Asian American High School Students’ Views on Mental Health and the Use of Mental Health Services

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By

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Abstract

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Numerous years of research show there are racial and ethnic disparities in the quality, access, use, and completion of mental health services (MHS). The National Institute of Mental Health reports one in five individuals between the ages of 13 and 18 have or will have a serious mental condition and that half of all cases begin by the age of 14 (n.d.). In addition, half of all students 14 years of age or older with mental illness drop out of high school. According to the American Psychiatric Association, Asian Americans and Pacific Islanders are the least likely populations to seek help for mental health issues (2007). The purpose of this study was to research the affect Asian American students’ personal histories had on their willingness to seek and use mental health services as many youths do not receive appropriate MHS and delayed treatment only makes the issues worse. A
sample of 28 Asian American students, ages 14 to 18, who attended a high school in a middle- to upper-class California city completed questionnaires regarding their background information and experiences with mental health services. The researcher hypothesized that Asian American students who were raised in more traditional Asian homes and/or recently emigrated to America would hold more closed views on mental health issues and services (e.g., these issues are not discussed in public, they are kept personal and are addressed through the family). Statistical analysis suggested foreign-born students and students with foreign-born parents were more likely to seek and use services compared to US-born students and students with US-born parents. The data also suggested that as the participant’s age and years spent living in the USA and California increased, his or her willingness to seek and use mental health services decreased.
Mental health problems affect everyone, irrespective of gender, ethnicity, race, or sexual orientation (National Institute of Mental Health [NIMH], n.d.). According to the NIMH (n.d.), one in five adults in the United States (US), which equates to 43.8 million adults, experiences a mental illness and one in twenty-five adults, or roughly 10 million adults, lives with a serious mental illness. The NIMH goes on to say an estimated 13.9% of Asian adults, the lowest percentage of all ethnic and racial groups, are living with a mental health condition (n.d.), although this number may be an underestimation as many individuals are hesitant to report mental illness.

Chu and Sue (2011) state that lower rates of mental health services (MHS) use does not equate to a lower need for the services. Cheryl Holm-Hansen (2006) and Carrasco and Weiss (2005) reported an overall similar prevalence rate of diagnosable psychiatric conditions among all ethnic and racial groups. The studies Chu and Sue (2011) reviewed varied in that the studies found lower, similar, and higher rates of mental illnesses for Asian Americans than their White counterparts. Although commonly classified as one group, Asian Americans are composed of various subgroups whose histories and cultures are widely diverse. When broken into their separate ethnic groups, higher rates of mental illness are found for Asian subgroups compared to White individuals.

According to Hoeffel, Rastogi, Kim, and Shahid (2012), four statisticians who worked for the United States Census Bureau, the Asian population was the fastest
growing racial group in the country between 2000 and 2010. In 2011, Chu and Sue reported “Asian Americans comprise 5% of the US population but 60% of the world’s population.” Despite the growing number of Asian Americans (AAs) in the United States, rates of MHS use has not increased for this population. AAs and Pacific Islanders are the least likely populations to seek help for mental health issues (American Psychiatric Association, 2007). The 2015 “Racial/Ethnic Differences in Mental Health Service Use among Adults” report by the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that from 2008 to 2012, Asians were the least likely population to use mental health services, including outpatient services, and prescription psychiatric medications, regardless of gender and age.

Numerous years of research show there are racial and ethnic disparities in the quality, access, use, and completion of MHS. This issue was highlighted in the Department of Health and Human Services’ 2001 supplemental executive summary regarding the 1999 Surgeon General’s report on mental health, the 2003 President’s New Freedom Commission on Mental Health report (Holm-Hansen, 2006), the 2012 National Healthcare Disparities Report, and the 2015 National Institute of Mental Health Strategic Plan for Research. Even with efforts to bring attention to this national problem, there seem to only be changes in theory but not in practice as many individuals from minority ethnic and racial groups do not receive appropriate mental health care. This includes most children, regardless of ethnicity or race (Holm-Hansen, 2006).

The mental health of Asian American children has not been heavily studied. Plus, the studies that have been conducted on these groups have resulted in inconsistent findings because of different methodologies, including various definitions of MHS, data
collection procedures, and subject pools. The NIMH reports one in five individuals between the ages of 13 and 18 have or will have a serious mental condition and that half of all cases begin by the age of 14 (n.d.). In addition, half of all students 14 years of age or older with mental illness drop out of high school. A 2005 press release by the NIMH reports “anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20’s… Young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive.” Cheryl Holm-Hansen found several studies that showed Hispanic and Latino children were the least likely of all ethnic and racial groups to receive MHS compared to White children. Hispanic and Latino youth were one-third as likely and Asian, Pacific Islander, and African American youth were one-half as likely to receive MHS (Holm-Hansen, 2006). Even with knowledge about the statistics and negative outcomes for youth who suffer from mental illness, many youths do not receive appropriate MHS and delayed treatment only makes the issues worse.

Most of the research on the mental health of minority groups has been conducted on adults. As such, recommendations and efforts to reduce the disparity in MHS are based on the research conducted on adults. Based on studies conducted on older adult Asian Americans, including college students, there are high rates of anxiety, depression, and suicide for this group (American Psychiatric Association, 2007). The problem is that Asian American individuals are not seeking and using MHS at similar rates that White individuals are even though research studies have found both groups to have similar rates of mental illness (Carrasco & Weiss, 2005; Holm-Hansen, 2006).
The reasons as to why the Asian American population seeks and uses MHS at lower rates compared to other populations include demographic, systemic, social, organizational, and cultural factors (Abe-Kim, J., Takeuchi, D., Hong, S., Zane, N., Sue, S., Spencer, M., Appel, H., Nicdao, E., & Alegria, M., 2007; Anyon, Y., Ong, S., & Whitaker, K., 2014; Carrasco, M., & Weiss, J., 2005; Chu, J. P., & Sue, S., 2011; Gudiño, O., Lau, A., & Hough, R., 2008; Han, M., & Pong, H., 2015; Holm-Hansen, 2006; Jacob, J., Gray, B., & Johnson, A., 2013; Kung, W., 2004; Lee, S., Juon, H., Martinez, G., Hsu, C., Robinson, E., Bawa, J., & Ma, G., 2009; Leong, F., & Lau, A., 2001; Li, H., & Seidman, L., 2010; Miller, M., Yang, M., Farrell, J., & Lin, L., 2011; National Alliance on Mental Health, 2011; Nguyen, Q., & Anderson, L., 2005; Park, M., & Chesla, C., 2010; Tung, W., 2011; Yoo, S., Goh, M., & Yoon, E., 2005). The hypothesis is then if Asian American students are living in a middle- to upper-class city in California, then they may not face the same barriers to accessing MHS and should have more open views about mental health services compared to Asian Americans who have recently emigrated to the US and/or reside in low-income neighborhoods. The purpose of this study is to find out the affect Asian American students’ personal histories have on their willingness to seek and use mental health services, when controlling for geographic location and the availability and access to MHS is the same.

