CULTURAL CONTRIBUTORS TO STIGMA AROUND THERAPY AND DISCUSSING MENTAL HEALTH TOPICS AMONGST ASIAN AMERICAN COLLEGE STUDENTS

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On my honor
I have neither given nor received
unauthorized aid on this thesis.

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ABSTRACT

Many Asian Americans undergo mental health issues, despite mainstream America's portrayal of them as a "successful minority" through the model minority myth. However, mental health service utilization for this demographic has historically been low, largely because of stigma amongst other reasons. Asian Americans have unique sociocultural backgrounds that inform their conceptualization and attitudes toward Western paradigms of therapy and other mental health topics. In a time of heightened anxiety from COVID-19, remote learning, and amplified anti-Asian discrimination, it is crucial to contextualize if and how Western therapy can be an appropriate form of treatment that serves Asian American college students. With a focus on the broadly cultural factors of acculturation status and Asian rooted worldviews, this study uses primary survey data to investigate potential predictors for Asian American identifying college students' stigma against seeing a therapist. This study also has an interest in potential contributors to discomfort discussing mental health concerns and therapy with parent(s). Findings show that aspects of acculturation status and worldviews have suggestive effects on stigma around seeing a therapist and other mental health topics. Though Asian American college students today overall may be more receptive of therapy, Western therapists and mental health frameworks as a whole should take into consideration different acculturation statuses and adherences to Asian rooted worldviews in order to better support this population.

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Rates of mental illness amongst Asian Americans have been rising (SAMHSA 2018), despite mainstream American society's portrayal of Asian Americans as a "successful" minority group. This increase may be related to Asian Americans' unique lived sociocultural experiences that inform both their mental health issues and ways of coping. Asian Americans have also historically confronted racism particularly rooted in stereotypes like the model minority myth, perpetual foreigner, and yellow peril, amongst others. Today, many Asian Americans also face the unique challenges of being racialized with the COVID-19 pandemic and encounter increased discrimination as a result, exacerbated by references to the "Chinese virus" and "kung flu" (Cable News Network 2020; Forbes 2020). Therefore, it is an especially appropriate time to prioritize better understanding Asian Americans' perceptions about mental health topics and treatments. Also, college students' mental health has suffered overall during the pandemic due to unique challenges of remote learning amongst other matters (Son et al. 2020); but this may be more acute for Asian Americans living in intergenerational households (Lee, Su, and Yoshida 2005). As psychotherapy is broadly the standard form of formal mental health service in America, it is critical to analyze whether therapy is appropriate form of treatment serving Asian American college students during these times.

Scholars suggest that although Western diagnostic models and cultural frameworks may identify different mental illnesses amongst Asian Americans, worldview differences in conceptualizing mental illnesses and coping strategies might lead to lower engagement with mental health services for this population (Kramer et al. 2002; Lee, Lei, Sue 2001; Nguyen et al. 2012; Tewari and Alvarez 2009). For example, in many Asian cultures, there are high rates of stigma regarding mental illness and the choice to seek therapy for it. This is largely due to shame of being seen as weak by the family and tainting the family name, which is informed by

collectivist orientations (Kramer et al. 2002; Markus and Kitayama 1991; Tewari and Alvarez 2009). In addition, the tendency to express and treat mental illness for its physical symptoms is informed by the cultural framework of mind-body holism (Lee, Lei, Sue 2001; Wong et al. 2010); and the belief that life events including mental illnesses are short-term and subject to change and thus should not be made a big deal is informed by what scholars term naive dialecticism (Nisbett et al. 2001; Spencer-Rodgers et al. 2009; Wong et al. 2010). However, little research in this area has focused on Asian American college students, who might not adhere to these views as strongly as previous generations. Lee, Su, and Yoshida (2005) underline that U.S.-raised Asian children of immigrants often struggle to balance family values and expectations with mainstream Western values and lifestyles. These parent-child tensions over different levels of acculturation may present themselves even more often now that many college students are home for remote learning.

In this study I aim to understand what might inform Asian American college students' stigma against seeing a therapist for mental health. I will focus on broadly construed cultural factors, particularly acculturation status and adherence to Asian rooted worldviews, to examine the extent to which they might shape stigma against seeing a therapist. I am also interested in familial conflict in terms of what might inform participants' discomfort discussing mental health concerns and therapy with their parent(s). Drawing on a survey of N=111 Asian American college students, I ask: what factors, with a particular interest in acculturation status (generation, primary home language) and adherence to worldviews (collectivism, mind-body holism, and naive dialecticism), might inform their stigma against seeing a therapist for mental health? I also analyze what factors broadly might be driving familial conflicts of discomfort discussing mental health topics and therapy.

LITERATURE REVIEW

There are several factors that shape one's mental health in general, as well as attitudes toward certain mental health treatments. This paper will address matters concerning acculturation status, familial tensions around mental health topics, and broadly Asian worldviews and their relationships with Western paradigms of mental health—therapy specifically. Based on these contexts, is Western therapy an adequate form of mental health treatment serving Asian American college students?

Acculturation Status on Mental Illness and Treatment

Generation

Future generations' mental health and opinions surrounding it can be shaped by how deeply previous generations acculturate to the mainstream host society, and/or retain traditions from their ethnic and cultural backgrounds. Conflicting worldviews by generation can lead to the experience of dissonance, in which varying degrees of acculturation among members of the same family result in familial conflict (Lee and Mjelde-Mossey 2004). For example, Chang and Natsuaki (2013) found that second generation Asian Americans were significantly more likely to experience this familial acculturation gap than their parents' generation. In addition, participants in a study conducted by Lee et al. (2009) report that being a 1.5 or second generation immigrant was a strong contributor to increased levels of stress in their lives. Common stressors from their experiences were pressure to meet parental expectations and family obligations. Some second generation Asian Americans believe they must try harder to succeed in America, through educational and economic achievement, to repay what they view as parental sacrifice of coming to the U.S. for the "American Dream." As a result, they often sacrifice their personal autonomy

and wellbeing to accomplish that redemption (Tran 2016).

In terms of mental health and treatment, college students with higher acculturation tend to be more likely to recognize personal need for professional psychological help, be tolerant of stigma, and open to discussing their problems with a service provider (Tewari and Alvarez 2009). It usually takes three generations to accept Western medical practices more readily than traditional models (Kramer et al. 2002). Mia Tuan's book (1998) describes that, similar to white ethnics, third-plus generation Asian ethnics grow up in families where U.S. born parents do not have as much retained cultural heritage to pass on. By the third generation, cultural values and practices linking to ancestral homelands have been diluted, lost, or reconstructed (Zhou 1999). Abe-Kim et al. (2007) finds that third generation Asian Americans had higher rates of service use than first or second generations, and they had significantly higher perceptions of helpfulness than did the second generation. The findings suggest that second generation Asian Americans are more similar to their immigrant parents in their patterns of service use and treatment ratings of perceived helpfulness. Broadly construed, different influences and pressures affect different generations, and the potential misunderstandings and tensions exchanged in intergenerational spaces can produce psychological stress and contradictory values in ways of coping.

Language Dissonance

Language dissonance between the child and the generations above them is another factor that captures acculturation statuses and differences. Segmented assimilation theory (Portes and Zhou 1993) describes three processes that summarize relations between immigrant children, their parents, and the wider ethnic community: consonant, selective, and dissonant acculturation. Consonant acculturation occurs when the children and parents both adapt to mainstream American culture and ultimately abandon their home language and cultures. On the other hand,

selective acculturation is when parents and children both learn American ways while remaining embedded in their ethnic culture. Lastly, dissonant acculturation is when children of immigrants adapt to mainstream American culture faster than their foreign-born parents. Language is a vital component of culture. Some words and meanings that are available in English may not translate the same into other languages. For example, some patients do not report their "conditions" because some explanations make no sense in their cultural surroundings, such as "fear of fatness" for self-starvation in Hong Kong and "sadness" to be treated with pills in Japan (Watters 2010). If those language and cultural contexts are retained in the Asian American diaspora, there may be tensions with English and mainstream American cultural contexts, in which younger generations may be more absorbed in. Due to this lack of thorough translation and mutual understanding of certain concepts, Asian American families wherein a non-English language is primarily spoken at home could further inform stigma against mental illness and therapy.

Familial Stigma Surrounding Mental Health Topics

Complementing the literature of Asian American acculturation differences, tensions can also be manifested within the household through discomfort expressing mental health concerns and therapy seeking. Many scholars have discussed the shame, stigma, and loss of face associated with going to counseling within Asian American communities, especially if the parent is a first generation Asian immigrant (Tewari and Alvarez 2009). Loss of face is defined as the importance of one's moral reputation and social integrity that is gained and maintained by the performance of specific roles recognized in interpersonal dynamics between family members and society (Zane and Yeh 2002)—mental illness and seeking outside help for it are typically viewed as disruptors to this moral reputation and social integrity. Children often keep secrets from their parents because of the perception that their parents would disapprove of their Western influenced

behaviors and opinions (Tewari and Alvarez 2009). This could include discussing with parents about mental health issues and therapy in ways that are largely informed by Western frameworks and discourses.

Worldviews on Mental Illness and Treatment

To examine potential predictors of stigma against seeing a therapist, this study draws on the Asian cultural worldviews focused on in Wong et al. (2010): collectivism, mind-body holism, and naive dialecticism, because their work and other theoretical and empirical literature largely support the notion that these worldviews might play a crucial role in determining mental illness lay beliefs and professional help seeking. Much literature is confident that cultural factors influence expressions of mental illness, as well as stigmatize mental illnesses and treatments (Brown et al. 2013; Hahm and Yasui 2019; Kramer, et al. 2002; Lee and Mjelde-Mossey 2004; Tewari and Alvarez 2009; Watters 2010). Though there are practical reasons that hinder Asian Americans from seeking mental health services, such as financial and geographic realities, lack of awareness of mental health services, lack of knowledge about mental health, and linguistic barriers (Lee et al. 2009; Leung and Lau 2001), key cultural concepts that inform many Asians' and Asian Americans' ways to address mental health problems are collectivism (Kramer et al. 2002; Okazaki 1997; Tewari and Alvarez 2009; Wong et al. 2010; Yeh et al. 2006), mind-body holism (Kramer, et al. 2002; Lee, Lei, and Sue 2001; Leung and Lau 2001; Ngyuen, Shibusawa, and Chen 2012; Wong et al. 2010), and naive dialecticism (Wong, et al. 2010).

Collectivism

Collectivism refers to a value orientation wherein life and development involve seeking

and maintaining interdependent relationships; the needs and harmony of the collective are prioritized over the individual's (Tewari and Alvarez 2009). Independent self-construal, or individualism, is practiced mainly by American and Western European cultures, and interdependent self-construal, or collectivism, is practiced primarily by Asian, African, Latin American, and Southern European cultures (Markus and Kitayama 1991). Collectivist traditions discourage open displays of emotion in order to save face, for maintaining social and familial harmony. In many Asian cultures, mental illness is stigmatized— seen as shameful and unacceptable—such that expressing psychological illness not only brings shame to the self but also to the family (Kramer et al. 2002).

Even after recognizing having a mental illness, traditional Western methods of coping and treatment undermine collectivist orientations. In Western individualistic orientations of coping, seeking help from a mental health care professional is encouraged. However, this action in itself is often deemed culturally inappropriate from a collectivistic perspective. For example, in Sri Lanka, one-on-one counseling was seen as individual healing away from the community, and thus problematic (Watters 2010). From a collectivist perspective, since one's behaviors, emotions, and motivations are not independent of interpersonal functioning of the community, they should not be addressed outside the group. Instead, coping strategies appropriate to collectivist orientations, as suggested from subjects in a study by Yeh et al. (2006), may include: adjusting to the social context rather than trying to change the problem, familial coping, intercultural coping, relational universality (seeking comfort from someone with a shared experience), increasing religious or spiritual activity, indigenous healing, and/or just suppressing their problems to maintain social harmony.

