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Presenting Issues, Severity of Problems and Treatment Outcomes of Asian College Students

BY

Earl Anthony Evangelista

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Arts in Clinical Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

2004
YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
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Running Head: ASIAN COLLEGE STUDENTS

Presenting Issues, Severity of Problems, and Treatment Outcomes of Asian College Students

Earl Evangelista

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Abstract

The current study attempts to add to the limited body of literature on Asian American and Asian international students in counseling. Presenting issues, severity of problems, treatment outcome, and gender interactions of Asian American and Asian international college students were examined and compared to non-Asian college students. Data for this study were obtained from an existing database from an East Coast university counseling center. The overall sample consisted of 209 males and 297 females, all of whom were seeking treatment for the first time at the counseling center. The primary groups of interest were Asian American students (n = 66) and Asian international students (n = 44). At the time of the first session clients were asked to complete the Personal Information Form (PIF) and the Behavioral Health Questionairre-20 (BHQ-20). At every following session, the BHQ-20 was administered. It was hypothesized that Asian American and Asian international students would present with more academic, career, and somatic problems. They were also expected to report greater severity of problems at the beginning of treatment and less benefit of counseling after treatment. Lastly, it was believed that gender and ethnicity would interact, specifically that Asian males would report the greatest severity of problems and the least amount of benefit from counseling. Results indicated that Asian American and Asian international students did report more concern for academic and career problems, but did not report more somatic problems. With regard to severity of problems Asian American and Asian international clients reported greater severity and were more likely to seek treatment in a crisis/emergency basis. Lastly, at the end of treatment Asian international clients still had the greatest severity. When the difference of final and initial BHQ-20 scores, benefit

from counseling ratings, and number of sessions were compared across the three groups no differences were found. Treatment implications and suggestions for future research are also discussed.

Dedication

I would like to dedicate my thesis to my fiancée, April Larson, for her love, support, and encouragement. Thank you for always being my best friend. Although I am not perfect, you are my reason to change and try to be a better person. I hope our future together will be full of spontaneity, adventure, and love.

I would also like to dedicate this thesis to my mother, Elisa Evangelista. I will never be able to repay you for you sacrifices, or constant support and love. I hope to continue to make you proud. One of the most important lessons that you have taught me is that people never stop living, learning, or loving.

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The United States has been referred to a "melting pot" of races and cultures. As majority and minority cultures are exposed to each other they learn and adapt from each other's ways. As cited by Eddy and Spaulding (2000), from 1980 to 1994 the number of Asian and Pacific Islanders residing in the United States doubled to 8.5 million. The trend is only expected to continue, with the projected population being 40 million by 2050. The most current figure cited by Kim and Omizo (2003) was that there are more than 10.2 million Asian Americans in the United States, making it the second fastest growing ethnic minority group. As the Asian American population increases, so does the number of international students from all nations. In 1989 nearly 500,000 students in the United States are from another country (Hayes & Lin, 1994).

Despite the increases of Asian American and international student populations, these groups tend to underutilize mental health and counseling services. However, contrary to popular belief, research has shown that Asian Americans do have levels of psychological disturbance as high as or even higher than the majority population (Atkinson & Lowe, 1995). Therefore, the underutilization is not due to being able to manage stress and other mental health difficulties better than other cultural groups. It is argued that Asian Americans experience a significant amount of stress as their Asian norms and values conflict with the majority American norms and values. International students would be expected to experience even more difficulties adjusting to a completely new culture as well as loss of family and social support. Despite these factors, both groups are less likely to seek counseling (Hayes & Lin, 1994).

The fact that Asians do not utilize counseling services makes it difficult to research presenting issues and treatment outcomes of Asians and Asian Americans. It is

important to analyze the barriers that keep these groups away from treatment. The lack of research continues to be a major challenge in providing the most beneficial mental health care treatment to the Asian population.

The purpose of this review was to evaluate the small body of literature on Asians and their counseling experiences. More specifically, the following section will present a review of the research on cultural values, acculturation, presenting issues, and lastly, treatment outcomes of Asians and Asian Americans. Presenting issues can be defined as self reported difficulties of the participant's life (e.g., academic problems, depression, and anxiety). Finally, the current study will attempt to add to Asian literature by examining presenting issues, severity of issues, and treatment outcome of Asians from an east coast university.

Cultural Values

Asian cultures tend to value authoritarian orientation, interdependence, conformity, intense relationships, extended family structure, the expectation and use of silence, and stress the importance of collective goals and responsibilities (Chandras, Eddy, and Spaulding, 2000). Authoritarian orientation refers to a respect for elders in the family and community. Also, authoritarian orientation refers to a respect for those with higher education or those higher in the chain of command hierarchy of one's occupation. Interdependence refers to the acknowledgment that one's action affects others. Asians appreciate the use of silence as a valuable tool to relax, concentrate, and reflect about life or concerns. Another value is to maintain harmony with people around them and the environment. They are expected to be aware of others and how they may react to their actions. Even personal attributes are expected to be minimized to maintain modesty (Abe

& Zane, 1990). Additionally there are well-defined rules and expectations of behaviors in relationship to others (Byon, Chan, & Thomas, 1999).

Another common Asian value is stoicism. If one is going through a difficult time, he or she is expected to deal with it individually. Requiring help may be viewed as a sign of character weakness and if the problem proves too difficult to deal with individually, one is expected to turn to the family first. This is consistent with the finding of Byon, Chan, and Thomas (1999) with Korean international students, of whom 50% reported the belief that they would never need counseling services. When these students were asked how they would handle personal and academic problems, they ranked their sources of help in the following order: self, family, friends, and religion.

If turning to the family is not enough to solve a problem Asians may seek professional help or counseling. However, seeking additional help may bring shame on the family. Consistent with the value of interdependence, the behavior of the individual reflects on the family as a whole. Also, it may be seen as a family flaw because as a family they could not solve the problem. Asians may be more willing to cope or solve problems on their own rather than bring shame on themselves or their families. Similar coping patterns are also seen in Latino and Native American cultures. Family problems and difficulties are considered to be private matters (Atkinson & Lowe, 1995). Overall, Asian values inhibit disclosing and seeking any help for personal problems. The lack of seeking help creates a "model minority" perception for others to view Asian Americans (Abe & Zane, 1990).

The "model minority" is expected by the majority population to achieve exceptionally well in educational tasks, and thus are expected to be successful financially

and in their careers. They are expected by the majority culture as well as their own to be able to work though adversity and stressful times. They are also viewed as having less psychological and social problems (Soleberg et. al, 1994). Like other stereotypes, Asian Americans are thought, and perhaps pressured, to fit into a "mold" possibly by both the majority population and their own minority group. Thus, it is not expected that Asian Americans would ever need counseling or mental health services. This trend can be damaging as Asian Americans may continue to avoid counseling despite dealing with crisis life events.

Acculturation

Acculturation can be defined as a process of giving up one's traditional cultural values, norms, and behaviors while taking on the values, norms, and behaviors of the dominant culture (Atkinson & Lowe, 1995). Acculturation has been found to have an effect on Asian Americans help-seeking attitudes and behaviors for professional mental health. Research indicates there is a relationship between acculturation and help seeking attitudes and behaviors. However, results have conflicted, and it is unclear whether increased acculturation leads to increased or decreased help-seeking behaviors. Some research has found that as acculturation increases so do help seeking attitudes and behaviors (Atkinson & Gim, 1989). Other research has found the opposite, as acculturation increases subjects were less likely to seek professional help (Gim, Atkinson, and Whitely, 1990). Lastly, research has also found acculturation plays a role in a mediating chain with help seeking attitudes and behaviors. Acculturation affects attitudes toward psychological help, and their attitude affects their willingness to seek help for problems (Kim and Omizo, 2003).

Atkinson and Gim (1989) compared levels of acculturation of Asian Americans to attitudes towards mental health. The sample consisted of 263 Chinese Americans (136 men and 127 women), 185 Japanese Americans (77 men and 108 women), and 109 Korean Americans (61 men and 48 women) all of whom were undergraduate students at a major west coast university. Each participant filled out a three-part questionnaire consisting of demographic questions, an acculturation scale called the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA), and the Attitudes Toward Seeking Professional Help Scale (ATSPHS). The SL-ASIA consisted of 16 items measuring language, identity, friendship choice, and behaviors. Low, medium, and high levels scored on the SL-ASIA reflect low, medium, and high levels of acculturation. Results showed a direct relationship between attitudes toward professional psychological help and acculturation. The study reported that Asian American students were able to recognize a personal need for professional psychological help, be tolerant of the stigmas associated with psychological help, and be more willing to openly discuss their problems if they reported higher levels of acculturation. Those who scored lower on the SL-ASIA held a stronger tie to their Asian background and were less likely to seek professional help (see also Sodowsky, Lai, & Plake, 1991).

There is additional supporting evidence of the positive relationship between acculturation and attitudes toward professional psychological help that is seen when studying international students. As cited by Abe and Zane (1990), international students identified significantly more psychological maladjustment in their life than did their Asian American counterparts. This finding supports the contention that increased acculturation is related to increased adjustment and willingness to seek help.

International students may still have close ties to their home culture and thus would be less acculturated. Therefore, Asian international students may be more unwilling to seek help than Asian Americans.

Contrary to the previous studies, one study found an inverse relationship between acculturation and help seeking (Gim, Atkinson, & Whitely, 1990). Like Atkinson and Gim (1989) participants filled out a demographic questionnaire and the SL-ASIA. In addition participants were given the Personal Problems Inventory, which consists of 15 problems common to all college students, plus five concerns that minority college students often experience. Participants were asked to rate the severity of each problem, and then rate how willing they would be to see a counselor for that problem. Thus Gim, Atkinson, and Whitely (1990) compared acculturation to willingness to seek help for specific problems. It was found that when low acculturated students recognized a problem or concern, they were more willing to seek help. The authors noted that low acculturation corresponds to greater ties to Asian American cultural values. A low acculturated student may be more willing to seek a respectable authority figure for help, such as a therapist or counselor.

The conflicting results between the Gim, Atkinson, and Whitely (1990) and Atkinson and Gim (1989) studies may be a result of the different methodologies. Asians may be more willing seek help, or assess whether they would seek help, for specific problems as in (Gim, Atkinson, & Whitely, 1990), rather than more generally rating their attitudes towards mental health and willingness to seek help (Atkinson & Gim, 1989).

