

A RESEARCH REPORT OF THE RESEARCH CONSORTIUM OF COUNSELING & PSYCHOLOGICAL SERVICES IN HIGHER EDUCATION

Counseling Utilization by Ethnic Minority Students

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Published on-line by
The Counseling & Mental Health Center
The University of Texas at Austin
100W. Dean Keeton St.
1 University Station A3500
Austin, Texas 78712-5731

<http://www.utexas.edu/student/cmhc/research/rescon.html>

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Key Words: university students, psychotherapy, treatment research, ethnic minorities

Abstract

While multicultural awareness in counseling has risen substantially in the last decade, little research has examined counseling utilization and outcomes for ethnic minorities on university campuses. A sample of 1,166 African American, Asian American, Caucasian, and Hispanic help-seeking university students from over 40 universities nationwide filled out the Outcome Questionnaire 45 at the first and last therapy sessions. Caucasian students attended significantly more sessions than all other groups. Further, greatest distress was found at intake in Asian American clients, followed by Hispanic, African American, and Caucasian students. All groups appeared to benefit from therapy, as noted by a decrease in symptomatology, but none of the groups met the criteria for clinically significant change. Implications for therapists working with minority clients are discussed.

Counseling Utilization by Ethnic Minority Students

Although multicultural awareness is on the rise, there is still a remarkable dearth of research regarding the use of counseling services and outcomes for racial and ethnic minorities. This same trend is seen when examining research in university counseling centers, where studies have primarily evaluated counseling utilization and outcome by university students as a whole, not by particular racial and ethnic groups (Glen, McNair, & Hight, 1988; Snell, Hill, Mallinckrodt, & Lambert, 2001; Vonk & Thyer, 1999). Bernal and Scharron-Del-Rio (2001) have addressed the need for future research in identifying the efficacy of therapy for ethnic minorities. Our aim is to ameliorate this scarcity of research by examining the differences among African American, Asian American, Hispanic, and Caucasian students in therapy attendance after intake, and severity at both intake and last session. The exploration of these factors will assist therapists in becoming more culturally sensitive to the needs of their clients by increasing their understanding of how minority students currently utilize university counseling services. Further, we aim to identify whether present university counseling services are, in fact, meeting the mental health needs of these groups.

Numerous factors appear to lead minority individuals to utilize counseling services less frequently than Caucasian individuals (Steward, Jackson & Jackson, 1990; Thompson, Neville, Weathers, & Poston, 1990; Watkins & Terrell, 1988). One factor suggested by Atkinson, Morton, and Sue (1998) is that minorities may perceive mental health services as unrelated to their needs and thereby do not initiate services. With little attention focused on the psychological needs of minorities in counseling centers and the common utilization of Western-oriented counseling styles, which emphasize an intrapsychic etiology model, minorities may feel that most counseling services simply do not apply to them (Austin, Carter, & Vaux, 1990; Thorn & Sarata, 1998). Unfortunately, beliefs that counselors cannot be helpful may often extend to those members of minority groups suffering from more severe forms of emotional disorders, potentially preventing them from seeking counseling (Hatch, Friedman, & Paradis, 1996). Further, counselors untrained in culturally sensitive therapy models, a dearth of bilingual counselors, few counselors with similar ethnic/racial backgrounds, and a lack of cultural sensitivity may lead minorities to feel misunderstood by therapists in counseling communities (Atkinson, et al., 1998; Atkinson, Jennings, & Liongson, 1990). Potential stigma regarding the use of mental health services, still found among African American, Asian American, and Hispanic cultures, may further diminish the likelihood of seeking counseling services (Leong, Wagner, & Tata, 1995; Neighbors, Caldwell, Thompson, & Jackson, 1994; Sue, 1994; Thorn & Sarata, 1998). For example, Asian Americans may view psychological problems as marks of weakness, which reflect negatively upon the character of individuals who seek professional mental health services (Root, 1998). Hispanic individuals may carry stigma regarding therapy for other reasons, such as the importance of seeking help from family or religious community members, rather than sharing private information with outsiders (Altarriba

& Bauer, 1998). A study of African American and Latino youth found that these two groups were much less likely to seek help from professionals than Caucasians and more likely to use family resources for their personal problems (McMiller & Weisz, 1996). Associated stigma, in conjunction with feelings that mental health services may be irrelevant to their needs, serve as powerful forces in keeping minority individuals from utilizing counseling services.