Based on an analysis of the demographic information on possible Asian American participants at the American high school in the middle- to upper-class California city, multiple students do not fit the typical profile of a traditional and/or newly emigrated Asian American individual. Based on the geographical location, the students live in a middle- to upper-class city, meaning systemic factors may not be as big of an issue as it is
for Asian Americans living in low-income neighborhoods. Their families are able to afford the necessities of living in that type of neighborhood, including paying for the mortgage or rent and utilities, buying groceries and clothing, and maintaining their vehicles. Furthermore, numerous students do not come from dual-parent households; their parents are separated or divorced. According to Vespa, J., Lewis, J., and Kreider, R. (2013), three employees of the Fertility and Family Statistics Branch of the US Census, 81% of Asian family households were headed by a married couple and 13% of Asian children lived in a home headed by one parent. The eastern value system of Asian countries includes a family or group orientation that values interpersonal harmony and saving face (e.g., avoiding humiliation, retaining respect) within their communities. Divorce can be considered an unattractive quality as it represents a family being divided, which goes against the beliefs and teachings of more collectivistic Asian cultures. One other characteristic the possible participants share is that only a few of them are classified as English Learners, meaning they were either born in the US or have acculturated at a pace that does not warrant extra support in terms of English language acquisition.

In the proposed study, randomly selected Asian American students, who live in the same city of and attend an American high school in a middle- to upper-class city, provide their demographic information and experiences related to mental health services. The students are asked to provide demographic information, including their age, gender, ethnicity, and places of birth. They are also asked to share information about their families, including who lives in the home, the marital status of their parent(s), and the incorporation of cultural traditions and beliefs in the home. Then the students are asked to complete a questionnaire regarding personal, familial, and extrafamilial use of mental
health services and their knowledge about services available on and off of their high school campus.

The researchers would like to see which factors (i.e., demographic, systemic, cultural) affect Asian American students’ knowledge of and willingness to use MHS. The belief, based on previous studies, is that the Asian American students who were raised in more traditional Asian homes and/or have recently come to America may have a closed view on mental health issues and services (e.g., these issues are not discussed in public; they are kept personal and are addressed through the family). As a result, they would not be willing to use mental health services. Conversely, students who have been raised in a more American-minded home and/or have not had much exposure to the Asian countries and cultures have an open view on mental health issues and services (e.g., they can go to professionals to seek help, it is acceptable to seek outside help). In addition, because of where they live, these students may have knowledge of services available in their school and in the community and accessing such services would not be a matter of systemic issues.

This study has the potential to provide other researchers and interested parties with information on the factors that affect Asian American students’ perceptions of mental health issues and services, especially when systemic issues may not be the main barrier to accessing and using MHS. Using this information, individuals can come up with effective ways to address mental health issues that Asian American students may be experiencing, while staying within the confines of their cultural beliefs and teachings. Individuals may also use the information obtained from this study to improve their
programs currently in place and/or to develop new programs to implement to address Asian Americans’ mental health issues.

The following chapters give insight into the formulation of this thesis. Chapter two is composed of the preliminary research conducted on Asian Americans’ mental health ranging from the years 2000 to 2015. Study findings indicate Asian Americans used mental health services at lower rates than other ethnic and racial groups despite experiencing similar rates of mental illness. Chapter three describes the design and implementation of the study, based on the preliminary research, including what type of data to collect and a positive approach to encourage participation in the study. Chapter four presents the results of the study based on the data collected from the Asian American student participants. Chapter five summarizes all chapters and discusses how the study supports and/or contradicts the researcher’s hypothesis. It also provides information on the limitations of the study and where future research may be needed.
Chapter 2
Literature Review

Numerous researchers have commented on the disparity between the mental health services (MHS) by Asian Americans (AAs) and non-Asian Americans (Gudiño, Lau, & Hough, 2008; Ling, Okazaki, Tu, & Kim, 2014; Nguyen & Anderson, 2005; Park & Chesla, 2010; Yoo, Goh, & Yoon, 2005; Tung, 2011; Zhou, Tao, Chen, Main, Lee, Ly, Hua, & Li, 2012). Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, and Alegria, (2007) report only about 17% of AAs who have met the diagnostic criteria for mental disorders based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) actually appear to look for MHS. The National Alliance on Mental Illness, NAMI, (2011) reports AAs use mental health services the least compared to other ethnic groups.

Numerous researchers have conducted studies on this topic with findings similar to NAMI’s claim that AAs have the lowest rates of mental health service utilization. There is increasing evidence that Asian American children are more likely than their White or African American counterparts to experience depression and engage in dangerous behaviors like self-injury and committing suicide (Anyon, Ong, & Whitaker, 2014; Anyon, Whitaker, Shields, & Franks, 2013). The likelihood of these dangers happening increases with the stresses AA children experience at school and within the family based on their ethnicity and culture. Li and Keshavan (2010) state AA adolescents, ages ten to nineteen, have high rates of unmet mental health needs.
Unfortunately, “minority youth with significant mental health problems are less likely than White children to receive needed MHS” (Gudiño et al., 2008).

Anyon et al. (2014) conducted a study using existing data that was collected from students who participated in a school district – city – county school-based mental health prevention program implemented at 15 high schools in a large urban school district. The program provided students with free school-based health education and therapy. Using the California Healthy Kids Survey (CHKS), a survey about resiliency and protective factors and risk behaviors, epidemiological data was collected for 8,466 students, which Anyon et al. (2014) used. More than half of the sample was Asian (58%), with Chinese students making up the largest subgroup of Asians (67%). Asian students were more likely to report living in dual-parent households and less likely to report using the school-based mental health services offered by the program than peers from different ethnic backgrounds.

After statistical analyses, Anyon et al. (2014) found boys and children living in dual-parent households reported lower levels of using the free school-based mental health services. Results also indicated Asian youth reported higher levels of depressive symptoms compared to their non-Asian counterparts but were less likely to use the free services available through the program. They believed “negative attitudes toward formal services and preferences to rely on friends and family during times of stress may be stronger for Asian adolescents” (Anyon et al., 2014).

Commonly referred to as a single ethnic minority group, Asian Americans are composed of more than twenty subgroups (i.e., Cambodian, Chinese, Filipino, Japanese, Korean, Laotian, Vietnamese, etc.) that have their own unique cultural, linguistic,
demographic, and immigration backgrounds (Leong and Lau, 2001). Although there are differences between the histories and beliefs of each Asian subgroup, there are also many similarities. There are a variety of barriers that make it difficult for children of color to receive MHS; multiple people (e.g., family members, friends, peers, teachers, and community members) and contexts (e.g., demographic, systemic, social, organizational, and cultural) affect service use (Anyon et al., 2014).

Gudiño et al. (2008) conducted a study using existing data from the Patterns of Care (POC) study. Garland, Hough, McCabe, Yeh, Wood, and Aarons’s (2001) POC 2-year longitudinal study consisted of a random sample of 1,715 youths between the ages of 6 and 18 who had an active case involving public sectors of care, including alcohol/drug, child welfare, juvenile justice, mental health, and public school services for students with emotional disturbances, in California’s San Diego County during the second half of the 1996 to 1997 fiscal year. Participants were asked about their demographic information (e.g., age, gender, race/ethnicity, and medical insurance status), mental health problems, and service use; caregivers provided their immigration statuses.