In contrast to these studies, Kim and Omizo (2003) hypothesized that attitudes toward seeking professional counseling and willingness to seek a counselor were two

different constructs, i.e., an attitude versus a behavior. Perhaps, at face value, the previous research found conflicting results because they were actually studying two different constructs. Also, rather than studying acculturation, the Kim and Omizo's study compared the concept of enculturation (i.e., the process of socialization to the norms of one's own culture, including values, ideas, and concepts that are salient for the culture) to both attitudes and behaviors. Results showed that as adherence to cultural values and attitudes increased, attitudes toward seeking professional psychological help decreased, and vice versa. An inverse relationship was also found between enculturation and willingness to seek help. An unexpected result was that attitudes toward seeking psychological help might act as a mediator between enculturation and willingness to seek help. In other words, as Asian Americans experience difficulties and stress, their cultural values would affect their attitudes toward psychological help, and their attitudes toward seeking psychological help, in turn, would affect their willingness to seek help for the problem.

Gender

The reported research on gender, Asian Americans, and willingness to seek counseling is varied. Some research has found that Asian American females were more willing to seek help (Gim, Atkinson, & Whitely, 1990; Kamoya & Eells, 2001). Again, this may be due to a cultural influence that men are expected to be more stoic and self sufficient, and women more emotionally expressive. Other research found no such gender differences (Atkinson & Gim, 1989; Atkinson & Lowe, 1995; Solberg et. all, 1994; Sodowsky, Lai, & Plake, 1991). Research with no gender differences show that gender is not a critical factor in the acculturation process. In other words, whether one is

male or female does not influence to what extent the majority culture's values will be accepted. It should also be noted that across most cultures females are more likely than males to seek counseling.

Despite the cultural conflict and attitudes towards counseling and mental health, some Asian Americans do seek professional counseling. Asian Americans have displayed several trends that may be reflective of their cultural values. The trends include presenting issues such as seeking counseling for academic or vocational problems rather than for personal problems, increased severity of presenting problems when seeking counseling, an increase likelihood of describing somatic symptoms rather than emotional symptoms; and treatment outcome such as early termination of treatment and less satisfaction of the treatment received. Research in these areas is presented below.

Presenting Issues

Academic or Vocational Problems. There is a strong body of evidence that Asians and Asian Americans will seek counseling for academic or vocational problems rather than personal or psychological concerns (Lee & Mixson, 1995; Tracey, Leong, & Glidden, 1998). It is believed that Asian Americans may be willing to seek counseling for academic or vocational reasons because it is congruent with their cultural beliefs and expectations. Asian Americans are expected to excel in educational and career tasks. Gim, Atkinson, and Whitely (1990) found that Asian Americans rate financial and academic or career concerns as their greatest problems. Academic and career counseling allows Asian Americans to further develop and work towards their cultural goals. Counseling for personal, emotional, or psychological difficulties does not serve such a cultural goal (Atkinson and Lowe, 1995).

This trend is an important for the following reason. As already stated, Asian Americans and international students experience just as much, or even more, distress or psychological problems when compared to the majority White American population. As Asian Americans seek academic or career counseling it is very well possible that they bring with them the emotional and psychological distress that their culture has taught them to overlook. It is easier for them to admit academic or career difficulties even though emotional or psychological distress drives their problems.

In Pitzman's (2003) study, however, contradictory results were found. This study analyzed the presenting problems of 63 Asian Americans, 28 Asian international, and 353 non-Asian college students. Each group was compared by their primary presenting complaint: career/academic concerns, psychological/interpersonal concerns, and "personal and career" concerns. 92.3% of Asian internationals presented with personal problems only, as compared to 58.9% of Asian Americans, and 78.0% of non-Asians. None of the Asian internationals presented with just career concerns, as compared to the 7.1% of Asian American students, and 4.3 on non-Asian students. Lastly, 7.7% of Asian internationals presented with a combination of career and personal problems, compared to 33.9% of the Asian American students, and 17.7% of non-Asians. Again, it was hypothesized that those with an Asian cultural background would have presented significantly more often with career and educational concerns. Pitzman's results may have differed from other studies due to the make up of the sample population. Most other studies use Asian samples from areas where Asians are a more dominant minority such as Hawaii and West coast cities. Pitzman's sample population was from an East coast

university. It may be that Asians in this area have different experiences and perceptions than those from areas that have a greater Asian population.

Somatic Symptoms. There also seems to be a trend that rather than ascribing emotional or psychosocial symptoms to problems, Asian Americans describe somatic discomfort. Somatization is described as an individual's physical response to emotional or psychological stress. For example, an Asian client may describe symptoms of depression as difficulty sleeping, loss of appetite, or loss of energy rather than feelings of despair, confusion, or loss of interest in previously enjoyable activities. Lippincott & Mierzwa (1995) studied a sample population of 147 undergraduate students (85 American and 62 Asian international students) that were randomly selected from the undergraduate population. Participants took a modified Brief Symptom Inventory (BSI), a self-report questionnaire of somatic and psychological symptoms. Each item on the BSI is rated on a 5-point scale of distress ranging from none at all (0) to extremely (4). The BSI was modified by asking "How likely would you seek counseling/psychological services if you were distressed by...?" as opposed to the original question, "How much are you distressed by...?" The BIS has a seven-item somatization subscale that was used as the basis of this study. The items queried include symptoms of faintness or dizziness, pains in the heart and chest area, nausea, trouble catching your breath, hot or cold spells, numbness or tingling in parts of the body, and feeling weak in the body. Results found that Asian international students scored significantly higher on the somatization subscale than American students. This tendency of describing somatic symptoms may have been found because the practice is culturally congruent with the Asian cultural norms, i.e., it is more culturally appropriate to experience health related difficulties than emotional or

psychological problems. This finding is an important one for counselors and therapists who are working with Asian Americans or international students to note. Professionals may fail to recognize that the physical symptoms that these minority groups are reporting may be related to emotional or psychological difficulties.

Severity of Problems. Due to cultural influences which predisposes Asians against seeking professional counseling, research has shown that Asian American and international students avoid or put-off seeking help until severity reaches an emergency or crisis level. In Gim, Atkinson, and Whiteley's 1990 study an inverse correlation was found between acculturation and the severity of the presenting problem. Asian Americans who were less acculturated experienced higher degrees of psychosocial stresses. The researchers hypothesized that those who are less acculturated are less able to adapt to American norms, values, and expectations and hence experience greater stress and difficulty. Asians in general hold beliefs contrary to American norms, thus it is expected that they may experience more severe problems. Also, those less acculturated may also hold a stronger belief in overcoming problems and difficulties on their own. Therefore, Asian Americans will continue to attempt to solve problems on their own despite increasing severity.

Another study investigated psychological maladjustment while attempting to control for possible culturally misinterpreted confounds. Abe and Zane (1990) measured psychological maladjustment among 46 foreign-born Asian students, 29 Asian American students, and 61 White American students. Rather than simply comparing maladjustment between the three groups, this study attempted to control for confounding factors. This study specifically factored out socio-economic status, social desirability, other-

directedness, self-consciousness, and extroversion from maladjustment levels. Social desirability, other directedness, self-consciousness, and extroversion were thought to be confounds in measuring maladjustment because items on the maladjustment scale may be culturally misinterpreted. The cultural interpretation by the subject may conflict with how the rater interprets the results. For example, a subject may report that he or she is more concerned about others in a group than concerned about themselves, they do not like drawing attention to themselves, and deny positive attributes and exaggerate negative attributes. Such reports may project insecurity, anxiety, and social passivity, all of which are perceptions of being psychologically maladjusted rather than adhering to their Asian cultural background. Subjects were given five self-report scales: a demographic questionnaire; a self-consciousness scale that measured public self-consciousness, private self-consciousness, and social anxiety; an other-directedness and extroversion scale that assessed how often one acts according to how he or she believes they looked to others and having attention put on them; a social desirability scale; and the Personal Integration (PI) subscale of the Omnibus Personality Inventory (OPI) that assessed maladjustment. Results showed significant differences of maladjustment levels across all three groups prior to controlling for any confounds. White Americans showed the lowest level of maladjustment and Asian international students showed the highest. After controlling for the influences of social desirability, self-consciousness, other-directedness, and extroversion the trend of maladjustment still held true. SES was not found to be a covariant. The significant difference in maladjustment found between White Americans and Asian Americans, and Asian Americans and foreign born Asians, again, adds to the evidence that lower acculturation has a relationship to severity of problems.

Treatment Outcome

Early Termination. Research has found Asian Americans who did seek treatment tended to terminate counseling early. Byon, Chan, and Thomas (1999) cite that Asian Americans drop counseling after the first session at a 50% rate as opposed to the 30% drop out rate of majority population. This may be due to the misconception or inconsistency of what is expected in counseling. Asian Americans tended to expect expert advice and knowledge to flow from an authority figure (Atkinson & Matsushita, 1991). They sought out advice that consists of practical solutions to their problems. Asian Americans rated direct structured service to be the most helpful as opposed to freely talking about events in their life (Kim & Ommizo, 2003). Most American counselors, on the other hand, promote openness and expect their client to actively participate in the treatment. Their approach is more collaborative with the client. Emotions and the sharing of emotions tends to play a large role in American counseling and therapy. A counselor probing for emotions and openness may create a stressful situation for an Asian American client looking for concrete directives (Hartman & Askounis, 1989).

Lower Satisfaction of Treatment. Asian culture also appears to play a part in the post session reactions to the treatment received. Lee and Mixson (1995) found that Asian Americans were significantly less satisfied with their counseling experience. The sample consisted of 73 Asians and 255 Caucasian clients who had at least one counseling experience from the university counseling center. Both groups reported their experience as helpful, but Asians reported their experience as less helpful than Caucasian clients. Not only did Asians report less helpfulness, but they also described their counselors at a

lower competency level than did Caucasian clients. Again, this dissatisfaction may be due to cultural conflicting expectations of counseling and the actual experience.

Finally, Atkinson and Matsushita (1991) examined the possible relationship between counseling style, counselor ethnicity, and perceived counselor credibility. It was found that all of these variables might be related. Subjects, who were all Asian Americans, were asked to rate the effectiveness of a counselor prior to listening to an audiotape of a session. They were told the counselor's ethnicity. Subjects were exposed to one of four conditions. Each condition was created by crossing ethnicity (Asian or White) by counseling style (directive or nondirective). Those exposed to White-American counselors rated the counselors lower than those who were exposed to Asian counselors regardless of counseling style. Subjects also preferred the directive counseling approach over the nondirective approach, however, Asian counselors using a non-directive counseling style still rated higher than White counselors using a directive counseling style. The highest rated group, as expected, was the Asian counselor using a directive counseling style. These results supported the hypothesis that Asian Americans would not seek treatment because of a perception that a counselor of a different culture will not be able to understand and help them. Also, the results add to the evidence that Asian Americans may terminate early due to lack of ethnic match and perceived ineffectiveness of non-directive counseling style.