These factors may also provide an explanation for why minorities frequently fail to return for additional appointments after an initial session. Sue, Fujino, Hu, Takeuchi, and Zane (1991) found that African Americans averaged far fewer sessions and terminated more quickly than Caucasians within the Los Angeles County Mental Health System. Barnes (1994) likewise reported that racial/ethnic minorities are far less likely to return for more appointments and report having fewer sessions than Caucasian counterparts. However, Flaskerud and Liu (1991) found a significant increase in the number of sessions when both an ethnic and language match existed between client and therapist. Hence, factors affecting counseling utilization can be changed to better meet the needs of racial/ethnic minority clients. Overall, racial/ethnic minorities appear to return less often for future sessions and average fewer sessions overall in comparison to Caucasians when such factors are not addressed.

Racial/ethnic differences have been explored not only in the utilization of counseling services, but also in the types and severity of disorders seen among different populations. Race related differences have been found in rates of alcoholism, phobic disorders, general anxiety disorder, obsessive compulsive disorder, and somatization disorders (Adebimpe, 1994). For example, African Americans may report higher levels of negative symptomatology than Caucasians (Adebimpe, 1994; Jones-Webb & Snowden, 1994; Lefley, 1994). Prior research offers some suggestions as to why such differences may exist. Mays and Albee (1992) indicate that ethnic minorities experience greater social stressors in association with psychological conditions than Caucasians. Atkinson et al. (1998) further speculate that increased reporting of symptoms may be the result of elevated stress levels caused by higher poverty and unemployment rates, discrimination and racism, recent relocation, and loss of support systems. Further, if ethnic minorities perceive counselors as lacking cultural sensitivity or knowledge (Atkinson, et al., 1998; Atkinson, et al., 1990), they may postpone the seeking of services, causing an increase in their initial symptomatology at intake. However, other reports indicate that when one controls for sociodemographic differences, these differences of severity are negligible (Adebimpe, 1994; Jones-Webb & Snowden, 1994; Lefley, 1994). Problems of minority under-representation in community-based surveys of mental health service utilization may further complicate these findings (Cheung & Snowden, 1990).

Hypotheses

Thus, an important extension of prior research is to identify whether or not these racial/ethnic differences do exist both in counseling utilization and severity of symptomatology. Given that past research has focused primarily on racial/ethnic differences found in community agency settings, this particular study aims to extend findings to university student populations, where counseling centers predominantly follow short-term models of care, reveal higher attrition rates of clientele, and have a greater diversity of clients (Tyron, 1999). While it would be ideal to investigate differences between each ethnic minority group individually, sample sizes prevent such in-depth analyses. Hence, we place together clients from Asian American, African-American, and Hispanic backgrounds in our initial hypotheses and analyses, while later providing some information for each individual group through post-hoc analyses, as appropriate. We believe such information to be valuable as these trends regarding counseling utilization appear across minority groups providing support for further research into the correction of such problems for all ethnic minority groups.

Hence, our hypotheses are as follows. First, because prior research has indicated that minority individuals are less likely to seek therapy and stay in therapy, we hypothesize that these same phenomena will be found in university populations. Thus, we hypothesize that members of racial/ethnic minority groups will attend fewer sessions of therapy than Caucasians. Second, with some evidence regarding increased symptomatology for clients of minority status, we hypothesize that there will be greater severity of presentation at intake for students of minority status. Specifically, because prior research suggests that counseling services often do not cater to the needs of minority clients and because they employ Western-oriented counseling styles, we hypothesize that Caucasians will experience more positive outcomes than minority students, even when controlling for severity at intake and number of sessions attended.

Method

The Research Consortium of Counseling and Psychological Services in Higher Education (hereafter referred to as the Research Consortium) was founded in 1990 to further research efforts into counseling processes in university settings. This Research Consortium comprises 40 - 50 universities, primarily state-supported, which are located across the nation. Enrollment ranges from 2,000 to 50,000 with most schools in the range of 15,000 to 25,000. During the time period of the reported study (1997-1998), 4,679 clients agreed to participate in the study, a representation of approximately 30% of students seeking counseling at these centers. *Participants*

The sample of 1,166 participants was selected from the 4,679 clients who agreed to participate in the study during the 1997 - 1998 school year. Given that approximately 73% of those seeking treatment from these counseling centers were Caucasian, the researchers

oversampled minorities for this study, a common technique for studying underrepresented populations (Jang & Smith, 1997; Krause, 1998). The 1166 participants were selected by using the following criteria: (1) that they filled out the intake questionnaire which asked demographic information and (2) that they filled out enough of the outcome measures for the researchers to use specified guidelines for dealing with missing data to reach criterion validity. In this case, the researchers used the Outcome Questionnaire 45, which requires that a mean substitution procedure can be employed if the client fills out 75% or more of the measure (Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994). We made the criteria slightly more stringent to insure the validity of our effectiveness data by performing a mean substitution procedure if the participants filled out 80% or more of their measures (Lambert, et al., 1994).