Gudiño et al. (2008) used the POC study’s data collected on Asian Americans, Pacific Islanders, and Hispanic Americans. Their study consisted of information from a total of 457 youths. Results of their study found a higher percentage of youth from non-immigrant families using MHS compared to youth from immigrant families. Data analysis also found that Hispanic Americans, insured youths, and females were more likely to receive MHS than their counterparts. Gudiño et al. (2008) suggested that any differences in the use of MHS between youths from non-immigrant and immigrant
families could possibly be attributed to demographic information, including the various barriers to accessing and receiving mental health services.

Demographic characteristics have been found to be a factor in Asian’s mental health service use. The research reviewed by Yoo et al. (2005) and the findings of the Gudiño et al. (2008) study both found females were more likely than men to use mental health services. Leong and Lau (2001) stated AA women faced “difficulties associated with dual oppression, being conferred inferior status in terms of both race and gender.” Therefore, Asian females were more likely than Asian males to suffer from emotional distress and also held more positive views about seeking services (Han and Pong, 2015). Still, AA women were less likely to report a need for MHS compared to White women (Spencer, Chen, Gee, Fabian, and Takeuchi, 2010).

Age also plays a role in mental health service use. Elderly AAs tend to be less acculturated. They hold more traditional beliefs and attitudes about mental health problems and treatment (Leong and Lau, 2001), meaning they are less likely to seek and use services. Contrary to the findings of the Anyon et al. study, Han and Pong (2015) state younger Asians, especially males, who may hold less traditional Asian values, may have more positive views about seeking services.

There are systemic issues that may hinder children of color from receiving needed services. Systemic factors include the lower availability of services in the communities they live in and a lack of MHS providers who offer low fees, extended hours, and conduct outreach to the minorities in the communities. In addition, minorities may not be aware of or understand available services (Abe-Kim et al., 2007). The Anyon et al. (2013) study found Chinese American students who lived in San Francisco, a city with a
large Chinese population, were less likely than students of other ethnicities to know about school-based health programs. Many of the Chinese American students believed they did not need mental health services, which was why they were not aware of the programs available in their school.

Included in systemic factors that affect MHS use are financial and practical barriers. These include a lack of jobs, child care, and insurance coverage or having to work multiple jobs (Leong and Lau, 2001). Parents may be unable to take time off to seek mental health services. Transportation is also a problem as parents may lack transportation or the facilities are too far from their homes. With more capital comes more services and opportunities. There are more culturally competent service providers and resources available in middle- and high-class urban areas, though not all minority families can afford to live in these cities. Though services provided by public schools are free, there usually has to be an identified need and Asian individuals tend to hide their mental health problems. Even if a need for services is identified, parents may prefer to use out-of-school resources as Asian individuals are concerned about how other people perceive them and their families (Kung, 2004). Sadly, the cost of treatment is not always affordable or high on the list of the family’s financial responsibilities.

Ling et al. (2014) sought to gain the perspective of service providers regarding the mental health needs of AA students and the barriers they faced to MHS access and use. They found their first few participants by reaching out to organizations that served the Asian American community. Then, they used snowball sampling to recruit more participants from Brooklyn, Manhattan, and Queens. Their sample consisted of 16 Chinese, Korean, or White service providers, 4 males and 12 females, which included
Asian American program coordinators and organization leaders, mental health counselors, psychologists, and social workers who worked in various settings (e.g., afterschool programs, community organizations, hospital inpatient and outpatient units, and mental health community clinics). Some of the professionals in their sample were bilingual; they provided services at least one other language other than English. Some had experience working with second-generational Asian American youth as well as Asian youth who recently immigrated to the United States of America.

The Ling et al. (2014) study participants reported structural issues as a major barrier to Asian American adolescents accessing and using MHS. Many of the low-income AA parents in the New York area where the study was conducted were working long hours to take care of their families. As a result, there was not enough time or energy to attend to their children. Another issue was immigration status. Some parents were undocumented, eliciting adolescents’ hesitation to look for formal services. Furthermore, these adolescents were worried about their parents’ risk of being deported.

Social factors are another set of barriers that affect MHS use among minority populations. Social relationships and networks influence individuals’ help-seeking behaviors or take the place of formal mental health services (Anyon et al., 2014). Unfortunately for individuals who have recently immigrated to the United States, many have lost support systems consisting of family members and friends left in their country of origin. Individuals turn to those they know and trust in times of need. They receive information from others about what services are available, including the quality of care and perceived effectiveness (Anyon et al., 2014). They are either encouraged or discouraged by the other person in the personal relationship to seek professional help.
They may even seek support from the other person in the relationship instead of consulting with mental health professionals. The downside to receiving information through word of mouth is that Asian Americans may not hear about the mental health issues their peers are experiencing as their peers may also be Asian Americans. Asian Americans’ unwillingness to talk about mental health problems in public may contribute to feelings that AAs do not usually experience such problems.

Organizational factors may affect the use of MHS. For example, identification of need and the ease of access varies from community settings to school settings. With regard to community-based services, individuals may receive care prompted by personal or familial concerns. With regard to school-based services, staff, specifically teachers, help to identify students who may need or benefit from mental health support at school.

Within the school, there are some issues which may prevent AA students from being identified for and receiving appropriate MHS. School staff may focus on students who exhibit externalizing behaviors as they disrupt the learning environment and disregard or remain unaware of students exhibiting internalizing behaviors. Children who exhibit externalizing problems are more likely to receive services than children with internalizing problems (Gudino et al., 2008). Externalizing problems, like aggression, hostility, hyperactivity, impulsivity, and non-compliance, are more easily identifiable than internalizing problems, like anxiety, depression, and social withdrawal (Ling, Huebner, He, and Zhong, 2015) due to the fact that they can disrupt the lives of the child with such problems and the lives of others around the child. Internalizing problems can cause major distress for the child although they may not negatively affect the lives of others. In addition, they may be considered appropriate behaviors in cultures that value
the suppression of emotions, such as Asian cultures. Therefore, it may be more difficult to detect internalizing problems, which results in many AA youth’s mental health problems being overlooked.

The Gudiño et al. (2008) study looked at youths’ MHS use. They found that when youths exhibited externalizing behaviors during the baseline phase, they were twice as likely to receive MHS during the two years of the POC study. Additionally, MHS use for externalizing need was higher for youths from immigrant families. For youths with internalizing behaviors, MHS use was higher for those from non-immigrant families. Study findings also indicated that almost half (45.99%) of the whole sample received school-based services and externalizing problems increased the chances of receiving such services, regardless of the family’s immigration status. Overall, youths from non-immigrant families were more likely to receive MHS in general and when there was an internalizing need present; youths from immigrant families were more likely to receive MHS when there was an externalizing need.

Internalizing behaviors cause major distress for the student and may be aligned with cultural expectations of how Asian children should behave and present themselves. Anyon et al. (2014) state “emerging evidence suggests that teachers often expect Asian American youth to be perfectionist, anxious, and shy, while also perceiving them to be less hostile, disruptive, and aggressive than Black or Latino youth.” This expectation is shaped by the model minority myth and Asian cultures’ ideas of proper communication style.