Mind-body Holism

Another widely held worldview in Asian cultures is mind-body holism, a concept that understands psychological and physical problems as inseparable and mutually reinforcing of each other (Ngyuen, Shibusawa, and Chen 2012; Wong et al. 2010). Many Asian Americans have reported symptoms of neurasthenia, a condition that consists of fatigue, weakness, aches and pains, sleep disturbances, and gastrointestinal problems (Lee, Lei, and Sue 2001). For instance, one 40 year old Chinese immigrant, "Mrs. A," sought medical care expressing concern about frequent pounding of her heart, shortness of breath, body aches, and sleeplessness—in which a social worker later helped her understand that her symptoms were viewed in Western medicine as depression and anxiety (Ngyuen, Shibusawa, and Chen 2012). Because of the belief that mental and physical wellbeing are connected, many Asian Americans report somatic symptoms and seek medical professionals or alternative healers for psychological problems, rather than seeking out psychotherapy (Leung and Lau 2001; Wong et al. 2010). Furthermore, stigma around mental illness in Asian societies makes it more acceptable and warranting of medical attention for psychological distress to be expressed through the body rather than just the mind (Lee, Lei, and Sue 2001). Although Asian American patients tend to present physical symptoms, they are aware of the psychological components of their illness and see it as more private, thus focus on sharing the physical aspects of care when seeing a physician (Tewari and Alvarez 2009). Given the principle of mind-body connection, Asian Americans often find Western treatment's idea of seeing a mental health *specialist* as particularly problematic because it is believed that health issues should be treated holistically (Tewari and Alvarez 2009).

Naive Dialecticism

Naive dialecticism refers to a set of East Asian lay beliefs that consist of the expectation

and normalization of change (reality is a dynamic process), acceptance around contradiction (old vs. new, good vs. bad, etc. are seen as dependent on one another for their existence), as well as holism (nothing in human life or nature is isolated, but related) (Nisbett, et al. 2001; Spencer-Rodgers, et al. 2009). Given these beliefs, positive and negative life experiences, including psychopathology, tend to be viewed as relatively short-term and subject to change. The underreporting of psychological distress has also been linked to a belief that anxiety and depression are normal responses to life's stresses (Tewari and Alvarez 2009). Wong et al. (2010) found that Asian Americans who believed depression would last a short duration of time had lower probability of seeking professional help. Furthermore, many Asian Americans would seek help at the last minute only when their symptoms become more palpable and severe (Wong et al. 2010). Many who believe in naive dialecticism emphasize that a part is not meaningful except in connection to the whole, so it is critical to pay attention to one's situational context—which also gestures to collectivism and mind-body holism.

Finding Appropriate Treatments

The American mental health care system sometimes fails to consider Asians' and Asian Americans' culturally informed expressions of mental illness because these expressions are not always precisely covered in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)—which has become the global standard (Watters 2010). Counseling and psychotherapy are generally the standard forms of mental health service in America. Because much of counseling and psychotherapy are suffused with white middle-class biases and worldviews, and because most counselors and therapists are trained in this context, it is probable that they will adopt a similar white middle-class orientation in their therapeutic relationships, diagnoses, and treatments (Liu, Pickett Jr., and Ivey, 2007). Also, many Asian

Americans who do choose to partake in psychotherapy often prematurely terminate their treatments because they do not find it culturally relevant or effective (Yeh, et al. 2006). As a result, psychotherapy may conflict with Asian Americans who strongly adhere to the earlier stated cultural worldviews, or are more heavily impacted by acculturation tensions. So, it is unclear what today's Asian American college students think of traditionally Western mental health services, such as therapy. Are current Asian American youth more accepting of standard Western therapy? Especially in a pandemic-ridden time of heightened anxiety and racism against Asians and Asian Americans, this study is critical because it addresses contemporary college-age Asian Americans' acculturation statuses/tensions, familial conflicts, and cultural worldviews, and the potential relationships between those factors and stigma against seeing a therapist for their mental health.

METHODS AND DATA

Participants and Data Collection

This study draws on an original survey I fielded comprising 60 total questions. I focus here on 10 items from that survey. Purposive sampling was used to reach the target population of concern: Asian American identifying college students. However, because many institutions only have the category "Asian," I created a survey question that asked if the participant identifies as "Asian American," and only those who answered "yes" received the next question asking for their generation in the U.S.. I used the generation variable to restrict the overall data to Asian American respondents. I obtained from the registrar a list of "Asian" identifying students currently attending Colorado College, and directly emailed the survey to everyone on that list. I also emailed 41 Asian cultural organizations from eight random college campuses across the U.S. to distribute to their organization members, in order to attempt to achieve a geographical

range of colleges. It is unknown if and how many of those organizations actually distributed the survey. I also shared the survey to personal networks via social media platforms. Along with the survey distribution, recipients were notified of an incentive of a random draw for a $25 Amazon gift card. 111 complete responses were used for data analysis. I describe the sample in Table 1.

Table 1: Descriptive Statistics of Participants and Variables (N=111)

	n (%)
Ethnicity	
Asian Indian	12 (10.8)
Bi/Multi	18 (16.2)
Chinese	29 (26.1)
Filipino	7 (6.3)
Korean	11 (9.9)
Other	25 (22.5)
Vietnamese	9 (8.1)
Gender	
Female	77 (69.4)
Male	31 (27.9)
Non-binary	3 (2.7)
Year in School	
First Year	36 (32.4)
Second Year	22 (19.8)
Third Year	20 (18.0)
Fourth Year	32 (28.8)
Fifth Year+	1 (0.9)
Parent(s)' Highest Level of Education	
Less than BA	30 (27.0)
Bachelor's	21 (18.9)
Graduate/Professional	60 (54.1)
Generation in the U.S.	
1.5 Generation	16 (14.4)
2nd Generation	37 (33.3)
2.5 Generation	24 (21.6)
3rd Generation+	15 (13.5)
Adopted	16 (14.4)
Other	3 (2.7)

Primary Home Language	
Non-English	39 (35.1)
English	72 (64.9)
Sharing Mental Health Concerns with Parent(s)	
Comfortable	59 (53.15)
Uncomfortable	52 (46.85)
Telling Parent(s) if Seeing Therapist	
Comfortable	69 (62.2)
Uncomfortable	42 (37.8)
Views on Suppressing Emotions to Not Burden Others	
Suppress	53 (47.75)
Don't Suppress	58 (52.25)
How much Mental Health Impacts Physical Health	
A lot	20 (18.0)
A moderate amount	55 (49.6)
A little or not at all	36 (32.4)
Views on Duration of Mental Illnesses	
Short	15 (13.5)
Non-short	96 (86.5)
Stigma Against Seeing Therapist for Mental Health	
Non-stigma	72 (64.9)
Stigma	39 (35.1)

Variables

The main goal of this study is to investigate what might be informing Asian American college students' stigma against seeing a therapist for mental health. Drawing on a survey of N=111 Asian American college students, I focus on what factors, with specific interest in acculturation status (generation, primary home language) and worldviews (collectivism, mind-body holism, and naive dialecticism), might inform their stigma against seeing a therapist for

mental health. I also consider what factors broadly might be driving familial conflicts of discomfort discussing mental health concerns and therapy with parent(s). I used STATA to conduct these analyses.

Acculturation Status Variables

I used generation and primary home language to capture acculturation statuses of the participants and their parent(s) and attempt to recognize how "Americanized" their home environments or upbringings were, as these may have suggestive effects on shaping how the participant views mental health related topics. Respondents indicated generation from the following options: "1st Generation (you immigrated to the U.S. after age 12)," "1.5 Generation (you immigrated to the U.S. before age 12)," "2nd Generation (born in the U.S., parents immigrated to the U.S.)," "2.5 Generation (born in the U.S., one parent born in the U.S., one parent immigrated to the U.S.)," "3rd Generation+ (born in the U.S., both parents born in the U.S.)," "Adopted," or "Other." Because of the different vocabularies and connotations surrounding mental health concepts, capturing segmented assimilation (Portes and Zhou 1993) via language dissonance may be important. Therefore, I asked whether or not English is the primary language spoken at home to try to capture language conflict.[1]

Familial Conflict Variables

To measure familial conflict, catered towards topics of mental health and therapy, questions about if the student is comfortable sharing with their parent(s) if they had mental health concerns, and if the student is comfortable telling their parent(s) if they were seeing a therapist were used to capture potential stigma coming from family. Both questions had response

[1] Since the participant is attending higher education in the U.S., their English fluency is assumed.

categories of "Strongly agree," "Agree," "Somewhat agree," "Somewhat disagree," "Disagree," and "Strongly disagree." The response categories were collapsed into a dichotomous "Agree" (indicating comfort) and "Disagree" (indicating discomfort) for simplicity.

Worldview Variables

The broadly Asian rooted worldviews I focus on are collectivism, mind-body holism, and naive dialecticism, which draw from the cultural worldviews studied by Wong et al. (2010). Their work and other theoretical and empirical literature largely suggest that these worldviews might play a crucial role in determining mental illness lay beliefs and professional help seeking behaviors. To measure the concept of collectivism, questions were adopted from the Asian American Values Scale (AVS) Multidimensional (Kim, Li, and Ng 2005). I used the question "I believe it is better to hold one's emotions inside than to burden others by expressing them" to represent collectivism because it touches upon the concept of burden and shame when expressing emotion, and is specific to the context of mental health and Western paradigms of outwardly expressing thoughts and emotions. The Likert-scale response options were collapsed into "Agree" or "Disagree." To measure the concept of mind-body holism, I used the question "At times you feel mentally unwell, to what extent is your physical health impacted?" because it situates the student in a time they feel mentally unwell and analyzes their physical health in tandem. Response options were "A lot," "A moderate amount," "A little," and "Not at all." "A little" and "Not at all" were collapsed together due to low response rates for each category. To measure the concept of naive dialecticism, I used the question "I believe mental illnesses last for a short duration of time" because it captures attitudes about life events being fleeting, while gearing it specifically towards mental illness. Again, the Likert-scale response options were collapsed into "Agree" or "Disagree."

Stigma Against Therapy Variable

The main outcome of interest, stigma against seeing a therapist for mental health, was measured by the question: "I would feel or have felt uncomfortable seeing a therapist for my mental health because of what some people might think of me." This was used as the dependent variable because it assumes a situation wherein the participant is going through a challenging time and poses therapy as the option to cope, and then captures their attitudes about comfortability in seeing a therapist depending on stigma from others. The response categories for this question are: "Strongly agree," "Agree," "Somewhat agree," "Somewhat disagree," "Disagree," and "Strongly disagree." The categories were collapsed into "Agree" and "Disagree" to create a dichotomous dependent variable.

Demographic Variables

Gender and parent(s) highest educational attainment were used to measure demographic variables for this project. In addition to gender, the survey asked for the highest education level of "Parent 1" and "Parent 2" separately. The response options for respective parent(s)' education were as follows: "Less than middle school graduate," "Less than high school graduate," "High school graduate," "Some college," "Associate's degree," "Bachelor's degree," "Graduate or professional degree," and "Unsure." These options were collapsed into "Less than BA ("Unsure" was also included here)," "Bachelor's," and "Graduate/Professional degree." Results for both parents' education were combined into a single new variable.

Data Analysis Plan

The central analyses of this study are based on logistic regressions, due to the dichotomous nature of the dependent variables. I report logit coefficients instead of odds ratios

due to the size of the confidence intervals and to provide a clearer visualization of estimates. Stigma against seeing a therapist for mental health is regressed against the demographic, acculturation, familial conflict, and worldview variables. In addition to this main analysis of stigma against seeing a therapist as the primary outcome of interest, logistic regressions of the familial conflict variables 1) discomfort sharing mental health concerns with parent(s) and 2) discomfort telling parent(s) if seeing a therapist are each respectively analyzed against the demographic variables and acculturation variables. In addition to tables, I show coefficient plots to better visualize the logistic regressions of all the analyses. To complement the coefficient plots, I also display margins graphs for certain predictors to offer a more accessible presentation of different variables' effects on the outcomes of interest. Acculturation status and worldviews are my main interests, so I provide margins graphs delineating those variables for therapy against stigma. Since I am broadly interested in potential predictors for discomfort sharing mental health concerns with parent(s) and discomfort telling parent(s) if seeing a therapist, I present margins graphs for the relationships that have significant and/or suggestive effects.