The Present Study

Previous literature has shown several limitations. As already stated most Asians choose to not seek counseling for their problems, making research of presenting issues, severity of problems, and treatment outcome of Asians difficult. Additionally, many

studies were conducted in geographical areas where Asians were much more abundant in the population such as West coast cities or Hawaii in order to obtain the required number of subjects. It is possible that the experiences of Asians in more densely Asian-populated areas are quite different from the experiences of Asians from an area where Asians are more of a minority. Generalization from these studies is thus more difficult. Furthermore, most studies simply asked subjects to complete several questionnaires. From the questionnaires, researchers make inferences based on correlations and other statistical trends. Such practices do not study clients who are in or have been in counseling. The current study attempted to add to the growing body of literature on the Asian population in counseling by using a sample population from an area that does not have a concentrated population of Asians and by using actual Asians who were in counseling. Asian American college students, Asian international college students, and non-Asian college students seeking treatment were compared in terms of their presenting issues, severity of problems, response to treatment, and gender influences.

Additionally, unlike in other studies, Asians at this university did not underutilize counseling services. The number of Asian students seeking treatment was approximately proportional to the number of Asians attending the university. One possible reason for this may be the relative success of outreach programs to Asian students.

The current study was an extension of Pitzman's (2003) study that used a similar sample pool. Pitzman analyzed treatment outcomes, presenting issues, and compared demographic information for Asian American, non-Asian, and Asian international college students. Pitzman found no significant treatment outcome differences between Asian American and non-Asian college students. Results did indicate, however, that

Asian students rated significantly higher maladjustment at their final session than non-Asian students. When comparing treatment outcomes of Asian American and Asian International students, no significant differences were found. Also, no significant differences were found between these groups when the final session's level of maladjustment was compared. In terms of initial severity of problems, non-Asian clients presented with less severe symptoms than Asian clients, however, no significant differences were found between Asian American and Asian international students. Other results found that Asians presented more often for concerns about academics, feelings of anxiety, problems with a relationship, and depression. Concerns about academics were consistent with previous literature (Lee & Mixson, 1995; Tracey, Leong, & Glidden, 1998). Lastly, Pitzman reported no gender differences in terms of presenting issues, severity of problem, or treatment outcome.

Data for this current study were collected from an East Coast university counseling center. Clients were asked to complete the Personal Information Form (PIF) and the Behavioral Health Questionnaire (BHQ) at the time of the intake. Also, clients were asked to complete a BHQ at every subsequent session. The data obtained from the questionnaires will be analyzed in the current study in four research questions. Hypotheses are also generated based on those questions.

1a. Are there significant differences in the content of presenting issues across the three groups (Asian American, non-Asian American, and Asian international students)? Are there significant differences in the content of presenting issues between Asian and Non-Asian clients?

Consistent with previous research and other literature, it was hypothesized that Asian American and Asian international students would be more likely to present with issues related to educational or career issues. Literature argues that Asians are more willing to seek academic and career help because it is acceptable in the Asian culture to be concerned about these goals and not acceptable to admit personal and family difficulties (Lee & Mixson, 1995; Tracey, Leong, & Glidden, 1998).

1b. Do Asian American and Asian international students present with more somatic symptoms than non-Asian students?

This study also focused on the specific symptoms that the client has been experiencing in relationship to somatic or non-somatic symptoms (e.g., lack of sleep and lack of energy versus low self worth and feelings of hopelessness). In line with previous research, it was believed that Asian American and Asian international students would be more likely to present with somatic concerns rather than with emotional concerns (Lippincott & Mierzwa, 1995). Presenting more somatic symptoms may be due to an Asian cultural acceptance for showing concern for physical problems rather than emotional problems. Acculturation may also produce a difference between Asian American students and Asian international students. It was hypothesized that Asian international students, who were assumed to have even stronger ties with their Asian cultural background, would present with significantly more somatic concerns than Asian American students.

2. Are there significant differences across the three groups in how severe the problems impact the client's life at the start of treatment?

Previous research has found that asking for professional help to deal with problems and difficulties can be seen as a sign of personal and family weakness in the Asian culture. Rather than seek help, Asians are more likely to try to fix a problem on their own or with the help of family. Asians may not seek help until the problem has grown excessively too large and out of control. Therefore, it was hypothesized that Asians would be more troubled by their presenting problems when seeking counseling. Likewise, Asian international students were expected to wait even longer, which could have shown an even more increased level of severity of symptoms when compared to Asian Americans (Abe & Zane, 1990; Gim, Atkinson, & Whiteley, 1990; Hartman & Askounis, 1989). Lastly, percentage-wise for each group, it was expected that Asian Americans and Asian internationals would report significantly more crisis or emergency levels of severity when seeking counseling.

3. Are there treatment outcome differences between Asian American, Asian international students, and non-Asian students?

There has been little research on the Asian American population in counseling and therapy due to clients terminating early (Lee & Mixson, 1995). Also, research has shown that Asians are less likely than non-Asian students to report that their counseling sessions were beneficial (Byon, Chan, & Thomas, 1999). Such outcome differences across groups may be due to the Asian culture's lowered expectations of the possible benefits of counseling, concerns whether a non-Asian counselor can understand an Asian client's experiences, and a preference of counseling styles (i.e., directive or non-directive) (Atkinson & Matsushita, 1991; Kim & Ommizo, 2003). The difference in

cultural expectations may also contribute to a trend of Asians attending fewer sessions than non-Asians.

The current study planed to replicate results of the previous literature. At the time of intake and prior to each session, the clients were asked to fill out a questionnaire that asked them to rate how often they had been distressed by certain issues. Asians, especially Asian international students, were expected to report the least amount of change from their first intake session to their last session, report the least amount of benefit from counseling, and attend fewer sessions than non-Asian students.

4. Does gender significantly impact Asians' presenting problems and treatment outcomes in counseling?

Males in the Asian culture are expected to be stoic and it is less accepted for them to seek outside help. The same expectations are held for women, yet it is more accepted for them to seek and need help (Gim, Atkinson, & Whitely, 1990; Kamoya & Eells, 2001). Therefore, it was hypothesized that Asian males would present with more somatic symptoms, present more severe symptoms, and benefit less from counseling than Asian females.

Method

Client Sample

Data were gathered for this study from an existing database. Originally the database consisted of information obtained from 801 college students seeking counseling from an East Coast university's counseling center in the 2001 to 2002 academic year. The academic year began the summer semester of 2001 and ended after the spring semester of 2002. For the purposes of this study only the information from new intakes or new emergency intakes was used. Returning clients were not studied as it would be

difficult to accurately interpret treatment outcome as the start date of psychotherapy is not known for these clients. Data were analyzed to obtain the following demographic information: gender, age, year in school, ethnic status, marital status, parents' marital status, religious affiliation, as well as international student status. Other relevant treatment variables were also examined include the following: referral source, history of previous counseling or therapy, client's medical history/problems, and family history of significant medical, emotional, and substance abuse problems. First, the overall sample of new intakes and new emergency intakes was analyzed, and then Asians as a whole group (consisting of Asian Americans and Asian international clients) were analyzed.

Overall the sample consisted of 506 clients. Of these, 209 were male (41.3%) and 297 were females (58.7%), ranging in age from 17 to 46 (M = 22.22). Eighty-one clients were freshman (16.0%), 94 of the clients were sophomores (18.6%), 91 were juniors (18.0%), 87 were seniors (17.2%), 119 were graduate students (23.5%), and 27 were in other groups (5.4%). Information on class status was missing for 7 clients (1.4%). Of those who indicated their ethnic background, 314 were Caucasian (62.1%), 100 clients were Asian (19.8%), 20 were African American (4.0%). 21 were Latino (2.4%), 3 were Native American (.6%), and 37 clients considered themselves as other (7.3%). With respect to marital status, the majority of the clients were single (n = 425, 84%), 62 clients were either married or in a committed relationship (12.3%), 2 clients were from separated (.4%), and 3 clients were divorced (.6%). Most clients came from households that had parents that were either married or in a committed relationship (n = 353, 69.8%). Twenty-two clients indicated their parents were separated (4.3%), 82 clients came from divorced homes (16.2%), and 24 clients had parents who were widowed (4.7%). With respect to religious affiliation, most clients identified themselves as Catholic (n = 118, 23.3%), followed by Protestant (n = 79, 15.6%), "Other" (n = 55, 10.9%), Jewish (n = 47, 9.3%), Hindu (n = 15, 3.0%), Moslem (n = 13, 2.6%), and Buddhist (n = 5, 1.0%). One hundred forty-six (28.9%) reported not having a religious affiliation.

As for treatment relevant information, just less than half of the clients were self-referred (n = 218, 48.9%). Others were referred by friends (n = 79, 15.6%), student health and wellness (n = 45, 8.9%), faculty (n = *29,* 5.7%), and relatives (n = 23, 4.5%). A little over half of the clients had never received any personal counseling or therapy before (n = 281, 55.5%), and most did not have any significant medical problems (n = 366, 72.3%). With regards to the client's family history, less than half reported no major medical problems (n = 233, 46.0%), with 171 (33.8%) reporting a family history of medical problems, and 67 (13.2%) unsure. For family history of emotional problems, 179 (35.4%) reported a history and 90 (17.8%) were unsure. Lastly, 141 clients (27.9%) reported a family history of substance abuse while 40 (7.9%) were unsure.

Asian clients were the primary ethnic group of interest in this study. As mentioned earlier, there were 100 Asians who were either new intakes or new emergency clients. Fifty-nine (59%) were female, and 41 (41%) were male. Their ages ranged from 18 to 37. More specific demographic and treatment relative information is broken down by Asian American and Asian international groupings.

Of the 100 Asian clients, 63 (63%) were Asian American and 34 (34%) were Asian international clients. With regards to Asian American students, 40 were female (60.6%) and 24 were male (39.4%) with ages ranging from 18 to 33. The class ranking of the Asian American clients breaks down as follows: 13 freshmen (19.7%), 13 sophomores (19.7%), 14 juniors (21.2%), 17 seniors (25.8%), 7 graduate students (10.6%), and one considered in the other grouping (1.5%). Most reported being single (n = 59, 89.4%), and had parents who were still married or in a committed relationship (n = 53, 80.3%). Most Asian American students reported not having any religious affiliation (n = 19, 28.8%), followed by Protestant (n = 14, 21.2%), Hindu (n = 13, 19.7%), Catholic (n = 9, 13.6%), and Other (n = 28.8%).

For treatment relevant information, 22 (33.3%) of the Asian American students were self-referred followed by 13 (19.7%) who were referred by a friend, and 6 (9.1%)

by faculty. Most Asian American students did not have any significant medical problems (*n* = 51, 77.3%). With respect to family history of medical, emotional, or substance abuse problems, a little over half of the Asian American students reported no medical problems (*n* = 39, 59.1%) or no emotional problems (*n* =38, 57.6%) , and most reported no substance abuse (*n* = 50, 75.8%) problems.

