucasians. This suggests that once in treatment, Asian Americans' attitudes and beliefs are more positively affected by the counseling experience than Caucasian's attitudes, which are slightly higher at the beginning of treatment. Also, Liao, Rounds, and Klein (2005) found that more acculturated Asian Americans view help-seeking more positively than less acculturated Asian Americans. In a college setting, Filipino and White-mix clients are more likely to endorse personal or emotional concerns than are other Asian American groups, and the authors suggested that this may be due to their greater exposure to Western culture (Tracey, Leong, & Glidden, 1986). Despite the findings from these studies, Asian Americans are still less likely to hold positive attitudes and beliefs about professional mental health services and initiate treatment than are Caucasians. Asian American college students cite counseling as the least helpful resource to deal with distress (Atkinson, Kim, & Caldwell, 1998). This suggests that some aspect of the mental health system may negatively affect these individuals' attitudes towards counseling. Tata and Leong (1994) proposed factors that influence Asian American's attitudes and beliefs towards counseling including: credibility of the service provider(s), therapist race/ethnicity, therapist counseling approach, congruence between the client and therapist attitudes, and conveyance of cultural competency. Therefore, Asian American's attitudes and beliefs towards help-seeking are shaped by the ways that mental illness is conceptualized and expressed, and their cultural values and expectations.

Mental illness conceptualization

The distinction between normal and abnormal thoughts, behaviors, and emotions are socially and culturally constructed. Norms and mores in a given culture provide individuals with prescriptions for culturally appropriate ways to express mental illness. Also, individuals learn a cultural script that involves culturally acceptable explanations for the causes of mental illness. There may be a variety of ways that individuals within and between cultures conceptualize mental illness and express mental illness.

In examining emotional and psychological problems among Asian Americans, Luk and Bond (1992) described a cultural explanation of distress that assumes that "serious emotional problems are caused if one attempts to oppose either the forces of nature or one's proper places in a tightly connected interpersonal network" (as cited by Mallinckrodt, Shigeoka, & Suzuki, 2005; p. 228). Similarly, Asian American college students and university counselors tend to hold dissimilar etiological beliefs about serious mental health problems (e.g., depression, substance abuse), such that Asian Americans are more likely to explain these disorders as "demons/spirits, punishment for sins, and a weak mind" (p. 235). This is in contrast to Caucasian students, who tend to hold similar etiological beliefs to counselors, such as depression has a biological cause. Akutsu and Chu (2006) examined the types of clinical problems reported among seven Asian American groups at ethnic-specific mental health programs. They found that more acculturated groups, such as the Chinese and Japanese, were more likely to present with a broader range of mental health problems than were less acculturated groups, such as Cambodians and Vietnamese. The authors noted that more acculturated Asian American groups are more familiar with Western conceptualizations of mental illness than less

acculturated Asian American groups. Therefore, the extent to which Asian Americans conceptualize mental illness as a supernatural, religious, and/or moral issue may lead to less belief in the need for professional psychological services and less seeking of mental health services. As a result, these individuals may instead seek services with a religious leader, traditional healer, or alternative practitioner (Steel, et al., 2006). However, few studies have examined the relationship between mental illness conceptualization and help-seeking among Asian Americans.

Another construct related to mental health conceptualization is "distress threshold," or the extent to which a problem becomes noticeably stressful emotionally and/or psychologically. An individual's distress threshold may not lead to a formal diagnosis of a mental disorder, but may influence help-seeking behaviors. An individual may not recognize the seriousness of a psychological issue because the individual and his family may accommodate or excuse abnormal behaviors (Pescosolido, Boyer, & Lubell, 1999). This is evidenced by the lower rates of mental disorders such as schizophrenia in Asian countries than in the United States (Dana, 2002). In Asian American culture, an individual is an extension of his/her family, and a mental illness is seen as stigmatizing to both the individual and the family (Dana, 2002). The extent to which people prefer to reduce stigma (or "save face") will influence their decision to address the psychological problem and seek mental health services. Therefore an individual's distress threshold and prescriptions for acceptable regulation of distress are culturally defined (Betancourt & Lopez, 1993; Marsella, 2003).

Stigma

There has been increasing emphasis on Asian Americans' recognition, assessment, treatment, and acceptance of mental illness. However, stigma remains one of the primary barriers to accessing psychological services (Corrigan, 2004; Wynaden, et. al., 2005). Corrigan (2004) delineates two types of stigma—public stigma and self-stigma that interact to influence an individual's intentions to seek psychological services and actual help-seeking behaviors. Public stigma is defined as the general public's negative perceptions of an individual based on his/her membership in a particular group (e.g., mentally ill), and self-stigma is the internalization of public stigma, resulting in negative self-perceptions. These two forms of stigma may explain why individuals who are suffering from psychological distress do not seek treatment. To avoid labeling, prejudice, and discrimination from others, an individual may choose not to seek treatment for psychological problems. In regards to self-stigma, an individual may avoid seeking mental health services in order to avoid the internalization of negative societal attitudes about people with mental disorders, and subsequent diminished self-esteem.

Many ethnic minorities identify stigma as a barrier to seeking services for a psychological problem. For Asian Americans, there is the phenomenon of maintaining "face" (Zane & Yeh, 2002), which relates to both public and self-stigma. Face is embedded in psychosocial and interpersonal factors, and it entails "claims about one's character in terms of traits, attitudes, and values…and performing one or more specific social roles that are well recognized by others" (p. 125). Face serves as a function of maintaining harmony among individuals, and is more prevalent in collectivistic cultures.

Face concerns may motivate an individual to avoid the stigma of seeking psychological services in order to protect his reputation and the reputation of his family and community. Despite the importance of saving face in the Asian American community, Mak and Chen (2006) noted that not seeking help has a significant bearing on the experience of psychological distress. According to the Face-negotiation theory (Ting-Toomey, 2005 as cited by Mak & Chen, 2006), an individual who places pressure on himself to avoid face-losing situations may increase psychological distress. For example, Tracey, Leong, and Glidden (1986) found that Asian American college students were less likely than Caucasians to seek professional services because they did not want to publicly admit their psychological problems. In addition, Asian Americans were more likely than Caucasians to discuss problems related to academic/vocational concerns as opposed to emotional/psychological problems. Similarly, in a qualitative study among Asian American community members, leaders, and health care professionals, Wynaden et al. (2005) found that stigma and shame are key factors in the reluctance to seek mental health services. Further, among an internet sample of Asian Americans and Caucasians that screened positive for depression, Asian Americans were more likely to: be embarrassed if their friends knew they were getting professional help for an emotional problem, not want their employer to know that they were getting professional help for an emotional problem, and believe that if they had depression then their family would be disappointed in them.

Psychological Symptoms

Symptom severity may also influence an individual's decision to seek psychological services; the higher the degree of distress, the more likely an individual will seek and use mental health services. Abe-Kim, Takeuchi, and Hwang (2002) analyzed data from the Chinese Psychiatric Epidemiological Study and found that psychological distress (e.g., problems with emotions, nerves, drugs) was a significant predictor of use of mental health services among Chinese Americans. Among Asian American college students, symptom severity predicted attitudes towards seeking help (Tracey, Leong, & Glidden, 1986), and Asian Americans reported the highest level of distress at intake compared to Caucasians and other ethnic minorities (Kearny, Draper, & Baron, 2005). Wynaden et al. (2005) suggested that help-seeking among Asian Americans is a difficult process, and professional psychological treatment is sought out only after symptoms are so severe that family resources cannot manage the individual's distress. Despite the significant link between symptom severity and use of services, the discrepancy between rates of mental disorders and use of mental health services is greater for Asian Americans than Caucasians (Abe-Kim et al., 2007).

The *DSM-IV-TR* (APA; 2000) is used to guide mental health professionals in the diagnosis of mental disorders, and inform treatment of mental disorders. The DSM is deeply rooted in a European American emic and its accuracy in diagnosis of mental disorders among ethnic minorities has been criticized (Dana, 2002). In response to this criticism, the task force of DSM-IV-TR added the Appendix I Outline for Cultural Formulations, which notes that culture may affect the ways that psychological symptoms are manifested. The outline for cultural formulations suggests that clinicians should

assess the client's cultural identity, cultural orientation or acculturation status, cultural conceptualizations of mental illness, cultural factors that affect the client-clinician relationship, and aspects of the client's psychosocial environment that indicate the ways that the individual experiences stressors.

The literature examining the cultural expression of mental disorders among Asian Americans has emphasized the concept of somatization, the manifestation of physical symptoms in response to psychosocial stressors (Dana, 2002). Physical symptoms may be the more likely expression of psychological distress as opposed to cognitive or emotional symptoms. Somatization occurs more among ethnic minority groups that discourage emotional labeling and expression of psychological distress. In fact, some Asian American ethnic minority groups lack terms for "depression" in their native language.

Expressing physical symptoms influences the treatment that is sought by Asian Americans. Studies indicate that general medical practitioners are often the first resource consulted for depression (Dana, 2002) and somatic symptoms are the main complaint among Asian Americans in psychiatric hospitals (Lin, Carter, & Kleinman (1985) as cited by Dana, 2002). In addition, the extent to which someone experiences somatic as opposed to cognitive and affective symptoms may affect the accuracy of diagnosis. Despite the acknowledgement that cultural factors influence the expression of mental disorders in the appendix of the DSM-IV-TR, the manual still conveys the European American emic perspective to diagnosis (Dana, 2002). Subsequently, there is still a concern among mental health professionals that the majority of clinicians and assessment

measures will under-diagnose or mis-diagnose affective disorders among Asian Americans based on the difference in the manifestation of symptoms (Dana, 2002).

Summary

Overall, help-seeking behaviors among Asian Americans are influenced by a variety of variables, including health related attitudes and beliefs, enculturation, degree of psychological distress, conceptualization of mental illness, family level variables, and stigma surrounding mental illness. However, there is a paucity of studies that have empirically examined the collective effects of these variables in relation to help-seeking intentions and behaviors. The current study will attempt to address this relationship in order to better inform the development of culturally sensitive and appropriate services, such as outreach and treatment.

Models of Help-seeking

There are a variety of models that attempt to integrate multiple factors into a conceptualization of help-seeking behaviors. Several help-seeking models will be reviewed and critiqued to explain Asian Americans' help-seeking behaviors for psychological concerns. Components of these models that are relevant to the current study will guide the conceptualization of help-seeking behaviors among Asian Americans (e.g., psychological distress).

The Health Belief Model (HBM; Rosenstock, 1966) is a value-expectancy theory that explains people's cognitions and behaviors regarding their health. The basic tenet of the HBM is that seeking help is influenced by a "desire to avoid illness or to get well; and the belief that a specific health action available to a person would prevent illness" (p. 78).

The conceptual framework outlines four major factors that may interact to influence an individual's help-seeking, including: 1) Perceived Susceptibility, people's perception of their risk of developing a specific condition; 2) Perceived Severity, people's assessment of the seriousness of developing the condition, or not undergoing any form of treatment for the condition; 3) Perceived Benefits, people's beliefs in the effectiveness of available treatments; and 4) Perceived Barriers, identified obstacles to seeking professional help.

Despite the applicability of the HBM in examining help-seeking behaviors in the medical field, including use of services for breast cancer (Wang, et al., 2008), testicular self-examination (McClenahan, et al., 2007), and vaccinations (Mok, Yeung, & Chan, 2006), the HBM has not been rigorously tested to explain the use of mental health services for treatment of particular mental disorders. Also, meta-analyses (e.g., Harrison, Mullen, & Green, 1992) have shown limited evidence for the predictive validity of the HBM. Another caveat is that the model does not fully integrate the effects of social, cultural, and racial variables on help-seeking behaviors. While Rosenstock (1966) has acknowledged that demographic variables influence an individual's health related perceptions, attitudes, and subsequent behaviors, he does not delineate this in the model itself. Therefore, researchers and practitioners may find it difficult to apply the HBM to racial/ethnic minorities' help-seeking behaviors.

Another model is the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). The TRA posits that people's help-seeking behaviors are influenced by their intentions to seek psychological services (Ajzen, 1988). These intentions are influenced by two factors: a) Attitude toward the behavior, an individual's

appraisal of the costs and/or benefits of seeking mental health services; and b) Subjective norm, an individual's perception of how others would view him/her for seeking psychological services. The underlying assumption of this conceptual framework is that certain behaviors are under volitional control. Based on the recognition that not all behaviors, especially help-seeking are under "volitional control," the TRA was modified and the Theory of Planned Behavior was conceptualized (TpB; Ajzen, 1985).