The model minority myth is the idea that Asian American adolescents are high achieving, hard working, and do not suffer from psychological problems (Ling et al.,
In Asian cultures, education is encouraged and highly valued, so much that parents are willing to sacrifice and endure hardships to ensure their children receive a quality education (Jacob, Gray, and Johnson, 2013). With higher education comes better chances at living a stable and fulfilling life due to financial security and access to resources. This is why AA children are expected to earn good grades and select a safe major that will more than likely lead to employment. In Asian families, being a good son or daughter means being academically and occupationally successful (Lee et al., 2008).

Although the model minority myth may be considered a positive stereotype in that AAs are believed to be successful individuals who do not suffer from mental illnesses, it creates stress for Asian individuals who may not be able to live up to these standards. For example, Asian students whose families have recently emigrated from another country may be experiencing school-level challenges; they are expected to excel in an American school where they may be beginning to learn the English language and how the American school operates. Youth who cannot not live up to the expectations of the model minority myth may experience anxiety and oftentimes do not seek help due to feelings of embarrassment, frustration, or failure. Additionally, many of them deny or try to hide their anxiety symptoms and do not seek help because experiencing psychological problems disproves the model minority myth. Anyon et al. (2013) found Chinese American students in San Francisco, California, who accounted for 45% of the students in high school and 25% of the students in school-based mental health programs, associated mental health service need with admission of psychological problems or inappropriate behaviors. Ling et al. (2014) also mentioned the findings of the Eisenberg et al. (2009) study in which Asian American and international university students
associated higher stigma with help-seeking behaviors; therefore, many of them did not seek mental health services.

Cultural factors are major barriers for minority youth to using MHS (Gudiño et al., 2008) due to the conflicting beliefs and teachings between the Eastern and Western value systems (Jacob et al., 2013). For example, the Eastern system is comprised of agriculture and traditional values whereas the Western system is industrialized and holds modern values. Other values in the Eastern system include a family or group-orientation, a large emphasis on extended family, interpersonal harmony, statuses determined by the person’s age and position in the family, and suppressing emotions. (Jacob et al., 2013). The opposite goes for the Western system, which includes an individual orientation, an emphasis on the nuclear and blended families, independence, statuses determined by effort and success, and expression of emotions (Jacob et al., 2013). The Western value system of the United States of America conflicts with the Eastern value system of Asian countries. In addition to the stigma attached to mental illnesses (Park and Chesla, 2010; Han and Pong, 2015), Miller, Yang, Farrell, and Lin (2011) state there are “immigration factors (e.g., acculturation and generational status), English proficiency, acculturation gap, and experiences of racism and discrimination” that affect the mental health and overall well-being of AAs.

There continues to be stigma attached to mental illness, which may be more prominent among Asian cultures than in American culture (Li and Seidman, 2010; Nguyen and Anderson, 2005). Emotional and mental problems are viewed negatively, similar to disobedience or disrespect, as they all have the potential to bring shame to the family (Nguyen and Anderson, 2005). As previously mentioned, Asian individuals are
concerned about how other people perceive them and their families (Kung, 2004). Asian societies tend to be collectivistic in nature so concerns about shame and losing face (e.g., suffering a loss of respect, being humiliated) within the community are held by all family members. It is important for Asian family members to conduct themselves in a manner that positively contributes to the family’s status and reputation, whether they are in America or their country of origin.

Part of the stigma attached to mental illness is based on beliefs about its cause. According to Nguyen and Anderson (2005), some Asians believe those who have mental illnesses may be possessed by supernatural beings like spirits and demons. Mental illnesses are also seen as payback for family members’ or ancestors’ wrongdoings. Some Asian Americans may consider certain negative behaviors (e.g., dangerous, disruptive, or psychotic behaviors) as signs of mental health problems (Leong and Lau, 2001). Han and Pong (2015) and Lee, Juon, Martinez, Hsu, Robinson, Bawa, and Ma (2008) mention studies about Asians’ beliefs that emotional distress is a consequence of thinking negative thoughts, having a weak personality, and lacking self-control and willpower. The Chinese American students who participated in the Anyon et al. (2013) study believed other students who frequently used the school-based health programs at their school were typically “bad” students who were having personal and relationship problems or wanted to engage in inappropriate behaviors. Mental health problems are considered to be negative reflections of the individual, his or her family, and their ancestors. “Therefore disclosing that one has mental illness is considered to be shameful (Kung, 2004; Lee et al., 2009)” (Han and Pong, 2015).
The shame tied to suffering from a psychological problem or having a family member who is suffering from one affects service use. The person with the problem and his or her family members may hesitate from seeking out and using MHS because of the negativity associated with mental illnesses. There are negative connotations with the institutionalization of family members who have mental illnesses (Park and Chesla, 2010). It is the admission of the presence of a mental illness and it goes against the belief of relying on the family for support (Anyon et al., 2014; Han and Pong, 2015). Many Asian individuals do not seek or use mental health services as they do not want to bring shame to their families and risk being judged by others. They may feel guilty and even blame themselves for having mental illnesses (Tung, 2011).

In the Ling et al. (2014) study, the service provider participants commented on stigma and discrimination as major stressors contributing to AA adolescents’ need for mental health services. They felt the stigma associated with mental health need and services needed to be addressed, especially among Asian populations. Based on their clients’ experiences, educational and psychological problems were highly associated with shame. Both positive stereotypes, like the model minority myth, and negative stereotypes did not help native and foreign born Asian youths; they experienced racial discrimination from individuals of different and same ethnic backgrounds.

Depending on the belief about the cause of mental illnesses, some people may believe the impacted person is going through a phase. Other people may believe the problem will resolve itself. There are also people who believe they can solve the problem on their own. Asian Americans tend to use more passive coping strategies to deal with their problems, which include avoidance, minimizing the problem, social withdrawal, and
accepting their fate (Han and Pong, 2015; Kung, 2004). These factors contribute to low rates of MHS use among Asians.

Asian youth may express their emotional problems consciously or unconsciously through ways that do not require voicing their feelings. When experiencing mental illnesses, “Asian adolescents tend to internalize their distress and focus on the physical symptoms of psychological problems” (Anyon et al., 2014). They are more likely to describe their physical ailments and related symptoms as many Asians consider mental health problems to be organically based. Somatic complaints can be manifestations of emotional complaints and may be more culturally acceptable forms of distress. In these cases, Asians are likely to seek medical help instead of psychological help (Nguyen and Anderson, 2005).

The lack of culturally competent providers and linguistically appropriate services and cultural or racial differences between the client and MHS providers affects utilization practices. According to Lee et al. (2008), “approximately 70 AA providers are available to every 100,000 AAs in the United States, compared to 173 White providers per 100,000 Whites.” There is a limited availability of culturally competent providers and linguistically appropriate services, meaning many individuals may receive services from a MHS provider who is not of the same culture or ethnicity or is not experienced in providing services to specific ethnic groups. With the Asian American population rapidly growing in America, service providers in areas with a large Asian American presence will most likely encounter them in practice.

Western MHS practices include techniques and treatments that conflict with Asian cultural beliefs, such as expressing feelings and sharing family matters with
outsiders. AAs who do use MHS demonstrate higher rates of treatment failure and dropout compared to their White counterparts. They also report the most adverse experiences with services out of all ethnic groups (Park and Chesla, 2010).