In conjunction with the logistic regression analyses and to situate the importance of this overall study, I present potential mental health decline due to the increased racism against Asians and Asian Americans linked with COVID-19. In an attempt to capture the current amplified racism against Asians and Asian Americans, participants were asked about their recent experiences. These questions asked how often they perceived or experienced discrimination because of their race, before and during COVID-19, and how often they felt anxious in public because of their race/ethnicity, before and during COVID-19. Response options were “Always,” “Often,” “Sometimes,” “Rarely,” and “Never.”

RESULTS AND DATA ANALYSIS

Overall, this sample (N=111) demonstrates low levels of stigma against seeing a therapist (about 65% non-stigma, 35% stigma), which differs from much of the literature which highlights that Asian Americans largely stigmatize therapy and other mental health topics (Abe-Kim, et al. 2007; Leung and Lau 2001; Tewari and Alvarez 2009; Yeh, et al. 2006). Potential familial stigma—which could influence how participants' view mental health topics and therapy in general—is more evenly distributed: about 47% uncomfortable sharing mental health concerns with parent(s); and about 38% uncomfortable telling parent(s) if they were seeing a therapist.

Part 1 of this study's analysis addresses potential predictors for stigma against seeing a therapist. Figure 1 presents the logit coefficients and 95% confidence intervals of all the independent variables (gender, parental education level, generation, primary home language, discomfort sharing mental health concerns with parent(s), discomfort telling parent(s) if seeing a therapist, beliefs about suppressing emotions, mental health impact on physical health, and beliefs about mental illness duration) on seeing a therapist.[2] Figure 1 suggests that men are more likely to stigmatize seeing a therapist than women, but overall there is no clear gender effect.[3] Students are less likely to stigmatize seeing a therapist if their parent(s) hold Bachelor's degrees, but more likely to stigmatize if their parent(s) hold Graduate or Professional degrees. There is no clear effect of parental education on participants' stigma against seeing a therapist. All generations, relative to the 1.5 generation, are increasingly more likely to stigmatize seeing a therapist. The effects on stigma against seeing a therapist are not clear for 2nd generation, 2.5 generation, and Other students. 3rd generation+ exhibit suggestive effects, and adopted students

[2] Refer to Appendix A for Table 2, which presents the logit coefficients.
[3] Non-binary people were dropped from the analysis because failure was predicted perfectly.

are significantly more likely to stigmatize seeing a therapist. Households with English as the primary language are less likely to stigmatize seeing a therapist, but overall there is no clear language effect. Those uncomfortable discussing with their parent(s) about mental health concerns are more likely to stigmatize seeing a therapist, though overall there is no clear effect. Those uncomfortable telling their parent(s) if they were seeing a therapist are significantly more likely to stigmatize seeing a therapist. Those who do not suppress emotions have a lower likelihood of stigmatizing seeing a therapist. Whether or not one suppresses emotions has suggestive effects on stigma against seeing a therapist. Those whose physical health is impacted by mental health a moderate amount are less likely to stigmatize seeing a therapist, and even less likely to stigmatize if their physical health is impacted a little or not at all. Overall, there are no clear effects of mind-body impact on stigma against seeing a therapist though. Finally, without clear effects, those who believe mental illnesses do not last a short duration of time are less likely to stigmatize seeing a therapist.

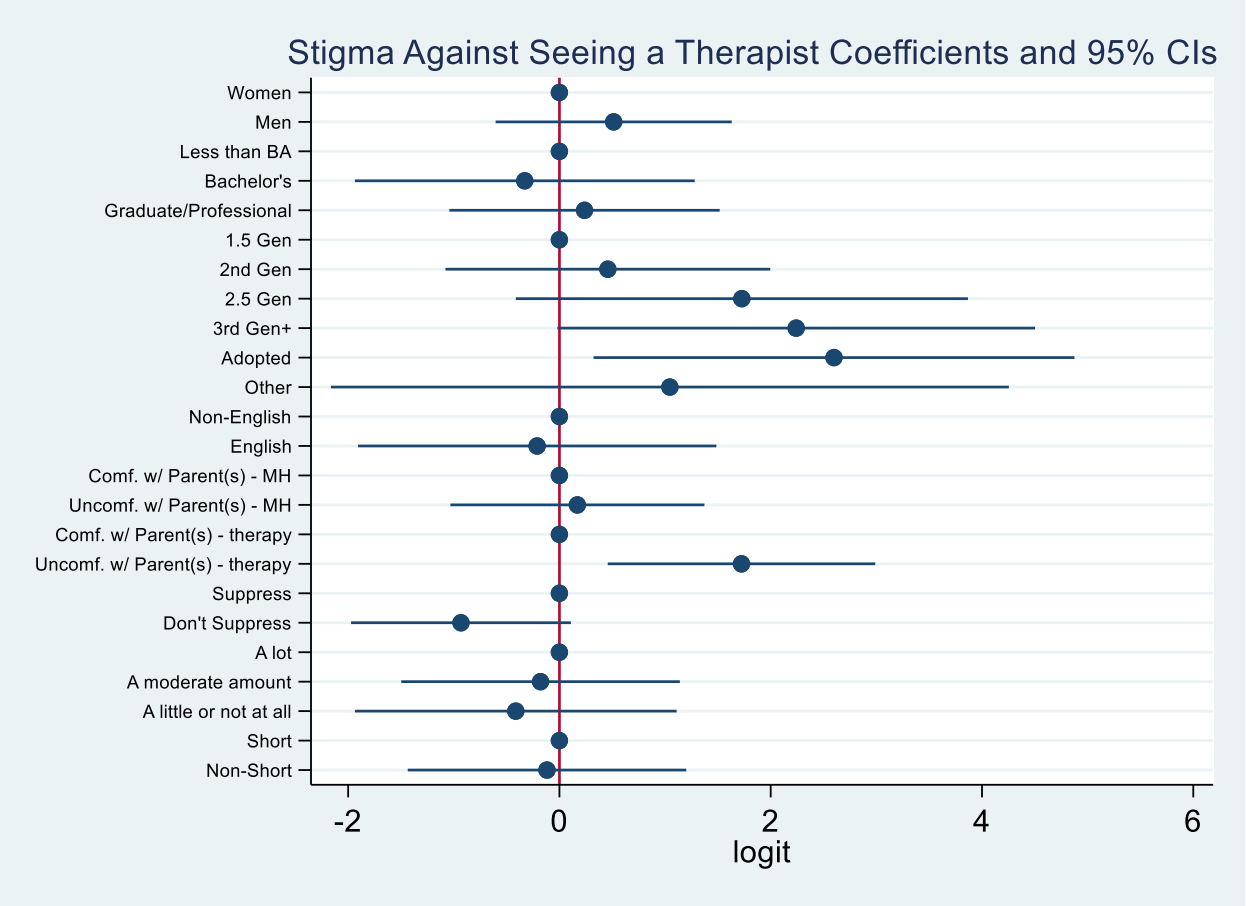

Figure 1. Stigma Against Seeing a Therapist Coefficient Plots and 95% Confidence Intervals.

Figure 2 and Figure 3 present probabilities of stigma against seeing a therapist by each acculturation variable. Figure 2 suggests that stigma increases with generation, and is highest amongst adoptees. Figure 3 suggests that probability of stigma against seeing a therapist for mental health is a little higher amongst students from households in which English is not the primary language.

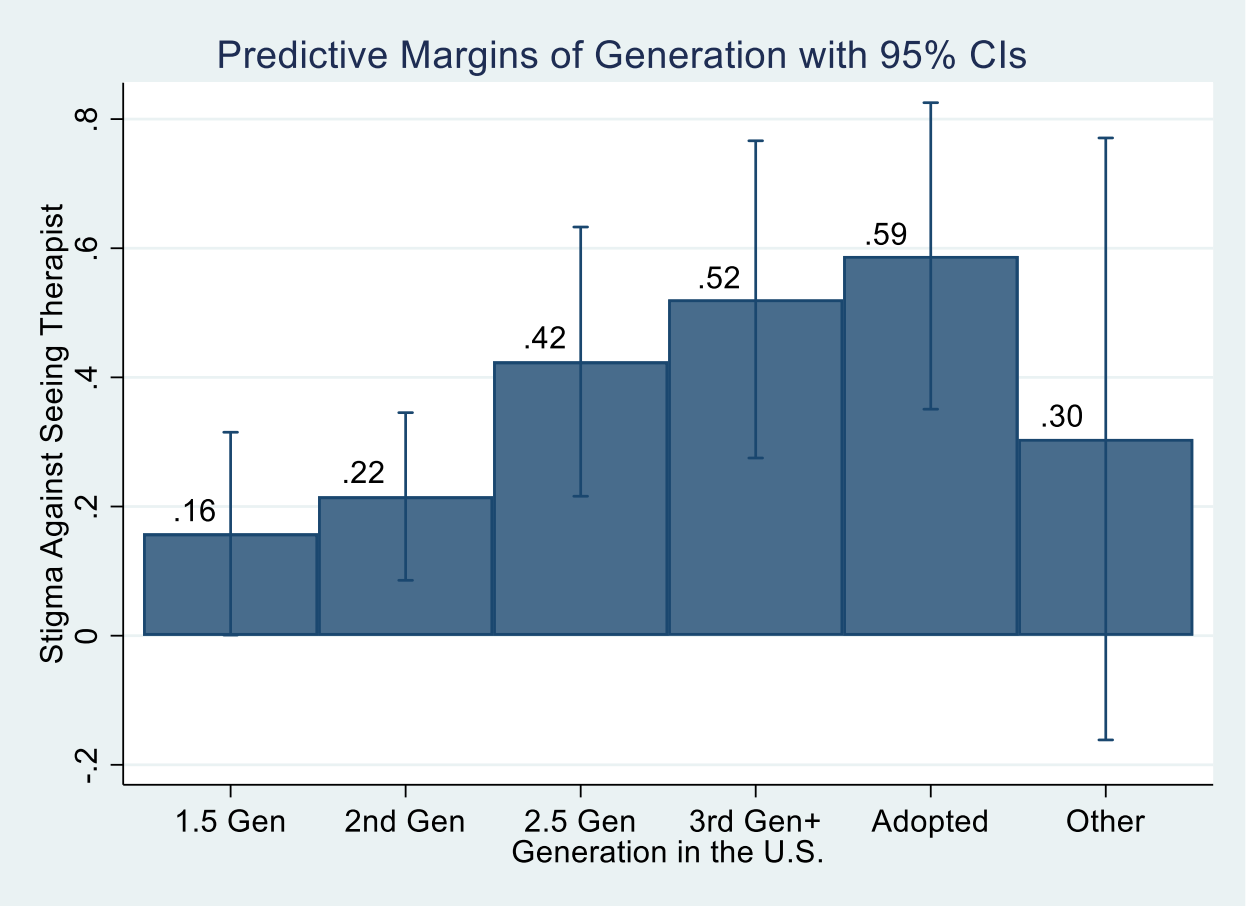

Figure 2. Predictive Margins of Stigma Against Seeing a Therapist by Generation.