The TpB maintained the essential features of the TRA, but added the factor of perceived behavioral control, an individual's appraisal of the feasibility of seeking psychological services. Ajzen postulated that an individual's perception of behavioral control affects help- seeking intentions, and therefore, perceived control can indirectly influence actual help-seeking behaviors via intentions. In addition, congruence between perceived and actual control is likely to directly affect help-seeking behaviors. Therefore, the basic tenet of the TpB is that an individual's intentions to seek psychological services are influenced by the following factors: a) attitudes toward seeking psychological services; b) the perception of the approval or disapproval of seeking psychological help by others in an individual's life; and c) the perception of the ease or difficulty of seeking psychological services, which is affected by internal (e.g., severity of symptoms) and external factors (e.g., lack of culturally responsive treatments; Ajzen, 1988). More positive appraisals of all three factors will theoretically lead to the increased likelihood that individuals will intend and seek psychological services.

The Information-Processing Model is a more recently developed stage model that posits that the decision to seek professional help is grounded in people's perceptions of

their distress and their belief in their ability/inability to cope with the perceived distress (Vogel, Wester, Larson, & Wade, 2006). According to this model, help-seeking behaviors are influenced by four major factors, including: 1) the encoding and interpretation of internal and external cues by the individual; 2) the generation and evaluation of options; 3) the decision as to the best course of action; and 4) evaluation of the specified behavior. The authors suggest that at each of these stages, there are barriers to an individual seeking psychological help. For example, if an individual attributes depressive symptoms to a poor night's sleep, he will less often seek mental health services (stage 1). The authors also note that social, cultural, racial, and gender role norms influence an individual's implemented behavior (stage 3).

Despite its utility, the Information-Processing Model has some limitations. First, it has not been empirically tested. Therefore, it is not yet known if this model is applicable across multiple ethnicities, specifically among Asian Americans. Second, Vogel, Wester, Larson, and Wade acknowledge that not all individuals will experience the stages linearly or experience all of the stages. Third, the lack of explanation of cultural factors on help-seeking behaviors may limit the applicability of this model among ethnic minorities, especially among Asian Americans.

A theory that may better explain help-seeking patterns among Asian Americans is the Network Episode Model (NEM; Pescosolido, 1991; 1992; Abe-Kim, Takeuchi, & Hwang, 2002; see Appendix, *Figure 1*). The NEM is based on the premise that the decision to seek psychological services is essentially a social process, and is a function of an individual's social networks that the individual interacts with during a period of

psychological distress (Pescosolido & Boyer, 1999). These points of contact include individuals from the community, treatment systems, and social service agencies. In contrast to the other theories previously reviewed, the NEM conceptualizes help-seeking behaviors "as the patterns and pathways of practices and people consulted during an episode of illness" (p. 407).

The NEM consists of the interaction between four factors including: 1) illness career, the ways that an individual copes with psychological distress, making note of the timing of coping, and pathways and patterns of care; 2) support system, the dynamic social support system of an individual that includes structure, content, and functions of the system; 3) treatment system, charting the structure, access, content, and barriers of an individual's treatment system; and 4) social context that the other three factors are deeply embedded in, and takes into account social and geographical location, personal health background, nature of the event (illness characteristics), and organizational constraints.

Pescosolido and Boyer suggest that the meaning that people attribute to their psychological symptoms will likely determine the form of coping/treatment they will seek. The meaning that people ascribe to their psychological symptoms is a function of their daily interactions with individuals in their social networks. For example, if people note that their symptoms are due to fatigue, they may visit a physician, amend their sleep regimen, exercise, and take vitamins. However, if their friends and relatives convey positive attitudes toward mental health services and suggest that suffering may be a sign of depression, they may seek psychological help.

A path model that appears applicable to Asian Americans' help-seeking behavior is Cramer's help-seeking model (Cramer, 1999; Liao, Rounds, & Klein, 2005). Cramer (1999) theorized that help-seeking behavior is influenced by four factors: a) attitudes toward seeking counseling; b) available social support; c) distress level; and d) self-concealment of information that one perceives as negative (e.g., symptoms indicative of a psychological disorder; as cited by Liao, Rounds, & Klein, 2005). Cramer (1999) noted that a high level of distress and more positive attitudes toward counseling led to the increased likelihood that an individual would seek mental health services for problems stemming from a psychological disorder. Higher levels of distress were related to impaired social support and higher levels of self-concealment. Also, self-concealment was related to less positive attitudes towards counseling and impaired social support. The factors outlined by Cramer are important when examining the help-seeking behaviors of Asian Americans, particularly the concept of self-concealment, or loss of face (Liao, Rounds, & Klein, 2005). Liao, Rounds, and Klein (2005) added acculturation (behavioral acculturation and adherence to Asian Values) to Cramer's model (see Figure 2) and found that this improved model fit to the data collected from a sample of Asian and Asian American college students.

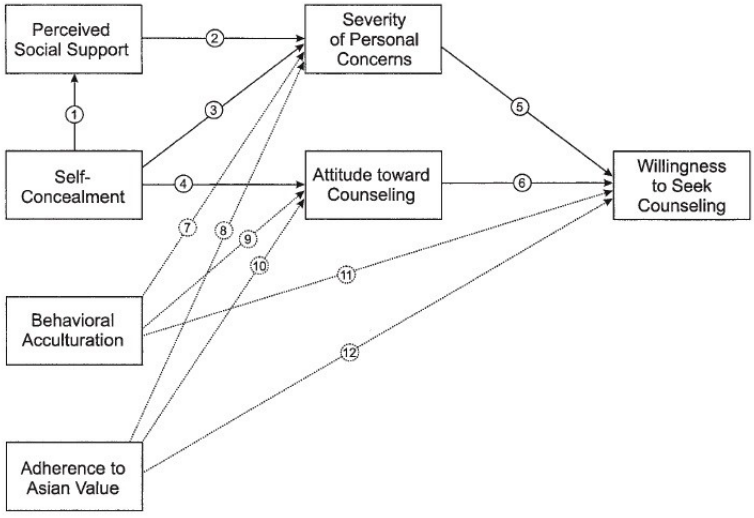

Figure 1:A Revision of Cramer's help-seeking Model

These help-seeking models have many similarities. While factors that affect help-seeking are labeled with different terms (e.g., attitude towards help-seeking behavior vs. perceived benefits), these models appear to be accounting for similar components. First, they all acknowledge that etiological explanations or interpretations of mental health issues are a key factor in affecting help-seeking behavior. Second, to some extent, most individuals will assess their attitudes towards counseling, weighing the costs and benefits of, and barriers to seeking treatment. Third, when making decisions about whether or not to seek treatment, individuals will assess their level of social support and significant others' perceptions of their seeking counseling.

The major differences among the models are the extent to which each integrates and explains the effect of social, cultural, racial variables on help-seeking behaviors. Some models are more superior (e.g., NEM) to others (e.g., HBM) in delineating these variables in their models. For instance, while the HBM acknowledges that these

variables affect help-seeking perceptions, attitudes, and behaviors, these factors are not outlined within the actual model. This model is in contrast to the NEM and Cramer's Revised Help-seeking Model that are more integrative of these factors, and the latter model is more specific in explaining how Asian American cultural variables may influence help-seeking behaviors.

The present study, including the hypotheses will be informed by the common factors among these models. In addition, the NEM (1991; 1993) and Cramer's revised help-seeking model (2005) will provide the conceptual framework for examining help-seeking intentions and behaviors among Asian American college students. Specifically the components of enculturation, illness characteristics (severity of psychological distress), attitudes toward counseling (attitudes toward seeking out mental health services), community network content (health related attitudes and beliefs), stigma, intentions to seek help, and actual help-seeking behaviors will be examined.

The Present Study

The aim of the present study is to examine cognitive, social, and interpersonal factors that influence psychological help-seeking among Asian American college students. Research questions for the study include: How does membership in an ethnic minority group affect symptom presentation? How do cultural norms affect help-seeking attitudes and behaviors among Asian Americans? Do Asian Americans hold more self-stigmatizing beliefs about mental illness, or perceive more stigma from family members or members of their racial group/culture than do Caucasians? Are Asian Americans less

likely to conceptualize psychological distress as a problem requiring professional help, and as a result less likely to seek help at all, or to seek help from a non-professional source? The main study hypotheses are:

1) Asian Americans will report higher levels of somatic distress and lower levels of anxiety and depression than will Caucasians.

2) Asian Americans will report more negative attitudes toward professional psychological help-seeking than will Caucasians.

3) Asian Americans will be more likely to conceptualize mental illness as having a spiritual cause than will Caucasians.

4) Asian Americans will be less likely to intend to seek counseling than will Caucasians.

5) Asian Americans will be more likely to seek informal or semiformal help and less likely to seek formal/professional counseling than will Caucasians.

6) Less enculturated Asian Americans will report more positive attitudes towards psychological help-seeking than will more enculturated Asian Americans, and will therefore be more likely to report seeking professional psychological help.

7) The group of three cognitive variables (help-seeking attitudes, mental illness conceptualization, and (self and other) stigma), and enculturation will predict help seeking intentions and behaviors above and beyond need for treatment (psychological symptoms).

Method

Participants

Participants were 216 undergraduate students enrolled at an east-coast university. The students were solicited through an online website for recruitment of undergraduates enrolled in psychology courses and received course credit for their participation. Due to the nature of the study, individuals who self-identified as Asian American (an individual who is of Vietnamese, Korean, Chinese, Japanese, Cambodian, Laotian, or Thai descent) or Caucasian, were at least 18 years of age, and had ever considered seeking help for a problem with emotions, nerves, relationships, or mental health were invited to participate. Inclusion criteria for the study also included a minimum stay of 5 years in the United States, in order to screen out individuals who were only here to attend college.

A power analysis indicated that in order to conduct an ANOVA with two groups with a significance level of .05, a moderate effect size, and power of at least .80, a sample size of 64 was needed per racial group. In addition, in order to conduct a multiple regression with 8 independent variables with a significance level of .05, a moderate effect size of .3, and power of at least.80, a sample of 107 is needed for each racial group (see Cohen, 1992). Based on the collected sample of 216 undergraduates, the study was able to detect medium effect sizes.

The sample was comprised of 50% Asian Americans (N=108), and 50% Caucasians (N=108). More specifically, Asian Americans reported which sub-ethnic group they identified with: Thai (N= 4; 3.7%), Cambodian (N= 5; 4.6%), Chinese (N= 24; 22.2%), Japanese (N= 2; 1.9%), Korean (N=38; 35.2%), Vietnamese (N= 25; 23.1%), Mixed (N= 8; 7.4%), and Unspecified (N= 2; 1.9%). There were 157 females (72.7%) and 59 males (27.3%). Participants ranged in age from 18 to 43, with a mean age of 21.06 (SD=4.19), and represented all undergraduate classes (freshman: 32.4%; sophomore: 23.1%; junior: 23.1%; and senior: 21.3%). Overall, while fathers of the respondents had more formal education than mothers, earning a college or graduate school degree (38.5% and 53.7% respectively), fathers and mothers with less than a high school degree was equivalent (6.9%). Approximately 25.5% of participants reported that they were slightly spiritual or religious, and 33.8%% of participants reported that they were at least moderately spiritual or religious, including 16.7% who self-identified as strongly spiritual/religious, and 10.2% who self-identified as very strongly spiritual/religious. These data are summarized below in Table 1.