There is incongruence between western mental health practices and the Eastern value system. Western MHS typically require patients to think about and share their thoughts and feelings that are causing them distress. This is contrary to Asians’ beliefs about suppressing their emotions (Jacob et al., 2013) and avoiding negative thoughts (Kung, 2004). Another issue has to do with communication style. Because of cultural teachings, Asian individuals generally respond more to “a directive, problem-solving approach that offers immediate and tangible help leading to interpersonal harmony” (Kung, 2004) and formal Western psychological treatments may be more growth-oriented and individualistic in nature. Because the individual is the focus of treatment, he or she is encouraged to put their own goals before the goals of their group (Leong and Lau, 2001). Such factors may prevent AAs from seeking services, initiating contact with providers, and consistently using services.

Cultural factors may be even more prominent barriers for immigrant families and MHS utilization. According to Gudiño et al. (2008), the minority children with immigrant parents may experience more barriers when accessing MHS compared to the minority children with U.S.-born parents. The difficulties with accessing and using MHS can be attributed to limited English proficiency, lower levels or a lack of formal education, and a lack of medical coverage resulting in less access to health providers and regular medical checkups. Moreover, immigrant families have a stronger devotion to traditional cultural
beliefs and attitudes. These cultural beliefs and attitudes include and affect immigrant families’ beliefs about mental illness and the stigma related to mental illness.

Acculturative stressors cause conflict and make it difficult for people to seek and use mental health services (Ling et al., 2014; Han and Pong, 2015). Many immigrant AA children suffer from “language conflict, social conflict, perceived discrimination, perceptions of a closed society, and perceived acculturation gap between parents and children” (Miller et al., 2011). For immigrant parents and their children, acculturation is taxing on both parties as they are all adjusting to the United States of America in terms of the climate, culture, food, language, society, and norms. Conflict may arise as 1.5-generational AAs, those who were born outside of the United States of America and immigrated before or during their early teen years, may adjust to the new country at a faster pace than their parents (Jacob et al., 2013). Conflict can also occur as second-generational AAs born in the United States become used to their American culture that their foreign-born parents may not have adopted or adapted to. Both 1.5- and second-generation AA youth become the cultural and language brokers for their parents who did not grow up in the same American environment (Ling et al., 2014). In addition, conflict may arise as the children begin to adopt the ways of the new country and neglect the traditional ways of their country of origin, due to a lack of exposure or lack of practice. For example, the American idea of independence conflicts with the Asian teachings of interdependence.

Acculturation factors contribute to individuals’ positive and negative experiences and mental health service avoidance and use. According to several studies reviewed by Han and Pong (2015), AA students with higher levels of accepting and adapting to the
American culture means more positive perceptions of mental health services and more willingness to use them. Conversely, AA students who hold more traditional Asian values have more negative perceptions of MHS. These experiences may lead to psychological problems that may or may not be addressed, depending on the person’s cultural beliefs and what that particular culture teaches is acceptable and the norm.

Abe-Kim et al. (2007) conducted a study using existing data from the National Latino and Asian American Study (NLAAS). The NLAAS was the first epidemiological household survey which studied the mental health need and use of MHS among Latinos and AAs in the United States. Participants were interviewed face-to-face or through the telephone regarding immigration-related issues (e.g., immigration status, age during immigration, number of years living in the United States, and English-language proficiency) and MHS-related issues (e.g., psychiatric disorders, use of services, types of services, and treatment satisfaction). Abe-Kim et al. (2007) focused on the data collected from AAs who lived in the United States and were at least eighteen years of age. All in all, their sample consisted of 2,095 Asian American participants.

Findings from the Abe-Kim et al. (2007) study indicated AAs used mental health services at a lower rate than the general population, regardless of need. Those with and without diagnosed mental disorders were less likely than the general population to seek services. Furthermore, service use varied between U.S.-born and immigrant AAs. Those who were born in the United States were more likely than immigrants to use services. Second-generation AAs were similar to their immigrant parents in lower rates of service use compared to their Americanized children.
Cultural attitudes and beliefs may affect minority parents’ recognition of their children’s behavioral and emotional problems and their response to seek for help for their children. Asian children are expected to be respectful and quiet and to conduct themselves in an appropriate manner, especially when in the presence of others. As a result, symptoms associated with internalizing behaviors, such as anxiety, withdrawal, and depressed affect, may appear less concerning to parents as these may be considered culturally acceptable or normal emotional responses and expressions of distress. Symptoms associated with externalizing behaviors, such as aggression, impulsivity, and noncompliance, are representations of behaviors that violate the expectations, norms, and rules of interdependent cultures.

Culture may contribute to a lack of parents’ knowledge and understanding of mental health issues and theories. Many AAs may not even be aware of how important mental well-being is to overall well-being (Lee et al., 2008). Culture also shapes the explanatory framework people hold for psychological problems, including differing evaluations of child behavioral and emotional problems and what is considered serious, beliefs about the causes of these problems, and thoughts about the best way to resolve these problems.

Among Asian cultures, there is a large emphasis on the family system. “Family is the basic unit of society, and the individual within that unit must value the family as a whole and must achieve success and prosperity for the family, rather than the individual” (Jacob et al., 2013). It is more acceptable to turn to family members for help than professionals who have studied and practiced providing services to individuals with mental health issues. For Asian individuals who try to address and solve their mental
illnesses on their own, they rely on their family first should their efforts prove ineffective (Han and Pong, 2015). Even then, they would seek help from their immediate family and then extended family if needed.

There are certain roles and responsibilities delegated to each person in traditional Asian families, which gives insight into how decisions are made. Different expectations are placed on males and females. The father generally heads the household and holds the most authority. If he has a son, authority is usually passed to the eldest son. Together, the father and oldest son make decisions for the family and their choices are absolute (Jacob et al., 2013). In addition, sons are typically given more freedom than daughters. Women take on more subordinate roles. They are expected to be subservient to their husbands and his parents and perform more traditionally feminine chores like cooking and cleaning. Children are taught about family cohesion, filial responsibility (e.g., respect, service, and sacrifice for elders), and social harmony over personal happiness (Park and Chesla, 2010). Because of the importance of filial responsibility, or the duty of adult children to care for and support their aging parents, multiple generations, including grandparents, parents, married and unmarried children, and extended family, may be living in one home.

Commonly, parents seek MHS on behalf of their children. Depending on the family structure and who the patriarch is, decisions made regarding children may not always be up to the child’s parents. With more traditional individuals heading the household, children’s problems are not always detected or considered to be serious by adults even though they may cause major distress for the child. According to the Lee et al. (2008) study, young Asian American adults avoided speaking to their parents about
their mental health problems as they did not want their parents to worry. “Minority parents are less likely than Whites to recognize child mental health problems... and when problems are recognized, minority parents often hold explanatory models that divert help-seeking to sources other than MHS” (Gudiño et al., 2008).

Cultural norms influence what types of assistance are considered acceptable. “Many Asian Americans find extrafamilial interventions... to be stigmatizing, shameful, and a violation of the family hierarchy, reflecting inadequacy on the part of the family members” (Anyon et al., 2014). Seeking and using extrafamilial interventions, or professional mental health services, is believed to represent the family’s failure to care for its members. It is also believed to contribute to the family losing respect among extended family, friends, and the community. Therefore, individuals from various Asian cultures may be less likely to seek and use mental health services compared to their peers of non-Asian descent.

