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Perceptions of Mental Illness and Psychotherapy in a Sample of Asian, Hispanic, and White American College Students

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Abstract

This study investigated views of mental illness and psychotherapy of 1,143 ethnically diverse (e.g., Asian, Hispanic, White) undergraduates, ages 17 to 30. Results indicated that Asians typically reported the greatest misconceptions of mental illness and the least confidence in psychotherapy in contrast to White and Hispanic participants. Males expressed higher levels of negativity about psychotherapy and the mentally ill than female participants. Ethnicity and gender influenced views of mental illness and openness to seeking mental health services, even among a demographic sample (i.e., psychology college students) likely to view psychological disorders and treatment in a positive light. Future research is needed to explore variables that may contribute to these ongoing attitudinal trends.

Introduction

Mental illness continues to be a serious health problem in the United States (Surgeon General Report, 2001). An estimated 26.2 percent of Americans ages 18 and older suffer from a diagnosable psychological disorder in a given year. For example, annually 20.9 million American adults (i.e., 9.5 percent of the U.S. population) succumb to a mood disorder (Kessler, Chiu, Demler, & Walters, 2005), while an estimated 40 million adults meet criteria for an anxiety disorder (Regier, Farmer, Rae, Myers, Kramer et al., 1993). Mental illnesses, for the most part, are "equal opportunity" disorders and occur across all racial and ethnic groups in the United States (U.S. Department of Health & Human Services [USDHHS], 2000; Regier et al.).

Young adults represent the age group at greatest risk for the onset of many of the major psychiatric disorders, including schizophrenia, bipolar and major depressive disorders, anxiety disorders, as well as substance abuse (American Psychiatric Association, 2000). They are more likely to hold favorable views of the mentally ill and of psychological interventions than their older counterparts; education has also demonstrated a positive relationship with opinions of psychological disorders and treatment (Furnham & Wardley, 1990; Trute & Loewen, 1978; Trute, Tefft, & Segal, 1989). Women have typically expressed greater support of the mentally ill and of psychological treatment than men (De Crane & Spielberger, 1981; Johnson, 1988; Komiya, Good & Sherrod, 2000; Leaf, Livingston-Bruce, Tischler & Holzer, 1987; Leong & Zachar, 1999; Morrison, de Man, & Drumheller, 1994). Prior therapy experience has also been found to display a positive relationship with views of psychiatric disturbance and treatment (Desforges, Lord, Ramsey, Mason, Van Leuwen, et al., 1991; Holmes, Corrigan, Williams, Canar & Kubiak, 1999; Csipke & Mori, 2002; Mori, Brouillard, Kawasaki, Hispanic, Zavala & Chan, 2001; Penn, Kommana, Mansfield, & Link, 1999). Finally, previous research has shown a correspondence between attitudes towards mental illness and psychotherapy and help-seeking behavior (Anthony, Medway, Christensen, Korten, Jacomb, & Rodgers, 2000).

Review of Related Literature

Investigating current mental health perceptions among ethnic minority groups such as Asians and Hispanics is critical since these populations have traditionally underutilized mental health services (Chen,

Sullivan, Lu, & Shibusawa, 2003; Kaniasty & Norris, 2000; Snowden & Cheung, 1990; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). The factors behind the psychological underutilization rates of Asian and Hispanic Americans remain unclear, although several variables have been hypothesized. Suggested reasons include discrepancies in how mental illness and psychotherapy are viewed (Hall & Tucker, 1985; Lawson, Kahn, & Heiman, 1982), perceived social stigma attached to receiving psychological services (Fischer & Turner, 1970; Zhang, Snowden & Sue, 1998), what types of consultation/treatment should be accessed (Kaniasty & Norris, 2000; Leaf et al., 1987), and barriers to therapy, such as language differences between clients and therapists, culturally insensitive aspects of therapy, and lack of financial resources (Marcos, Alpert, Urcuyo & Kesselman, 1973; Russell, Fujino, Sue, Cheung, & Snowden, 1996; Toupin, 1980; Wells, Hough, Golding, Burnam & Karno, 1987).