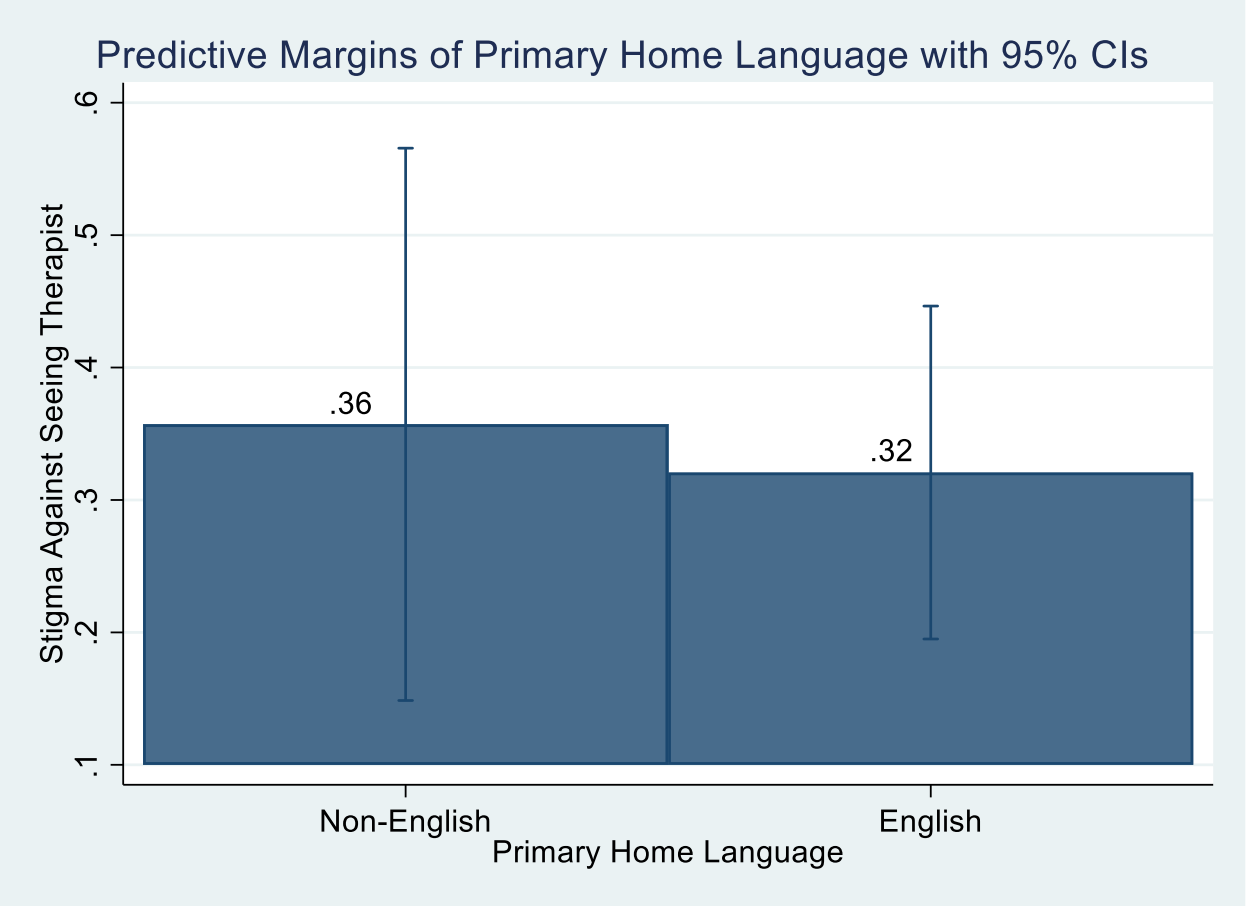

Figure 3. Predictive Margins of Stigma Against Seeing a Therapist by Primary Home Language.

Figure 4, Figure 5, and Figure 6 visualize probabilities of stigmatizing seeing a therapist by beliefs about suppressing emotions, how much physical health is impacted by mental health, and beliefs about mental illness duration. Figure 4 indicates that those who believe it is better to suppress emotions to not burden others are more likely to stigmatize seeing a therapist. Figure 5 suggests that those whose physical health is impacted by mental health a lot are most likely to stigmatize seeing a therapist, compared to those whose mind-body influence are anything less. Figure 6 suggests that the probability of stigma against seeing a therapist is higher for people who believe that mental illnesses last a short duration of time.

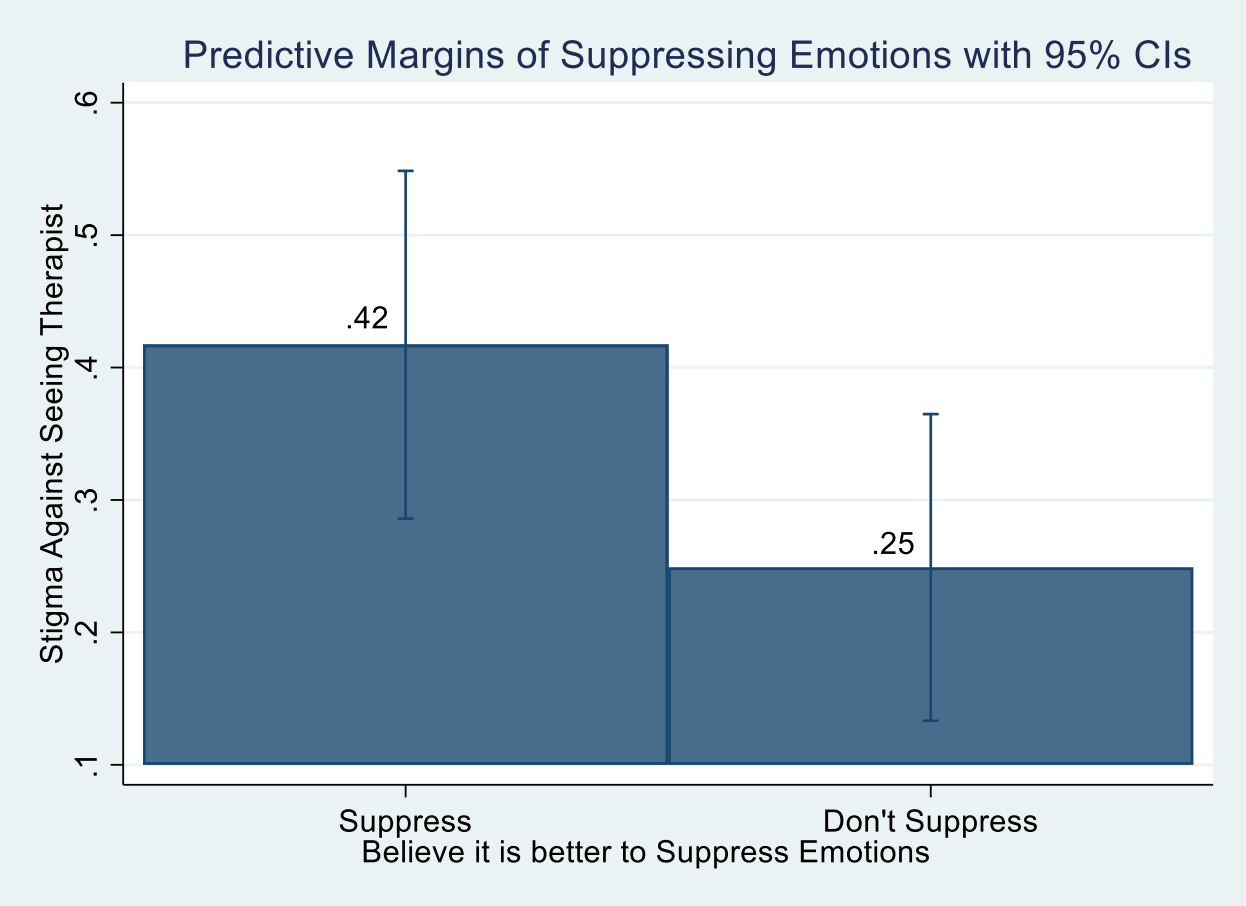

Figure 4. Predictive Margins of Stigma Against Seeing a Therapist by Beliefs about Suppressing Emotions.

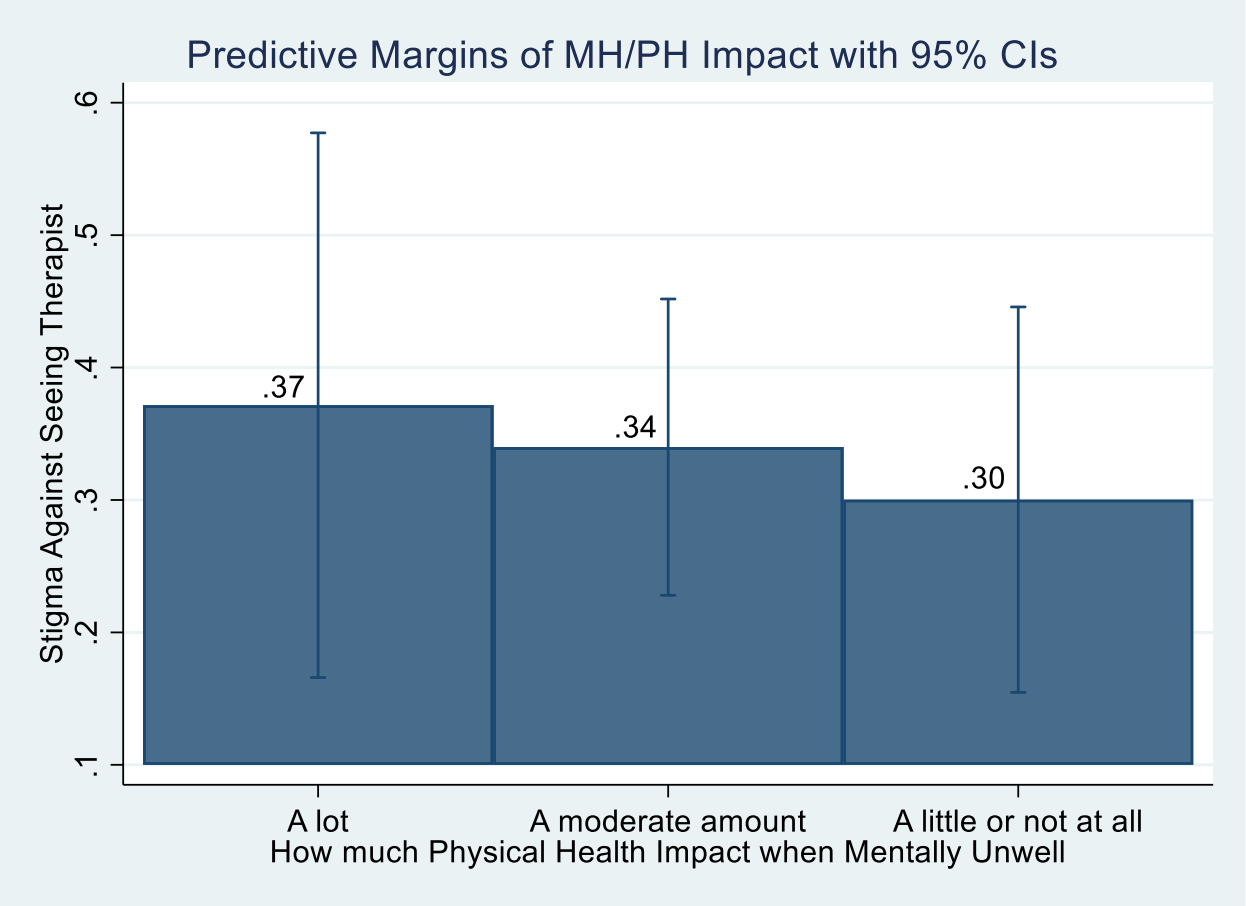

Figure 5. Predictive Margins of Stigma Against Seeing a Therapist by Mental Health Impact on Physical Health.