Professional services are commonly considered as the last resort when even the family’s efforts are not helping, when more acceptable sources of help are ineffective, and when social and legal services come into play. Depending on the Asian culture and beliefs, there are certain sources of help that are considered less stigmatizing than mental health professionals, which include acupuncturists, fortunetellers, herbalists, and spiritual leaders. The severity of the problem may increase by delaying professional treatment and as a result the mentally ill person may finally seek out mental health services. Delaying or leaving mental illnesses untreated puts the individual at risk of truncated academic achievement, drug and substance abuse, unemployment, poverty, unhealthy relationships, and suicide (Li and Seidman, 2010). This is why Park and Chesla (2010) believe
“understanding AA family caregiving is particularly important because disproportionately high rates of AAs with mental illness reside with or receive regular care from their family.”

Park and Chesla (2010) conducted a study using twenty MHS providers from the San Francisco Bay Area who provided services to Asian American patients and their families within the last five years. They were recruited using flyers and presentations at inpatient and outpatient facilities and snowball sampling. The sample consisted of sixteen Asian American participants and four White participants who were psychiatrists, psychologists, registered nurses, and social workers. They were interviewed about their theoretical and treatment approaches and experiences working with the Asian American population, with an emphasis on how the family helped or hindered the treatment process.

Findings from the Park and Chesla (2010) study indicate family served as both a solution and a problem, depending on the clients’ situation and family system. For some patients, close family ties served as a benefit. The family was aware of what the mentally ill person was going through so they were supportive and more accommodating to his or her needs. The family helped by bringing the patient in for services, providing background information, and making sure the patient took prescribed medications. For other clients, close family ties served as an obstacle to dealing with their mental illnesses. The family made it difficult to send patients to care facilities as it went against their cultural beliefs. Some families ignored the patients’ mental illnesses and expected them to carry out the roles and responsibilities given to them. Also, some families were overinvolved and overstepped the boundaries set in the treatment plan.
Chapter 3

Methods

This correlational study is being conducted to determine the affect Asian American high school students’ personal histories, including demographic and cultural factors, have on their willingness to seek and use mental health services, when the availability and access to MHS is the same as they all attend the same high school and live in the same middle- to upper-class California city. It is believed that these Asian American students may not face the same barriers to accessing MHS and should have more open views about mental health services compared to Asian Americans who have recently emigrated to the US and/or reside in low-income neighborhoods.

Hypotheses

Two hypotheses contributed to the design of this study. The first hypothesis was if Asian American students were raised in more traditional Asian homes and/or recently emigrated to America, then they would hold more closed views on mental health issues and services and they would not be willing to use MHS. Conversely, if Asian American students were raised in less traditional Asian homes, emigrated to America as a young child, and/or did not have much exposure to their Asian cultures, then they would hold more open views on mental health issues and services and they would be willing to use MHS.

Participants

The following is a description of the Asian American students who might participate in the study and the procedures used to collect data from them. The school
registrar provided the researcher with an electronic spreadsheet of the names of all of the students enrolled in the high school with a federal designation of “Asian,” or “Two or more races,” which included a race/ethnicity of, but not limited to, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, and Vietnamese. The researcher used Microsoft Excel, an electronic spreadsheet program, to randomly select students to participate in the study by using a formula, which assigned a random number to each student. The students’ last names were sorted in ascending order of the randomly assigned number and the first 100 students from the top of the list were selected to participate in the study.

Based on an analysis of the demographic information obtained through the high school’s information management system, randomly selected Asian American students’ ages ranged from 14 to 18 years of age. The largest ethnic group represented was Filipino, followed by Chinese, and then Korean. There were slightly more females than males and the majority of the students were in general education. Only a few students were classified as English Language Learners. The majority of the households were headed by married couples and lived in homes. The largest number of children living in the home was four children.

**Data-Gathering Instruments**

An introduction letter, parent consent form, adolescent assent form, and questionnaire were sent to each student’s home via the United States Postal Service. Selected students over the age of 18 were provided with an introduction letter, adult consent form, and questionnaire. Of the 100 packets mailed to 100 randomly selected students’ homes, 28 completed packets were returned for use in the study.
With the research indicating many Asian Americans faced systemic and cultural factors to accessing and using MHS, the questions on the questionnaire asked about these barriers. Questionnaire items included the students’ birthplace, their parents’ birthplace, the number of years they have resided in California, their religion, and the incorporation of traditional values in their home. The questionnaire included “Yes/No” responses, boxes to check, and spaces to write information in.

**Research Design**

A quantitative cross-sectional survey research design was used for this study via a self-administered, paper and pencil questionnaire. The researcher designed the study with confidentiality in mind due to the topic being studied therefore the questionnaire was sent directly to the students’ homes. It was felt that pulling students out of their classes to complete the questionnaires on campus would not be welcomed by parents as they and their children would not directly benefit from participating in the study. Therefore, questionnaires would be sent home along with information about the study and consent forms to participate. An added benefit was that the students could complete the questionnaires in their own homes. These steps were taken to ensure a high response rate from the randomly selected participants.

**Procedures**

The consent forms in the study packets included information regarding study procedures and confidentiality. The steps to participating in the study were written in a step-by-step fashion, outlining what the parents and their children were to do upon receipt of the study materials. The steps taken by the researcher to maintain confidentiality, with regard to the participants’ identifiable information, data storage, data access, and data
retention, were stated. This information was provided to ensure the parents’ and students’ could make an informed decision about agreeing to participate in the study.

Upon receipt of the packet, the parents and/or students would open the envelope and see a letter of invitation printed on the high school’s letterhead. The letter introduces the researcher and purpose of the study. The next page is the parent consent form which states that the parent should read all of the study information and decide whether or not to allow their child to participate in the study. If the parent agrees, then he or she would give the next paper, the adolescent assent form, to their child to read over. If the student also agrees to participate, then he or she would mark the correct choice and complete the questionnaire on the last few pages of the packet. When finished answering the questionnaire, the student would return it with the consent forms to the high school psychologist’s mailbox, the counseling office secretaries, the psychologist, or the psychologist intern/researcher.

The two-month timeline from mid-February 2016 to mid-April 2016 was set to allow enough time for data collection, data analysis, and completion of the thesis by the researcher’s college thesis submission deadline. The researcher would begin the selection process during the first week of February 2016. Then, the participants would be contacted through the mail in mid-February when the packets would be sent to their homes. The data would be collected for one month, giving the parents and students enough time to read through the multiple forms, complete the questionnaires, and return them to the high school. Next, the data would be entered into an electronic spreadsheet and analyzed from approximately the third week of March 2016 to the first week of April 2016. This way,
the researcher could report the results and discuss the findings of the study in time for the thesis submission date.
Chapter 4

Results

The researcher wanted to find out which factors (i.e., demographic, systemic, cultural) affected Asian American students’ knowledge of and willingness to use MHS, when the availability and access to MHS was controlled; they all attended the same high school and lived in the same middle- to upper-class California city. The belief, based on previous studies, was that the Asian American students who were raised in more traditional Asian homes and/or recently came to America had a closed view on mental health issues and services (e.g., these issues are not discussed in public; they are kept personal and are addressed through the family). As a result, they would not be willing to use mental health services. Conversely, students who were raised in a more American-minded home, emigrated to America as a young child, and/or did not have much exposure to the Asian countries and cultures had an open view on mental health issues and services (e.g., they can go to professionals to seek help, it is acceptable to seek outside help).

