

Attitudes of Asian American medical students towards mental health

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Introduction

Asian Americans are the fastest growing demographic in the United States and are expected to be the largest by 2055.¹ Therefore, clinicians must be equipped to meet the mental health needs of this population, especially since Asian Americans have the lowest rate of mental health service usage compared to other groups.² It's important to know what factors limit access for them. Since attitudes influence behavior, we examine attitudes as a potential factor. Our study builds on the work of Ting and Hwang (2009),³ who studied attitudes in Asian American undergraduates. Our goal is to update the literature and to conduct a study on a unique population. To our knowledge, this is the first specifically examining attitudes in Asian American medical students.

Aims and Objectives

- 1) Determine attitudes towards mental health and mental health treatment in Asian American medical students
- 2) Determine the factors (e.g., economic, social, psychological, cultural) that shape these attitudes and therefore help-seeking behavior.
- 3) Improve clinicians' understanding of what barriers prevent Asian American students from seeking mental health treatment

Methods

Over a 3-month period, we emailed a cross-sectional survey to medical students at the Oakland University William Beaumont School of Medicine. Respondents needed to be >18 years old, identify as Asian American, and be enrolled as a student in the program.

Our survey consisted of 4 different sections: demographic information, the Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPHS-SF), the Vancouver Index of Acculturation (VIA), and the Barriers to Mental Health Counseling (BMHC) scale.

The ATSPPHS-SF is a 10-item questionnaire rated on a Likert scale and has two subscales: Openness and Value and Need. Openness describes openness to mental health counseling. Value and Need describes an individual's perceived value of and need for mental health counseling.

Methods (Continued)

The VIA is a 20-item questionnaire containing two subscales: heritage culture and mainstream culture. It rates acculturation to each respective culture. We include this as prior studies suggest that mainstream acculturation is associated with more positive attitudes towards mental health.

The BHMC is a 27-item questionnaire that determines barriers to mental health. Specifically, it shows how factors like Negative Perceived Value, Ingroup Stigma, Discomfort with Emotions, Lack of Knowledge, and Cultural Barriers limit access to care.

For questionnaires with unequal number of questions per subscale, we calculated the Adjusted Score. The Adjusted Score is the (subscale score/maximum score) x100. We analyzed data using Pearson's correlation test, t-tests, ANOVA, and post-hoc analysis. We set the significance level at $p < 0.05$.

Results

15 individuals met screening criteria and completed the survey. 9 were female and 6 were male. They identified as Chinese ($n=4$), Indian ($n=4$), Vietnamese ($n=3$), Filipino ($n=1$), and Taiwanese ($n=1$).

We found no significant differences in help seeking attitudes between gender or between ethnicity (Figure 3). Help seeking attitudes were not significantly correlated with age, heritage acculturation, or mainstream acculturation (Figure 1). Age was not significantly correlated with acculturation, help seeking attitudes, or barriers to counseling (Figure 1). Neither mainstream nor heritage acculturation was significantly correlated with help seeking attitudes, age, or barriers to counseling.

Interestingly, respondents demonstrated high openness towards counseling ($M=77.92$, $SD=17.95$) but were neutral about its value/need ($M=48$, $SD=14.47$ $p=4.56 \times 10^{-5}$).

When comparing the VIA and BHMC, Negative Perceived Value was correlated with both Openness and Value/Need. Discomfort with Emotions was correlated with Value/Need and Negative Perceived Value. Lack of Access was correlated with Openness, Negative Perceived Value, and Discomfort with Emotions (Figure 1). Finally, cultural barriers was rated significantly higher than lack of knowledge as a barrier to counseling ($p=0.005$, Figure 2).

	1	2	3	4	5	6	7	8	9	10	11
1. Age	-										
2. Heritage culture	-0.01	-									
3. Mainstream culture	-0.36	-0.38	-								
4. Openness	0.18	0.14	-0.33	-							
5. Value and Need	-0.33	-0.11	0.24	-0.47	-						
6. Negative Perceived Value	-0.37	0.07	0.17	-0.68 ^{††}	0.74 ^{††}	-					
7. Ingroup stigma	0.03	-0.02	-0.08	-0.12	0.16	0.14	-				
8. Discomfort with emotions	-0.41	-0.09	-0.02	-0.42	0.54 [†]	0.64 [†]	0.18	-			
9. Lack of Knowledge	-0.42	-0.49	0.19	-0.21	0.24	0.38	0.09	0.31	-		
10. Lack of access	-0.43	-0.24	0.42	-0.59 [†]	0.58 [†]	0.79 ^{†††}	0.28	0.61 [†]	0.39	-	
11. Cultural Barriers	-0.32	-0.48	0.32	-0.44	0.43	0.21	-0.10	0.26	0.16	0.17	-