Prior studies have consistently found differences of opinions of mental illness and psychotherapy across ethnicity (De Crane & Spielberger, 1981; Hall & Tucker, 1985; Lawson, Kahn, & Heiman, 1982; Sue, Wagner, Ja, Margullis, & Lew, 1976; Whaley, 1997). Typically, American ethnic minority members (e.g., African American, Asian, Hispanic), in contrast to White Americans, demonstrate higher levels of negativity in their views of mental illness and psychotherapy. These negative attitudes remain relatively stable across time (i.e., 20 years; Green, McCormick, Walkey & Taylor, 1987).

Angermeyer and Dietrich (2006) conducted a literature review of studies of public beliefs and attitudes towards people with mental illness that were published between 1990 and 2004. These authors referenced only one article relevant to the focus of the present study, that of American ethnic influences on views of mental illness and psychological help-seeking: Whaley (1997) reported that Asian and Hispanic respondents perceived the mentally ill as more dangerous than White respondents. Since the majority of U.S. studies on views of psychological help-seeking were conducted in the 1970s and 1980s, the present study investigated whether such attitudinal differences persist to the present, especially among Asian and Hispanic Americans, the two fastest growing ethnic minority groups in the U.S. Their combined census figures indicate that they now constitute 15.9% of the U.S. population, almost doubling in size in the past 20 years (U.S. Bureau of the Census, 2002). Therefore, exploring the extent to which ethnic and gender influences may persist in regards to opinions of mental illness and psychological help-seeking in a sample that should be positively predisposed to these topics – that of a young adult cohort of psychology college students - appeared to be an appropriate test of said influences.

The Present Study

The focus of the present study was to assess the views of mental illness and psychological interventions across Asian, Hispanic, and White American college students. It was hypothesized that Asian and Hispanic participants would express greater pessimism about mental illness and psychological interventions than their White cohorts, with Asians indicating the highest degree of negativity. Gender differences were hypothesized to emerge as well, with women endorsing more benevolent views of mental illness and psychotherapy than men. It was anticipated that independent of prior personal experience with mental illness and/or psychological intervention(s) and family-of-origin income, both ethnic and gender differences would be demonstrated.

Method

Participants

There was an insufficient number of African American ($n = 37$), American Indian ($n = 3$), and Other Ethnic ($n = 76$) participants in the original sample of 1,259 for group comparison purposes, so these individuals were dropped from subsequent analyses. Participants were 1,143 undergraduates ($n = 408$ or 35.7% White; $n = 391$ or 34.2% Asian; $n = 344$ or 30.1% Hispanic), predominantly female ($n = 755$; 66.1%), enrolled in introductory psychology classes at a large public university in Orange County, California, who received course credit in exchange for their study participation. White participants typically did not identify a specific ethnic affiliation. The aggregated Asian group was predominantly Vietnamese ($n = 105$; 27.6%), Chinese ($n = 79$; 20.7%), Filipino ($n = 82$; 21.5%), Korean ($n = 37$; 9.7%), and Japanese ($n = 31$; 8.1%). Hispanic participants primarily identified as being of Mexican ($n = 262$; 86.2%) ancestry. Ages of

participants ranged from 17 to 30, with a mean age of 20.1, a median age of 19.0, and a modal age of 18. Socioeconomic background was estimated based on participants' reported family-of-origin income, with the largest group endorsing an annual income in the \$50,000 to \$74,999 range.

The majority of participants ($n = 909$; 79.5%) denied ever receiving psychotherapeutic services. 23.1% of women and 15.2% of men in the sample reported prior counseling experiences. White respondents (32.6%) were the most likely to have undergone psychotherapy, followed by Hispanic (18.6%), and then Asian (9.2%) participants.