Once these criteria were met, we took a simple random sample of the remaining Caucasians in order to provide more equal cell sizes across ethnicities.

The total average number of sessions attended after intake for this sample was 2.25 ($SD=3.3$). The large number of clients with few sessions is due in part to the short-term model adhered to by most of the counseling centers in the consortium and the natural attrition effect common to such centers (Tyron, 1999). This indicates that the sample used in this research is true to the nature of the counseling centers from which the data were gathered.

The mean age of students in the sample was 22.3 ($SD=4.9$). Ethnic composition of the sample was as follows: 11.6% African-American, 16.0% Asian-American, 29.5% Hispanic, 25.8% Caucasian, and 17.1% International students. The majority of the sample was female (66.2%). Further demographic information is summarized in Table 1 (see Table 1).

Table 1

Ethnicity and Academic Classification of Participants

	Frequency	Percent
Ethnicity		
African American	135	11.6
Asian American	187	16.0
Hispanic	344	29.5
Caucasian	301	25.8
Academic Classification		
Freshman	153	16.0
Sophomore	188	19.6
Junior	226	23.6
Senior	255	26.6
Graduate	123	12.8
Other	14	1.5

The counseling centers in this consortium primarily employed psychologists with some psychiatrists, licensed professional counselors, and clinical social workers, along with trainees in psychology and social work. Of the approximately 360 therapists and counselors who participated in this research study, many different field specializations were represented, but the largest single overall group consisted of counseling or clinical psychologists (35.3%). Of these 360 therapists, 230 were post-graduate professional staff and saw 78% of clients, while student trainees accounted for 130 counselors/therapists and saw approximately 22% of clients in this sample. The largest group of trainees was psychology interns (42.5%). For those counselors with trainee status, regular supervision was offered as part of their training experience. Trainees reported a mean of 2.57 years of experience ($SD = 3.74$), while professional staff reported a mean of 11.62 years of experience ($SD = 8.90$). The counselors in the study reported a mean age of 37.44 ($SD=10.34$). The majority of counselors were female (63.9%) and Caucasian (79.4%). African American counselors composed 6.9% of the sample, followed by Asian Americans (4.9%), Hispanics (4.4%), Internationals (3.9%), and American Indians/Alaskan Natives (.5%). Non-Caucasian therapists saw 24.6% of the student sample. Because many of the therapists are located at APA accredited internship sites which emphasize multicultural/cross-cultural counselor education, many therapists in this study participated in multicultural counseling training. However, records of this training were not included in the data collected for this sample.

Measures

For this study, the subjects filled out several different measures, including information about demographic characteristics and presenting concerns. The demographics collected covered such variables as age, race, sex, academic classification, major, and grade point average. A questionnaire about specific presenting problems was also included to provide the therapists a tool with which to begin exploring client issues. Demographic information was obtained first, followed by the presenting concerns questionnaire.

The primary measure of therapeutic outcome used in this study was the Outcome Questionnaire 45 (OQ45) developed by Lambert, Lunnen, Umphress, Hansen, and Burlingame (1994), which has been found to be particularly useful in examining the efficacy of psychotherapy (Kadera, Lambert, & Andrews, 1996). The OQ45 consists of 45 items in a Likert-type five-point scale. The total scale also contains three subscales measuring symptom distress, social-role functioning and interpersonal relationships. The symptom distress subscale, consisting of 22 items, taps into emotional and lifestyle stressors such as depression, anxiety, stress, substance abuse, and suicidality. The social role subscale, consisting of 9 items, measures the student's levels of dissatisfaction with and distress regarding school and employment, family roles, and leisure. In this subscale, conflicts at work/school, being