Of the 34 Asian international clients 19 (55.9%) were female and 15 (44.1%) were male. The ages ranged from 18 to 37. There was 1 freshman (2.9%), 9 sophomores (26.5%), 0 juniors, 6 seniors (17.6%), 16 graduate students (47.1%), and 2 in other groupings (5.8%). Like the Asian American sample group, most Asian international students were single (*n* = 28, 82.4%), with some married or in a committed relationship (*n* = 14.7%), as well as one who was divorced (2.9%). Again, like the Asian American students, the majority of Asian international students came from parents who were still married or were in a committed relationship (*n* = 27, 79.4%). Most Asian international students reported no religious affiliation (*n* = 17, 50.0%), followed by Other (*n* = 4, 11.8%), Moslem (*n* = 3, 8.8%), Catholic (*n* = 2, 5.9%), Buddhist (*n* = 2, 5.9%), Hindu and (*n* = 1, 2.9%) Protestant (*n* = 1, 2.9%).

Treatment relevant information for Asian international students found most were self-referred to the counseling center (*n* = 14, 41.2%) followed by 8 (23.5%) referred by faculty, and 3 (8.8%) by the student health clinic. Most Asian international students did not have any significant medical problems (*n* = 25, 73.5%). For family history of medical, emotional, or substance abuse problems, 21 (61.8%) of Asian international students reported no family medical problems, 20 (58.8%) reported no family emotional problems, and most reported no substance abuse (*n* = 28, 82.4%) problems.

Measures

Personal Information Form (PIF). The PIF was developed by Michael Mond, Ph.D. (personal communication, 2002) director of the counseling center from which this

data was obtained. The PIF, which is completed when a client presents for counseling, was designed to gather demographic information, personal history, and presenting problems for new clients to the university counseling center (see appendix A). The PIF is comprised of three sections: presenting issues, demographic questions, and a problem checklist.

The client is first asked for identifying and contact information. The client is also asked to describe the type of service they are interest in receiving (i.e., help with personal issues, help with career issues, or other).

The PIF's demographic questions inquire about the client's *affiliated school on campus*, *age*, *gender*, *marital status* and *parent's marital status* [i.e., single, married/committed relationship, separated, divorced, other], *ethnic status* [i.e., African-American, Asian, Latino, Native-American, Caucasian, and Other], *religion* [i.e., Buddhist, Catholic, Hindu, Jewish, Moslem, Protestant, Other], *international student status*, *class year* [i.e., freshman, sophomore, junior, senior, graduate student, graduated, post graduate], *current academic status* [i.e., in good academic standing, academically dismissed, reinstated, on probation], and *academic major*.

The PIF goes on to inquire about other relevant variables. These variables include: *referral source* [e.g., self, friend, relative, residential life staff, faculty, staff] *previous experience at the counseling center*, *previous experience from another agency* [i.e., never, previously, and currently], *personal medical problems*, and *family history of medical, emotional, and substance abuse problems*.

The PIF concludes with a problem checklist. Using a Likert-type scale 0 [(not a problem, 1 (slight problem), 2 (moderate problem), 3 (serious problem), and 4 (severe

problem)] the client is asked to rate how severely each of the 46 issues are affecting his/her life. The issues fall into the following 13 categories: *career issues, academic issues, relationship issues, self-esteem issues, anxiety issues, existential issues* (i.e., generally unhappy, gay/lesbian issue, concern about being a member of a minority, and confusion over religious issues), *depression, eating disorder issues, substance abuse disorders, sexual abuse or harassment issues, stress and psychosomatic symptoms, sexual dysfunction issues, and unusual thoughts or behavior* (i.e., irritable, angry, or hostile feelings; thinking is very confused; fear of loss of contact with reality; violent thoughts, feelings, or behaviors, etc.). The last question asks the client to assess their overall suicidal risk (i.e., extremely low risk, low risk, moderate risk, high risk, extremely high risk).

The PIF has not been tested on reliability and validity, as it has been revised several times. However, based on client reports, therapist reports, and comparisons to responses of other measures (e.g., the BHQ), the PIF does have significant face validity and evidence of criterion related validity and construct validity (Mond, personal communication, 2002).

Behavioral Health Questionnaire - 20 (BHQ-20). The BHQ-20 is a questionnaire designed to briefly measure and monitor session-by-session outcomes of how clients feel counseling is progressing (Kopta & Lowry, 2002) (see appendix B). This client self reporting tool uses 4 scales to measure mental health: Well-Being (i.e., evaluation of emotional distress, motivation/energy, and life satisfaction), Psychological Symptoms (i.e., assessment of depression anxiety, drug/alcohol abuse, and risk of harming one's self or others), Life Functioning (i.e., how one functions at work/school, intimate

relationships, non-family relationships, and life enjoyment), and lastly Global Mental Health which is comprised of the sum of all 20 responses.

The BHQ-20 was administered at the time of intake as well as after each counseling session. The first three items measure general well-being. Overall, lower mean scores on the BHQ correspond to greater severity. The first question asks clients to rate how distressed they feel using a Likert-type scale ranging from 0 (extremely) to 4 (not at all). The second question asks for a rating on life satisfaction, using a Likert-type scale ranging from 0 (not satisfied) to 4 (very satisfied). The third question asks clients to rate their energy and motivation level, again, using a Likert-type scale ranging from 0 (not at all energetic) to 4 (very energetic).

The next grouping of questions asks about psychological symptoms. Questions 4 to 16 ask clients to use a Likert-type scale ranging from 0 (almost always) to 4 (never) and rate how often they have been distressed in the last two weeks by the symptoms listed. Some of the items in this section include the following: feeling fearful or scared, drugs and alcohol use, feelings of hopelessness, wanting to harm others, feeling nervous, and heart pounding or racing.

The final section measures the client's overall life functioning. For items 17 through 20 clients are asked to rate how they have been getting along in the following areas of life over the previous two weeks: work/school, intimate relationships, social relationships, and life enjoyment. Clients were asked to use a Likert scale rating of 0 (terribly) to 4 (very well). Lastly, a Global Health score is obtained by summing the 20 items.

Two additional questions are also asked at the end of the BHQ-20. The results of these items are not included in any of the scales of this tool (i.e., Well-Being, Life Functioning, Psychological Symptoms, or Global Mental Health). Item 21 asks clients to indicate on a scale ranging from 0 (I've gotten much worse) to 4 (I've gotten much better) how much they feel they have benefited so far from being in psychotherapy or counseling. Using the same Likert scale, item 22 asks clients to indicate how much they have benefited so far from taking medication if they are also receiving medication from the center.

Kopta and Lowry (2002) conducted a study on the BHQ-20 to assess its psychometric properties. Participants in the study were comprised of 4 adult samples: community adults not in counseling, college undergraduate students not in counseling, college undergraduate students currently receiving counseling from the university counseling center, and adult outpatients currently in counseling outside of the university. To determine reliability and validity, the BHQ-20 was administered with the Behavior and Symptom Identifications Scale -32 (BASIS-32), the COMPASS Treatment Assessment System (COMPASS), the Outcome Questionnaire-45.2 (OQ), and the Symptom Checklist-90-Revised (SCL-90-R). The BASIS-32 is a self-report measure used to assess a client's level of difficulty over the previous week in 5 domains: relations to self/other, depression/anxiety, daily living/role functioning, impulsive/addictive behavior, and psychosis. The COMPASS assesses therapist rating, need for treatment, presenting problems, current well-being, current symptoms, and current life functioning. The OQ is a 45-item self-report measure used to assess a client's symptom distress, interpersonal relations, and social role performance. Lastly, the SCL-90-R is a 90-item

self-report distress inventory. The checklist measures 3 global indices of distress, as well as 9 symptom dimensions: somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Result of Kopta and Lowry's (2002) study found the BHQ-20 to be a valid and reliable measure of symptoms common to counseling clients. The internal consistency coefficients for Global Mental Health ranged from .89 to .90; Well-Being ranged from .65 to .74; and Life Functioning ranged from .72 to .77. As the BHQ-20 was correlated to other related established measures, high correlations were found. Also, the BHQ-20 was found to be a strong measuring tool for outcome treatments. The BHQ-20 was able to statically show improvement of symptoms from the intake scores to scores obtained from successive sessions.

For the current study there were 65 cases in which a BHQ score was not recorded at the time of the first session. Those 65 cases were not included when initial BHQ scores were used to analyze severity of problems.

Results

The data were analyzed using a variety of *t*-tests, ANOVAS, and Chi-square tests on data collected from the Behavioral Health Questionnaire-20 (BHQ-20) and the Personal Information Form (PIF). As mentioned previously, the BHQ was given after each session, and the PIF was administered at the first session. Several transformations to the existing database were made for the analyses; these will be discussed with the relevant analyses.

Presenting Issues. The first group of questions examined whether there were significant differences in the content of presenting issues between ethnic groups. To measure presenting issues, mean scores of each of the problem categories of the PIF were obtained for each client. Mean scores of the PIF categories were used rather than sums due to an uneven number of items assessing each problem area. Greater mean scores correspond to greater difficulty in that problem area. Differences in presenting issues across Asian Americans, Asian international, and non-Asians were assessed by 13 analyses of variance (ANOVAs). Thirteen *t*-tests were also conducted to compare the problem area ratings of Asians (collapsing the Asian American and Asian international groups) with non-Asians. The IVs were the ethnicity grouping (Asian American, Asian international, and non-Asian for the ANOVAs and Asian and non-Asian for the *t*-tests) and the DVs were the mean scores for each of the 13 categories.

Results of the ANOVAS indicated that Asian Americans ($M = 1.67$, $SD = .95$) had greater concern for academic-related issues $F(2, 462) = 3.19$, $p < .05$, than other groups. Specifically, results of a post hoc analysis found that Asian Americans were more concerned about academic problems than non-Asians ($M_{AA} = 1.67$, $SD_{\mathrm{AA}} = .95$; $M_{\mathrm{NA}} = 1.38$, $SD_{\mathrm{NA}} = .89$). Also, Asian international clients ($M = 1.61$, $SD = 1.47$) had a greater concerns for career difficulties $F(2, 467) = 5.16$, $p < .05$ than other groups. Post-hoc analyses indicated that Asian internationals reported more concern for career difficulties than non-Asians ($M_{\mathrm{AI}} = 1.61$, $SD_{\mathrm{AI}} = 1.47$; $M_{\mathrm{NA}} = .94$, $SD_{\mathrm{NA}} = .1.26$).

When comparing Asians with non-Asians, *t*-test results indicated that Asians ($M = 1.65$, $SD = .95$) had greater academic concerns than non-Asians ($M = 1.38$, $SD = .89$), $t\ (463) = -2.50$, $p < .05$. Also, results indicated that Asians ($M = 1.41$, $SD = 1.44$) had

greater career concerns than non-Asians (*M* = .94, *SD* = 1.26), *t* (468) = -2.83, $p < .05$. There were no other significant differences in presenting issues between ethnic groups.