Measures

Participants completed a questionnaire packet composed of demographic items and the following measures:

1. Conceptions of Mental Illness (CMI; Nunnally, 1961). The CMI questionnaire measures an individual's attitudes and beliefs regarding mental illness. The questionnaire consists of 60 items arranged on a 7 point Likert scale with 1 = Completely Disagree and 7 = Completely Agree. Lower scores are more consistent with the views of mental health professionals and reflect (more) accurate views of mental illness. In addition to a total score, there are 10 factors: Factor One - Look and Act Different; Factor Two - Will Power; Factor Three - Sex Distinction; Factor Four - Avoidance of Morbid Thoughts; Factor Five - Guidance and Support; Factor Six - Hopelessness; Factor Seven - Immediate External Environment vs. Personality Dynamics; Factor Eight - Non-Seriousness; Factor Nine - Age Function; and Factor Ten - Organic Causes. The CMI has previously been used with ethnically diverse college students (Sue, Wagner, Ja, Margullis & Lew, 1976). Cronbach's alpha for the CMI scores of the present sample was .81, demonstrating acceptable internal reliability.
2. Attitudes Toward Seeking Professional Psychological Help (ATP; Fischer & Turner, 1970). This questionnaire was designed to measure an individual's perception of mental health professionals, psychotherapy, as well as her/his willingness to seek help for mental health issues. The ATP consists of 29 items using a 4 point Likert answer format, with 0 = Strongly Disagree and 3 = Strongly Agree. Items load on to four different factors: Factor One - Recognition of Personal Need for Professional Help (RECOG); Factor Two - Tolerance of the Stigma Associated with Psychiatric Help (STIGMA); Factor Three - Interpersonal Openness regarding one's problems (OPEN); and Factor Four - Confidence in the Mental Health Profession (CONFID). Positive attitudes are indicated by higher scores. Fischer and Turner reported internal reliability coefficients of .86 and .83, as well as test-retest reliabilities ranging from .89 (5 days) to .73 (2 months). Internal reliability of the ATP for the present sample (Cronbach's alpha = .86) was consistent with those found by Fischer and Turner.

Procedure

The site university's institutional review board approved this study, and all procedures were followed in accordance with APA ethical guidelines for research with human participants. Individuals signed up for the study through the Psychology 101 Experiment pool. Participants were run in a campus lab in small groups of 3 to 6 by ethnically diverse, male and female experimenters. Experimenters read a scripted brief introduction and then distributed informed consent forms. Participants read along as the experimenter read aloud the informed consent, which covered the focus of the study, the type of questions they would be asked, assurances of anonymity and privacy, and their rights as research participants, such as their right to decline to answer any item without penalty. After participants signed the informed consent (no individual declined participation), these were gathered by the experimenter and participants were then given a paper-and-pencil protocol to complete. The protocol was comprised of a demographic information questionnaire, the CMI, and the ATP. When done, participants turned in their protocols, were debriefed, thanked, given experiment credit slips, and dismissed.

Results

GPOWER analysis, a software program designed to calculate the number of participants required to demonstrate desired effect sizes, alpha levels, and power values (Erdfelder, Faul, & Buchner, 1996), indicated that to determine a medium effect size ($f^2 = 0.25$), a minimum sample of 372 was needed. This criteria was met and exceeded ($N = 1,143$). A 2 (Gender) X 3 (Asian, White, Hispanic) multivariate analysis of covariance (MANCOVA) was conducted across the dependent measures of interest with both previous counseling experience and income entered as the covariates. Prior therapy experience and income were selected as covariates due to consistent findings in the literature (Desforges et al., 1991; Holmes et al., 1999; Milville & Constantine, 2006; Mori et al., 2001; Penn et al., 1999) that both indices demonstrate positive relationships to views of mental illness and psychotherapy. We hoped to statistically account for the contribution of previous counseling and income to better ascertain ethnic and gender influences on attitudes towards psychopathology and intervention. Wilks' Lambda values are reported for all MANCOVA findings. Results indicated significant main effects for Ethnicity ($F(30,1600)=5.14, p<.000$) and Gender ($F(15,800)=6.28, p<.001$), but not for their interaction ($F(30,1600)=1.29, p<.136$).