Table 1

Demographic Information of the Sample

Variable	N	%
Race		
Asian American	108	50
Caucasian	108	50
Gender		
Male	59	27.3
Female	157	72.7
Year in School		
Freshman	70	32.4
Sophomore	50	23.1
Junior	50	23.1
Senior	46	21.3
Mother's highest level of education		
Less than HS	13	6.9
HS	41	25.5
Some college	70	29.2
Bachelor's degree	55	25.5
Graduate/professional degree	25	13
Father's highest level of education		
Less than HS	10	6.9
HS	48	21.8
Some college	34	17.6
Bachelor's degree	61	30.1
Graduate/professional degree	51	23.6
Extent of spirituality/religiosity		
Not at all	22	10.2
Slightly	36	16.7
Moderately	73	33.8
Strongly	55	25.5
Very strongly	30	13.9

Procedure

The study was announced through an online website for recruitment of undergraduates enrolled in psychology courses. There were two recruitment postings—one for Caucasian college students and one for Asian American college students. The messages described the purpose of the project, as gathering information on different factors that affect help-seeking intentions and behaviors of Caucasian and Asian American college students, respectively. The inclusion criteria for the study were individuals over the age of 18 who had ever considered seeking help for a problem with emotions, nerves, relationships, or mental health, and identified as either Caucasian or Asian American. For the purpose of the current study, Asian American was defined as an individual who is of Vietnamese, Korean, Chinese, Japanese, Cambodian, Laotian, or Thai descent. Inclusion criteria for the study also included a minimum stay of 5 years in the United States, in order to screen out individuals who were only in the United States to attend college. Individuals who met the inclusion criteria were allowed to sign up on the online recruitment system, and received a link to complete the survey.

This study followed standard consent procedures in online research. Participants were first shown an informed consent form that detailed eligibility requirements, risks, benefits, confidentiality, and the researcher's contact information. Participants were asked to press the "Submit" button at the bottom of the form confirming that they met the inclusion criteria, they have read the informed consent form, and understood that they voluntarily consented to participate in the present study. Upon consenting to participation in the study, participants were presented with the remainder of the questions on the survey, including demographic information (e.g., age, gender, year in college,

race/ethnicity, country of origin for participant and parents, religious orientation, and parents' highest level of education), and scales assessing psychological symptoms, mental health stigma, and psychological help-seeking attitudes, intentions and behaviors. No identifying information was collected. A randomly generated number was assigned to participants by the Internet survey website upon completion of the survey. These numbers could not be connected to the participants' survey responses. After completing the survey, the participants were provided with a departmental reaction form to their participation in the study, a mental health referral list, and the contact information of the researcher.

Measures

The initial items on the survey directed the students to provide demographic information, including age, year in college, race/ethnicity, parents' highest level of education, extent of spirituality, and citizenship status.

Enculturation. The *Asian Values Scale* (*AVS;* Kim, Atkinson, & Yang, 1999) assessed an individual's adherence to Asian cultural values (e.g., "One should not deviate from familial and social norms"). The 36-item scale measured six Asian values, including conformity to norms, family recognition through achievement, emotional self-control, humility, collectivism, and filial piety. The items were rated on a 7-point scale, ranging from 1 (*strongly disagree)* to 7 (*strongly agree)*, and higher scores indicated greater adherence to Asian cultural values. The *AVS* has demonstrated satisfactory psychometric properties, including an $\alpha = .78$ among college students (Liao, Rounds, & Klein, 2005), and in the initial item construction study, $\alpha = .81$ (Kim, Atkinson, & Yang,

1999). Subscale internal consistency reliability estimates for the present sample was α = . 78) In addition, Kim, Atkinson, and Yang (1999) demonstrated discriminant validity between the *AVS* and the *SL-ASIA* (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987).

In order to better discriminate among the varying levels of enculturation among Asian Americans, Kim and Hong (2004) utilized G. Rasch (1960) modeling and created the *Asian Values Scales-Revised (AVS-R*). Based on their analyses, the authors suggest using a 25-item scale on 4-point scale, ranging from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*), and higher scores represented greater levels of enculturation.

Attitudes Toward Seeking Psychological Help. The *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF*; Fischer & Farina, 1995) assessed an individual's attitudes towards seeking help from mental health professionals when he/she is experiencing psychological distress (e.g., "If I believed I was having a mental breakdown, my first inclination would be to get professional attention"). The original scale contained 29 items (Fischer & Turner, 1970), whereas the shortened version included 10 items. These 10 items were selected based on the highest item correlations with the original 29-item measure. The items were rated on a 4-point scale ranging from 0 (*strong disagree)* to 3 (*strongly agree),* and higher scores represent more positive attitudes towards seeking professional psychological help. While the original scale conceptualized attitudes toward seeking psychological help as a multi-dimensional construct, including the recognition of need for mental health services, stigma tolerance, interpersonal openness, and confidence in mental health practitioner, the current research indicated that this construct is better conceptualized as uni-

dimensional (Fischer & Farina, 1995). The reliability and validity of the *ATSPPHS-SF* has been examined among college students and primary care patients, and has demonstrated satisfactory internal consistency (Elihai, Shweinle, & Anderson, 2007). Subscale internal consistency reliability for the present sample was α = .81.In addition, the measure has been significantly correlated to treatment-related stigma and intentions to seek psychological help.

Mental Illness Conceptualization. The *General Social Survey (GSS*; National Opinion Research Center, 1972*)* assessed societal trends throughout the United States, and included questions about demographics, behaviors, and attitudes of Americans. As of 1996, the *GSS* included the *MacArthur Mental Health Module* that examines a variety of mental health topics, such as the attitudes and etiological beliefs of mental illness. In order to examine participants' conceptualization of mental illness, the *MacArthur Mental Health Module* was used in this study through two vignettes. The first vignette depicted major depression, according to the *DSM-IV-TR* criteria, while the second vignette depicted a "troubled" person that did not meet the *DSM-IV-TR* criteria for a mental disorder, but nevertheless is experiencing psychological distress. Upon reading the vignettes, the participants was asked to rate the extent to which they believed that the causes of the individual's psychological distress was due to the following: "[The individual in the vignette's] own bad character;" "A chemical imbalance in the brain;" "The way "[the individual in the vignette] was raised;" "Stressful circumstances in "[the individual in the vignette's] life;" "A mental or psychological problem;" and "God's will." The responses were rated on a 4-point scale ranging from 1 (*not likely at all)* to 4

(*very likely),* and higher scores represented greater causal attributions for the problem. Mental illness conceptualization has been commonly assessed through the use of vignettes (Karasz, 2005; Link et al., 2004), especially through the use of the *MacArthur Mental Health Module* of the *GSS* (Link et al., 1999; Martin, Pescosolido, & Tuch, 2000).

Self-Stigma for Seeking Psychological Help. The *Self-Stigma of Seeking Help Scale (SSOSH*; Vogel, Wade, & Haake, 2006) included 10 items and assessed the extent to which individuals internalize stigmatizing feelings related to seeking mental health services (e.g., "I would feel inadequate if I went to a therapist for psychological help"). The items were rated on a 5-point scale, ranging from 1 (*Strongly disagree)* to 5 Strongly agree), and higher scores represented greater levels of self-stigma. The scale has demonstrated satisfactory psychometric properties with reliability ranging from α = .86-.91. Subscale internal consistency for the present sample was α = .88. Also, validity has been demonstrated through correlations with attitudes towards professional help seeking (r = .65) and intentions to seek counseling (r = .37) among a college student sample (Vogel, Wade, & Haake, 2006).

Family and Cultural Stigma for Seeking Psychological Help. The *Stigma Scale for Receiving Psychological Help (SSRPH;* Komiya et al., 2000) included 5 items and assessed an individual's perception of the stigma that would result from seeking professional psychological services. The items were rated on a 4-point scale, ranging from 0 (*Strongly Disagree)* to 3 (*Strongly Agree)*, and higher scores represented a greater degree of stigmatizing feelings as a result of receiving mental health services. For the purposes of this study, items were modified in order to assess stigma from an individual's

family and culture as opposed to the general public. Therefore, the phrases "in my family" (e.g., "Seeing a psychologist for emotional or interpersonal problems carries a stigma *in my family*) and "in my racial/ethnic group or culture" (e.g., "Seeing a psychologist for emotional or interpersonal problems carries a stigma *in my racial/ethnic group or culture*) were added to the end of each of the five questions to assess the family and racial/ethnic/culture-related stigma, respectively. In the item construction study, the *SSRPH* had a coefficient alpha of .72, and was found to be negatively related to attitudes towards seeking psychological help (r = -.40). Subscale internal consistency reliability estimates for the family and cultural stigma were α = .89 and α = .91, respectively.

Psychological Symptoms. The *Symptom Checklist-90 (SCL-90;* Derogatis, Lipman, & Covi, 1973) assessed psychopathology in nine areas (e.g., obsessive-compulsive symptoms and paranoid ideation). For the purpose of this study, the subscales for Anxiety, Depression, and Somatization Subscales were used in order to assess an individual on the respective symptoms. There were 12 items on the Depression and Somatization subscales and 10 items on the Anxiety subscale used to assess the level of symptoms experienced within the past week. In the present study, the scales were modified to assess for symptom distress within the past month. These items were rated on a 5-point scale, ranging from 1 (*not at all)* to 5 (*extremely),* and higher scores represented greater levels of psychological distress. The responses to each subscale were totaled to yield an overall score of each of the symptom areas, reflecting an individual's level of distress from symptoms of anxiety, depression, and somatization (e.g., van Kamp et al., 2006). The coefficient alphas for the subscales ranged from .77 for the Psychoticism

subscale to .90 for Depression (Derogatis, 2000), and the Anxiety Subscale was correlated with the Beck Anxiety Inventory and the Depression Subscale was correlated with the Beck Depression Inventory. For the present study, internal consistency estimates were .87 for Anxiety, .89 for Depression, and .86 for Somatization.

Intentions to Seek Help. The *Intentions to Seek Counseling Inventory* (*ISCI*; Cash, Begley, McCown, & Weise, 1975) assessed an individual's willingness to seek mental health services in response to psychological and interpersonal problems (e.g., "How likely would you be to seek counseling if you were experiencing general anxiety")? The 17-item measure contained 3 subscales, including psychological and interpersonal concerns, academic concerns, and drug use concerns. However, since the current study's focus was to examine help seeking for psychological distress, only the psychological and interpersonal subscales were used, which contained items related to depression, anxiety, and social problems. The items were rated on a 4-point scale ranging from 1 (*very unlikely)* to 5 (*very likely)*, and higher scores represented a greater willingness to seek psychological help. In a factor analytic study, the ISCI demonstrated high reliability (α = .90; Cepeda-Benito & Short, 1998), and was similar for college students, α = .87 (Vogel, Wade, & Hackler, 2007). Internal consistency for the present sample was α = .76. The ISCI has been found to be correlated with attitudes towards seeking psychological help (r = .36-.61; Kelly & Achter, 1995; Vogel & Wester, 2003). Also, a list of help providers was given to participants. The participants were asked to rank order the sources they would seek help from if they were experiencing one of the

problems previously mentioned in the ISCI. The lowest ranking of one indicated that the participant was least likely to seek help from that particular source of help.

Help Seeking. Help seeking was also assessed through questions that inquired about participants' perceptions of their need to seek mental health services for social, emotional, or psychological problems (e.g., Was there ever a time during the past 2 months when you ***thought*** that you might need to seek help for a problem with emotions, nerves, relationships, or your mental health?) and participants' actual help seeking behaviors (i.e., "In the past 2 months have you ***actually*** sought help for a problem with emotions, nerves, relationships, or your mental health?"; "Have you ***ever*** sought help for a problem with emotions, nerves, relationships, or your mental health?"). Participants that responded affirmatively to seeking help were asked to indicate the type of services sought. Participants that sought help within the two-month period were asked to indicate the source of help and the frequency of help seeking behaviors. These items were adapted from the guidance, feedback, and positive social interaction scales of Barrera, Sandler & Ramsay's (1981) Inventory of Socially Supportive Behaviors. Items similar to the Inventory of Socially Supportive Behaviors can be found in the COPE scale (Carver, Scheier, and Weintraub, 1989), which assessed seeking social support for instrumental reasons ($\alpha = .75$). In the current study, a summation of items into a single subscale produced a similar estimate of internal consistency ($\alpha = .77$).

Results

Design Overview.

This was a cross-sectional study. The relationship between the predictor variables of enculturation, psychological symptoms (depression, anxiety, and somatic symptoms), attitudes toward professional help seeking, mental illness conceptualizations, and stigma for seeking mental health services, and outcome variables of intentions to seek counseling, seeking psychological services in the two months prior to the study, and psychological help-seeking throughout one's life were examined through F-test comparisons of means, correlations, and multiple regressions.