Presenting somatic symptoms were also examined. The research question of interest was whether or not significant differences in reported level of somatic symptoms existed across ethnic groups. An ANOVA and a *t*-test were conducted using the somatic subcategory of the PIF problem checklist as a measure of somatic difficulties. Ethnic groups (Asian American, Asian international, and non-Asian) was the IV, and the mean of the somatic subcategory was the DV for the ANOVA. Results indicated that there were no significant differences across the three groups *F* (2, 464) = 2.17, *p* = .12. A *t*-test was conducted with the ethnic groupings (Asian and non-Asian) as the IV, and the mean of the somatic subcategory as the DV. Results indicated that there was no significant difference between Asians (*M* = .95, *SD* = .96) and non-Asians (*M* = .90, *SD* = .86), *t* (465) = -.413, *p* = .68

Severity of Problems. The second group of questions examined whether there were significant differences in how severe the problems impacted the client's life before seeking treatment. Severity of problems was operationally defined in three ways: (1) the client's initial BHQ score, (2) the response to question 28 of the PIF problem checklist (i.e., Suicidal thoughts, feelings, behaviors) and (3) intake status (whether or not the client was seen initially on a crisis or walk-in basis).

Are there significant differences in severity between ethnic groups using the initial BHQ score as an indicator? An ANOVA and a *t*-test were conducted. Ethnicities were the IVs (Asian American, Asian international, and non-Asian for the ANOVA and Asian and non-Asian for the *t*-test) and the initial BHQ score was the DV. As mentioned

previously, the initial BHQ score was missing for 65 clients, who were omitted from this analysis. Results of the ANOVA found that Asian internationals had significantly more severe initial BHQ scores F (2, 438) = 3.96, $p < .05$, than did non-Asians ($M_{AI} = 2.36$, $SD_{AI} = .76$; $M_{NA} = 2.71$, $SD_{NA} = .59$). T-test results showed that Asians as a whole ($M = 2.56$, $SD = .64$) reported significantly more severe initial BHQ scores than did non-Asians ($M = 2.71$, $SD = .59$), t (439) = .1.96, $p < .05$.

The study also examined whether there were significant differences in severity across ethnic groups with respect to PIF 28 (suicidal thoughts, feelings, behaviors), with larger ratings to PIF 28 representing greater severity. Again, an ANOVA and a t-test were conducted. Ethnicities were the IVs (Asian American, Asian international, and non-Asian for the ANOVAs and Asian and non-Asian for the t-tests). The ANOVA results indicated that there were no significant differences across the three groups F (2, 466) = 2.17, $p = .12$. Likewise, the t-test also did not indicate a significant difference in severity between Asians ($M = .31$, $SD = .74$) and non-Asians ($M = .47$, $SD = .88$), t (116.44) = .133, $p = .13$.

Are there significant differences in severity across the three groups using the intake status as a measure of severity? A chi-square analysis was conducted using ethnic grouping (Asian American, Asian international, and non-Asian) as the IV and the intake status as the DV. Clients who were seen for an initial evaluation on a walk-in basis and/or in a crisis state were considered emergency intakes. Results of the chi-square test indicated a relationship between ethnic grouping and type of intake, X^2 (2, $N = 506$) = 9.70, $p < .05$, with Asian clients being more likely to present for counseling in a crisis

state. Specifically, 33.3% of Asian Americans and 32.4% of Asian internationals were evaluated on a crisis/emergency basis as opposed to 18.7% of non-Asians.

Treatment Outcome. The third group of questions analyzed treatment outcome differences between the ethnic groups. Treatment outcome was operationally defined in four ways: (1) the difference between the final BHQ score and the initial BHQ score, (2) the final BHQ means, (3) the response to BHQ number 21 (benefited from counseling) from the last BHQ completed by the client, and (4) the number of total sessions. Each operational definition of treatment outcome (i.e. BHQ difference scores, final BHQ mean, final response to BHQ 21, and number of sessions) was analyzed using ANOVAs and *t*-tests. The IVs were the ethnicity groupings (Asian American, Asian international, and non-Asian for the ANOVAs and Asian and non-Asian for the *t*-tests). The DVs were the BHQ difference scores, final BHQ mean, final response to BHQ 21, and number of sessions.

Are there significant differences in treatment outcome between the ethnic groups using the difference between the final and initial BHQ scores? Greater benefit from treatment was defined as a greater positive difference between the final BHQ means and initial BHQ means. As mentioned earlier, there were 65 cases in which a BHQ score was not recorded at the first session. For those cases the difference of final BHQ and first available BHQ (usually second session) scores was used. Also, 134 clients only attended one session of counseling. For those cases a difference score of zero was used for this analysis. ANOVA results indicated that there were no significant differences across the three groups $F(2, 503) = 1.00, p = .37$. *T*-test results also found that Asians ($M = .24$, *SD*

= .49) were not significantly different than non-Asians (M = .25, SD = .53), t (116.44) = .79, p = .77.

Are there significant differences in treatment outcome between ethnic groups using final BHQ scores as a measure of treatment outcome? Lower BHQ scores represented greater severity of problems, and thus less benefit from counseling. The ANOVA results found that Asian internationals had the greatest severity at the end of counseling F (2, 482) = 3.17, $p < .05$. Post hoc tests indicated that Asian internationals reported significantly more severe symptom scores than did non-Asians (M_{AI} = 2.89, SD_{AI} = .58; M_{NA} = 3.00, SD_{NA} = .57). The independent samples t-test conducted indicated that Asians (M = 2.84, SD = .61) reported significantly greater distress at the end of therapy than did non-Asians (M = 3.00, SD = .57), t (483) = .31, $p < .05$.

Are there significant differences in treatment outcome between the Asian ethnic groups when the response to BHQ 21 (benefited from counseling) from the last BHQ completed by the client is used as a measure of treatment outcome? The ANOVA did not find any significant differences across the three groups F (2, 350) = 2.50, p = .08. The independent samples t-test, likewise, did not indicate a significant difference between Asians (M = 2.66, SD = .66) and non-Asians (M = 2.83, SD = .71), t (351) = 1.73, p = .08.

Are there significant differences in treatment outcome between ethnic groups when the number of sessions is used as a measure of treatment outcome? The ANOVA conducted found no significant differences across the three groups F (2, 503) = 2.50, p = 2.16. The independent samples t-test, likewise, found that Asians (M = 4.55, SD = 5.22) did not differ significantly in total number of sessions from non-Asians (M = 5.65, SD = 5.70), t (504) = 1.75, p = .08.

Gender Interaction. The fourth grouping of questions examined gender and its interaction effects on presenting problems, severity of problems, and treatment outcome of Asians and non-Asians. Presenting problems, severity of problems, and treatment outcome were operationally defined as they were in the previous three question groupings.

Does gender have an effect on presenting issues for Asians and non-Asians? Thirteen 2 (male vs. female) x 2 (Asian vs. non-Asian) ANOVAs were performed. Again, the means for each of the problems of the PIF's problem checklist were used to measure the presenting issues. Gender and ethnicity were the IVs, and the means for each problem area were the DVs. Results showed a gender main effect, regardless of ethnic background, for the problem areas of self-esteem, relationship problems, eating-related concerns, anxiety, and somatic problems. Specifically, females reported having greater concern in the following areas: self-esteem ($M_F = 1.33$, $SD_F = 1.17$; $M_M = .92$, $SD_M = 1.04$); $F\ (1,1,1) = 10.44, p < .05$), relationship problems ($M_F = .77$, $SD_F = .54$; $M_M = .65$, $SD_M = .51$); , $F\ (1,1,1) = 3.91, p < .05$, eating concerns ($M_F = .87$, $SD_F = 1.24$; $M_M = .31$, $SD_M = 1.23$); $F\ (1,1,1) = 20.80, p < .05$, and somatic problems($M_F = 1.01$, $SD_F = .91$; $M_M = .76$, $SD_M = .80$; $F\ (1,1,1) = 5.47, p < .05$.

Two ANOVAs were conducted with client grouping (Asian male, Asian female, Non-Asian male, and Non-Asian female) as the IVs, and the mean scores for the academic and career subgroups of the problem checklist as the DVs. Interaction effects between ethnicity and gender were found for academic problems, $F\ (1, 1, 1) = 3.80, p < .05$, and career problems, $F\ (1, 1, 1) = 7.13, p < .05$. Specifically, results showed that Asian females ($M = 1.78$, $SD = 1.03$) had significantly more academic concerns than non-

Asian females (*M* = 1.32, *SD* = 1.03). With regards to career concerns, Asian females (*M* = 1.50, *SD* = 1.57) had significantly higher ratings than non-Asian females (*M* = .76, *SD* = 1.17). Lastly, non-Asian males (*M* = 1.21, *SD* = 1.34) had significantly more career concerns than non-Asian females (*M* = .76, *SD* = 1.17).

Does gender have an effect on severity of problems for Asians and non-Asians when seeking treatment? The initial BHQ score, response to PIF 28 (suicidal thoughts, feelings, and behaviors), and intake code were used to measure severity of problems. When initial BHQ scores and responses to PIF 28 were analyzed, two 2 (male vs. female) x 2 (Asian vs. Non-Asian) ANOVAs were performed. Gender and ethnicity were the IVs, with the initial BHQ scores and responses to PIF 28 was the DVs. Results showed a main effect of gender for initial BHQ scores. Females (*M* = 2.65, *SD* = .61), regardless of ethnicity, were found to have higher initial BHQ scores more severe problems than males (*M* = 2.73, *SD* = .60), F (1,1,1) = 4.93, $p <.05$. Results did not show a main effect of gender or ethnicity, or an interaction effect of gender and ethnicity for suicidal ideation or behavior.

A chi-square analysis was conducted to assess gender differences in intake status. Client grouping (Asian male, Asian female, Non-Asian male, and Non-Asian female) was used as the IV and the intake status as the DV. Results of the chi-square test indicated a relationship between ethnic grouping and type of intake, X^2 (3, N = 506) = 9.90, $p < .05$. Specifically, Asians, whether male (31.7%) or female (33.9%), were more likely to be treated on an emergency basis as were non-Asian males (19.6%) or females (18.1%).

Are there gender differences in treatment outcome for Asians and Non-Asians? The BHQ difference scores, final BHQ means, final BHQ 21 response, and number of

sessions were, again, used to measure treatment outcome. A separate 2 (male vs. female) x 2 (Asian vs. Non-Asian) ANOVA was performed for each treatment outcome measure. Gender and ethnicity were the IVs, and the BHQ difference scores, final BHQ means, final BHQ 21 response, and number of sessions were the DVs. Results did not show any significant differences for the BHQ difference scores and final BHQ 21 scores. As reported previously, a main effect of ethnicity was found when final BHQ means were compared. Specifically, Asians ($M = 2.84$, $SD = .61$), regardless of gender, were found to have more severe problems at the end of treatment than non-Asians ($M = 3.00$, $SD = .57$), $F(1,1,1) = 3.57$, $p < .05$ when the final BHQ means were compared. Results also showed a main effect of ethnicity for the number of sessions. Non-Asians ($M = 5.65$, $SD = 5.70$), regardless of gender, were found to have more treatment sessions than Asians ($M = 4.55$, $SD = 5.22$), $F(1,1,1) = 3.93$, $p < .05$.