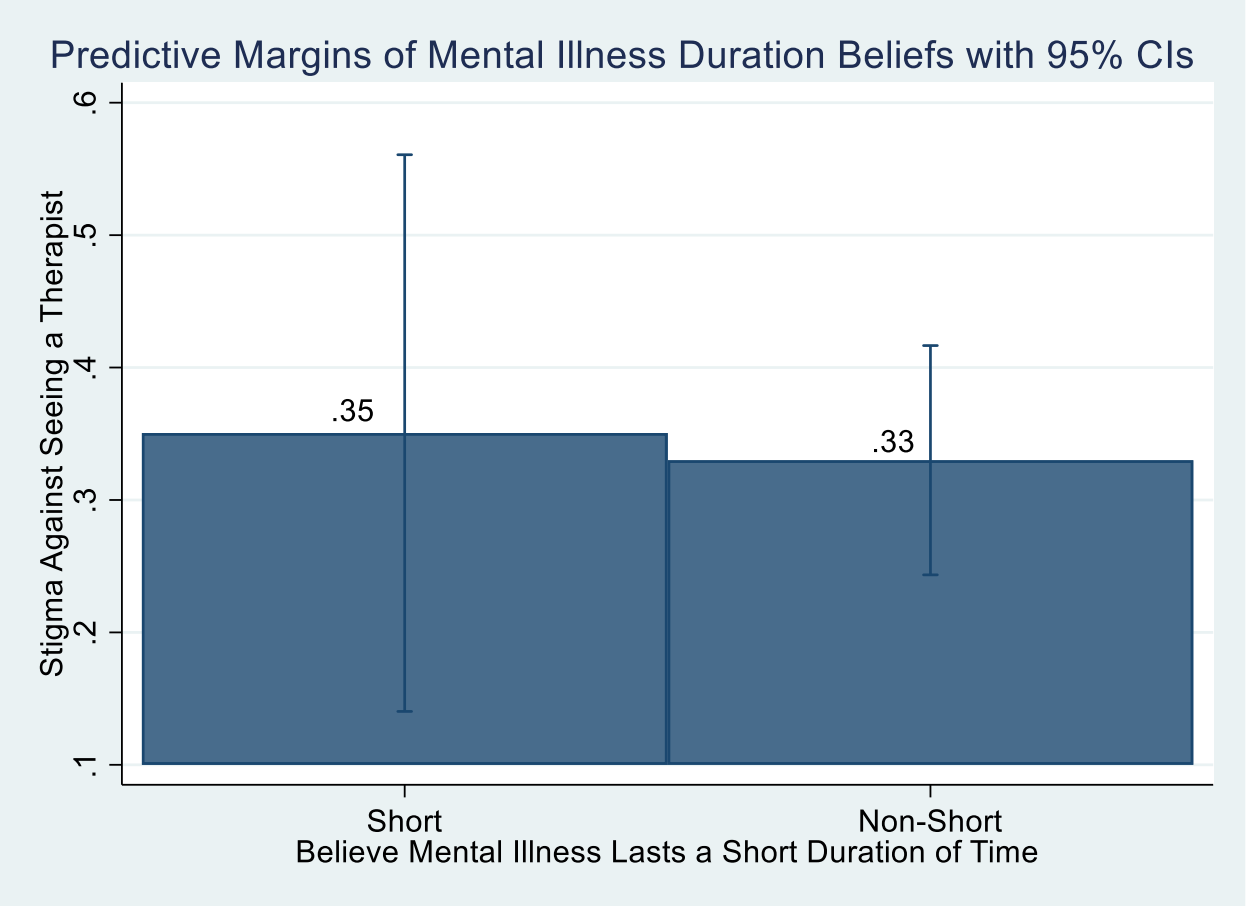

Figure 6. Predictive Margins of Stigma Against Seeing a Therapist by Beliefs about Duration of Mental Illness.

I am also interested in familial conflict (discomfort sharing mental health concerns with parent(s), discomfort telling parent(s) if seeing a therapist) as dependent variables to visualize potential predictors of stigma around mental health topics that stem from parent(s). Figure 7 exhibits discomfort sharing mental health concerns with parent(s) against gender, parent(s)' highest level of education, generation, and primary home language.[4] Men and non-binary individuals are less likely than women to feel discomfort sharing mental health concerns with their parent(s), though there is no significant gender effect. Students with parent(s) holding Bachelor's, or a Graduate or Professional degree are less likely to feel discomfort expressing

[4] Refer to Appendix B for Table 3 which presents the logit coefficients.

mental health concerns with their parent(s), relative to students with parent(s) with anything less than a Bachelor's degree. Those with parent(s) holding Graduate or Professional degrees present suggestive effects on discomfort sharing mental health concerns with parent(s). All generations, Adopted, and Other are less likely to feel discomfort sharing mental health concerns with parent(s), though overall there is no clear generation effect. Finally, those with English as the primary home language are less likely to feel discomfort sharing mental health concerns with parent(s), though overall primary home language has no clear effect.

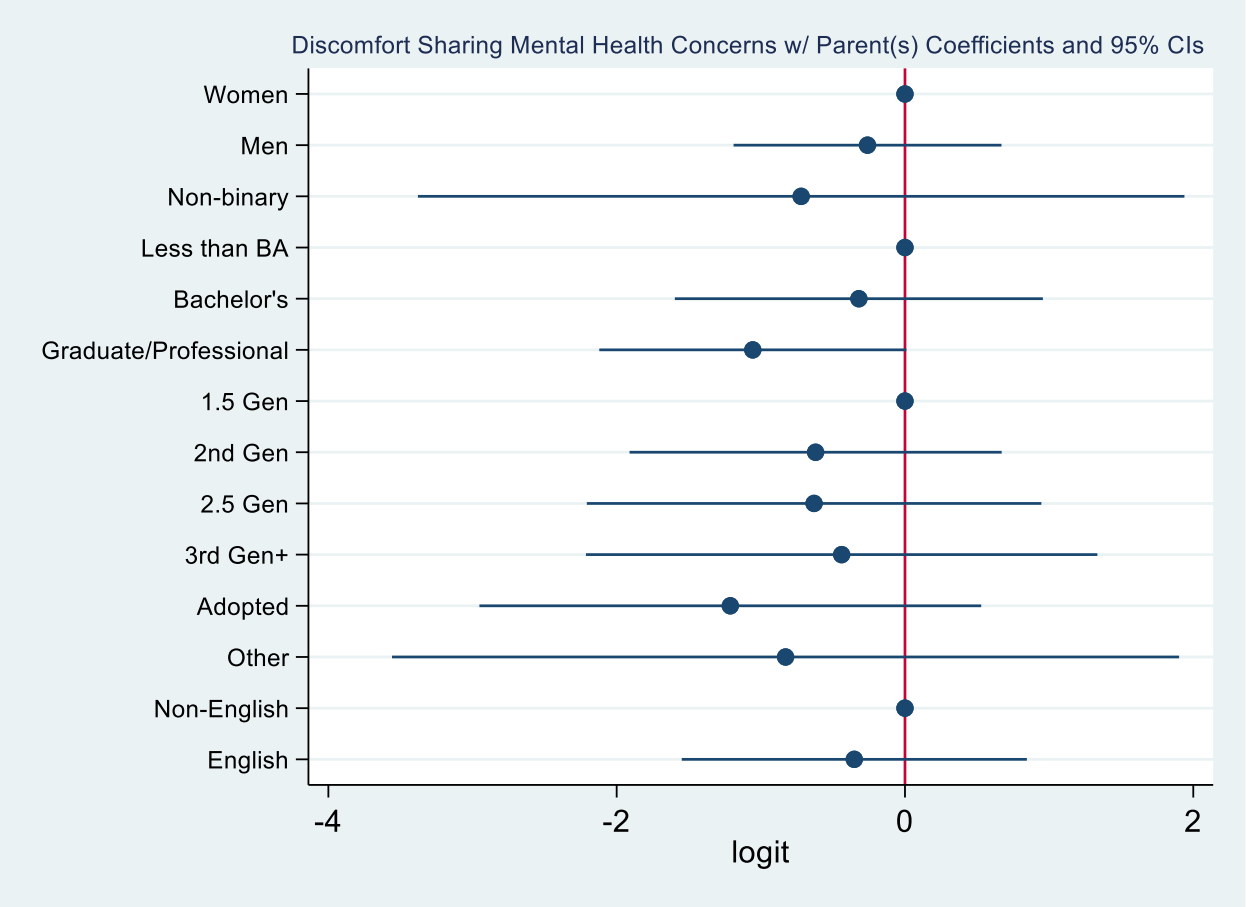

Figure 7. Discomfort Sharing Mental Health Concerns w/ Parent(s) Coefficient Plots and 95% Confidence Intervals.

Figure 8 displays the predicted probability of discomfort sharing mental health concerns with parent(s) by parent(s)' highest education level. The graph displays that the more highly

educated the parent(s), the less likely the participant will feel discomfort sharing mental health concerns with them.

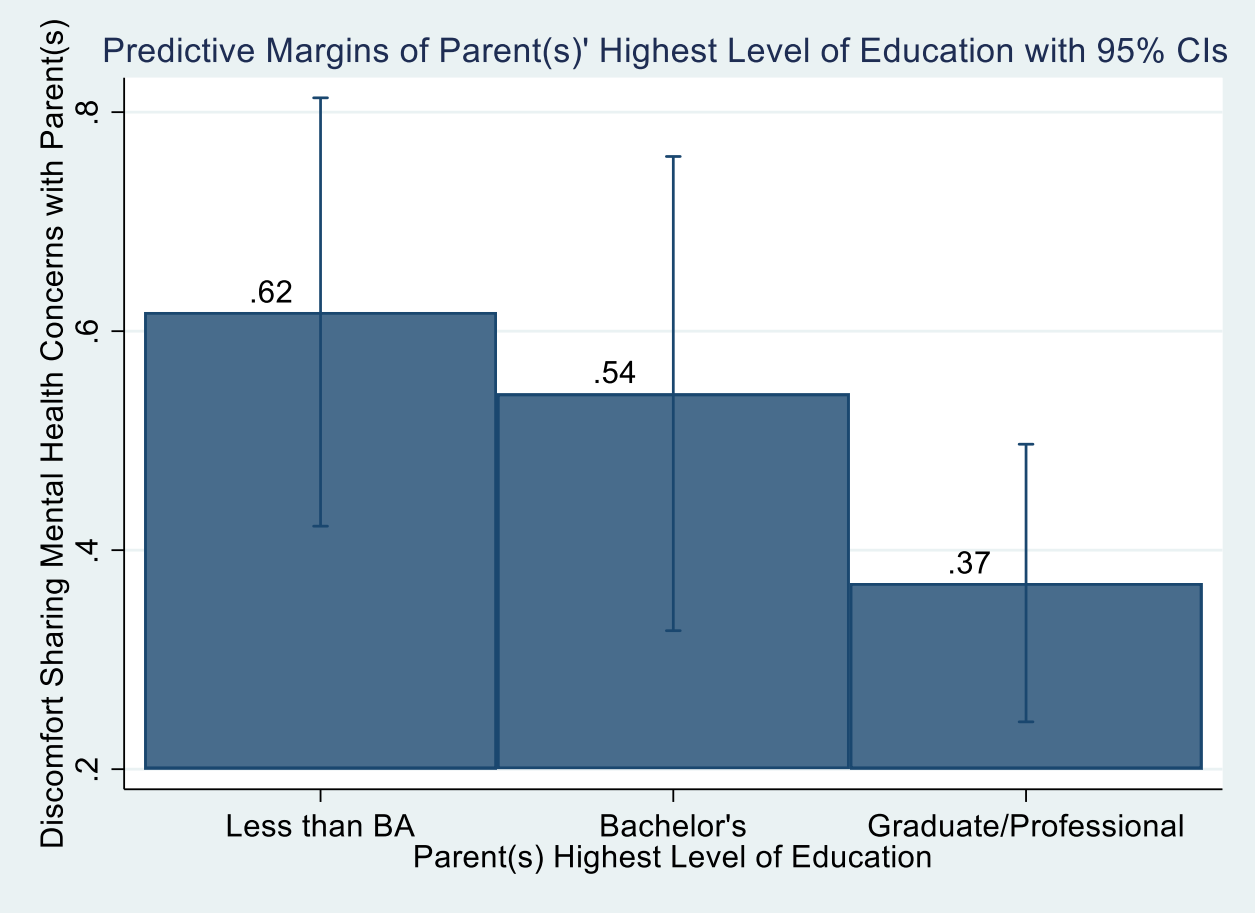

Figure 8. Predictive Margins of Discomfort Sharing Mental Health Concerns with Parent(s) by Parent(s)' Highest Level of Education.

Figure 9 presents discomfort telling parent(s) if seeing a therapist against gender, parent(s)' highest level of education, generation, and primary language at home.[5] Men are slightly more likely to feel discomfort telling their parent(s) if they were seeing a therapist, relative to women.[6] There is no clear gender effect on discomfort telling parent(s) if seeing a therapist. Relative to students with parent(s) holding anything less than a BA, students who have parent(s) with Bachelor's degrees are more likely to feel discomfort telling their parent(s) if they

[5] Refer to Appendix C for Table 4, which presents the logit coefficients.
[6] Non-binary people were dropped from the analysis because failure was predicted perfectly.

were seeing a therapist, and those with parent(s) holding Graduate or Professional degrees are less likely to feel discomfort. There is no clear parental education effect on students' discomfort telling parent(s) if they were seeing a therapist. All generations, Adopted, and Other have lower likelihoods of feeling discomfort telling parent(s) if they were seeing a therapist, though overall there is no clear generation effect. Lastly, those with English as the primary home language have lower likelihood of discomfort telling parent(s) if they were seeing a therapist. Primary home language has suggestive effects on discomfort telling parent(s) if seeing a therapist.