overworked, and inefficiency in these different realms are assessed. The interpersonal relationship subscale, consisting of 11 items, identifies clients' satisfaction with interpersonal relationships, especially marital and family relationships and friendships (Kadera, et al., 1996; Lambert, et al., 1994). Although previous research indicates that the three subscales may not be as distinct as the developers originally hoped, they are useful in clinical applications (Muller, Lambert & Burlingame, 1998). The researchers in this study particularly focused on the subscales, given the step-wise recovery commonly seen in psychotherapy with individuals often showing improvements and remissions on their way to recovery, and the arguments by other researchers concerning the multi-dimensional nature of clients' concerns and recovery (Howard, Lueger, Maling & Martinovich, 1993; Kopta, Howard, Lowry & Beutler, 1994). Previous research, for example, found that distress symptomatology remitted most quickly in psychotherapy, whereas characterological traits and problems remitted more slowly (Kopta, et al., 1994). Reliability and validity studies indicate that the OQ45 is a reliable and valid instrument, which distinguishes well between clinical and non-clinical subjects (Umphress, Lambert, Smart, & Barlow, 1997). Previous psychometric testing revealed internal consistency levels of .93 and test-retest reliability of .84. Concurrent validity has been shown with other measures, such as the Beck Depression Inventory (Beck, et al., 1961), Symptom Checklist-90-R (Derogatis, 1977), and Social Adjustment Scale (Weissman & Bothell, 1976), ranges from .53 to .88 (Kadera, et al., 1996; Umphress, et al., 1997). In the present sample, the scores on the OQ45 resulted in a coefficient alpha of .92, indicating good reliability. The subscale coefficient alphas for the present sample are as follows: symptom distress - .91, interpersonal relations - .75, social role - .63.

Due to the nature of the all-client sample without a non-client control group ($M = 71.17$, $SD = 25.02$), the researchers relied upon previous research performed with the OQ to determine clinical and non-clinical cutoff scores based on the formula developed by Jacobson and Truax (1991), and used by Lambert and others (Jacobson & Truax, 1991; Kadera, et al., 1996; Lambert, et al., 1994; Wells, Burlingame, Lambert & Hoag, 1996). Based on the Jacobson and Truax formulas applied to the OQ45, the cutoff score demarcating clinical and non-clinical groupings is 63. A 15-point change in pre-post scores indicates statistically reliable change (the Reliable Change Index). A combination of dropping at least 15 points and falling below the 63 cutoff defines clinically significant change or recovery.

Since we have chosen the OQ45 as our primary scale, it is important to note the cross-cultural validity of the instrument. While little research has been done investigating the cross-cultural validity of the scale, one study in particular provides evidence of its validity with other populations. Nebeker, Lambert, and Huefner (1999) found no significant differences between African-American and Caucasian clients in scores on the OQ45, suggesting that the OQ45 does not under- or overpathologize African-American individuals.

Procedure

Participants were given the OQ45 to complete before each weekly psychotherapy session, with their first OQ filled out before their initial intake. Only the data from those centers that directed clients to fill out questionnaires before each session and intake were included. Of those students who agreed to participate, the overall return rate was 90%. Participants filled out the OQ forms in a manner consistent with the instructions, which asked them to answer the questions "Looking back on the past week including today," (Lambert, et al., 1994). Participants completed their questionnaires in the waiting room before they were called in to sessions. The researchers in this study relied on the criteria outlined in previous research to determine whether clients were clinical or non-clinical at intake, and whether recovery, improvement, or no change occurred for each group (Kadera, et al., 1996; Jacobson & Truax, 1991). The breakdown of clinical and non-clinical participants is shown in Table 2 (see Table 2).

Table 2

Clinical and Non-Clinical Classifications by Ethnicity at Intake

Ethnicity	N	%
African American		
Clinical	64	55.2
Non-Clinical	52	44.8
Asian Americans		
Clinical	113	65.7
Non-Clinical	59	34.3
Hispanics		
Clinical	190	59.9
Non-Clinical	127	40.1
Caucasians		
Clinical	129	51.4
Non-Clinical	122	48.6
Total		
Clinical	595	57.7
Non-Clinical	437	42.3

Recovery, reliable change, and no change were determined by several criteria. First, subjects who started in the clinical category and by the end of therapy scored in the non-clinical category, with a difference greater than 15 between the scores, were classified as "Recovered." If clinical subjects demonstrated reliable improvement (a 15-point drop in their score), but their total score did not fall below 63, they were classified as "Improved Clinical." If non-clinical subjects also improved reliably (i.e., a 15-point drop in OQ scores in pre- and post-measures), they were classified as "Improved Non-Clinical." If either the clinical or non-clinical samples demonstrated a reliable increase in total score (a 15-point increase), they were classified as "Deteriorated Clinical" and "Deteriorated Non-Clinical" respectively. If, however, the subjects did not demonstrate enough of a difference in scores to be determined reliable (less than a 15-point increase), they were classified as "No Change." In order for the subjects to meet the previously listed criteria, they must have made those differences by the last (termination) session in order to be classified according to the criteria above, regardless of improvement or digression on a session by session basis. The breakdown of recovery categories is shown in Table 3.