Discussion

Research on Asians in counseling has been difficult due to the cultural trend of Asians not seeking help. Studies that were conducted took place in areas where Asians were more abundant in the population (e.g., Hawaii and West coast cities). Therefore, results are difficult to generalize to Asian Americans who live in areas where Asians are more of a minority. The current study attempted to add to the small body of literature focused on Asian Americans in counseling by using a sample population of Asians not from a heavily Asian-concentrated population (i.e., an East coast university). An existing data base was used to examine Asian Americans, Asian international students, and non-Asians with respect to presenting issues, severity of problems, treatment outcomes, and gender interactions in counseling.

Presenting Problems

It was hypothesized that Asian Americans and Asian internationals would have more concerns with academic and career difficulties than would non-Asians (Lee & Mixson, 1995; Tracey, Leong, & Glidden, 1998). Again, academic and career concerns have been found to be highly valued in the Asian community. For Asians, it may be more acceptable to seek help for academic or vocational problems than for emotional problems. The current study partially supported previous research. Asians (a collapsed group of Asian Americans and Asian internationals) were significantly more likely to have academic and career concerns than were non-Asians. No other significant differences were found for any other problem areas. When Asian American and Asian international clients were examined separately, Asian Americans showed the most concern for academic problems and Asian internationals showed the most concern for career problems. The difference in primary problems (i.e., academic problems for Asian Americans and career problems for Asian internationals) may be attributed to the type of education each group is predominantly seeking (i.e., undergraduate versus graduate education). According to the demographic information a little under 85% of the Asian Americans were in school to obtain their bachelor's degree. A bit over half of the Asian international clients were attempting to complete their graduate program or were already past that point. Graduate programs tend to teach specific knowledge and skills necessary to be qualified for specific careers. Undergraduate programs tend to be more general about a field. Asian internationals may seek treatment for career difficulties because most of them are in a program that is training them for that specific career. Also, Asian

Americans at this university may be highly motivated towards graduate school. Asian internationals may be more interested in pursuing career goals.

It was also hypothesized that Asians would report significantly more somatic problems than non-Asians. Asians are expected to describe symptoms in terms of physical difficulties rather than emotional difficulties. For example, an Asian client may describe symptoms of depression as difficulty sleeping, loss of appetite, or loss of energy rather than feelings of despair, confusion, or loss of interest in previously enjoyable activities (Lippincott & Mierzwa, 1995). Similar results were not found in the present study. Asians and non-Asians did not significantly differ in the amount of somatic symptoms reported. As it was mentioned earlier the current study is continuation of Pitzman's 2003 study which analyzed clients from the same university only a year prior. Pitzman's results also did not report significant differences of somatic symptoms across groups. The present study's results may not support previous literature due to the differences in sample population. Previous studies use sample populations where Asians are more abundant in the population. There may be more of a pressure to hold on to Asian traditions and expectations in those areas. In Asian cultures it is more acceptable to report somatic difficulties rather than other types of difficulties. When Asians are more of minority, they may feel less pressure to hold on to Asian traditions. These minorities may also be assimilated enough to acknowledge non-somatic symptoms that are also causing problems in their lives and, therefore, may feel less of a need to emphasize somatic symptoms.

Severity of Problems

It was hypothesized that those with and Asian background would report the greatest severity of problems. This was expected to occur due to Asian customs of attempting to solve or fix problems by one self or within the family prior to seeking professional help. Seeking help outside of the family can be seen as a sign as family weakness, and could bring shame upon the family because as a family the problem could not be solved (Abe & Zane, 1990; Gim, Atkinson, & Whiteley, 1990; Hartman & Askounis, 1989). It was also hypothesized that acculturation would play a role in severity of presenting problems. Asian internationals were expected to report significantly more severe problems than Asian Americans and non-Asians.

The hypothesis that those with an Asian background would report more severe problems than those without an Asian background was partially supported. When severity was measured by comparing initial emotional distress, the Asian group did report significantly more severe problems than non-Asians. When separated into Asian American and Asian internationals, Asian internationals specifically were found to report significantly greater distress than non-Asians. No differences were found between Asian American and non-Asian or Asian Americans and Asian Internationals. Acculturation may play a role here. Asian internationals, with the expected least amount of acculturation, may have avoided seeking help until the problem became too severe. Asian Americans, who are expected to be more acculturated than Asian internationals, may seek help before severity of problems increases.

When level of suicidal tendencies was used to measure severity of problems, no significant differences across any ethnic grouping were found. It was thought that Asians would report more severe symptoms for this item due to previous literature finding

Asians seeking help when their symptoms became too severe to handle on their own (Abe and Zane, 1990; Gim, Atkinson, & Whiteley, 1990). It was believed that self harming ideation could be used as an index of severity. However, suicidal thoughts, emotions, and behaviors may not have been an accurate measure of severity of problems. Additionally, having suicidal ideation may have a different meaning in the Asian culture. Suicide could be seen as a sign of personal and/or family weakness. As mentioned earlier Asians tend to value stoicism and avoid family shame. Therefore, Asian clients may not even admit to self-harming thoughts even if they had them.

The strongest support for Asians presenting greater severity of problems than non-Asians was found when comparing intake status. About one-third of Asian American and Asian international students sought counseling when they felt they were in an emergency/crisis state rather than calling in and setting a future appointment. Less than one-fifth of the non-Asian clients sought counseling on a walk in or emergency/crisis state rather than setting an appointment. Using the intake status may be the most accurate measure of the severity. There is little room for error as the client reports whether or not their problems are so severe that they need to seek someone at that moment or if they can wait and set up an appointment. An alternative explanation may be that Asian may be averse to waiting for a scheduled appointment. For Asians, acknowledging that they need help may be difficult; waiting for that help may be even an even more difficult task.

With regards to significant differences of severity between Asian Americans and Asian internationals, no differences were found between the two groups. It seems that acculturation did not play a factor in severity as expected. This result could be attributed

to a limitation of this study. Acculturation between the two groups was never measured. It was just assumed that Asian internationals would be less acculturated than Asian Americans. The two groups may be more similar in terms of acculturation than expected.

Treatment Outcome

Research on the Asian American population in counseling is minimal and difficult to obtain due to clients terminating early and seeking help less often than non-Asians (Lee & Mixson, 1995). It was hypothesized that Asians, especially international students, would report the least amount of change from their first intake session to their last session, report the least amount of benefit from counseling, and attend fewer sessions than non-Asian students. These hypotheses were based on previous literature. Cultural differences between Asians and Americans have been found to lead to concerns about whether a non-Asian counselor can understand an Asian client's experiences, and preferences of counseling styles (i.e., directive or non-directive) (Atkinson & Matsushita, 1991; Kim & Ommizo, 2003). Additionally, Byon, Chan, & Thomas (1999) found Asians reported their counseling sessions were less beneficial than non-Asian students.

Hypotheses were only minimally supported. At the conclusion of therapy, Asians, especially Asian international clients, showed the greatest severity of problems. It may be that Asian international clients improved the least because their problems were the most severe initially. No differences between groups were found when examining BHQ difference scores, client's belief regarding benefits obtained from counseling, or the total number of sessions attended. Again, the lack of significant differences could have been due to differences of sample population. The current study, as opposed to most previous literature, used Asian subjects who were from areas not heavily populated with

Asians. Perhaps Asian Americans and Asian internationals that are more of a minority feel less pressure to hold onto Asian cultural norms. Being more of a minority pressures Asians to become assimilated to the majority population and its norms, and thus they simply could have benefited from counseling as much as non-Asians.

Role of Gender

Asian males were expected to present with more somatic symptoms, present more severe symptoms, and benefit less from counseling than Asian females and non-Asians. This hypothesis is based on literature that found Asian males to hold strong stoic values. They are expected to seek help when problems become too severe and find it difficult to accept the help when it is offered (Gim, Atkinson, & Whitely, 1990; Kamoya & Eells, 2001). Results did not support this hypothesis.

Gender main effects were found when presenting problems were compared. Females in general reported problems with self-esteem, relationships, eating issues, anxiety, and somatic symptoms. Interaction effects were found with academic and career concerns; in both cases, Asian females reported significantly more difficulty than non-Asian females. When severity of problems was assessed, females had more severe initial BHQ scores than males.

Finally, it is possible that Asian males did not report more severe problems or less benefit because they were attempting to minimize their problems. Perhaps even the act of reporting problems on a questionnaire pushes boundaries and values of asking for help.

Limitations

There are several limitations to the present study. First, clients and data were obtained from a university counseling center. The experiences of Asian American, Asian

international, and non-Asian college students differ from the general population. College students' attitudes, values, expectations, and perceptions can make generalizing results to wide populations difficult. Also, the clients in the current study attended a highly selective private university. The results from this study, therefore, may not generalize to students from other non-private universities or the general population.

The second limitation was found when analyzing severity of problems. When initial BHQ scores were analyzed, 65 cases did not have a BHQ score for the first session. It is not known why BHQ scores were not recorded for those cases. It is possible that BHQ scores were not obtained when the client was seen in a crisis/emergency basis and the client was not asked to complete one. Had those 65 cases been included, results may have varied.

Limitations were also found in the analysis of treatment outcome. Again, there were 65 cases in which the initial BHQ score was missing. Since BHQ difference scores were used to measure treatment outcome, the first available BHQ score (usually from the second session) was used for these 65 cases. This may have resulted in an inaccurate measure of treatment outcome for these cases. Additionally, 134 clients only attended one session and a BHQ difference score of zero was used for those cases. Results may have been different if those cases were not included in the analysis. Also, using a difference score of last and first sessions does not take into account session by session improvements or regressions. These fluctuations are not accounted for and thus overall improvement may be misrepresented when only looking at the first and last sessions.

Lastly, another limitation is that acculturation was not measured. Rather, assumptions were made as to the acculturation levels for each of the three groups. Asian

Americans were assumed to be more acculturated than Asian internationals. This assumption may not be true on an individual basis. Further research should accurately measure acculturation to determine its relationship to treatment outcome.

Clinical and Research Implications

Despite the limitations of this study, the results do add to the limited body of literature on Asian American and Asian clients in psychotherapy. Some of the present findings contradict the previous literature. Previous literature may misguide those working in the counseling field with Asians, Asian Americans, and Asian international students. Further research should continue to use sample populations that more accurately represent Asian minorities to better understand their needs. Further research can help counselors address the presenting issues of Asians, help them before problems become too severe, and improve treatment outcomes.