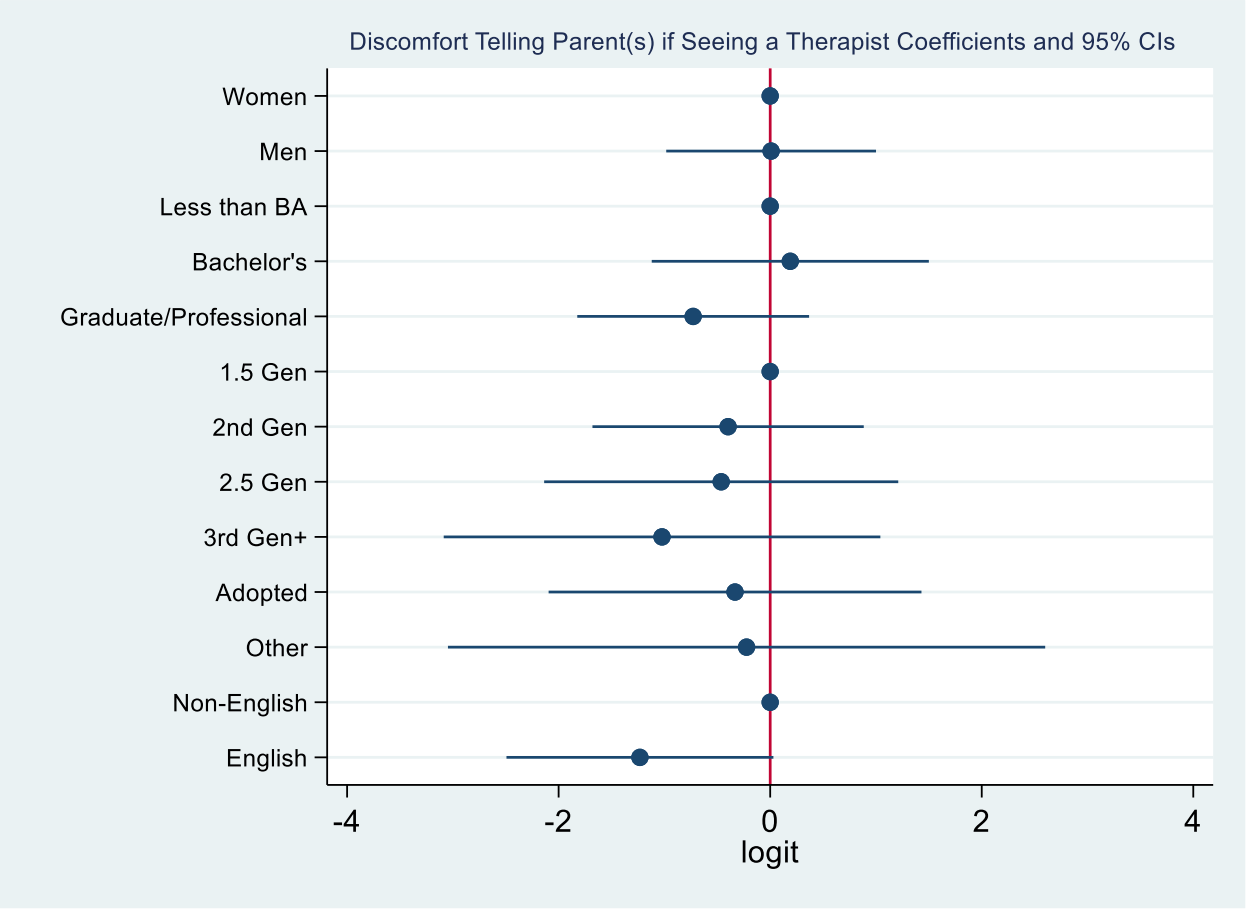

Figure 9. Discomfort Telling Parent(s) if Seeing Therapist Coefficients and 95% Confidence Intervals.

Figure 10 displays the predicted probability of feeling discomfort telling parent(s) if seeing a therapist by primary home language. The graph shows that participants from primarily

non-English speaking households are more likely to feel discomfort telling their parent(s) if they were seeing a therapist.

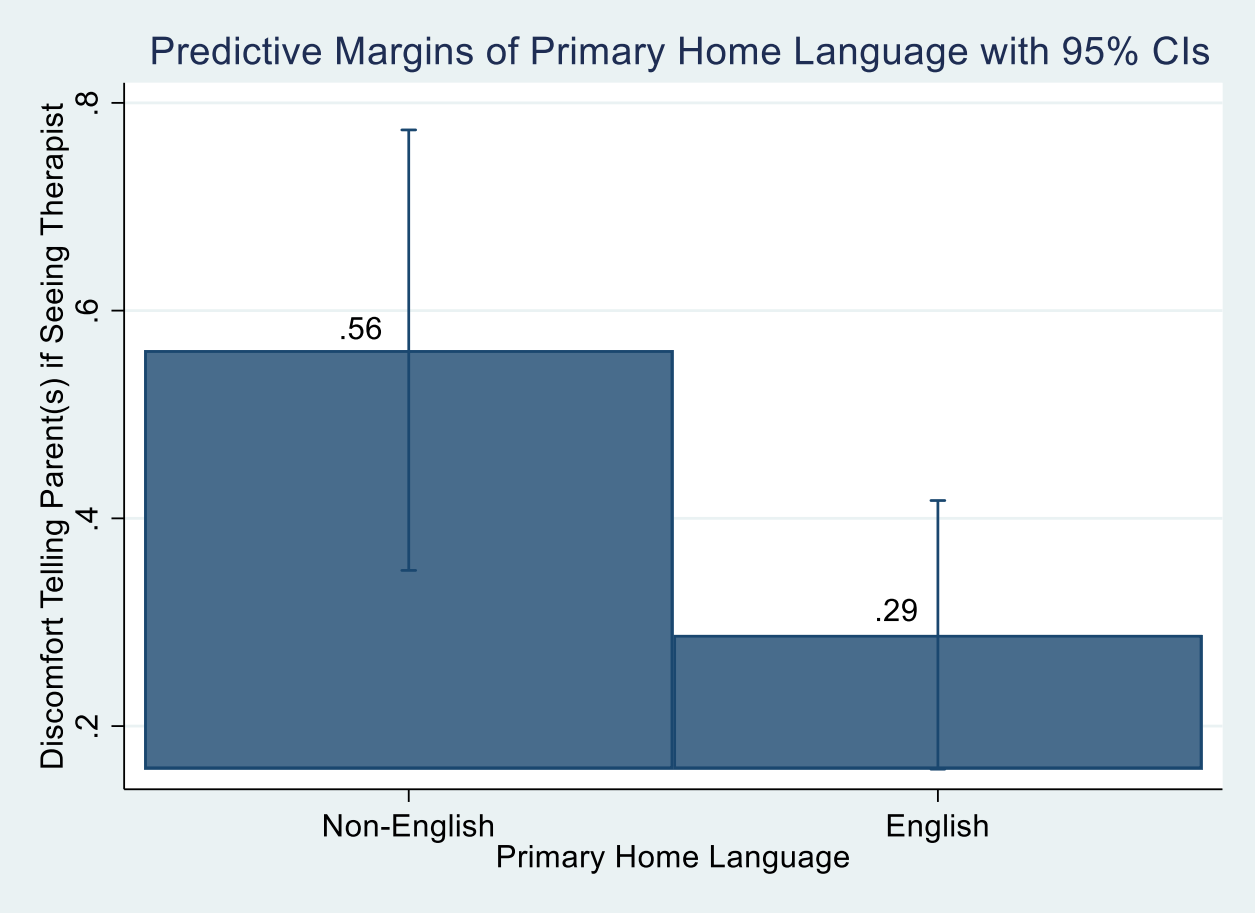

Figure 10. Predictive Margins of Discomfort Telling Parent(s) if Seeing a Therapist by Primary Home Language.

DISCUSSION

Part 1 of this study examines the potential predictors for stigma against seeing a therapist amongst Asian American college students, with specific interest in acculturation status and worldviews. Findings show suggestive effects for generation and collectivism, and significant effects for discomfort telling parent(s) if seeing a therapist, on stigma against seeing a therapist.

Acculturation Status. All generations, are increasingly more likely to stigmatize seeing a therapist, relative to the 1.5 generation, as well as adopted and other. These results also indicate that being an adopted Asian American student has significant effects on stigma against seeing a therapist, and being 3rd generation+ has suggestive effects. These generation results contradict much of the literature, which finds that by the 3rd generation, Asian Americans will have overall acculturated to the host culture and thus consider Western medical practices more helpful than preceding generations (Kramer et al. 2002; Zhou 1999). Also, 3rd generation Asian Americans on average have higher rates of mental health service use than 1st or 2nd generations (Abe-Kim et al. 2007). So, the results of this study are surprising because we see a reversed direction in stigma against seeing a therapist amongst the generations (stigma is higher the longer for the lineage in the U.S.), which contradicts the literature that largely suggests that stigma reduces the longer the lineage is in the U.S.. This could be indicative of stigma against therapy and mental health topics being embedded in American culture as well. Another idea could be that Asian American youth of more recent generations are more dissociated from their parent(s)' ways in general, and thus are more receptive of pursuing services like therapy which may be far removed from what their parent(s) are familiar with. On the other hand, 3rd generation+ or adopted individuals who are assumed to have grown up with more "Americanized" parent(s), could be more wary of what their parent(s) think. Not much research was done on Asian American adoptees in this study though, so more research should be done on them. In terms of primary home language, households with English as the primary language are less likely to stigmatize seeing a therapist. Though there is no clear effect, the results are congruent with the literature about dissonant acculturation (Portes and Zhou 1993) because non-English households likely have parent(s) who do not speak English fluently, whereas their children do—so tensions such as

stigma around American mental health services could manifest within that disconnect. Therefore, views on stigma and therapy could be informed by (mis)translation and lack of mutual understanding of certain concepts, and Asian American families from non-English speaking households are acute to these tensions.

Familial Conflict. This study indicates that both those uncomfortable discussing with their parent(s) about mental health concerns and uncomfortable telling their parent(s) if they were seeing a therapist are more likely to stigmatize seeing a therapist relative to their counterparts who are more comfortable discussing such matters. This is consistent with the literature, which suggests that pressures and stigma stemming from family shape childrens' thoughts and behaviors—in this case stigma against seeing a therapist (Tewari and Alvarez 2009; Lee et al. 2009; Tran 2016). Those uncomfortable telling their parent(s) if they were seeing a therapist are significantly more likely to stigmatize seeking therapy. Though this is statistically significant in this study, note that this variable and stigma against seeing a therapist are both addressing the same concept, but one includes parent(s), so the connection is intuitive.

Worldviews. For collectivism, there are suggestive effects that those who do not suppress emotions have a lower likelihood of stigmatizing seeing a therapist. This parallels the literature, which underlines that those who adhere strongly to collectivist orientations feel more shame when expressing emotions, do so to save face, and are typically more intolerant of Western mental health services because of their individualist frameworks (Kramer et al. 2002; Tewari and Alvarez 2009; Watters 2010). Those who indicate it is better to suppress emotions to not burden others may be averse to opening up in general, let alone a therapist, and might instead find it better to maintain social harmony by adjusting to the social context rather than changing the problem (Yeh et al. 2006). As for mind-body holism, those whose physical health is impacted by

mental health a moderate amount are less likely to stigmatize seeing a therapist, and even less likely to stigmatize if their physical health is impacted a little or not at all. Consistent with the literature on mind-body holism, those whose physical health are impacted a lot when feeling mentally unwell are perhaps more in tune with their overall health and/or physical symptoms—thus more likely to be skeptical of therapy which specializes in mental health (Tewari and Alvarez 2009; Wong et al. 2010). Differences between the groups are not noticeably large, however, and there are no clear effects of mind-body holism on stigma against seeing a therapist in this study. Lastly, those who believe mental illnesses do not last a short duration of time are less likely to stigmatize seeing a therapist. Complementing the literature on naive dialecticism, those who believe that mental illnesses last a short duration of time are more likely to stigmatize therapy because of the normalization of change, contradiction, and holism in life (Nisbett, et al. 2001; Spencer-Rodgers, et al. 2009). Psychological problems tend to be viewed as normal responses to life, short term, and subject to change (Tewari and Alvarez 2009), and likelihood of seeking therapy is subsequently lower. Differences between each group is not noticeably large though and there are no clear effects of naive dialecticism on stigma against seeing a therapist in this study.