Univariate analyses (see Table 1) and follow-up t -tests (see Table 2) for Ethnicity demonstrated that Asians typically reported the greatest misconceptions of mental illness and the least confidence in psychotherapy in contrast to Hispanic and White participants. Generally, Asians reported the highest levels of stereotypic notions of the mentally ill and negative opinions of psychotherapy than Hispanic and White participants. Asians differed from Whites on the CMI subscales titled Look and Act Different, Will Power, Avoid Morbid Thoughts, Hopelessness, Environment, and Organic Cause, and on the ATP subscales of Recognition of Need for Help, Stigma Tolerance, Openness, and Confidence in Improvement. In all of these comparisons, Asians endorsed more misconceptions and pessimistic views of mental illness and psychotherapy than their White counterparts. Asian participants also endorsed greater misconceptions of the mentally ill and more negative attitudes towards psychological help-seeking than their Hispanic peers on several CMI and ATP subscales. Pairwise comparisons (t -tests) demonstrated only one between-group difference for Hispanics and Whites: Hispanics were more likely to think that potential recovery was limited (CMI Factor Six: Hopelessness).

Between-groups analysis of co-variance (ANCOVA) findings for Gender showed that men reported higher levels of stereotypic notions of the mentally ill than women in the sample. In addition, men endorsed less positive attitudes towards seeking psychological help than women. Table 3 lists the ANOVA results, means and standard deviations across Gender.

Table 1. Analysis of Co-Variance Results and Mean and Standard Deviation Scores across Ethnicity

| Scales | Asian <i>n</i> =265 <i>M</i> (<i>SD</i>) | White <i>n</i> =305 <i>M</i> (<i>SD</i>) | Hispanic <i>n</i> =252 <i>M</i> (<i>SD</i>) | <i>F</i> (2,814) |
|----------------------------------|--|--|---|------------------|
| CMI Total | 218.66 (23.66) | 194.19 (27.76) | 209.67 (25.37) | 38.11*** |
| CMI1: Look & Act Different | 13.71 (3.52) | 11.84 (3.56) | 13.03 (3.82) | 9.22*** |
| CMI2: Will Power | 14.60 (3.91) | 11.79 (3.76) | 12.91 (3.88) | 21.36*** |
| CMI3: Sex Distinction | 14.12 (3.69) | 13.19 (3.98) | 13.84 (4.07) | 2.84 |
| CMI4: Avoid Morbid Thoughts | 15.35 (4.73) | 12.05 (4.09) | 13.35 (4.47) | 27.01*** |
| CMI5: Guidance & Support | 15.14 (2.59) | 14.56 (2.86) | 14.73 (2.71) | 1.03 |
| CMI6: Hopelessness | 12.73 (3.01) | 11.41 (2.99) | 12.49 (3.36) | 6.58*** |
| CMI7: Environmt. vs. Personality | 16.98 (2.62) | 15.97 (2.78) | 16.21 (2.60) | 6.17** |
| CMI8: Non-seriousness | 12.27 (3.45) | 11.16 (3.39) | 12.09 (3.39) | 2.83 |
| CMI9: Age | 12.11 (3.19) | 11.92 (3.40) | 12.35 (3.14) | 0.96 |
| CMI10: Organic Cause | 14.46 (2.92) | 13.65 (2.59) | 14.26 (3.01) | 4.52** |
| ATP Total | 48.27 (10.89) | 56.19 (12.87) | 54.71 (12.61) | 18.29*** |
| ATP1: Recognize Need for Help | 13.38 (4.00) | 15.19 (4.67) | 14.75 (4.65) | 3.70* |
| ATP2: Stigma Tolerance | 8.14 (3.18) | 9.50 (2.98) | 9.33 (3.03) | 10.83*** |
| ATP3: Openness | 11.21 (3.35) | 14.23 (3.91) | 13.26 (3.79) | 30.86*** |
| ATP4: Confidence | 15.53 (4.22) | 17.26 (4.60) | 17.36 (4.48) | 7.01*** |

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

Note: CMI=Conceptions of Mental Illness Total scale range 60-300; higher scores indicate greater misperceptions and negative views of mental illness. ATP=Attitudes Toward Seeking Professional Psychological Help Scale range 0-87; higher scores reflect positive views of psychotherapy and mental health professionals. Environmt. refers to environment.