Descriptive Statistics

The overall mean subscale scores for depression and anxiety were (M = 29.35, SD=9.66) and (M= 18.44, SD= 6.67) respectively, where scores can range from 12-60 and 10-50 respectively. Despite less than mid-range means in relation to possible scores, gender-specific cut-off scores for the subscales would suggest that the sample reported experiencing psychological distress. According to van Kamp et al. (2007), cutoff scores for men are >22 for depression and >14 for anxiety. For women, the cutoff scores are >28 for depression and >18 for anxiety. The means and standard deviations for men were M= 27.25, SD= 9.15 for depression, and M= 16.56, SD= 5.17 for anxiety. Means and

standard deviations for women were M= 30.14, SD= 9.66 for depression, and M= 19.15, SD= 7.03 for anxiety. There are no established cut-off scores for the Somatization scales because it was not designed to be a diagnostic tool. Therefore, means and standard deviations were not calculated for the present sample.

The *ATTSPPH-SF* had score ranges from 11-16 for Asian Americans and 17-30 for Caucasians, indicating average and positive attitudes towards seeking help (Fisher & Farina, 1995). For the whole sample, the mean and standard deviation were M= 16.47, SD= 4.12, which demonstrated overall average attitudes towards seeking professional psychological help. While other studies with mixed ethnicity participants report slightly higher means, indicative of more positive attitudes toward seeking help (e.g., Hatchett, 2007), it is important to note that the present sample included only Caucasians and Asian Americans, the latter group characteristically holding more negative attitudes towards seeking psychological help. The means of the three subscales of stigma: self (M= 25.93, SD= 7.30), family (M=10.63, SD= 3.65), and cultural (M= 12.10, SD= 3.70) indicated moderate levels of stigma. The mean for self-stigma was markedly low in comparison to samples of other published studies among college students (e.g., Vogel, Wade, & Hackler, 2007). The means for family and cultural stigma were slightly higher in comparison to the mean score (M= 10.6, SD= 3.0) reported by Vogel, Wester, Wei, and Boysen (2005) who used the Stigma Scale for Receiving Psychological Help in their study. However, the scale was modified for the present study. Upon closer examination of the range of scores endorsed for all the subscales, some participants reported at the upper levels of scores of stigma (e.g., self stigma, range of scores was from 12-50).

Inclusion criteria for the present study were individuals who had ever considered seeking help from a medical doctor, mental health professional, clergy member, or self help group for a problem with emotions, nerves, relationships, or mental health. However, intentions to seek psychological help for mental health concerns were low, as indicated by the mean score of the *Intentions to Seek Counseling Inventory* interpersonal concerns subscale (M= 16.38, SD= 4.39), and in comparison to other published studies among college students (e.g., Vogel, Wade, & Hackler, 2007). Closer examination of specific mental health concerns revealed that there were some psychological issues where students would likely seek professional help. For instance, 75% (N=162) of participants reported that they were "somewhat likely" or "very likely" to seek psychological help for issues with depression. In contrast, 46.3% (N=100) and 31% (N=67) of respondents would seek psychological help for parental conflicts and concerns about sexual concerns respectively.

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participants, or adherence to Asian values. The range of possible scores for this scale is 25-100. Total scores and Chronbach's alpha coefficients were calculated for the SCL-90 (Depression, Anxiety, and Somatization subscales), ATSPPH, SSOSH, Family Stigma, Cultural Stigma, ISCI, and AVS--R (Table 2). Alpha coefficients for the scales indicated good internal consistency and were either similar or higher than estimates in other published studies.

Table 2

Internal Consistency Reliabilities

Measure/Scale	α	Mean	SD	Observed Range	Possible Range
SCL-90 Depression Subscale (12 items)	.89	29.35	9.66	13-56	12-60
SCL-90 Anxiety Subscale (10 items)	.87	18.44	6.67	10-39	10-50
SCL-90 Somatization Subscale (12 items)	.86	21.31	7.03	10-39	12-60
ATSPPH (10 items)	.81	16.47	4.12	5-27	0-30
SSOSH (10 items)	.88	25.93	7.30	12-50	10-50
Family Stigma (5 items)	.89	10.63	3.55	5-20	5-20
Cultural Stigma (5 items)	.91	12.10	3.60	5-20	5-20
ISCI (8 items)	.76	16.38	4.39	8-27	8-36
AVS (25 items)	.78	63.49	8.06	46-94	25-100

Preliminary Analyses

Analyses of variance (ANOVA) were used to examine whether there were differences between Asian Americans and Caucasians in demographic variables, such as age, year in college, religiosity, and parental education level. A chi square analysis was used to examine whether there were differences between the two ethnic groups for gender. The results revealed that there were no significant differences between the two ethnic groups on the variables of age, year in college, and religiosity ($p < .05$). However, there were significant differences on the remaining demographic variables. More specifically, Asian Americans had more of an equal number of males (N= 42) and females (N= 66) compared to Caucasians (males, N= 17; females, N= 91), (χ^2 (1, 216) = 14.57, $p < 0.01$). Asian Americans reported that their mothers ($F(1, 214)=13.60$, $p < .01$) and fathers ($F(1,214)=14.52$, $p < .01$) had less formal education than Caucasians.

Analyses of variance (ANOVA) were also used to examine whether there were gender differences in demographic, predictor, and outcome variables. When applicable, chi square analyses were used for dis-continuous outcome variables. There were no differences between males and females on the demographic variables of age, level in college, religiosity, and parental educational level. As previously mentioned, there was a difference based on ethnicity. While there were no gender differences in somatization

scores, females (M= 19.15, SD= 7.03) reported higher levels of anxiety (F (1, 214)= 6.66, p< .01) than males (M= 16.55, SD= 5.17). In addition, males (M= 27.25, SD= 9.15) reported lower levels of depression (F (1,214)=3.88, p< .05) than females (M= 13.14, SD= 9.76). Males (M= 15.07, SD= 4.22) also reported less favorable attitudes toward seeking psychological help (F (1, 214)=9.74, p< .01) than females (M= 16.99, SD= 3.97). There were no significant gender differences in reported levels of family stigma. However, males (M= 27.81, SD= 7.13, M= 13, SD= 3.77 respectively) reported higher levels of self-stigma (F (1, 214)= 5.52, p< .05) and cultural stigma (F (1, 214)= 4.88, p< .05) than female participants (M= 25.22, SD= 7.26, M=11, SD=3.62 respectively).

There were also significant gender differences on the help-seeking variables. Males reported that they would be less likely to seek psychological help for an interpersonal concern (F (1, 214)= 14.59, p< .01) than females (M= 14.58, SD= 4.21 vs. M= 17.06, SD= 4.27). Males (N= 95) were also less likely than females (N= 62) to have ever sought psychological services (χ^2 (1, 216) = 4.71, p < 0.01).

Comparisons of Asian Americans and Caucasians on Predictor and Outcome Variables

The first five hypotheses posited differences between Asian Americans and Caucasians in the predictor variables of psychological symptoms, attitudes towards help seeking, stigma (self and other), and mental illness attributions, and the outcome variables of help-seeking intentions and behaviors. Comparisons of the means of the aforementioned variables were calculated and examined through F-tests. The data was summarized in Table 3.

Psychological Symptoms

There were no significant differences between Asian American and Caucasian students on reported levels of depression and somatization. However, Asian American students reported significantly lower levels of anxiety (M= 17.32, SD=6.50) than Caucasian students (M= 19.56, SD= 6.67); (F (1 214)= 6.25, p< .01). Asian Americans reported higher levels of depression than either anxiety (M=11.97, t= 18.30, df =107, p< .01) or somatic symptoms (M= 8.78, t=10.20, df = 107, p< .01). Similarly, Caucasians reported higher levels of depression than either anxiety (M= 9.84, t= 14.36, df= 107, p< .01) or somatic symptoms (M= 7.20, t= 9.11, df= 107, p< .01).

Attitudes Towards Seeking Help

F-test comparisons revealed that Asian Americans reported less positive attitudes (M= 15.35, SD=3.87) towards professional help-seeking for a psychological concern than Caucasians (M= 17.58, SD= 4.08), F (1, 214)=17.00, p< .01). Based on the aforementioned cutoffs, on average, Caucasians had slightly positive attitudes toward help-seeking, whereas Asian Americans reported more neutral attitudes towards seeking professional psychological help.

Etiological Beliefs of Mental Illness

Participants were presented with a vignette of an individual who met the *DSM-IV-TR* criteria for major depressive disorder, and indicated the likelihood that the described individuals' issues were caused by various factors, including a person's character, biology, social circumstances, stress, a mental or psychological problem, or God's will.

Contrary to the researcher's hypothesis, participants did not significantly differ in endorsing God's will as a cause for the disorder. However, Asian Americans were significantly more likely than Caucasians to endorse a person's "own bad character" as a cause of the problem ($F(1, 214)=10.55$, $p< .01$). In contrast, Caucasians were significantly more likely than Asian Americans to note biological ($F(1, 214)=22.29$, $p< .01$) and psychological ($F(1, 214)= 14.85$, $p< .01$) attributions for the problem.

To compare possible differences in attributions that participants endorsed for the first vignette (an individual who met the *DSM-IV-TR* criteria for major depressive disorder) and the second vignette (a "troubled person" who exhibited psychological distress but did not meet the *DSM-IV-TR* criteria for a mental disorder), post-hoc tests were conducted. Specifically, a paired t-test revealed that Asian Americans were significantly less likely to endorse a person's "own bad character" for vignette one ($M= 1.85$, $SD= .84$) compared to vignette two ($M= 2.04$, $SD= .91$); $t(108)= -2.28$, $p< .05$). Alternatively, Asian American students were significantly more likely to endorse a biological cause for vignette one ($M= 2.69$, $SD= .82$) compared to vignette two ($M= 2.29$, $SD= .89$); $t(108)=3.98$, $p< .01$). Similar results were found for the endorsement of psychological attributions for vignette one ($M= 3.16$, $SD= .64$) and vignette two ($M= 2.64$, $SD= .85$) with Asian Americans significantly more likely to note psychological causes for the individual diagnosed with a mental disorder compared to the "troubled person" ($t(108)= 4.15$, $p< .01$). Caucasians endorsed personal characteristic, biological, and psychological attributions in a similar manner for the two vignettes.

Self, Family, and Cultural Stigma of Seeking Psychological Help

To examine whether Asian Americans and Caucasians differed on levels of stigma related to psychological help seeking, F-test comparisons of the means were calculated. Asian American students reported that they perceived significantly higher levels of self-stigma ($F(1, 214) = 9.06$, $p < .01$) and stigma from their family ($F(1, 214) = 24.10$, $p < .01$) and racial/ethnic group ($F(1, 214) = 37.59$, $p < .01$) for seeking professional psychological services than Caucasian participants did.

Help-Seeking Intentions and Behaviors

In order to examine whether there were differences in intentions to seek counseling for interpersonal concerns, F-test comparisons were conducted. An ANOVA indicated that Asian Americans ($M = 15.39$, $SD = 4.21$) were less likely than Caucasians ($M = 17.37$, $SD = 4.36$) to seek counseling for interpersonal concerns ($F(1, 214) = 11.56$, $p < .01$). Post-hoc analyses indicated that Asian Americans were less likely than Caucasians to seek help for the specific interpersonal concerns of general anxiety ($F(1, 214) = 11.44$, $p < .01$), depression ($F(1, 214) = 25.05$, $p < .01$), and feelings of inferiority ($F(1, 214) = 12.15$, $p < .01$).

Perceived need for professional help for a problem with emotions, nerves, relationships, or mental health, and help-seeking behaviors within the two-month period prior to participating in the study were assessed through self-report questions. A chi-square analysis indicated that Asian Americans perceived less of a need for mental health services in the two months prior to participation in the study than Caucasians (χ^2 (1, 216)

= 36.26, p< .01). However, there were no significant differences in help-seeking behaviors within the two-month period.

In contrast, Asian Americans were significantly less likely to have sought professional services for a problem with emotions, nerves, relationships, or mental health in their lifetime than Caucasians (χ^2 (1, 216) = 29.46, p < 0.01). While there were no significant differences between Asian Americans and Caucasians in the likelihood of seeking help from a mental health professional (e.g., psychiatrist, psychologist, social worker, or professional counselor) during the two-months prior to participation in the study, Asian Americans were less likely than Caucasians to have ever sought help from the aforementioned professional sources (χ^2 (1, 216) = 13.82, p < 0.01). There were no significant differences between the two groups of students on overall informal help seeking (e.g., friend, family member, self-help group). However, post-hoc analyses revealed that Asian Americans were more likely than Caucasians to seek help through reading a self-help book (χ^2 (1, 216) = 3.67, p < 0.5).