The questionnaire yielded a 28% response rate, meaning 28 out of 100 randomly selected Asian American students completed and returned the questionnaires. The lower-than-expected response rate may be the result of the following factors: no direct benefit to the student and/or their parents and guardians for completing the questionnaire; the voluntary nature of participating in the study; the amount of time required to read all of the consent forms and complete the questionnaire; and the mental health focus of the study.
The participants answered questions about themselves (e.g., age, ethnicity, gender, and birthplaces) and sample frequency counts and percentages are presented below. Twenty-eight Asian American students, between the ages of 14 and 18, participated in the study. Of the 28 participants, 14 (17.9%) were 14 years of age, six (21.4%) were 15 years of age, six (21.4%) were 16 years of age, seven (25%) were 17 years of age, and four (14.3%) were 18 years of age. Six (21.4%) were Filipino, five (17.9%) were Chinese, five (17.9%) were Korean, three (10.7%) were Japanese, three (10.7%) were Vietnamese, three (10.7%) were multiracial (Asian and Caucasian), two (7.1%) were Hmong, and one (3.6%) was Cambodian. Twenty (71.4%) participants were female and eight (28.6%) participants were male. Twenty (71.4) participants were born in the USA and the other eight (28.6%) were born in other countries. For students born outside of the USA, the number of years they have lived in the USA ranged from seven to 18 years with the majority of them moving directly to California from their birthplaces. The years spent living in California ranged from four years to 18 years.

The participants also answered questions about their family (e.g., makeup, parent’s marital status, birthplaces, and education levels, religion). The largest (n = 11, 39.3%) household makeup consisted of two parents and siblings followed by two parents, siblings, and extended family (n = 7, 25%). The remaining participants reported living in households made up of one or two of the four subgroups (i.e., one parent, two parents, siblings, extended family). Majority of the participants’ parents were married (n = 22, 78.6%) and were born in countries other than the USA (n = 16, 57.1%). The years the participants’ parents have resided in the USA ranged from 0 to 45 years. Parents’ education ranged from some high school to having a Ph. D. with the largest group of ten
(35.7%) having a Bachelor’s degree. The three largest religions reported were Christianity \((n = 10, 35.7\%)\), Buddhism \((n = 9, 32.1\%)\), and Catholicism \((n = 7, 25\%)\). One \((3.6\%)\) participant reported Taoism and one \((3.6\%)\) other participant reported more than one religion. When asked if the parent was traditional in his or her cultural beliefs, an equal amount \((n = 14, 50\%)\) reported “yes” and “no.” When asked if the parent incorporated cultural beliefs and traditions into their home, 15 \((53.6\%)\) participants reported “yes” and 13 \((46.4\%)\) participants reported “no.”

Additionally, participants were asked about previous and future experiences with professional help for mental illness. They answered questions about familial, extra familial, and personal MHS use. Eleven \((39.3\%)\) of the 28 participants reported knowing a person who sought professional help for mental illness; of the 11, five \((45\%)\) were of Asian ethnicity. Six \((21.4\%)\) participants reported a family member seeking professional help for assistance and three \((10.7\%)\) reported he or she sought professional help. Of the 25 \((89.3\%)\) participants who reported never seeking professional help for mental illness, seven \((25\%)\) reported “yes” to considering seeking services, 11 \((39.3\%)\) reported “no,” and ten \((35.7\%)\) did not provide an answer to the question.

The researcher developed a nine-item index to represent the help-seeking behaviors of the participants. The nine questionnaire items are: (a) “Would you know where to seek mental health services?”; (b) “Do you know about the mental health services available on campus?”; (c) “If you ever needed to, would you look into obtaining more information about the mental health services available on campus?”; (d) “If you ever needed to, would you use the mental health services available on campus?”; (e) “Do you know about the mental health services available off of campus?”; (f) “If you ever
needed to, would you look into obtaining more information about mental health services offered outside of the school setting?”; (g) “If you ever needed to, would you use mental health services that were available outside of the school setting?”; (h) “Do you believe it is okay for people to seek professional help for mental illness?”; and (i) “Do you believe it is okay for you to seek professional help for mental illness?” The measurement showed a very good internal reliability with this sample (Cronbach’s alpha = .91).

T-tests were conducted to compare help-seeking behaviors with various factors the participants reported. For example, a t-test was conducted to compare the help-seeking behaviors of female and male participants. There was no significant difference in the scores for females (M = 8.45, SD = 2.26) and males (M = 9.25, SD = 2.43); t(26) = - .83, p = .42). A t-test was conducted to compare the help-seeking behaviors of participants born in and outside of the USA. As shown in Table 1, there was a significant difference in the scores for US-born (M = 8.05, SD = 1.82) and foreign-born participants (M = 10.25, SD = 2.71); t(26) = -2.51, p = .019). Furthermore, there was a significant difference in the scores for participants’ parents who were born in the USA (M = 7.14, SD = 1.46) and outside of the USA (M = 9.68, SD = 2.38; t(21) = -2.60, p = .02). As far as parents being traditional in their cultural beliefs, there was no significant difference between those who were (M = 8.21, SD = 2.08) and those who were not (M = 9.14, SD = 2.48; t(26) = 1.07, p = .29). There was also no significant difference between parents who incorporated cultural beliefs and traditions in the home (M = 8.2, SD = 2.37) and those who did not (M = 9.23, SD = 2.17, t(26) = -1.20, p = .24).

Additionally, t-tests were conducted to determine the effect of knowing someone who has sought professional help for mental health illness on help-seeking behaviors.
Knowing someone who sought help for mental illness did not seem to affect help-seeking behaviors \( (t(26) = -0.92, p = .37) \), nor did having a family member who sought professional help \( (t(26) = -1.45, p = .16) \).

The researcher wanted to know about the relationships between help-seeking behaviors and participants’ ages and the years spent living in America. A Pearson correlation coefficient was computed to assess the relationship between help-seeking behaviors and age. There was a large, negative correlation between the two variables \( (r = -0.50, p = .01) \), indicating that as age increases, help-seeking behaviors decrease. There was also a large, negative correlation between the number of years spent living in America and help-seeking behaviors \( (r = -0.61, p = .00) \), indicating that as the number of years spent living in the USA increases, the tendency to seek help for mental illness decreases. There was a moderate, negative correlation between years spent living in California and help-seeking behaviors \( (r = -0.42, p = .03) \).

A one-way between subjects Analysis of Variance (ANOVA) was conducted to compare the effect of various factors (i.e., ethnicity, household makeup, parent’s marital status, parent’s education level, religion) on the participants’ help-seeking behaviors. Based on the study sample, there was no significant effect of ethnicity \( (F(7, 27) = .87, p = .55) \), household makeup \( (F(7, 20) = .67, p = .69) \), or religion \( (F(4, 23) = .43, p = .79) \) on help-seeking behaviors. Parents’ marital statuses \( (F(3, 24) = 1.17, p = 0.34) \) and the years parents have resided in America \( (F(8, 19) = 1.72, p = .16) \) also did not appear to have a significant effect on participants’ help-seeking behaviors. As shown in Tables 2 and 3, the years participants spent living in America appeared to have a significant effect on
help-seeking behaviors (F(8, 19) = 3.79, p = .008), as did their parents’ education levels (F(5, 22) = 10.07, p = .00).