Demographics. Men are more likely to stigmatize seeing a therapist than women, though there are no clear gender effects for this study. Men being more likely to stigmatize seeing a therapist complements the literature wherein immigrant Asian men who use mental health services seek help less frequently than women (Tewari and Alvarez 2009). On the other hand, this differs from a study done by NAWHO (2001) that points to Asian American women's silence around mental health topics in order to save face for themselves and their families. This possibly indicates that Asian American women may be becoming more tolerant of stigma against

therapy and other mental health subjects. Next, students are less likely to stigmatize seeing a therapist if their parent(s) hold Bachelor's degrees, but interestingly, more likely to stigmatize if their parent(s) have Graduate or Professional degrees. Though there is no clear parent education effect, there is no clear explanation from the literature for this difference (Hauser 1994).

Part 2 of this study examines potential predictors of familial conflict: participants' discomfort sharing mental health concerns with parent(s) and discomfort telling parent(s) if they were seeing a therapist. Results from this study indicate suggestive effects for parental education on discomfort sharing mental health concerns with parent(s), as well as suggestive effects for primary home language on discomfort telling parent(s) if seeing a therapist. The students with parent(s) holding Bachelor's, or a Graduate or Professional degree are less likely to feel discomfort expressing mental health concerns with their parent(s), compared to students with parent(s) with anything less than a Bachelor's degree. Suggestive effects are exhibited for those with parent(s) with Graduate or Professional degrees. This may indicate that working class parent(s) are less in tune and/or tolerant of mental health subjects, and their children are more uncomfortable speaking with them about it. Parent(s) with Bachelor's and Graduate or Professional degrees, on the other hand, have more exposure and language for mental health concepts so their children may be less hesitant to address those topics with them. Finally, there are suggestive effects for primary home language on discomfort telling parent(s) if seeing a therapist. English speaking households are less likely to stigmatize seeing a therapist, which complements the literature that describes language as a vital part of culture (Brown et al. 2013; Kramer et al. 2002; Tewari and Alvarez 2009; Watters 2010). Language informs comprehension of concepts and paradigms, such as therapy—a broadly white middle-class orientated practice

(Liu, Pickett Jr., and Ivey 2007), therefore it is not a surprise that there are higher chances of non-English speaking Asian American households to question and doubt Western therapy.

Implications

Acculturation effects were salient in this study. This study found unexpected generation effects, wherein 3rd generation+ and adopted Asian American students are more likely to stigmatize seeing a therapist. With data from this study and the literature, we can assume that despite generation in the U.S., there are no clear patterns in stigma against therapy. Therefore, U.S. mental health institutions should put more effort into addressing and overturning the different facets of their services that may cause stigma amongst different Asian Americans. This study also found that Asian American students from primarily non-English speaking households were more likely to feel discomfort telling their parent(s) if they were seeing a therapist. Mental health services should consider ways to bridge these linguistic and cultural gaps that may be catalyzing familial stigma, and in tandem, overall stigma against therapy. Finally, regarding Asian rooted worldviews, though there were no outstanding effects on stigma against therapy, adherence to all three worldviews analyzed indicate higher likelihood of stigma. This shows that psychotherapy services should be culturally competent in engaging with their Asian American patients; and that mental health care frameworks to begin with should consider these worldviews.

Overall, this study demonstrates that today's Asian American college students may be more receptive of therapy. Much of counseling and psychotherapy are suffused with white middle-class biases and worldviews, and most counselors and therapists likely will adopt a similar white middle-class orientation in their therapeutic relationships, diagnoses, and treatments (Liu, Pickett Jr., and Ivey, 2007). Although Asian American college students to various extents have been co-opted, and continue to be co-opted, into white middle-class

structures, it would be inappropriate to negate their unique backgrounds and lived experiences as young Asian Americans with middle-class, white judgements. Amongst other unique lived experiences, Asian Americans encounter increased racism and stress, particularly during the COVID-19 pandemic.[7] Although addressing and overturning the roots of structural issues causing mental health decline in the first place should be the long term goal, in the short-term, it is imperative for mental health institutes to implement services that better understand and support young Asian Americans. There are multiple cultural factors unique to young Asian Americans—such as acculturation statuses and worldviews as demonstrated in this study—that may influence stigma against therapy and overall Western mental health concepts. Especially in a pandemic-era time of heightened anxiety and anti-Asian hate, it is crucial to understand how Western mental health services, such as therapy, can be more culturally sensitive to better support Asian American college students.

Limitations and Future Research

This study has several limitations. There are a diversity of communities within the umbrella category of "Asian American," and I planned to use ethnicity as a demographic variable to examine outcomes. However, due to the small sample size and low variability of participants' ethnicities, I was unable to use ethnicity in the analyses. Though there was no multicollinearity, the small sample size of this study could have influenced the overall wide confidence intervals in the analyses. Future research should take the above limitations into account. Future research should also address why Asian American adoptees and 3rd generation+ Asian Americans might stigmatize seeing a therapist more, as much of the literature has found

[7] Refer to Appendix D for Figure 11 and Figure 12, which present this study's sample's encounters with racism before and during COVID-19.

the opposite wherein less lineage in the U.S. and less acculturation correspond with more stigma.

CONCLUSION

This study sought to understand potential predictors of Asian American college students' stigma against seeing a therapist, with a focus on broadly construed cultural factors of acculturation status and adherence to Asian rooted worldviews. This study also broadly examined familial conflict in terms of what might inform participants' discomfort discussing mental health concerns and therapy with their parent(s). By analyzing survey data collected from a small sample of Asian American college students, this study found that aspects of acculturation status and worldviews have suggestive effects on stigma against seeing a therapist for their mental health. Particularly, being adopted or 3rd generation+, or subscribing to collectivist orientations of believing it is better to suppress emotions have significant or suggestive effects on stigma against seeing a therapist. The study also found that parental education level and primary home language have suggestive effects on discomfort sharing mental health concerns with parent(s) and discomfort telling parent(s) if seeing a therapist, respectively. In sum, there are cultural factors unique to young Asian Americans that influence stigma against therapy and overall Western mental health concepts. In a pandemic-era time of amplified anxiety and anti-Asian discrimination, it is crucial to understand how Western mental health services, such as therapy, can better serve Asian American college students.

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APPENDIX A

Table 2: Logistic Regression Results - Stigma Against Seeing Therapist for Mental Health

	Model 1
Gender	
Male	0.51 [-0.60,1.63]
Non-binary	0.00 [0.00,0.00]
Parent(s) Highest Education Level (Ref: Less than BA)	
Bachelor's	-0.33 [-1.94,1.28]
Graduate/Professional	0.24 [-1.04,1.52]
Generation (Ref: 1.5 Generation)	
2nd Generation	0.46 [-1.08,2.00]
2.5 Generation	1.73 [-0.41,3.87]
3rd Generation+	2.24 [-0.02,4.50]
Adopted	2.60* [0.32,4.88]
Other	1.05 [-2.16,4.25]
Primary Home Language (Ref: Non-English)	
English	-0.21 [-1.91,1.49]
Talking about Mental Health Concerns with Parent(s) (Ref: Comfortable)	
Uncomfortable	0.17 [-1.03,1.37]

Talking about Seeing Therapist with Parent(s) (Ref: Comfortable)	
Uncomfortable	1.72**
	[0.46,2.99]
Views on Suppressing Emotions to Not Burden Group (Ref: Suppress)	
Don't suppress	-0.93
	[-1.97,0.11]
How Much Physical Health is Impacted by Mental Health (Ref: A lot)	
A moderate amount	-0.18
	[-1.50,1.14]
A little or not at all	-0.41
	[-1.94,1.11]
Views on Duration of Mental Illnesses (Ref: Short)	
Non-short	-0.12
	[-1.44,1.20]
Gender	
Constant	-2.13
	[-4.35,0.10]
Observations	108

95% confidence intervals in brackets
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

APPENDIX B

Table 3: Logistic Regression Results - Discomfort Sharing Mental Health Concerns w/ Parent(s)

	Model 1
Gender (Ref: Female)	
Male	-0.26 [-1.19,0.67]
Non-binary	-0.72 [-3.38,1.94]
Parent(s)' Highest Level of Education (Ref: Less than BA)	
Bachelor's	-0.32 [-1.60,0.96]
Graduate/Professional	-1.06 [-2.12,0.01]
Generation (Ref: 1.5 Generation)	
2nd Generation	-0.62 [-1.91,0.67]
2.5 Generation	-0.63 [-2.21,0.95]
3rd Generation+	-0.44 [-2.21,1.33]
Adopted	-1.21 [-2.95,0.53]
Other	-0.83 [-3.56,1.90]
Primary Home Language (Ref: Non-English)	
English	-0.35 [-1.55,0.85]
Constant	1.42* [0.13,2.71]
Observations	111

95% confidence intervals in brackets
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

APPENDIX C

Table 4: Logistic Regression Results - Discomfort Telling Parent(s) if Seeing Therapist

	Model 1
Gender (Ref: Female)	
Male	0.01 [-0.98,1.00]
Non-binary	0.00 [0.00,0.00]
Parent(s)' Highest Level of Education (Ref: Less than BA)	
Bachelor's	0.19 [-1.12,1.50]
Graduate/Professional	-0.73 [-1.82,0.37]
Generation (Ref: 1.5 Generation)	
2nd Generation	-0.40 [-1.68,0.88]
2.5 Generation	-0.46 [-2.14,1.21]
3rd Generation+	-1.02 [-3.09,1.04]
Adopted	-0.33 [-2.09,1.43]
Other	-0.22 [-3.05,2.60]
Primary Home Language (Ref: Non-English)	
English	-1.23 [-2.49,0.03]
Constant	1.03 [-0.23,2.29]
Observations	108

95% confidence intervals in brackets
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

APPENDIX D

Figure 11. Experienced or Perceived Racial Discrimination Before and During COVID-19