Specific help-seeking activities to deal with difficulties in the past month (e.g., "Ask someone what they did in a situation that was similar to yours") were also assessed. An ANOVA revealed no significant differences between Asian Americans and Caucasians in the frequency in which they engaged in these help-seeking activities. However, post-hoc analyses revealed that Asian Americans engaged in the following help seeking activities less frequently than Caucasians: asked someone to do an activity to help get

their mind off of things (F (1, 214)= 4.77, p< .05) and asked someone to listen to them talk about their private feelings (F (1, 214)= 5.05, p< .05).

Table 3

Means, Standard Deviations, F-Test Comparisons, and Chi-Square Results of Predictor and Outcome Variables for Asian American and Caucasian College Students

Variables	Mean	SD	Observed Range	F	χ^2
SCL-90 Anxiety[1]				6.25**	
Asian Americans	17.32	6.5	10-39		
Caucasians	19.56	6.67	10-39		
SCL-90 Depression[2]				0.01	
Asian Americans	29.3	10	13-55		
Caucasians	29.41	9.36	16-56		
SCL-90 Somatization[3]				2.79	
Asian Americans	20.52	7.78	12-52		
Caucasians	22.11	6.13	12-39		
Attitudes toward psychological help-seeking[4]				17***	
Asian Americans	15.35	3.87	5-26		
Caucasians	17.58	4.08	5-27		
Personal character attribution for depression[5]				10.55**	
Asian Americans	1.85	0.84	1-4		

Caucasians	1.51	0.7	1-4		
Spiritual attribution for depression[5]				0.39	
Asian Americans	1.53	0.81	1-4		
Caucasians	1.46	0.72	1-4		
Biological attribution for depression[5]				22.29***	
Asian Americans	2.69	0.82	1-4		
Caucasians	3.16	0.64	1-4		
Psychological attribution for depression[5]				14.85***	
Asian Americans	2.83	0.79	1-4		
Caucasians	3.22	0.69	1-4		
Self Stigma[6]				9.06**	
Asian Americans	27.4	6.74	14-50		
Caucasians	24.46	7.56	12-41		
Family Stigma[7]				24.10***	
Asian Americans	11.79	3.43	5-20		
Caucasians	9.47	3.5	5-20		
Cultural group stigma[8]				37.59***	
Asian Americans	13.53	3.44	5-20		
Caucasians	10.68	3.4	5-18		
Intention to seek counseling for an interpersonal problem[9]				11.56**	
Asian Americans	15.39	4.21	8-25		
Caucasians	17.37	4.36	8-27		
Perceived need for psychological help in past 2 months					36.26***
Asian Americans	1.54	0.5	1-2		
Caucasians	1.15	0.36	1-2		
Recent Help Seeking					1.58
Asian Americans	1.79	0.41	1-2		
Caucasians	1.71	0.45	1-2		
Lifetime Help Seeking					29.46**
Asian Americans	1.59	0.49	1-2		
Caucasians	1.29	0.45	1-2		
Help seeking from mental health professional in past 2 mo					1.22
Asian Americans	0.42	0.77	0-3		
Caucasians	0.41	0.74	0-3		
Help seeking from mental health professional in lifetime					13.82**
Asian Americans	0.35	0.67	0-3		
Caucasians	0.73	0.87	0-3		

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

As measured by the Symptom Checklist-90 Anxiety Subscale, 2As measured by the Symptom Checklist-90 Depression Subscale, 3 As measured by the Symptom Checklist-90 Somatization Subscale, 4 As measured by the Attitudes Toward seeking Professional Psychological Help Scale—Short Form, 5 As measured by the General Social Survey MacArthur Mental Health Module Depression Vignette, 6 As measured by Self Stigma for Seeking Help, 7 As measured by the Family Stigma for Seeking Help, 8 As measured by the Cultural Stigma for Seeking Help, 9 As measured by the Intentions to Seek Counseling Inventory

Intra-Group Comparisons of Asian Americans on Predictor and Outcome Variables

A Pearson-product moment correlation indicated that there was no significant relationship between levels of enculturation and attitudes towards seeking psychological help. The average score on the Asian Values Scale (M= 63.49) indicated that the overall sample moderately adhered to Asian values. There was no significant relationship between levels of enculturation and use of psychological services within the two-month period prior to the study. In contrast, there was a significant correlation between enculturation and lifetime psychological service use ($r(106) = .22$, $p < .05$).

Multiple analyses were conducted in order to address the seventh hypothesis that attitudes towards help seeking, mental illness conceptualization, stigma, and enculturation would predict help seeking intentions and behaviors above and beyond the need for treatment (psychological symptoms). First, zero-order correlations were conducted to examine the relationship between predictor and outcome variables (refer to Table 4). Second, predictors that were significantly related to help seeking intentions were entered into a hierarchical regression to examine the amount of variance each predictor explained in help seeking intentions and behaviors. Lastly, predictors that were significantly correlated with help seeking behaviors were entered into a logistic regression, examining the probability of participants' seeking psychological services based on predictor variables.

Need for Treatment and Help Seeking

In the overall sample of Asian Americans and Caucasians, correlational analyses revealed significant relationships between reported help-seeking behaviors in the two-months prior to the study and anxiety ($r(214) = .20$, $p < .01$), depression ($r(214) = .24$, $p < .05$), and somatization ($r(214) = .14$, $p < .05$) symptoms. Among Caucasian college students, symptoms of anxiety ($r(106) = .22$, $p < .05$) and depression ($r(214) = .27$, $p < .01$) were significantly related to recent help-seeking behaviors, but somatization symptoms were not related to recent help seeking behaviors. In contrast, among Asian Americans, only reported symptoms of depression were significantly correlated with recent help seeking behaviors ($r(106) = .21$, $p < .05$).

There were no significant relationships between lifetime use rates of psychological services and reported symptoms of anxiety, depression, and somatization in the overall sample of Asian Americans and Caucasians. These relationships were similar among the Caucasians. However, among Asian Americans, symptoms of depression were significantly correlated with lifetime use of services ($r(106) = .21$, $p < .05$).

While psychological symptoms (anxiety and somatization), with the exception of depression, were not related to recent and lifetime help seeking among Asian Americans, these symptoms were correlated with specific support behaviors. Anxiety symptoms were significantly correlated with five of the nine support activities (r's ranged from .23 to .28), and the full scale of activities (combination of all activities; $r(106) = .29$, $p < .05$). Reported symptoms of depression were significantly related to six of the nine support behaviors, and the combined scale (r's ranged from .26 to .36). Somatization symptoms

were significantly related to two of the nine support activities and the combined scales (r's ranged from .20 to .24).

Attitudes Towards Seeking Psychological Help and Help-Seeking

Correlational analyses were conducted between attitudes towards seeking mental health services and recent and lifetime help-seeking behaviors. The analyses revealed that Asian Americans' attitudes towards professional help-seeking were significantly correlated with help-seeking behaviors in the two months prior to the study ($r = .19$, $p < .05$), but not significantly associated with lifetime help seeking behaviors.

Mental Illness Conceptualization and Help-Seeking

Asian Americans who attributed an individual's depressive symptoms to a biological cause were more likely to have sought psychological services in their lifetime ($r(106) = -.25$, $p < .05$). In contrast, the six mental illness attributions, and intentions to seek counseling for an interpersonal problems were not related to recent help seeking behavior in the two months prior to the study.

Attributing an individual's depressive symptoms to a spiritual cause was significantly related to one support-seeking activity (the student asking someone who he should see for assistance; ($r(106) = .31$, $p < .01$)). In addition, attributing an individual's depressive symptoms to stress was significantly related to two support-seeking activities, including the student asking someone for information to help him understand his situation ($r(106) = .22$, $p < .05$) and asking someone who he should see for assistance ($r(106) = -.29$, $p < .01$).

Stigma and Help-seeking

For the purpose of this specific hypothesis, a single stigma measure was calculated, and included the combination of the family and cultural stigma measures. These measures were correlated above .60 (r= .67). The correlations between family and self-stigma, and self-stigma and cultural stigma were below .50, and therefore, these measures were not appropriate to combine. Stigma was not significantly related with intentions to seek counseling for an interpersonal problem, recent and life-time help seeking behaviors, or specific help-seeking activities.

Perception of a Need for Mental Health Services and Help-Seeking

Among Asian Americans, there was a significant positive relationship between perceived need of mental health services in the two months prior to the study and recent help-seeking behavior (r (106)= .42, p< .001). Similarly, there was a significant positive correlation between perceived need for treatment and lifetime help seeking behaviors (r (106)= .40, p< .001).

Table 4

Intra-Group Correlational Analyses of Predictor and Outcome Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13
1 Anxiety	—												
2 Depression	0.739***	—											
3 Somatic	0.786***	0.518***	—										
4 Spiritual	-0.093	-0.138	0.080	—									
5 Biological	0.099	0.101	0.142	-0.029	—								
6 Psychological	0.129	0.188	-0.149	-0.080	0.338***	—							
7 ATSPPH	0.068	0.038	-0.143	-0.068	0.204*	0.126	—						
8 Enculturation	0.047	0.116	-0.069	0.066	-0.101	-0.160	-0.119	—					
9 Stigma	0.193*	0.219*	0.177	-0.128	0.142	0.026	-0.070	0.395***	—				
10 Help-seeking intentions	0.013	-0.041	-0.030	0.070	0.058	0.143	0.574***	-0.193*	-0.086	—			
11 Perceived Need for Tx	0.312**	0.411**	0.293**	-0.055	-0.108	-0.196*	0.007	0.057	-0.060	0.060	—		
12 Recent Help-Seeking	0.145	0.205*	0.123	-0.136	-0.035	-0.139	0.193*	0.046	0.015	0.243*	0.424***	—	
13 Lifetime	.0151	0.208*	0.100	0.02	0.252**	-0.128	0.174	0.215*	-	0.026	0.402**	.	—

Help-Seeking	8	0.088	*	397***	

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

Regression Analyses

The two variables that were significantly correlated with intentions to seek help, attitudes towards seeking mental health services and enculturation, were entered into a multiple regression analysis as predictor variables. Using forced entry and analyzing the 108 Asian American cases, the analysis revealed a significant model (F (1, 105)= 27.67, p< .001), accounting for 33% of the variance (Adjusted R^2= .33). The analysis also indicated that attitudes towards seeking mental health services were the only significant predictor in the model (B= .56, p< .05). The results from the multiple regression analysis are indicated below in Table 5.

Table 5

Summary of Multiple Regression Analysis for Predictors of Help-seeking Intentions Among Asian American Students (N=108)

	B	Std. Error	Beta	t	Sig.
Attitudes towards seeking help [a]	0.608	3.108	0.559	7.026	.000***
Enculturation [b]	-0.066	0.087	-0.127	-1.591	0.115

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

[a] As measured by the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, [b] As measured by the Asian Values Scale--Revised

A multiple regression analysis was conducted with symptoms of anxiety, depression, and somatization as predictor variables of social support activities (a summation of the participants' responses on the respective items). Employing the enter method, the analysis revealed a significant model when one, two, and three variables were entered as predictors. However, the model that included only anxiety and depressive symptoms as predictors explained the most variance, 10% (Adjusted R^2= .103). When the third variable was entered, less variance was explained of social support activities (Adjusted R^2= .095). Therefore, the optimal model included two predictors (F (3, 104)= 7.14, p< .01) with depressive symptoms being the only significant predictor of social support activities when both anxiety and depressive symptoms were entered as predictors. The results from this analysis are summarized in Table 6.