Some study findings were contradictory to what the current literature has reported on Asian American’s tendencies to seek and use MHS. Based on this study’s sample, there was no significant difference between the help-seeking behaviors of females and males. There was also no significant difference between participants who had parents who were traditional in their cultural beliefs and who lived in homes where their parents incorporated cultural beliefs and traditions and participants who did not. A surprising finding was that the more years spent living in America and California resulted in a decrease in the willingness to seek and use MHS. This finding was inconsistent with the researcher’s hypothesis that students who came to America as a young child would be more willing to seek and use mental health services.
Chapter 5

Discussion and Conclusion

There are ethnic and racial disparities in the quality, access, use, and completion of MHS despite reports of similar prevalence rates of diagnosable psychiatric conditions among all ethnic and racial groups. Asian Americans were reported to be the least likely population to use mental health services. Researchers believed this was due to various reasons, including demographic, systemic, and cultural factors, which may have all contributed to underreported mental illness among Asian Americans.

The purpose of this thesis was to research the affect Asian American students’ personal histories had on their willingness to seek and use mental health services, when the geographic location and the availability and access to MHS was the same for all students. Study findings suggested gender and knowing an individual, including family members, who sought professional help for mental health illness did not have an effect on the willingness to seek and use MHS. Having parents who were traditional in their cultural beliefs and incorporated cultural beliefs and traditions in the home also did not affect help-seeking behaviors and MHS use. Birthplace, including the participants’ and parents’ birthplaces, did have an effect on help-seeking behaviors. Foreign-born students and students with foreign-born parents were more likely to seek and use services compared to US-born students and students with US-born parents.

Results from the Pearson correlation coefficients suggested large, negative correlations between help-seeking behaviors and age and the years spent living in America and in California. The Pearson correlation coefficients indicated a large,
negative correlation between help-seeking behaviors and age, meaning as age increased, help-seeking behaviors decreased. Additionally, as the years spent living in the USA and California increased, the tendency to seek help for mental illness decreased.

Results from the one-way between subjects ANOVA indicated there was no significant effect of ethnicity, household makeup, or religion on help-seeking behaviors. Parents’ marital statuses and the years parents resided in America also did not appear to have a significant effect on participants’ help-seeking behaviors. Once again, the years participants spent living in America appeared to have a significant effect on help-seeking behaviors, as did parents’ education levels.

The one-way between subjects ANOVA analysis regarding parents’ education levels indicated several significant differences between different levels. The help-seeking behaviors of students with parents who completed some high school were significantly different from students with parents who earned Bachelor’s degrees, Master’s degrees, and Ph. Ds. Additionally, students whose parents graduated from high school were significantly different from students with parents who completed some college and earned a Bachelor’s degree, Master’s degree, and Ph. Ds.

Study findings were generally inconsistent with the review of research on the topic of Asian Americans and mental health service use. The researcher believed that knowing a person who previously sought and/or used MHS would encourage an individual to be more open to seeking and using MHS; study findings did not support this belief. The review of research indicated females and children from non-immigrant families were more likely to use MHS. Study findings suggested gender did not affect help-seeking behaviors and foreign-born students and students with foreign-born parents
were more likely to seek and use services. Surprisingly, the more years that were spent living in America and California resulted in a decrease in a participants’ willingness to seek and use MHS. The researcher was also surprised to find that having parents who were traditional in their cultural beliefs and living in homes where parents incorporated cultural beliefs and traditions did not have an effect on help-seeking behaviors. Several findings were inconsistent with the researcher’s hypothesis that Asian American students who were born in or came to America as a young child would be more willing to seek and use MHS. Findings also contradicted the researcher’s other hypothesis that Asian American students who were raised in more traditional Asian homes would be less willing to seek and use MHS.

The study had its limitations due to the subject pool and geographic location of where it was conducted, which may affect its generalizability to Asian Americans, both teenagers and as a whole. First, the study sample was on the smaller side consisting of 28 participants, although 100 randomly selected students were chosen to receive the questionnaires. It was a self-selected group, meaning they could decide to participate or not. It could have been that the students who chose to participate were more open to sharing about their beliefs and experiences with MHS. Results may be different if they study sample included students who did not choose to participate. Second, the students attended a high school in a middle- to upper-class city. Not only was the study sample composed of students between the ages of 14 and 18, but their experiences were unique because of their area of residence. Third, the participants completed the questionnaires in their homes, both as a convenience factor and to preserve anonymity. Answers on the
questionnaires may have been different if the students were to complete the questionnaire under the supervision of the researcher and/or at their high school.

Future research should continue to focus on Asian Americans’ help-seeking behaviors as they use MHS at much lower rates than other ethnic and racial groups. More research should be conducted on Asian American youth. Many schools provide mental health services and previous studies have shown that Asian American students are either unaware of services on their campus or believe they do not need such services, even if they actually do. It will be beneficial to find out what specific factors contribute to Asian American youth’s hesitance and refusal to seek and use MHS and denial of experiencing mental illness. Previous extensive research has been conducted on the various factors that play a role in Asian American adults’ tendencies to avoid professional MHS. It will be interesting to see if the younger Asian Americans’ thoughts, beliefs, and reasons for avoiding mental health services are similar to those of older Asian Americans.

As the review of research shows, Asian American adults and youth are less likely to use MHS compared to other ethnic and racial groups. This study’s findings indicate that Asian American teens are less likely to seek and use MHS, especially as they get older and spend more time living in the USA. This trend is influenced by demographic, systemic, and cultural factors that are introduced in early childhood and stay present throughout life. Professionals should try to use current literature and future study findings to understand how to appeal to Asian Americans in order to help them gain access to and use MHS. Asian American teens who suffer from mental illness and who do not receive help may very well turn into Asian American adults who continue to suffer from mental illness.
References


Appendix

Table 1

*Results of a t-test for Help-Seeking Behaviors by Birthplace*

<table>
<thead>
<tr>
<th>Birthplace</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>USA</td>
<td>Not USA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Participants'</td>
<td>8.05</td>
<td>1.82</td>
<td>20</td>
</tr>
<tr>
<td>Parents</td>
<td>7.14</td>
<td>1.46</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 2

One-Way Analysis of Variance of Help-seeking Behaviors by the Number of Years Spent Living in America

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>8</td>
<td>87.39</td>
<td>10.92</td>
<td>3.79</td>
<td>.008</td>
</tr>
<tr>
<td>Within Groups</td>
<td>19</td>
<td>54.72</td>
<td>2.880</td>
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<td>27</td>
<td>142.107</td>
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Table 3

One-Way Analysis of Variance of Help-seeking Behaviors by Participants’ Parents’ Education Levels

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<th>df</th>
<th>SS</th>
<th>MS</th>
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<tbody>
<tr>
<td>Between Groups</td>
<td>5</td>
<td>98.907</td>
<td>19.78</td>
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<td>Within Groups</td>
<td>22</td>
<td>43.20</td>
<td>1.964</td>
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<tr>
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