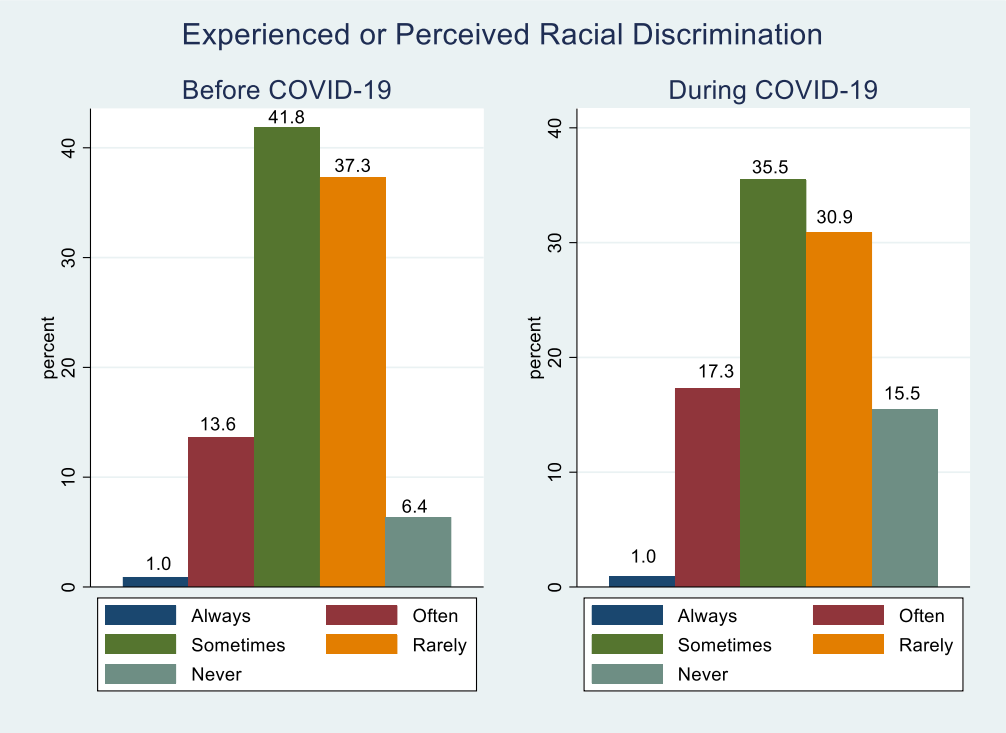
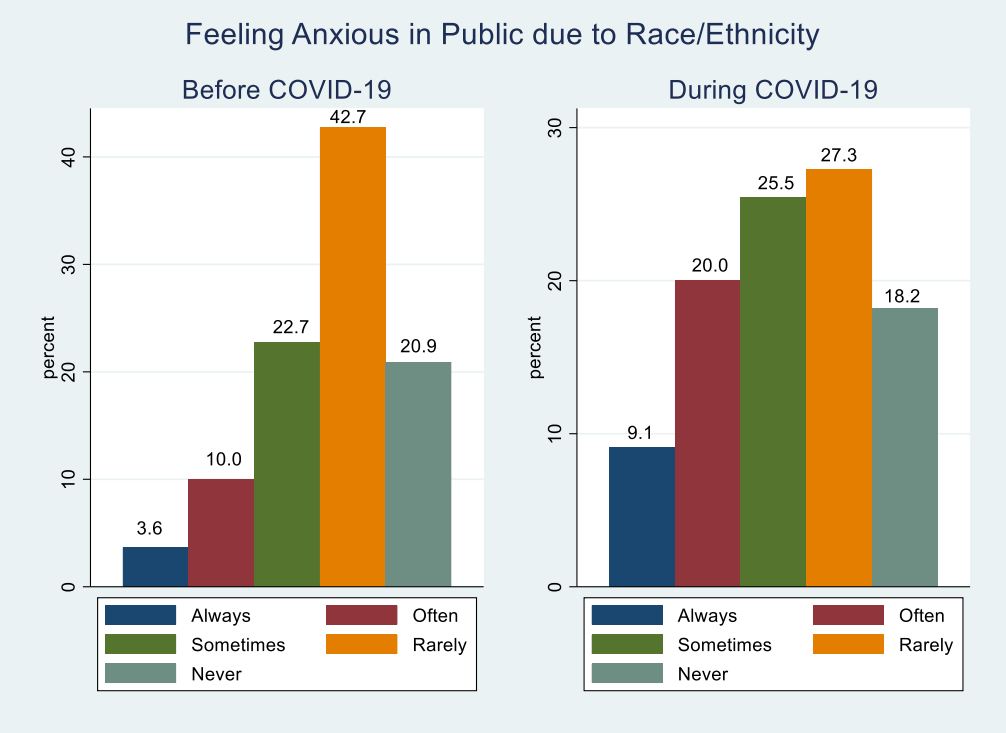


Figure 12. Feeling Anxious in Public due to Race Before and During COVID-19



APPENDIX E

Survey

Default Question Block

Beliefs and Wellbeing of Asian and Asian American College Students Consent Form

Minerva Ho
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Key information about this research study

The following is a short summary of this study to help you decide whether to be a part of the study. Additional information is provided later in the form.

You are invited to take part in a research study about the beliefs, health, and overall wellbeing of Asian and Asian American undergraduate college students. The purpose of this study is to examine the potential predictors of those values and health statuses of current Asian and Asian American identifying college students. You are invited to participate in an anonymous survey. This survey will take approximately 10 minutes. Upon completion of the survey, you may choose to enter a raffle for one $25 Amazon gift card. There are no foreseeable risks involved in participating, other than the risk that some questions may cause emotional discomfort.

Taking part in this study is completely voluntary. You should only decide to take part in the study because you want to do so. If you choose to be in the study you can withdraw at any time without consequences of any kind. You may choose to skip any question you do not wish to answer, but it is encouraged to complete the survey to the best of your ability. Participating in this study does not mean that you are giving up any of your legal rights.

The person in charge of this study is Minerva Ho. You can contact Minerva Ho at m_ho@coloradocollege.edu or (323)-384-6892. If you have any questions about whether you have been treated in an illegal or unethical way, contact the Colorado College Institutional Research Board chair, Dr. Amanda Udis-Kessler at audiskessler@coloradocollege.edu.

Additional information

Your identity and response will be anonymous and confidential, and no one will be able to identify you or your answers. If you choose to enter the raffle for a $25 Amazon gift card, upon completion of the survey, you will be redirected to a link with a separate survey where you can add your email information. This way, your identity cannot be matched in any way to your response to the main survey. All data will be kept on the researcher's personal computer. Any report of this research that is made available to the public will not include your name or any other individual information by which you could be identified unless you have specifically given permission to be identified publicly.

Upon completion of this research project, the primary researcher plans to destroy all information, including any identifying information and other research information.

The researchers do not plan to share the collected research information with other researchers in the future.

The researchers do not anticipate any psychological or any other form of harm to occur upon participation of this survey. But if you experience an injury or any other problem as a result of participating in the study, contact Minerva Ho as soon as possible at m_ho@coloradocollege.edu or (323)-384-6892. In such a situation, she cannot personally provide any medical or financial support, but can refer you to online resources that could be appropriate.

I have read the above information. Completing this survey indicates that I am 18 years of age or older and indicates my consent to participate in this research project.

I understand that I may print a copy of this form to keep for my records.

Select "Agree" to begin the survey.

Agree
Disagree

What ethnic origin do you identify yourself with? (check all that apply)

- Asian Indian
- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indonesian
- Japanese
- Korean
- Laotian
- Malaysian
- Mongolian
- Nepalese
- Okinawan
- Pakastani
- Sri Lankan
- Taiwanese
- Thai
- Tibetan
- Vietnamese
- Other

What is your gender identity? (check all that apply)

- Female
- Male
- Transgender
- Non-binary
- Other

Name of School

Year in School

- First Year
- Second Year
- Third Year
- Fourth Year

Fifth Year+

Do you identify as Asian American?

Yes

No

What is your generation in the U.S.?

1st Generation (you immigrated to the U.S. after age 12)

1.5 Generation (you immigrated to the U.S. before age 12)

2nd Generation (born in the U.S., parents immigrated to the U.S.)

2.5 Generation (born in the U.S., one parent born in the U.S., one parent immigrated to the U.S.)

3rd Generation+ (born in the U.S., both parents born in the U.S.)

Adopted

Other

On average, what is your household's annual household income?

Less than $19,999

$20,000 to $49,999

$50,000 to $99,999

$100,000 to $149,999

$150,000 to $199,999

$200,000 or more

What is your parents' marital status?

Married

Divorced

Separated

Widowed

Other

Who lives in your family's current household? (check all that apply)

Parents

Siblings

At least one grandparent

Extended family

Other

Who do you currently live with?

By yourself (on campus)

By yourself (off campus)

With roommate(s) (on campus)

With roommate(s) (off campus)

With family

Other

What is Parent 1's highest level of education?

Less than middle school graduate

Less than high school graduate

High school graduate

Some college

Associate’s degree

Bachelor’s degree

Graduate or professional degree

Unsure

What is Parent 2's highest level of education?

Less than middle school graduate

Less than high school graduate

High school graduate

Some college

Associate's degree

Bachelor's degree

Graduate or professional degree

Unsure

About how much need-based financial aid do you receive for your college?

None

Between none and 24%

Between 25% to 49%

Between 50% to 74%

Between 75% to 99%

100%

What was your class format during the Fall semester?

Online only

Hybrid (online and in-person elements)

In-person only

Other

Mental Health

How would you rate your overall mental health from the past 6 months?

Excellent

Good

Average

Poor

Terrible

How would you rate your overall mental health prior to COVID-19?

Excellent

Good

Average

Poor

Terrible

Who would you go to for support if you had mental health issues? (check all that apply)

No one/keep to myself

Friends

Significant other/partner

Siblings

Parents

Extended family

Religious/spiritual institutes and communities

Online resources

College faculty and mentors

College mental health resources

Therapist

Cultural/traditional healers (i.e. fortune tellers, herbalists, etc.)

Other

Does your school provide professional mental health services?

Yes

No

Unsure

If you chose "Yes," do you know how to access your school's mental health services?

Yes

No

Generational Dissonance

How often do you talk with your parent(s) (on the phone, video call, in person)?

Never

Once to a few times a year

Once to a few times a month

Once to a few times a week

Once to a few times a day

On average, how long are your conversations with your parent(s) (on the phone, video call, in person)?

5 minutes or less

6 to 30 minutes

31 to 59 minutes

An hour or more

Is English the primary language spoken in your family's home?

Yes

No

Is English Parent 1's primary language?

Yes

No

Is English Parent 2's primary language?

Yes

No

What is Parent 1's knowledge of English?

None

Limited

Fluent

What is Parent 2's knowledge of English?

None
Limited
Fluent

What is your knowledge of your ethnic/cultural background's language(s)?

None
Limited
Fluent

I feel pressured to meet my parent(s)' expectations.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I would feel comfortable talking about personal things with my parent(s).

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I would feel comfortable expressing mental health concerns to my parent(s).

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

If I was seeing a therapist for mental health issues, I would feel comfortable telling my parent(s) about it.

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

Adherence to Worldviews

How would you rate your overall physical health from the past 6 months?

Excellent

Good

Average

Poor

Terrible

How would you rate your overall physical health prior to COVID-19?

Excellent

Good

Average

Poor

Terrible

At times you feel mentally unwell, to what extent is your physical health impacted?

A lot

A moderate amount

A little

Not at all

I believe that my mind and body influence each other.

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

I feel aware of how both my mind and body are affected by stressors.

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

I believe the welfare of the group should be put before that of the individual.

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

Conforming to norms provides order in the community.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe it is better to hold one's emotions inside than to burden others by expressing them.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe positive and negative life events are short-term and subject to change.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe mental illnesses last for a short duration of time.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree

Strongly disagree

Treatment Perceptions

I have seen a therapist for my mental health.

Yes

No

If you chose "No," why not?

I am interested in seeking therapy for my mental health (if I had the time and resources).

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

I would feel or have felt uncomfortable seeing a therapist for my mental health because of what some people might think of me.

Strongly agree

Agree

Somewhat agree

Somewhat disagree

Disagree

Strongly disagree

I believe therapy can be helpful when one is going through a difficult time.

Strongly agree

Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe therapy would be helpful if I am going through a difficult time.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I have practiced or experienced at least one form of healing for my mental health that is rooted in my ethnic/cultural background(s). (i.e. meditation, acupuncture, qigong, coining, etc.)

Yes
No

If you chose "No," why not?

I am interested in practicing or experiencing forms of healing for my mental health that are rooted in my ethnic/cultural background(s) (if I had the time and resources).

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I would feel or have felt uncomfortable practicing forms of healing for my mental health that are rooted in my ethnic/cultural background(s) because of what some people might think of me.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe ethnically/culturally rooted forms of healing can be helpful when one is going through a difficult time.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

I believe ethnically/culturally rooted forms of healing would be helpful if I am going through a difficult time.

Strongly agree
Agree
Somewhat agree
Somewhat disagree
Disagree
Strongly disagree

COVID-19 Racism

Before times of COVID-19, how often did you experience or perceive discrimination against yourself because of your race/ethnicity?

Always
Often
Sometimes
Rarely
Never

During times of COVID-19, how often did you experience or perceive discrimination against yourself because of your race/ethnicity?

Always
Often
Sometimes
Rarely
Never

Before times of COVID-19, how often did you feel anxious or uncomfortable when in public because of your race/ethnicity?

Always
Often
Sometimes
Rarely
Never

During times of COVID-19, how often did you feel anxious or uncomfortable when in public because of your race/ethnicity?

Always
Often
Sometimes
Rarely
Never

Conclusion

In rank order, list your top 3 biggest stressors from the past 6 months.

Raffle

Would you like to enter the raffle for a chance to win a $25 Amazon gift card?

Yes

No