Table 6

Summary of Multiple Regression Analysis for Predictors of Social Support Activities Among Asian American Students (N=108)

	B	Std. Error	Beta	t	Sig.
Anxiety [a]	0.087	.141	.083	.614	.541
Depression [b]	.189	.092	.280	2.061	0.042*

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

[a] As measured by the Symptom Checklist-90 Anxiety Subscale, [b] As measured by the Symptom Checklist-90 Depression Subscale

A logistic regression analysis was executed with recent help seeking as the outcome variable, and significantly correlated variables with recent help seeking entered as predictor variables, including symptoms of depression, attitudes towards seeking mental health services, help seeking intentions, and perceived need for professional psychological services. Among the Asian American sub-sample (N= 108), the analysis revealed that the full model significantly predicted recent help seeking behaviors (omnibus χ^2= 28.06, df= 4, p< .001), and accounted for between 23% and 36% of the variance of the outcome variable. According to the analysis, the model could predict approximately 95.3% of individuals who did not seek help, and only 39.1% of individuals who actually sought professional psychological services. While symptoms of depression, attitudes towards seeking professional help, and intentions to seek help did not significantly predict recent help seeking behaviors, perceived need for professional psychological help did significantly predict the outcome variable (B = 2.52, Exp(B) = 12.37, p < .01). The results from the logistic regression are summarized below in Table 7.

Table 7

Summary of Logistic Regression Analysis for Predictors of Recent Help-seeking Behaviors Among Asian Americans (N= 108)

	B	Std. Error	Wald	Sig.	Exp(B)
Depression [a]	-.009	.030	.090	764	.991
Attitudes [b]	-057	.086	.433	.511	.945
Help Seeking Intentions [c]	-.137	.084	2.626	.105	.872
Perceived Need	2.515	.723	12.094	.001**	12.368

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

[a] As measured by the SCL-90 Depression Subscale, [b] As measured by the Attitudes Toward Seeking Professional Psychological Help—Short Form, [c] As measured by the Intentions to Seek Counseling Inventory

A logistic regression analysis was executed with life-time help seeking as the outcome variable, and significantly correlated variables with life-time help seeking were entered as predictor variables, including symptoms of depression, a biological etiological attribution for a depressive disorder, levels of enculturation, and perceived need for professional psychological services. Among the Asian American sub-sample (N= 108), the analysis revealed that the full model significantly predicted recent help seeking behaviors (omnibus χ^2= 27.95, df = 4, p< .001), and accounted for between 23% and 31% of the variance of the outcome variable. According to the analysis, the model could predict 79.7% of individuals who did not seek help, and 65.9% of individuals who did seek professional psychological services. While symptoms of depression and level of enculturation did not significantly predict recent help seeking behaviors, a biological etiological attribution of a depressive disorder (B = -.611, Exp(B) = .543, p < .05) and a perceived need for professional psychological help (B = 1.566, Exp(B) = 4.788, p < .01) significantly predicted the outcome variable. The results from the logistic regression are summarized below in Table 8.

Table 8

Summary of Logistic Regression Analysis for Predictors of Life-time Help-seeking Behaviors Among Asian Americans (N= 108)

	B	Std. Error	Wald	Sig.	Exp(B)
Depression [a]	-.019	.025	.590	.442	.981
Biological Etiological Attribution [b]	-.611	.297	4.244	.039*	.543
Enculturation [c]	.058	.030	3.837	.050	1.060
Perceived Need	1.566	.482	10.539	.001**	4.788

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

[a] As measured by the SCL-90 Depression Subscale, [b] As measured by the General Social Survey MacArthur Mental Health Module Depression Vignette [c]

Discussion

The current study examined a) the relationships among demographic and psychological variables and help seeking intentions and behaviors by Caucasian and Asian American students; and b) specific factors that may contribute to help seeking intentions and behaviors by Asian Americans. More specifically, the hypotheses posited that Asian Americans would report higher levels of somatic distress and lower levels of anxiety and depression than Caucasians. Secondly, Asian Americans would report more negative attitudes towards professional psychological help, and would be more likely to conceptualize mental illness as having a spiritual cause than would Caucasians. In regards to help seeking intentions and behaviors, it was hypothesized that Asian Americans would be less likely to intend to seek counseling, more likely to seek informal or semiformal help, and less likely to seek formal/professional counseling than would Caucasians. It was also predicted that less enculturated Asian Americans would report more positive attitudes towards psychological help-seeking than would more enculturated Asian Americans, and would therefore be more likely to report seeking professional psychological help. Lastly, it was hypothesized that the group of three cognitive variables: help-seeking attitudes, mental illness conceptualization, and (self and other) stigma, plus enculturation would predict help seeking intentions and behaviors above and beyond need for treatment (psychological symptoms).

Psychological Symptoms and Help-Seeking

While there were no differences between Caucasians and Asian Americans in their reported levels of depression and somatization, Asian Americans reported significantly lower levels of anxiety. The acculturation levels of the Asian American students may have affected the lack of significant differences in reported symptoms of depression and somatization between the two sub-ethnic groups. Given the study's requirements of a minimum stay of five years in the United States, this automatically excluded very recent immigrants, and contributed to a minimum level of American acculturation. According to Akutsu and Chu (2006), acculturated groups of Asian Americans are more likely to report a broader range of problems than less acculturated groups, especially depression. Zhang, Snowden, and Sue (1998) have suggested that with increasing acculturation, Asian Americans may not report symptoms of somatization for their emotional concerns. It is also a possibility that depression may be considered more serious than symptoms of anxiety, which may be conceptualized as stress that "everybody" experiences.

Symptoms of depression and anxiety were significantly associated with recent help-seeking behaviors among Caucasian students, but none of the psychological symptoms were related to overall lifetime help seeking behaviors among this group. Overall, Asian Americans were less likely to intend to seek help for an interpersonal concern and engaged in less recent and lifetime help seeking behaviors than Caucasians. However, it appears that reported symptoms of depression may significantly influence Asian Americans' recent and lifetime help seeking behaviors. These findings are consistent with Keary, Draper, and Baron (2005) who found that among college students

that attended counseling centers, Caucasians accounted for the majority of clientele, and were more likely than ethnic minority students to attend more counseling sessions. It also appears that Asian Americans present with the greatest distress at intake, including reporting higher levels of depression than Caucasians, suggesting that they may seek treatment when symptoms are at more extreme levels (Keary, Draper, & Baron, 2005; Centers for Disease Control and Prevention, 2001). Additionally, depression is one of the most common psychological disorders reported by Asian Americans that present for treatment (Akutsu & Chu, 2006; Centers for Disease Control and Prevention, 2001). Perceived emotional and instrumental support from family and friends is related to depressive symptoms (Mak & Chen, 2006), in which case when an Asian American individual's mood may be affected by interpersonal problems, it may be more of a motivator to seek treatment as compared to other psychological concerns.

Reported symptoms of anxiety, depression, and somatization were significantly related to Asian Americans engaging in informal social support activities. In contrast, among Caucasians, symptoms of anxiety and somatization were related to only one and two social support activities, respectively. The relationship between psychological symptoms and help seeking (informal and formal) may depend on levels of distress among Asian Americans, where lower levels of distress may relate to the use of informal sources of help seeking and higher levels of distress relate to the use of formal services. Cultural norms may also support this pattern of help seeking which dictate that problems should be solved within the family and community before taking them to professionals, or risk "losing face" (Abe-Kim, Takeuchi, & Hwang, 2007).

Attitudes Towards Seeking Mental Health Services and Help Seeking

Consistent with the current literature, Asian Americans reported significantly less favorable attitudes towards seeking professional psychological services than Caucasians (e.g., Atkinson, Kim, & Caldwell, 1998). Closer examination revealed that on average, Asian Americans had neutral attitudes towards seeking mental health services, whereas Caucasians had slightly positive attitudes towards professional psychological help seeking. These results may indicate that Asian American students do not necessarily hold negative attitudes towards psychological services per se. College outreach efforts, more refined multi-culturally competent treatments, and an increased level of cultural competence among mental health professionals can foster more positive attitudes towards mental health services. After all, Asian Americans' attitudes towards help seeking may be positively affected after coming in contact with outpatient services (Sue et al, 1991; Solberg, 1994). These results may depend on the level of acculturation among the Asian American sample. While Asian Americans had more neutral attitudes towards help seeking, albeit less favorable attitudes than Caucasians, these Asian Americans may have also become more acculturated to American interventions for distress. Less acculturated individuals tend to have less favorable attitudes towards psychological help seeking than more acculturated individuals (Tata & Leong, 1994; Zhang & Dixon, 2003; Liao, Rounds, & Klein, 2005).

Asian Americans that reported more positive attitudes towards psychological help seeking were more likely to intend to seek services and engage in recent help seeking behaviors than individuals that reported less favorable attitudes towards professional

psychological help seeking. However, upon further examination, attitudes towards seeking mental health services were not *predictive* of recent and lifetime help seeking behaviors. Rather, if individuals perceive the need for psychological services, they will be more likely to seek help. These results suggest that while individuals' attitudes towards help seeking may lead them to *consider* seeking treatment; acknowledgement of psychological distress may lead them from planning to seek treatment to actually seeking help.

Attitudes towards psychological help seeking were not related to informal help seeking. The presence of positive or negative help seeking attitudes did not dictate whether Asian Americans relied on informal sources of social support. Asian Americans may incorporate these social support activities in their lives regardless of whether they seek professional services (Abe-Kim, Takeuchi, & Hwang, 2002). Cultural and social norms prescribe that one relies on his family and friends for support and encouragement throughout his lifetime, especially during difficult times.

Etiological Beliefs of Mental Illness and Help Seeking

Contrary to the initial hypothesis, there were no differences between Asian Americans and Caucasians in endorsing "God's will" as a mental illness attribution for a depressive disorder. Among the overall sample of Asian Americans and Caucasians, approximately 86.1% endorsed being slightly, moderately, strongly, or very strongly spiritual or religious, indicating a fairly spiritual/religious sample. In addition, there were no significant differences between Asian Americans and Caucasians on the demographic variables of religiosity or spirituality, suggesting possible similarity in endorsing a

spiritual attribution for a depressive disorder. According to Solberg, Choi, Ritsma, and Jolly (1994), less acculturated individuals are more likely to engage in help seeking from religious leaders or church groups, and as previously noted, this sample on average, may be on the moderate to higher level of the acculturation continuum.

The ways in which an individual conceptualizes a problem is related to the sources of help seeking sought, and demographic variables may influence mental illness conceptualizations through acculturation, enculturation, and country of origin (Steel et al, 2006). Asian Americans were more likely to endorse a person's "own bad character" as an attribution for an individual suffering from a depressive disorder than Caucasians. Similar to previous studies, Asian Americans were also less likely to note biological and psychological attributions for an individual experiencing a depressive disorder than Caucasians, and also engaged in lower rates of recent and lifetime professional help seeking behaviors (Braun & Brown, 1998; Mallinckrodt, Shigeoka, & Suzuki, 2005). These results are consistent with the help seeking patterns among Asian Americans—the individual may first attempt to deal with stress himself, and if this is not effective, the individual will turn to family or friends for help (Zhang, Snowden, & Sue, 1998). The next line of support would be elders or community leaders, and lastly, professional psychological services. The implicit messages embedded in this help-seeking pattern is that the individual has some control over his personal/emotional problems, and that the common etiological explanations for mental illness might not be biological or psychological, making it less likely that an individual will seek professional psychological services as opposed to other sources of help.

Despite differences in endorsing a biological attribution for a depressive disorder, this biological attribution was predictive of lifetime help seeking behaviors among Asian Americans. Thus, if an Asian American individual conceptualizes his problem as biological, he will be more likely to seek professional psychological services in his lifetime. This is similar to previous studies that have noted that a match between an Asian American client's and counselor's mental health worldviews (e.g., biological) will likely result in treatment adherence in a professional psychological setting (Mallinckrodt, Shigeoka, & Suzuki, 2005). A caveat to these results is that Asian Americans that come to conceptualize their problem as biological may first seek medical services and referrals prior to coming into contact with a mental health professional (Steel et al., 2006).

Stigma and Help Seeking

Asian Americans reported more self, family, and cultural stigma in relation to psychological help seeking than Caucasians. These results are consistent with previous studies that noted that Asian Americans report stigma (self and others) when discussing barriers to psychological help seeking (Tracey, Leong, & Giddens, 1986; Abe-Kim, Takeuchi, & Hwang, 2002; Akutsu & Chu, 2006). According to Tracey, Leong, and Giddens (1986), Asian Americans are more sensitive to stigma in relation to problem recognition than Caucasians. In the current study, family and cultural stigma was combined in a single measure, and this variable was significantly associated with symptoms of depression. According to Okasaki and Kallivayalil (2002), Asian Americans are more likely than Caucasians to consider cultural norms in relation to reporting depressive symptoms.