Results of the current study do support the literature in that Asians were more likely than non-Asians to present with academic and/or career difficulties. For those in the helping field it may be useful to know that even though Asians may be seeking help for academic or career problems, it is possible that the client may have other difficulties or problem areas in their life. In the present study most Asians were seeking help for academic and career difficulties, yet, they still reported more difficulty in overall life functioning than non-Asians.

Also, it was found that Asians did seek treatment in a walk in or crisis/emergency state more often than non-Asians. Future research could address differences between Asians who are seen on an emergency basis from those who are not. This research could suggest strategies to reduce the number of Asians seen for evaluation or treatment when

they are in a crisis state. Further studies in outreach would help address concerns of Asians before the problems become too severe. How can potential Asian clients be reached without crossing cultural norms? Also, how can counselors help Asian clients within their boundaries and expectations? Such research would lead to better treatment outcomes.

Further research could also analyze the session-by-session treatment outcome for Asians and non-Asians. Perhaps by looking at fluctuations in emotional improvement and regressions, clinicians could find specific interventions that tend to benefit Asian clients. Likewise, they may also discover interventions that do not seem to be beneficial.

Lastly, further research could be conducted on single session clients. Researchers could follow up on clients that attended one session and chose not to attend any more. What were their reasons for not returning? Did they derive any benefit from the single session? Did anything change from the time the client decided to seek treatment to the time they decided they no longer needed it? More specific to the present study, are there any trends for Asians not continuing treatment? Answers to these questions, and others like them, could help clients recognize that they may need continued help. Also research in this area could help therapists intervene with Asian clients in the most beneficial and time effective manner.

Conclusion

As the United States continues to diversify, it is imperative to continue research on all groups of people. Conflicts and misunderstanding happen all too often due to misconceptions and inaccurate assumptions about Asians. The current study plays its small role in continuing to learn and understand the Asian and Asian American cultures.

However, these cultures are only two of thousands of minorities and subcultures found across the world. Research does not have to be confined to empirical studies. Research and learning about other cultures can happen on an individual basis simply by meeting new people, experiencing what is important to them, and also sharing one's own experiences with others. As the helping community continues to understand and learn about Asians and Asian Americans the services they provide will become more refined and beneficial. Asians and Asian Americans could be offered services in a pre-crisis state. Lastly, continued research will help bridge the difficult task of holding on to one's Asian heritage and assimilating to majority culture.

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

	Frequency n (%)		
Variables	Asian American	Asian International	Non-Asian
Gender			
Male	26 (39.4)	15 (44.1)	168 (41.4)
Female	40 (60.6)	19 (55.9)	238 (58.6)
Year in School			
Freshman	13 (20.0)	1 (2.9)	67 (16.8)
Sophomore	13 (20.0)	9 (26.5)	72 (18.0)
Junior	14 (21.5)	0 (00.0)	77 (19.3)
Senior	17 (26.1)	6 (17.6)	64 (16.0)
Graduate Student	7 (10.8)	16 (47.1)	96 (24.0)
Other	1 (1.5)	2 (5.8)	19 (6.1)
Religion			
Buddhist	1 (1.6)	2 (6.7)	2 (.5)
Catholic	9 (14.3)	2 (6.7)	107 (27.8)
Hindu	13 (20.6)	1 (3.3)	1 (.3)
Jewish	0 (00.0)	0 (00.0)	47 (12.2)
Moslem	1 (1.6)	3 (10.0)	9 (2.3)
Protestant	14 (22.2)	1 (3.3)	64 (16.6)
Other	6 (9.5)	4 (13.3)	45 (11.7)
None	19 (30.2)	17 (56.7)	110 (28.6)
Marital Status			
Single	59 (92.2)	28 (85.7)	338 (84.9)
Married/committed	3(4.7)	5 (14.7)	54 (13.6)
Separated	0 (00.0)	0 (00.0)	2 (.5)
Divorced	0 (00.0)	1 (2.9)	2 (.5)
Other	2 (3.1)	0 (00.0)	2 (.5)
Parents' Marital Status			
Married/committed	53 (84.1)	27 (87.1)	273 (68.4)
Separated	3 (4.8)	0 (00.0)	19 (4.8)
Divorced	3 (4.8)	2 (6.5)	77 (19.3)
Widowed	4 (6.3)	1 (3.2)	19 (4.8)
Other	0 (00.0)	1 (3.2)	11 (2.8)

Table 2
Treatment Related Variables for Asian Americans, Asian Internationals, and Non-Asians

	Frequency *n* (%)		
Variables	Asian American	Asian International	Non-Asian
Referral Source			
Self	22 (35.5)	14 (43.8)	182 (47.6)
Friend	13 (21.0)	2 (6.3)	64 (16.8)
Family	0 (00.0)	1 (3.1)	22 (5.8)
Faculty/Staff	13 (21.0)	8 (25.0)	35 (9.1)
Previous Counseling			
Previously	14 (22.2)	2 (6.7)	166 (43.3)
Never	47 (74.6)	26 (86.7)	208 (54.3)
Currently	2 (3.2)	2 (6.7)	9 (2.3)
History of Medical Problems			
Yes	9 (15.0)	5 (16.7)	81 (21.8)
No	51 (85.0)	25 (83.3)	209 (78.2)
Family History of Medical Problems			
Yes	14 (23.0)	6 (19.4)	151 (39.8)
No	39 (63.9)	21 (67.7)	173 (45.6)
Unsure	8 (13.1)	4 (12.9)	55 (14.5)
Family History of Emotional Problems			
Yes	3 (4.9)	5 (16.1)	171 (44.2)
No	38 (62.3)	20 (64.5)	152 (39.3)
Unsure	20 (32.8)	6 (19.4)	64 (16.5)
Family History of Substance Abuse Problems			
Yes	5 (8.1)	1 (3.2)	135 (35.0)
No	50 (80.6)	28 (90.3)	220 (57.0)
Unsure	7 (11.3)	2 (6.5)	31 (8.0)

Table 3
BHQ[a] Mean Scores and Number of Sessions by Ethnic Group

	Asian American			Asian International			Non-Asian		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*
Initial BHQ	2.65	.58	58	2.36	.76	24	2.71	.59	359
Final BHQ	2.89	.58	63	2.75	.67	30	2.97	.57	392
BHQ Difference Scores	.18	.48	66	.35	.52	34	.25	.53	406
Number of Sessions	4.58	5.25	66	4.50	5.25	34	5.65	5.70	506

Note. BHQ was administered at the first session and every subsequent session thereafter. Higher scores denote greater psychological health.
[a] BHQ = Behavioral Health Questionnaire.

Table 4
Means from PIF Checklist for Asian Americans, Asian internationals, and Non-Asians

	Asian American			Asian International			Non-Asian		
13 PIF[a] Problem Areas	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*
Anger	.40	.81	60	.21	.63	28	.26	.69	380
Unusual Behaviors	.45	.62	59	.39	.57	28	.43	.70	376
Somatic	.81	.84	59	1.22	1.11	29	.90	.86	379
Academic	1.67	.95	58	1.59	.97	28	1.38	.89	379
Anxiety	1.73	.97	59	1.36	1.20	28	1.53	1.02	377
Relationship	.77	.54	56	.72	.50	26	.72	.56	367
Existential	.60	.48	58	.66	.49	28	.55	.52	374
Self-Esteem	1.22	1.01	60	1.03	1.05	30	1.17	1.16	379
Depression	.90	.76	58	1.04	.90	28	.78	.78	373
Eating Disorders	.70	1.07	60	1.10	1.50	29	.61	1.08	380
Career	1.32	1.42	60	1.61	1.47	28	.94	1.26	382
Substance Abuse	.16	.37	58	.16	.49	28	.22	.50	379
Phy/Emot/Sex Abuse	.29	.58	59	.18	.37	28	.16	.43	375

[a] PIF = Personal Information Form. Higher scores denote greater maladjustment.

1a)	___ ___ - ___ ___ ___	PIF#
1b)	No longer Applicable	Client #
1c)	___	Semester Code (Summer=1, Fall=2, Spring=3)
1d)	___	Intake Code
1e)		Counselor Name

PERSONAL INFORMATION FORM: 2001-02 (PIF01)

WELCOME TO THE COUNSELING & STUDENT DEVELOPMENT CENTER! Please fill out the information requested below. All the information on this form will be kept strictly CONFIDENTIAL and will be used only to assist us in providing you with the best help. Thank You!

2) Name:____________, ________________, ______
(Last) (First) (M.I.)

3) Today's Date: _____/ ______/ ____
(month, day, year)

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

4b) ____________________, _____________, __________
(City) (State) (Zip)

4c) Local Phone Number: _______________________

4d) E-mail Address: ________________

4e) The Counseling Center may contact me by email: ___Yes___No

5a) Permanent Address: ________________
(street)

5b) __________________, _________, _________
(City) (State) (Zip)

5c) Perm. Phone Number:______________________

5d) Emergency Contact Person: _________________

5e) Emerg. Contact Person ph #:________________

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

7) Birth date: _____/______/______

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

____
____
____
____
____
____

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

① Hardly at all *② Mildly* *③ Moderately* *④ Severely*

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

____
____
____
____
____
____

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

① Help with personal issues *② Help with career issues* *③ Other (explain if you wish):*____________________	**FOR CC USE ONLY** -9) No Answer/Missing 1) 1 2) 2 3) 3	4) 1+2 5) 1+3 6) 2+3 7) 1+2+3

(Please turn page over)

- 2-

Name: ______________________________ Date: ________________

Available Schedule. To help us arrange a regular appointment for you please circle each hour that you are available. Circle as many hours as possible.