Table 2. Mean Differences across Ethnicity

| Scales | A vs. C | A vs.H | C vs. H |
|-----------------------------------|----------------------|----------------------|-----------------------|
| CMI Total | 19.89 ^{***} | 8.31 ^{**} | -11.27 ^{***} |
| CMI1: Look & Act Different | 1.38 ^{***} | 0.59 | -0.79 |
| CMI2: Will Power | 2.14 ^{***} | 1.56 ^{***} | -0.58 |
| CMI3: Sex Distinction | 0.82 | 0.21 | -0.60 |
| CMI4: Avoid Morbid Thoughts | 2.77 ^{***} | 2.04 ^{***} | -0.72 |
| CMI5: Guidance & Support | 0.33 | 0.25 | -0.08 |
| CMI6: Hopelessness | 0.98 ^{**} | 0.27 | -0.71 [*] |
| CMI7: Environment vs. Personality | 0.69 ^{**} | 0.76 ^{**} | 0.06 |
| CMI8: Non-seriousness | 0.70 | 0.22 | -0.48 |
| CMI9: Age | 0.09 | -0.31 | -0.40 |
| CMI10: Organic Causes | 0.74 ^{**} | 0.16 | -0.57 |
| ATP Total | -5.50 ^{***} | -5.01 ^{***} | 0.49 |
| ATP1: Recognize Need for Help | -0.92 ^{**} | -0.81 | -0.11 |
| ATP2: Stigma Tolerance | -1.14 ^{***} | -1.01 ^{**} | 0.13 |
| ATP3: Openness | -2.42 ^{***} | -1.80 ^{***} | 0.62 |
| ATP4: Confidence | -1.01 ^{**} | -1.38 ^{***} | -0.37 |

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

Note. A=Asian; C=White; H=Hispanic. CMI=Conceptions of Mental Illness Total scale range 60-300; higher scores indicate greater misperceptions and negative views of mental illness. ATP=Attitudes toward Seeking Professional Psychological Help Scale range 0-87; higher scores reflect positive views of psychotherapy and mental health professionals.

Table 3. Analysis of Co-Variance Results and Mean and Standard Deviation Values across Gender

| Scales | Male | Female | <i>F</i> (1,814) |
|-----------------------------------|------------------------|------------------------|------------------|
| | <i>n</i> =297 | <i>n</i> =525 | |
| | <i>M</i> (<i>SD</i>) | <i>M</i> (<i>SD</i>) | |
| CMI Total | 211.63 (26.01) | 204.10 (28.32) | 8.29** |
| CMI1: Look & Act Different | 13.37 (3.40) | 12.49 (3.84) | 7.60** |
| CMI2: Will Power | 13.54 (3.77) | 12.75 (4.13) | 3.62 |
| CMI3: Sex Distinction | 13.67 (3.83) | 13.70 (3.99) | 0.07 |
| CMI4: Avoid Morbid Thoughts | 14.24 (4.39) | 13.10 (4.71) | 7.03** |
| CMI5: Guidance & Support | 15.09 (2.65) | 14.64 (2.77) | 3.03 |
| CMI6: Hopelessness | 12.28 (3.10) | 12.10 (3.20) | 0.01 |
| CMI7: Environment vs. Personality | 16.68 (2.54) | 16.19 (2.78) | 4.22* |
| CMI8: Non-seriousness | 11.85 (3.49) | 11.78 (3.41) | 0.30 |
| CMI9: Age | 12.40 (3.18) | 11.95 (3.29) | 2.86 |
| CMI10: Organic Causes | 13.98 (2.79) | 14.17 (2.88) | 1.48 |
| ATP Total | 48.24 (11.33) | 55.98 (12.50) | 65.94*** |
| ATP1: Recognize Need for Help | 12.88 (4.28) | 15.37 (4.41) | 48.72*** |
| ATP2: Stigma Tolerance | 8.27 (3.01) | 9.42 (3.10) | 20.80*** |
| ATP3: Openness | 11.98 (3.60) | 13.51 (3.97) | 22.28*** |
| ATP4: Confidence | 15.09 (4.21) | 17.66 (4.42) | 54.54*** |

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

Note. CMI=Conceptions of Mental Illness Total scale range 60-300; higher scores indicate greater misperceptions and negative views of mental illness. ATP=Attitudes Toward Seeking Professional Psychological Help Scale range 0-87; higher scores reflect positive views of psychotherapy and mental health professionals.