Self, family, or cultural stigma was not related to help seeking intentions and behaviors among Asian Americans. It appears that while stigma may play a role in problem recognition and act as a barrier to treatment, stigma may not determine help seeking intentions or behaviors. Previous studies have emphasized identifying stigma as a barrier to psychological help seeking (Tracey, Leong, & Giddens, 1986; Wynaden et al, 2005; Chen, Kramer, Chen, & Chung, 2005), but there is a lack of empirical studies documenting the relationship between these variables among Asian American students. According to a recent study examining stigma and psychological help seeking among college students at a Mid-western university, there was a significant negative relationship between perceived public stigma and need for treatment among 18-22 year olds (Goberstein, Eisenberg, & Gollust, 2008). However, there was not a significant relationship between reported symptoms of anxiety and depression, perceived stigma, and help seeking behaviors in the overall sample of college students. Asian Americans were more likely than other ethnic groups to perceive public stigma for psychological help seeking and less likely to perceive a need for treatment. In addition, problem recognition was not significantly related to help seeking among Asian Americans. While the authors do not discredit the influence of stigma on psychological help seeking, they suggest continuing to examine the relative effects of perceived stigma on psychological help seeking behaviors. In addition, they suggest that outreach and treatment efforts be modified to best serve college students.

Future research can continue to empirically examine the relationship between stigma and help seeking variables for Asian American students. More specifically,

researchers must carefully conceptualize and measure the construct of stigma. For example, "loss of face" may be particularly useful in understanding the stigma that Asian Americans experience when seeking psychological services. However, measures of public stigma may not be capturing the variable of "loss of face."

Enculturation

Levels of enculturation were not related to help seeking attitudes and recent help seeking behaviors. However, levels of enculturation were significantly related to stigma for psychological help seeking and lifetime help seeking behaviors. More specifically, individuals who reported higher levels of adherence to Asian values were more likely to perceive stigma for psychological help seeking and less likely to seek help in their life-time than participants that reported lower levels of adherence to Asian values. As mentioned, Asian Americans and Caucasians did not differ in recent help seeking behaviors, but they did differ on lifetime help seeking behaviors. It may be that when an individual's distress is acute or his perceived distress threshold is reached in a shorter period of time (e.g., two months), there may be a greater perceived need for services compared to experiencing symptoms over the course of time (e.g., a lifetime).

The results are not completely consistent with Liao, Rounds, and Klein (2005) path models. According to the authors, attitudes towards seeking help mediate the relationship between self-concealment and willingness to seek help, and enculturation and willingness to seek help. The current study's results suggest that enculturation may have an indirect effect on self-concealment whereby individuals who adhere more strongly to Asian values may wish to reduce the possibility of experiencing stigma and

conceal their problems by not seeking psychological services. In addition, while attitudes towards seeking help were significantly related to help seeking intentions among Asian Americans, they were not related to adhering to Asian values or stigma. It appears that enculturation may relate more to how others may perceive their help seeking behavior and subsequent lifetime help seeking behaviors as opposed to their opinion of mental health services.

Enculturation is a complex construct, and was included in the study because there have been few empirical studies that have examined its relationship to Asian Americans' help-seeking intentions and behaviors. Comparatively, acculturation has been commonly examined in relation to help-seeking intentions and behaviors among Asian Americans, and the research has indicated mixed findings. While acculturation was not directly measured in the present study, acculturation may still have influenced the current results (e.g., reported psychological symptoms and mental illness conceptualizations). Future studies could benefit from careful conceptualization and measurement of the variables of acculturation and enculturation in relation to psychological help seeking among a sample of individuals with varying levels of acculturation and enculturation. For instance, should these variables be considered uni-dimensional or multi-dimensional? If an individual is highly assimilated into American culture (acculturation), does this translate into lower adherence to Asian values (enculturation)? Cramer's Revised Help-Seeking Model can perhaps be a useful tool in guiding future research.

Clinical Implications

Asian Americans are one the fastest growing ethnic minority groups in the United States (Braun & Brown, 1998). Given Asian Americans' increasing representation in higher education, it is important to understand ways to better meet the mental health needs of this group (Sue, 1994). The current study's results have clinical and counseling implications for mental health professionals on college campuses. Asian American students were less likely to seek mental health services in their lifetime than Caucasian students. One barrier to help seeking for Asian Americans continues to be the stigma of psychological services. College counseling centers need to find ways to de-stigmatize psychological help seeking behavior. Although Asian Americans had less favorable psychological help seeking attitudes than Caucasians, these attitudes were generally neutral. Therefore, fostering a positive view of college counseling centers can perhaps move students in the direction of developing more favorable attitudes towards mental health services and facilitate use of psychological services.

Fostering positive attitudes towards psychological services can include framing treatment as a way of enhancing a student's strengths, providing psycho-education to the Asian American community, and using non-traditional methods to outreach to students. Psycho-education to the Asian American community will allow community members to learn about mental health services from credible professionals that are held in high regard. In addition to ethnically representative professionals relaying information to the community, universities could be held accountable for recruiting counseling psychologists that are representative of the ethnic-student population that they serve. Counseling center psychologists can also provide students with self-help books and

online library resources (e.g., How to cope with depression), depicting diverse individuals on the website.

Integrated/holistic care on college campuses may better meet the mental health needs of Asian Americans, given that Asian Americans conceptualize their personal/emotional problems in a variety of ways. Asian Americans were less likely than Caucasians to note a psychological or biological attribution for a depressive disorder, and equally likely to endorse a spiritual attribution. Therefore, college campuses could provide outreach networks and work collaboratively with academic resources, ethnic minority and student organizations, and the health center (may include acupuncturists). Employees from different organizations on campus can serve as key ambassadors between students and counseling services. Furthermore, acknowledging depression symptoms may influence psychological help seeking among Asian Americans. Within the integrated care model, depression screenings may be helpful. For instance, offering anonymous online depression screenings may be less stigmatizing than having in-person depression screening days, and may encourage assessment and eventual use of the counseling center.

Social support activities appear to be important among Asian American college students in coping with interpersonal and psychological issues. Given Asian Americans students' reliance on the support of their friends in times of distress, counseling centers could develop peer assistance programs. For example, mental health professionals could train undergraduate students to provide outreach and work with peers on their difficulties. In addition, campuses can institute a similar model to the National Alliance on Mental

Illness (1996), which entails sending speakers into the community to discuss coping with their mental illnesses. This model can include Asian American peers, further de-stigmatizing help-seeking intentions and behaviors.

Limitations of the Study and Future Research Directions

There are several limitations of this study. First, the sample was restricted to a convenience sample of college students who participated in the study for course credit in psychology courses. A college sample may have better psychological adjustment than a similar aged community sample in order to deal with the economic, social, and intellectual demands of higher education. Given these students were in psychology courses, they may be more aware of mental health issues and psychological help seeking than students who are enrolled in courses in other disciplines (e.g., business). In addition, compared to a clinical sample, help seeking intentions and behaviors are expected to be lower among college students. While the study's requirements included participants who considered seeking help for a problem with emotions, nerves, relationships, or mental health, they still had relatively low levels of help seeking intentions and behaviors, making it more difficult to detect differences in predictor and outcome measures due to relatively low variance in responses.

Another limitation was that the study was a cross-sectional, retrospective study based on self-report, perhaps making it more challenging for participants' to accurately report help seeking intentions and behaviors occurring in the past in relation to current psychological distress. In addition, the cross-sectional study did not provide the opportunity to observe possible changes in attitudes towards help seeking, experiences of

psychological distress, and levels of enculturation that a prospective longitudinal study could assess.

There were also some limitations among the Asian American sample. For logistical purposes, the study's requirements included Asian Americans who have resided in the U.S. for five or more years. However, this excluded recent immigrants (less acculturated) that plan on residing in the U.S after completing their education. While the overall sample reported relatively moderate adherence to Asian values, adding variance to the predictor and outcome measures by including diverse participants (e.g., less acculturated/more enculturated Asian Americans) may help in detecting differences among the variables. This study also assumed relative homogeneity among the Asian American sub-sample. However, there may be important differences among the sub-ethnic Asian American groups on predictor and outcome variables.

Despite these limitations, there were a variety of strengths in this study. While the sample was primarily composed of college students, the study recruited a diverse Asian American ethnic population (e.g., Thai, Korean, Vietnamese), which included groups that have traditionally not been included in the literature. In addition, the sample size was large enough to detect medium effects. This study can add to our understanding of factors that may influence or discourage Asian American college students from seeking mental health services, including stigma, attitudes towards professional psychological help seeking, psychological symptoms, mental illness attributions, and levels of enculturation. Future outreach initiatives targeting Asian American students may include

facilitating problem recognition in light of actual psychological distress, and fostering more favorable attitudes towards counseling centers.

Based on the study's results, future research should examine the relative importance of stigma, acculturation, and enculturation in help seeking intentions and behaviors for Asian Americans of various ages. Revised pathway models based on the work of Cramer (2005) and subsequently Liao, Rounds, and Klein (2005) can be used to examine the effects of multiple variables on psychological help seeking. Lastly, comparisons between different ethnic Asian American college students (e.g., Thai, Chinese) can better inform how to best serve the needs of diverse college students.

Appendix 1

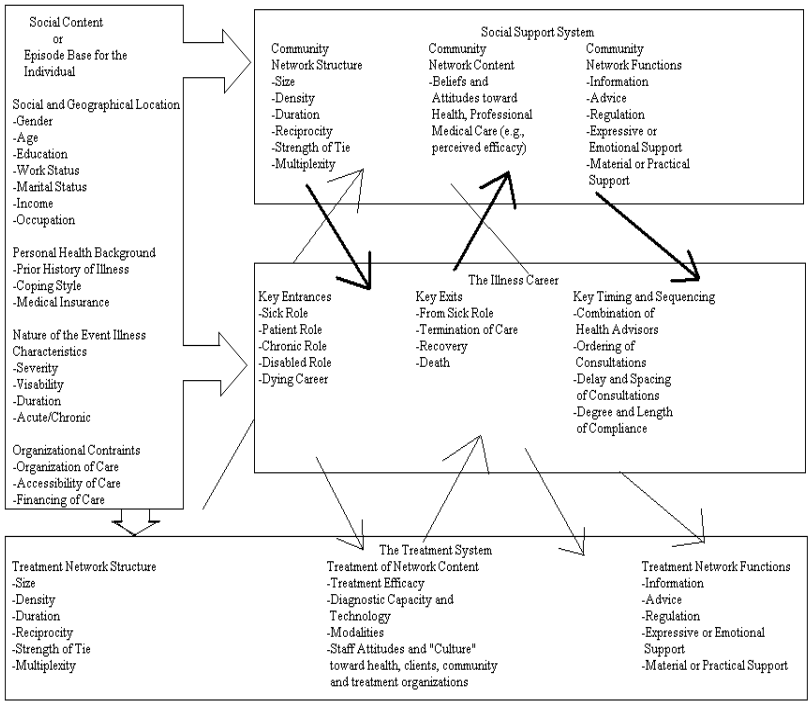

Figure 21.4.
Revised Network-episode
model

Figure 2:Pescosolido's Network Episode Model

Appendix 2: Online Questionnaire

Screening Question

Have you ever *considered* seeking help (e.g., from a medical doctor, mental health professional, clergy member, self-help group) for a problem with emotions, nerves, relationships, or your mental health?

____ Yes
____ No

Demographic Questionnaire

1. What is your gender?

____ Male
____ Female

2. What is your age? _____

3. Racial/Ethnic group:
____ Asian American (please specify): _____
____ Caucasian

4. Country where you were born:
____ Vietnam
____ Korea
____ China
____ Japan
____ Cambodia
____ Laos
____ Thailand
____ Other (please specify): _____

5. If you were not born in the United States, 5A please indicate your length of stay in the United States.

_____

6. (5B) If you were not born in the United States, please indicate your citizenship status (e.g., naturalized citizen).