[†] $p < 0.05$

$p < 0.01$ ^{††}

$p < 0.001$ ^{†††}

Figure 1: Correlation matrix demonstrating relationships between continuous and predictor variables. Items #2-3 represent acculturation (measured by the VIA). Items #4-5 represent help seeking attitudes (measured by the ATSPPHS-SF). Items #6-11 represent barriers to mental health counseling (measured by the BMHC)

Variable	M	SD	Range
Age	26.33	2.70	22-34
Level of acculturation			
Mainstream culture	53.47	8.50	36 - 69
Heritage culture	55.73	5.01	34 - 65
Help seeking attitudes (Adjusted scores)			
Openness*	77.92	17.95	50 - 100
Value and need*	48.00	14.47	25 - 75
Barriers to counseling (Adjusted scores)			
Negative perceived value	50.93	17.37	20 - 92
Ingroup stigma	50.40	12.55	28 - 76
Discomfort with emotions	58.40	12.72	32 - 80
Lack of knowledge**	43.11	18.20	20 - 80
Lack of access	54.00	16.75	20 - 80
Cultural barriers**	66.40	14.30	30 - 96

Figure 2: Summary of predictor and outcome variables.

*Asian American medical students demonstrated more openness to mental health counseling compared to their measured value in seeking professional help ($p=4.56 \times 10^{-5}$)

** ANOVA revealed a significant difference in means for the barriers to counseling ($p=0.005$). Post-hoc analysis of this revealed that cultural barriers were rated higher as a barrier to counseling than lack of knowledge. ($p=0.002$)

Comparison	p-value
Between Gender (Openness)	0.71
Between Ethnicity (Openness)	0.86
Between Ethnicity (Value and Need)	0.75
Between Gender (Value and Need)	0.82
Between Barriers**	0.005

Figure 3: Summary of statistical analyses.

** Refer to figure 2

Discussion/Conclusion

Our findings are similar to Ting and Hwang in that there was no difference in attitudes by gender, not was there a relationship between attitudes and acculturation. It differed in that there was no relationship between age and help seeking attitudes, nor was there a correlation between attitudes and acculturation. Respondents scored highly on openness towards counseling but neutral about its value. This is a possible area for intervention. High openness indicates willingness to receive counseling, but having neutral value in it might stop them from seeking it out. Culturally appropriate education campaigns could emphasize its value to improve outcomes. However, we can't fully reach this conclusion without a comparison group as it may be true of medical students in general.

The correlation between Negative Perceived Value and Help Seeking Attitudes is expected. It logically follows since "Perceived Value" itself is an attitude and is measured in the ATSPPHS-SF. Discomfort with Emotions was also correlated with Negative Perceived Value. This also follows - individuals uncomfortable with emotions are less likely to seek counseling and may therefore undervalue its utility/ have negative perceptions of it.

Interestingly, cultural barriers were rated the highest whereas lack of knowledge was rated the lowest. We could conclude that 1) lack of cultural understanding is a major barrier from this demographic and 2) Asian American medical students are knowledgeable about counseling services and its purpose. Again, its difficult to draw firm conclusions because the difference was only between the two of them, rather than consistently different compared to other barriers.

Discussion/Conclusion (Continued)

Finally, we have no satisfactory explanation for why lack of access (e.g. lack of time, financial means, etc.) is correlated with either openness, negative perceived value, or discomfort with emotions.

Thus, we conclude that Asian American medical students are open to mental health counseling, are neutral about its value, are knowledgeable about mental health services, and identify cultural differences as a barrier to access.

Sample size is a major limitation of our study. Only 15 individuals responded to our survey compared to the 107 undergraduates in Ting and Hwang. Statistical power is directly related to sample size and decreases Type II error. With our small sample size, our study has a high probability of false negatives. With more respondents, we might have yielded our expected results where attitudes correlated with age/acculturation and cultural barriers were rated highest.

Another limitation is lack of comparison group. This could show whether our results are unique to Asian Americans or are true of medical students in general. Additionally, this study was performed on medical students who are predominantly younger and come from higher socioeconomic backgrounds compared to the general population.⁷ Thus, we cannot generalize our findings to Asian Americans as a whole.

We propose a future study where we determine help seeking attitudes and interest in Psychiatry as a potential career (both before/after the mandatory Psychiatry clerkship). It is well known that patients have better communication with clinicians who come from a similar background to themselves.⁸ Thus, improving mental health outcomes for Asian Americans involves recruiting more Asian American psychiatrists/mental health clinicians. Understanding what factors shape a student's career interest in Psychiatry could prove useful in addressing that shortfall.

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