Monday	Tuesday	Wednesday	Thursday	Friday
9	9	9	9	9
10	10	10	10	10
11	11	11	11	11
12	12	12	12	12
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5

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

GROUPS & WORKSHOPS CURRENTLY OFFERED

_____Dissertation Support Group

_____Eating Awareness Group

_____First Steps: Discovering Careers That Fit

_____Family Relations/Family Problems Group

_____Freshman Support Group (Fall Only)

_____General Therapy Group

_____Graduate Women's Support Group

_____International Students Discussion Group

_____Managing Nursing School & Parenthood Group

_____Musical Performance Anxiety Workshop

_____Nursing Students Support Group

_____Stress Management/Relaxation Techniques Workshop

_____Substance Abuse Education & Recovery Group

_____Surviving Loss Group

_____Survivors of Sexual Abuse/Assault Group

_____Test Anxiety/Test Taking Strategy Workshop

_____Time Management Workshop

_____Understanding Your Emotional Intelligence Workshop

INTEREST IN OTHER POSSIBLE AREAS:

_____Assertiveness Training

_____Becoming A Master Student

_____Performance Anxiety/Stage Fright Group

_____Coping With Depression Group

_____Couples Group

_____Interpersonal Relationships Group

_____Gay, Lesbian & Bisexual Students Support Group

OTHER SUGGESTIONS:

____

____

- 3 -

1a)	__ __ - __ __ __	PIF#
1b)	No longer Applicable	Client #
1c)	__	Semester Code: (Summer=1, Fall=2, Spring=3)
1d)	__	Intake Code: (New Intake=1, 1V, 1SP or 1E; Returning Intake= 2, 2V, 2SP or 2E)
1e)	__ __	Counselor Code Number: Counselor Name: __________
3a)	__ __	Month: (1-12)
3c)	__ __	Current Year
6)	__ __ __-__ __-__ __ __ __	Social Security Number
8b)	__	Item Rating (from previous page)
9)	__	Type of help (from previous page)

(DO NOT WRITE ABOVE DOTTED LINE)

PLEASE FILL IN THE INFORMATION BELOW:

10) Affiliated schools:
① Homewood Campus
② Nursing School
③ Peabody Institute
④ Other (Name): __________

11) Your age: __________

12) Gender: ① Male ② Female

13) Marital status:
① Single
② Married/committed relationship.
③ Separated
④ Divorced
⑤ Other :

14) Parents' marital status:
① Married/committed relationship
② Separated
③ Divorced
④ Widowed
⑤ Other:__________

15) Specify ethnic status:
① African-American
② Asian: Specify__________
③ Latino(a)
④ Native-American
⑤ Caucasian
⑥ Other:__________

16) Religion:
① Buddhist
② Catholic
③ Hindu
④ Jewish
⑤ Muslim
⑥ Protestant
⑦ Other: __________
⑧ None

17) Are you a transfer student?
① No ② Yes

18) Are you an international student? ① No ② Yes
Country?

19) Are you a physically challenged student?
① No ② Yes

20) Do you have any concerns about possible Attention Deficit Disorder?
① No ② Yes

21) Class year:
① Freshman
② Sophomore
③ Junior
④ Senior.
⑤ Grad. stud.
⑥ Graduated
⑦ Post Graduate
⑧ Other:

22) Number of credits registered for this semester?
① None
② 1-6 credits
③ 7-11 credits
④ 12-16 credits
⑤ 17-18 credits
⑥ 19 or more credits

23) Current academic status?
① In good academic standing
② Academically dismissed
③ Reinstated
④ On probation

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

25) With Whom do you live? Check all that apply.
(√= Yes=1)
a)____Live Alone
b)____Live with roommates(s)
c)____Live with spouse
d)____Live with child(ren)
e)____Live with romantic partner
f) ____Live with parent(s)
g)____Live with other relative
h)____Other

(Please turn page over)

26) What is your academic major or program?
01___Undeclared at present

Arts & Sciences
02___Anthropology
03___Biology
04___Biophysics
05___Chemistry
06___Classics
07___Cognitive Science
08___Earth & Planetary Science
09___Economics
10___English
11___Environ. Earth Science
12___French
13___German
14___Hispanic & Italian Studies
15___History
16___History of Art
17___History of Science, Medicine, & Technology
18___Humanities Center
19___International Studies
20___Latin American Studies
21___Mathematics
22___Music
23___Near Eastern Studies
24___Philosophy
25___Physics & Astronomy
26___Public Health
27___Policy Studies
28___Political Science
29___Psychology
30___Sociology
31___Writing Seminars
32___Other Arts & Science_____

Area Majors
33___Humanistic Studies
34___Natural Sciences
35___Social & Behavioral Sc.
36___Other Area:___________

Engineering
37___Biomedical Engineering
38___Chemical Engineering
39___Civil Engineering
40___Computer Science
41___Electrical & Computer Eng.
42___Geography & Envir. Eng.
43___Materials Science & Eng.
44___Mathematical Sciences
45___Mechanical Engineering
46___Other Engineering

Nursing: Affiliated School
47__Regular Program
48__Accelerated Program
49__Other

Peabody: Affiliated School
50__Performance Certificate
51__GPD
52__Double Degree Program
53__Performance: Bachelors
54__Performance: Masters
55__DMA
56__AD
57__Music Education: Bachelors
58__Music Education: Masters
59__Ensemble Arts
60__Conducting
61__Other: List____________

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

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

29) Have you ever used our services before?
① No
② Yes (please give name of counselor below)

29a)Names: ________________
____

30) Have you received any personal counseling elsewhere?
① Never ② Previously ③ Currently

30a) Counselor:
Dates:______________

31) Any medical problems?
① No ② Yes (List problems below):

31a)

32) Are you currently using any medication(s)?
① No ②Yes (List below):

32a) ________________
____
____

33) Do you have insurance for mental health services?
① No ② Not sure ③ Yes

34) If yes to question #33 mark one below:
① through Johns Hopkins University.
② from a company independent of Johns Hopkins University.
③ I am covered under my parents' insurance policy.

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

36) Is there a history of medical problems in your family?
① No ② Yes ③ Unsure

37) Is there a history of emotional problem in your family?
① No ② Yes ③ Unsure

38) Is there a history of Alcoholism or substance abuse in your family?
① No ② Yes ③ Unsure

39) Are you adopted?
① No ② Yes ③ Unsure

40) Does anyone in your family own a gun?
① No ② Yes ③ Unsure

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PIF#:	__ __-__ __ __

PROBLEM CHECKLIST

The following information will help us learn about issues that are problematic for you. Please take the time to mark each of the following items with either a "0," "1," "2," "3," or "4" indicating the degree to which that issue is a problem for you at the present time. This list is not exhaustive, but covers many of the common problem areas seen by our Counseling Center staff. Thank you!

0 *Not a Problem (Or not Applicable)*	1 *Slight Problem*	2 *Moderate Problem*	3 *Serious Problem*	4 *Severe Problem*

Pr 01) Academic concerns; school work and grades
Pr 02) Test anxiety
Pr 03) Time management, procrastination, getting motivated
Pr 04) Stage fright, performance anxiety, speaking anxiety
Pr 05) Overly high academic standards for self
Pr 06) Pressures from competition with others
Pr 07) Pressures from family for success
Pr 08) Decision about selecting a major and/or career
Pr 09) Loneliness, homesickness
Pr 10) Relationship with roommate
Pr 11) Relationship with friends and/or making friends
Pr 12) Relationship with romantic partner
Pr 13) Concern regarding breakup, separation, divorce
Pr 14) Conflict/ argument with parents or family member
Pr 15) Shy or ill at ease around other
Pr 16) Self-confidence or self-esteem; feeling inferior
Pr 17) Concern over appearance
Pr 18) Anxiety, fears, worries
Pr 19) Feeling overwhelmed by a number of things; hard to sort things out
Pr 20) Problem adjusting to the University
Pr 21) Generally unhappy and dissatisfied
Pr 22) Confusion over personal or religious beliefs and values
Pr 23) Concerns related to being a member of a minority
Pr 24) Issues related to gay/lesbian identity
Pr 25) General lack of motivation, interest in life; growing sense of detachment& hopelessness
Pr 26) Depression
Pr 27) Grief over death or loss
Pr 28) Suicidal thoughts, feelings, behaviors
Pr 29) Eating problem (overeating, not eating, or excessive dieting)
Pr 30) Alcohol and/or drug problem
Pr 31) Alcohol/drug problem in family
Pr 32) Sexually abused or assaulted, as a child or adult
Pr 33) Physically or emotionally abused, as a child or adult
Pr 34) Concerns about health; physical illness
Pr 35) Physical stress (headaches, stomach pains, muscle tension, etc...)
Pr 36) Sleep problems (can't sleep, sleep too much, nightmares)
Pr 37) Sexual matters
Pr 38) Problem pregnancy
Pr 39) Irritable, angry, hostile feelings; Difficulty in expressing anger appropriately
Pr 40) Concern that thinking is very confused
Pr 41) Fear that someone is out to get me
Pr 42) Fear of loss of contact with reality
Pr 43) Violent thoughts, feelings, or behaviors
Pr 44) Have been considering dropping out or leaving school
Pr 45) Feel that someone is stalking or harassing me (e.g., by phone, letter, or email)

Pr 46)	If you answered 1- 4 on question Pr 28 above, please check (✓) below to indicate your overall risk of suicide: ___Extremely low risk, ___Low risk, ___Moderate risk, ___ High risk, ___Extremely high risk (will not kill self): (will kill self)

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Behavioral Health Questionnaire--20 (BHQ--20$_{TM}$)

Please answer these questions as they relate to the past two weeks or since your last session (whichever is most recent).

1. How distressed have you been?

Extremely distressed (0)
Very distressed (1)
Moderately distressed (2)
A little bit distressed (3)
Not at all distressed (4)

2. How satisfied have you been with your life?

Not satisfied at all (0)
Mildly satisfied (1)
Somewhat satisfied (2)
Satisfied (3)
Very satisfied (4)

3. How energetic and motivated have you been feeling?

Not at all energetic and motivated (0)
A little bit energetic and motivated (1)
Somewhat energetic and motivated (2)
Energetic and motivated (3)
Very energetic and motivated (4)

Please use the following rating scale:

4 Never
3 A Little Bit
2 Sometimes
1 Often
0 Almost Always

In the past two weeks or since your last session how much have you been distressed by:

4. Feeling fearful, scared. (4) (3) (2) (1) (0)
5. Alcohol/drug use interfering with your performance at school or work. (4) (3) (2) (1) (0)
6. Wanting to harm someone. (4) (3) (2) (1) (0)
7. Not liking yourself. (4) (3) (2) (1) (0)
8. Difficulty concentrating. (4) (3) (2) (1) (0)
9. Eating problem interfering with relationships with family and/or friends. (4) (3) (2) (1) (0)
10. Thoughts of ending your life. (4) (3) (2) (1) (0)
11. Feeling sad most of the time. (4) (3) (2) (1) (0)
12. Feeling hopeless about the future. (4) (3) (2) (1) (0)
13. Powerful, intense mood swings (highs and lows). (4) (3) (2) (1) (0)

14. Alcohol/drug use interfering with your relationships with family and/or friends (4) (3) (2) (1) (0)
15. Feeling nervous. (4) (3) (2) (1) (0)
16. Heart pounding or racing. (4) (3) (2) (1) (0)

Please use the following rating scale:

0 Terribly
1 Poorly
2 Fair
3 Well
4 Very well

How have you been getting along in the following areas of your life over the past two weeks or since your last session?
Leave blank if the item does not apply.

17. Work/School (for example, performance, attendance). (0) (1) (2) (3) (4)
18. Intimate Relationships (for example, support, communication, closeness). (0) (1) (2) (3) (4)
19. Nonfamily Social Relationships/Friends (for example, communication, closeness, level of activity). (0) (1) (2) (3) (4)
20. Life Enjoyment (for example, recreation, life appreciation, leisure activities). (0) (1) (2) (3) (4)

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