_____

7. Country where your mother was born: _____

8. Country where your father was born: _____

9. What is your current student status?

____ Freshman
____ Sophomore
____ Junior
____ Senior
____ Non-degree student
____ Other (specify) _____

10. To what extent do you consider yourself spiritual/religious?

____ Very strongly
____ Strongly
____ Moderately
____ Slightly
____ Not at all

11. What is your current religious affiliation? (Circle One)

Catholic Protestant (Specify) Other Christian Jewish

Muslim Hindu Buddhist Unitarian-Universalist Other None

12. What is your mother's highest level of education?

____ Less than high school
____ High school diploma
____ Some college
____ Bachelor's degree
____ Graduate/professional degree

13. What is your father's highest level of education?

____ Less than high school
____ High school diploma
____ Some college
____ Bachelor's degree
____ Graduate/professional degree

Asian Values Scale-Revised

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. One should be able to question a person in an authority position.	1	2	3	4

2. One need not minimize or depreciate one's own achievements.	1	2	3	4
3. Younger persons should be able to confront their elders.	1	2	3	4
4. One need not remain reserved and tranquil.	1	2	3	4
5. One need not focus all energies on one's studies.	1	2	3	4
6. One need not be able to resolve psychological problems on one's own.	1	2	3	4
7. One should not make waves.	1	2	3	4
8. One should be discouraged from talking about one's accomplishments.	1	2	3	4
9. One need not follow the role expectations (gender, family, hierarchy) of one's family.	1	2	3	4
10. One need not achieve academically in order to make one's parents proud.	1	2	3	4
11. Family's reputation is not the primary social concern.	1	2	3	4
12. One should not deviate from familial and social norms.	1	2	3	4
13. The worst thing one can do is to bring disgrace to one's family reputation.	1	2	3	4
14. One should think about one's group before oneself.	1	2	3	4
15. Occupational failure does not bring shame to the family.	1	2	3	4
16. One's achievements should be viewed as family's achievements.	1	2	3	4
17. Educational and career achievements need not be one's top priority.	1	2	3	4
18. One need not control one's expression of emotions	1	2	3	4
19. When one receives a gift, one should reciprocate with a gift of equal or lesser value.	1	2	3	4

20. One should consider the needs of others before considering one's own needs.	1	2	3	4
21. One should have sufficient inner resources to resolve emotional problems.	1	2	3	4
22. One should avoid bringing displeasure to one's ancestors.	1	2	3	4
23. Children should not place their parents in retirement homes.	1	2	3	4
24. One should be humble and modest.	1	2	3	4
25. Modesty is an important quality for a person.	1	2	3	4

Symptom Checklist-90 (Somatization, Depression and Anxiety subscales)

Please indicate below how the following problem has distressed or bothered you DURING THE PAST MONTH:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Headaches	1	2	3	4	5
2. Nervousness or shakiness inside	1	2	3	4	5
3. Faintness or dizziness	1	2	3	4	5

4. Loss of sexual interest or pleasure	1	2	3	4	5
5. Pains in heart or chest	1	2	3	4	5
6. Feeling low in energy or slowed down	1	2	3	4	5
7. Thoughts of ending your life	1	2	3	4	5
8. Trembling	1	2	3	4	5
9. Crying easily	1	2	3	4	5
10. Feelings of being trapped or caught	1	2	3	4	5
11. Suddenly scared for no reason	1	2	3	4	5
12. Blaming yourself for things	1	2	3	4	5
13. Pains in lower back	1	2	3	4	5
14. Feeling lonely	1	2	3	4	5
15. Feeling blue	1	2	3	4	5
16. Worrying too much about things	1	2	3	4	5
17. Feeling fearful	1	2	3	4	5
18. Heart pounding or racing	1	2	3	4	5
19. Nausea or upset stomach	1	2	3	4	5
20. Soreness of your muscles	1	2	3	4	5
21. Trouble getting your breath	1	2	3	4	5
22. Hot or cold spells	1	2	3	4	5
23. Numbness or tingling in parts of your body	1	2	3	4	5
24. A lump in your throat	1	2	3	4	5
25. Feeling hopeless about the future	1	2	3	4	5
26. Weakness in parts of your body	1	2	3	4	5
27. Feeling tense or keyed up	1	2	3	4	5
28. Heavy feelings in your arms or legs	1	2	3	4	5

29. Feeling everything is an effort	1	2	3	4	5
30. Spells of terror or panic	1	2	3	4	5
31. Feeling so restless you can't sit still	1	2	3	4	5
32. Heart pounding or racing	1	2	3	4	5
33. Feelings of worthlessness	1	2	3	4	5
34. The feeling that something bad is going to happen to you	1	2	3	4	5
35. Thoughts and images of a frightening nature	1	2	3	4	5

Self-Stigma of Seeking Help

	Strongly disagree	Disagree	Agree and disagree equally	Agree	Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist	1	2	3	4	5
6. It would make me feel inferior to ask a therapist for help	1	2	3	4	5
7. I would feel okay about myself if I made the choice to seek professional help	1	2	3	4	5
8. If I went to a therapist, I would be less satisfied with myself	1	2	3	4	5
9. My self-confidence would remain the same if I sought help for a problem I could not solve	1	2	3	4	5
10. I would feel worse about myself if I could not solve my own problems	1	2	3	4	5

Family Stigma for Seeking Psychological Help

	Strongly disagree	Disagree	Agree	Strongly agree
1. Seeing a psychologist for emotional or interpersonal problems carries a stigma *in my family*	1	2	3	4
2. It is a sign of personal weakness or inadequacy *in my family* to see a psychologist for emotional or interpersonal problems	1	2	3	4
3. People *in my family* will see each other in a less favorable way if they come to know someone has seen a psychologist	1	2	3	4
4. It is advisable for a person *in my family* to hide that s/he has seen a psychologist	1	2	3	4
5. People *in my family* tend to like less those who are receiving professional psychological help	1	2	3	4

Cultural Stigma for Seeking Psychological Help

	Strongly disagree	Disagree	Agree	Strongly agree
1.Seeing a psychologist for emotional or interpersonal problems carries a stigma *in my racial/ethnic group or culture*	1	2	3	4
2.It is a sign of personal weakness or inadequacy *in my racial/ethnic group or culture* to see a psychologist for emotional or interpersonal problems	1	2	3	4
3.People *in my racial/ethnic group or culture* will see each other in a less favorable way if they come to know someone has seen a psychologist	1	2	3	4
4. It is advisable *in my racial/ethnic group or culture* for a person to hide from people that s/he has seen a psychologist	1	2	3	4
5. People *in my racial/ethnic group or culture* tend to like less those who are receiving professional psychological help	1	2	3	4

General Social Survey- MacArthur Mental Health Module

After reading a description of the individuals below, please answer the question that follows. There are no right or wrong answers. I'm only interested in what you think of the individual.

1. For the past two weeks Jean had felt that something was wrong with her. When she sat and read the newspaper in the mornings before going to work, she could not concentrate on the words. Often during the day her eyes filled with tears, and she felt an intense sadness. Jean's friends at work tried to cheer her up, but they had no success. When her closest friend persuaded her to go to a movie they had both wanted to see, Jean could not pay attention. She felt she had no interest in anything she had once enjoyed.

In your opinion, how likely is it that Jean's situation might be caused by:

	Not likely at all	Not very likely	Somewhat likely	Very Likely
Her own bad character	1	2	3	4
A chemical imbalance in the brain	1	2	3	4
The way she was raised	1	2	3	4
Stressful circumstances in her life	1	2	3	4
A mental or psychological problem	1	2	3	4
God's will	1	2	3	4

2. Up until a year ago, life was pretty okay for John. While nothing much was going wrong in John's life he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people and although John sometimes argues with his family, John been getting along pretty well with his family.

In your opinion, how likely is it that John's situation might be caused by:

	Not likely at all	Not very likely	Somewhat likely	Very Likely
His own bad character	1	2	3	4
A chemical imbalance in the brain	1	2	3	4

The way he was raised	1	2	3	4
Stressful circumstances in his life	1	2	3	4
A mental or psychological problem	1	2	3	4
God's will	1	2	3	4

Attitudes Toward Seeking Professional Psychological Help Scale—Short Form

Please circle the number of the choice that best expresses your level of agreement with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention	0	1	2	3
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts	0	1	2	3
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy	0	1	2	3
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help	0	1	2	3
5. I would want to get psychological counseling if I was worried or upset for a long period of time	0	1	2	3
6. I might want to have psychological counseling in the future	0	1	2	3
7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help	0	1	2	3
8. Considering the time and expense involved in counseling/psychotherapy, it would have doubtful value for a person like me	0	1	2	3
9. A person should work out his or her own problems; getting psychological counseling would be a last resort	0	1	2	3
10. Personal and emotional troubles, like many things, tend to work out by themselves	0	1	2	3

Intentions to Seek Counseling Inventory

1. How likely would you be to seek counseling if you were experiencing the following:

	Very Unlikely	Somewhat Unlikely	Somewhat Likely	Very Likely
General anxiety	1	2	3	4
Shyness	1	2	3	4
Depression	1	2	3	4
Concerns about sexuality	1	2	3	4
Parental conflicts	1	2	3	4
Dating difficulties	1	2	3	4
Inferiority feelings	1	2	3	4
Lack of friends	1	2	3	4

2. Rank in order from most likely to least likely from whom would you be most likely to seek help if you were experiencing one of the problems noted above.

___ Psychiatrist
___ Family doctor
___ Other health professional (specify) _____
___ Psychologist
___ Social worker
___ Other counselor (specify) _____
___ Clergy member
___ Traditional or folk healer
___ School/academic advisor
___ Self-help group
___ Self-help book
___ Telephone helpline/hotline
___ Family member or friend
___ Other (specify) _____

Help-seeking

1. Was there ever a time during the past 2 months when you ***thought*** that you might need to seek help for a problem with emotions, nerves, relationships, or your mental health?

____ Yes
____ No

2. In the past 2 months have you ***actually*** sought help for a problem with emotions, nerves, relationships, or your mental health?

____ Yes
____ No

2a. Did someone close to you (e.g., family member, friend) suggest that you seek help?

____ Yes
____ No

2b. Please indicate the type of services you sought (check all that apply).
___ Psychiatrist
___ Family doctor
___ Other health professional (specify)
_____
___ Psychologist
___ Social worker
___ Other counselor (specify)
_____
___ Clergy member
___ Traditional or folk healer
___ School/academic advisor
___ Self-help group
___ Self-help book
___ Telephone helpline/hotline
___ Family member or friend
___ Other (specify) _____

2c. Did you do any of the following in the past month to try to deal with your problem?

	Not at all	Once or twice	About once a week	Several times a week	Every day or nearly every day	Who did you ask? (list all that apply)
1. Ask someone what they did in a situation that was similar to yours	1	2	3	4	5	
2. Ask someone to do an activity with you to help get your mind off of things	1	2	3	4	5	
3. Ask someone for information to help you understand the situation you were in	1	2	3	4	5	
4. Ask someone for information on how to do something	1	2	3	4	5	
5. Ask someone to listen to you talk about your private feelings	1	2	3	4	5	
6. Ask someone how they felt in a situation that was similar to yours	1	2	3	4	5	
7. Ask someone who you should see for assistance	1	2	3	4	5	
8. Ask someone what to expect in a situation that was about to happen	1	2	3	4	5	
9. Ask someone for feedback on how you were doing without saying it was good or bad	1	2	3	4	5	

2d. If you thought you might need help for a problem with emotions, nerves, relationships, or your mental health but did not actually seek help, what kept you from seeking help?

_____
_____
_____

3. Have you ***ever*** sought help for a problem with emotions, nerves, relationships, or your mental health?

____ Yes
____ No

3a. Did someone close to you (e.g., family member, friend) suggest that you seek help?

____ Yes
____ No

3b. Please indicate the type of services you sought (check all that apply).
___ Psychiatrist
___ Family doctor
___ Other health professional (specify)
_____
___ Psychologist
___ Social worker
___ Other counselor (specify)
_____
___ Clergy member
___ Traditional or folk healer
___ School/academic advisor
___ Self-help group
___ Self-help book
___ Telephone helpline/hotline
___ Family member or friend
___ Other (specify) _____

4. Has someone close to you (e.g., family member, friend) ever sought help for a problem with emotions, nerves, relationships, or their mental health?

____ Yes
____ No

4a. Please indicate the type of services they sought (check all that apply).
___ Psychiatrist
___ Family doctor
___ Other health professional (specify)
_____
___ Psychologist
___ Social worker
___ Other counselor (specify)
_____
___ Clergy member
___ Traditional or folk healer
___ School/academic advisor
___ Self-help group
___ Self-help book

___ Telephone helpline/hotline
___ Family member or friend
___ Other (specify) _____
___ Don't know

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