Discussion

Findings of the present study generally supported all hypotheses. Asian and Hispanic participants expressed more pessimistic views of mental illness and psychotherapy than their White peers. Asians, in particular, were the most negative in their opinions of the mentally ill and towards seeking psychological assistance. Similarly, male participants reported greater misconceptions of mental illness and negativity towards psychotherapy than female participants. Despite the fact that all participants were college students between the ages of 17 to 30 (e.g., an educated group of young adults), and statistically controlling for the respective influences of prior experience in psychotherapy and family-of-origin household income, ethnicity and gender were found to have independent effects on views of mental illness and accessing mental health intervention.

Mental Health Views of Ethnically Diverse Groups

Among the different aggregated ethnic groups in the study (e.g., Asians, Hispanics, Whites), Asians appeared to demonstrate the greatest number of attitudinal differences with their White counterparts. It appeared that all groups viewed mental illness as a serious health concern, one that could strike old and young, males and females alike, and that social support was vital to assisting the mentally ill. In addition, Asians were more likely than Whites to believe that mental illness was due to predominantly organic causes and environmental stressors rather than to personality factors, expressed greater pessimism regarding the prognosis of the mentally ill, and believed that having poor will power and dwelling on morbid thoughts contributed to the onset of mental illness. Not surprisingly then, Asian participants were less likely to recognize a need for psychological assistance, perceived greater social stigma as being associated with psychological treatment, were less open to mental health interventions, and less confident that therapy would be helpful than their Hispanic and White peers.

The implications of this finding, that Asians – despite education, financial resources, and access to mental health assistance – may remain negative about seeking mental health assistance, are multifaceted. Outreach programs providing information about mental illness or that promote the benefits of talking about personal problems (i.e., therapy) are less likely to be effective with Asians, in light of the present results. Underutilization of mental health services are likely to continue among this population. The case of Seung-Hui Cho, the Korean American college student behind the 2007 Virginia Tech shootings, is an example of the risks of health researchers overlooking resistance to mental health care that persists among Asians. Cho had been encouraged by his English professors and the campus police to seek psychological treatment, in one instance, undergoing a brief hospital stay after threatening suicide. He never complied with the discharge recommendation of outpatient therapy following his hospitalization (Wikipedia, 2007). Cho was socially isolated and apparently suffered from paranoid delusions. His family went into hiding immediately after the shootings, and Korean American organizations offered apologies to America for the shameful of his actions (Kang, 2007). His lack of psychological treatment led to tragic consequences.

Hispanic participants also differed from Whites in their (more negative) expectations of recovery from mental illness. Men in the present sample endorsed greater pessimism about mental illness and psychotherapy than women, consistent with prior research findings (Komiya et al., 2000; Leong & Zachar, 1999). Thus, despite increased information about mental illness and promotion of psychological treatment over the past 20 years (Angermeyer & Dietrich, 2006), ethnic and gender differences persisted in the present sample.

Cultural Values and Perceptions of Psychotherapy

Speculation as to possible explanations for ethnic group differences may include culturally-based values and traditions in reference to defining and responding to psychological disturbances. Asian cultures typically reinforce restraint of emotional expression and handling problems by oneself (Narikiyo & Kameoka, 1992; Nicholson & Kay, 1999; Sue, 1988) as preferable to not meeting role expectations and consequently, bringing a lack of harmony to the group. Tsui and Schultz (1985) reported that Asians are less likely to confide emotional problems to mental health professionals and other “strangers” than are Whites. For example, Zhang et al. (1998) found that Asians were less likely to mention their mental health problems to a psychiatrist, psychotherapist, or physician when compared to Whites. Consistent with this observation, Asian respondents in the present study indicated less openness and less confidence in psychotherapy than Hispanic and White participants.

In contrast, Hispanic cultures generally support a wide range of verbal and non-verbal expression of physical and psychological experiences (Gloria & Segura-Herrera, 2004). This might promote the process of seeking assistance for relief of emotional distress and of participating in therapy via talking about thoughts, feelings, and behaviors in detail. Culturally sanctioned practices may also promote help-seeking for psychological distress. In many Hispanic cultures, Catholicism is the dominant religion. Catholics are encouraged to discuss their concerns with church officials, such as confessing their sins to priests. Thus, the practice of sharing personal issues with authority figures or individuals outside of one's

family is familiar to many Hispanics. In support of this idea, Bhatt (2002) found a strong positive relationship between Hispanic respondents' religious faith (i.e., Catholic) and their willingness to seek counseling or therapy. The generally positive opinions of psychotherapy that were endorsed by Hispanic participants in the sample are congruent with this notion.

It is important to expand cross cultural research in this area as past studies have shown that immigrants and ethnic minority members in the U.S. experience many unique stressors compared to their non-immigrant or White counterparts, respectively. For immigrants, the challenges of adapting to life in a Western fast paced culture that is quite different from their own are formidable. Faced with learning a new language, new cultural norms, new daily life activities, often without the social and financial support from family or friends, can lead to significant depression, anxiety, low self-esteem, anger, and general emotional distress (Benisovich & King, 2003; Berry, 1990; Winkelman, 1994). At the same time, psychological counseling may itself be a foreign concept (Nishio & Bilmes, 1987) or simply an unacceptable option, due to perceived stigma or shame attached to disclosing emotional "weaknesses" to an outsider (Jaranson, 1990; Kinzie & Leung, 1993). Therapy services may also be unavailable, due to language, financial, or geographic barriers (Milville & Constantine, 2006).

For ethnic minority members, some of the same issues as those facing immigrants are also relevant. Accessing psychological assistance may not be possible due to lack of insurance and financial resources, language barriers, cultural mistrust of health professionals, or perceived violation of family privacy and social standing (Kim, 2004). Clearly, ethnic variables continue to influence views of mental illness and therapy and in turn, are likely to affect help-seeking behaviors. Further research with Asians and Hispanics is vital to overcoming resistance to consulting psychological professionals when needed among these ethnic groups.

Limitations of the Present Study

Caution should be exercised in generalizing the findings here. First, the results may not apply to ethnically diverse young adult populations in the United States. All participants were college students enrolled in psychology classes attending one large public university in Southern California. They may not be representative of young adults in general nor of individuals residing in other geographic regions in the U.S. and elsewhere. Secondly, aggregated Asian and Hispanic groups were used; studying specific ethnic subgroups may clarify different underlying influences on views of psychopathology and psychotherapy. Acculturation (e.g., adoption of the host culture, values, and practices) and enculturation (e.g., adherence to one's ancestral cultural values, beliefs, and behaviors) levels were not measured, and the extent of their contributions is unclear. The current data are self-report in nature. It may be that factors such as social desirability affected the responses of the participants. However, ethnic and gender differences in mental health attitudes that were found are consistent with those of past research studies (De Crane & Spielberger, 1981; Leaf et al., 1987; Mori et al., 2001).

Concluding Remarks

Ethnic influences continue to be minimally addressed in mental health research. The present study demonstrated that ethnic and gender differences persist across perceptions of mental illness and psychological services. These differences emerged regardless of family-of-origin income and prior counseling experience, in a young adult college student sample of Asian, White, and Hispanic Americans, a group that should have otherwise been predisposed to perceive mental illness and therapy in a relatively positive light. Future research efforts are encouraged to identify underlying within-group ethnic (such as enculturation) and gender (i.e., gender role adherence) variables that may contribute to these attitudinal differences and clarify their respective influences on psychological help-seeking behavior.

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