Table 3
Percentages in Recovery Category by Ethnicity

Category	Ethnicity				
	Total	African American	Asian American	Hispanic	White
Recovered	21.7	17.2	13.2	26.3	25.3
Improved Clinical	11.6	9.4	20.9	12.2	4.7
Improved Non-Clinical	8.7	9.4	6.6	5.8	14.0
Deteriorated Clinical	5.2	4.7	5.5	3.8	5.3
No Change	51.6	59.4	53.8	50.6	48.0
Deteriorated Non-Clinical	1.3	0.0	0.0	1.3	2.7

Results

Preliminary Analyses

A preliminary analysis was conducted to explore possible differences between students paired with a Caucasian or a non-Caucasian therapist. A two-way ANOVA with counselor ethnicity and client ethnicity as independent variables and difference scores between totals on the OQ45 at first and last sessions was conducted. No significant differences were found ($p > .05$).

Another preliminary analysis was conducted to explore possible differences between students paired with a trainee or staff therapist. A two-way ANOVA with client ethnicity and counselor trainee status as independent variables and difference scores between totals on the OQ45 at first and last sessions was conducted ($p > .05$). Thus, being seen by a trainee or a staff counselor had no impact on outcome.

Another preliminary analysis was conducted to explore possible differences between men and women in sessions attended, severity of symptomatology, and therapeutic outcome. An ANOVA was run to determine differences between the sexes in their utilization of counseling as measured by average number of sessions attended. No differences were found between women and men in number of sessions attended. Another ANOVA was run to determine differences between the sexes on severity of symptomatology at intake using the total score on the OQ45. Again, no differences were found. Finally, an ANOVA was run to determine if differences existed between the sexes in therapeutic outcome using differences in scores between the total score on the OQ45 at intake and at termination. No differences were found.

Primary Analyses

Sessions attended. An ANOVA was run to determine the differences among ethnic groups in their utilization of counseling, as measured by the average number of sessions each group attended. The result was significant [$F(3, 963) = 21.77, p < .01$]. Caucasian students attended more sessions than all other groups, followed by African American, Asian American, and Hispanic students in that order. A post-hoc test (Scheffe) demonstrated that the significant differences were between Caucasians and African Americans ($p < .01$), Caucasians and Asian Americans ($p < .01$), and Caucasians and Hispanics ($p < .01$). Significant differences were not found in mean number of sessions between all other ethnic groups ($p > .05$). The mean number of sessions attended by each grouping is shown in Table 4 (see Table 4).

Table 4
Mean OQ45 Differences Intake to Termination By Ethnic Group

		<u>OQ45</u>			<u>Symptom</u>			<u>Roles</u>					
<u>Interpersonal</u>													
Ethnic	Average #												
Group	of sessions	First	Last	Diff	First	Last	Diff	First	Last	Diff	First	Last	Diff
African													
American	2.2*	69.4*	58.8	10.6	38.7*	32.3	6.4	14.3*	11.9*	2.4	16.4	14.5	1.9
Asian													
American	1.9*	78.9*	67.8*	11.1	45.2*	37.6*	7.6	15.9*	14.2*	1.7	17.7	15.9*	1.8
Hispanic	1.6*	73.6	59.7	13.9	42.1	33.0	9.1	14.7*	12.3*	2.4	16.8	14.4	2.4
Caucasian	3.5*	67.2*	54.9*	12.3	38.9*	31.0*	7.9	12.6*	10.9*	1.7	15.7	13.0*	2.7

* Group differed significantly from one or more groups.

Symptomatology at intake. A univariate ANOVA was conducted to determine if there were significant differences among ethnic groups on the OQ45 total score and subscale scores at intake. The result was significant for the total score, [$F(3, 852) = 8.54, p < .01$]. A post-hoc test (Scheffe) demonstrated that the significant differences were between Asian Americans and Caucasians ($p < .01$) and African Americans and Asian Americans ($p < .05$), with Asian Americans reporting greater initial distress than Caucasians and African Americans. A follow-up ANOVA was run to determine if there were any significant differences among ethnic groups on their OQ subscale scores at intake. The mean differences on the Symptom Distress subscale score [$F(3, 852) = 6.41, p < .01$] and the Social Roles subscale score [$F(3, 852) = 16.70, p < .01$] were both significant. The mean differences among ethnic groups on the Interpersonal Issues subscale score were not significant [$F(3, 852) = 3.10, p = ns$]. A post-hoc test (Scheffe) demonstrated that the significant differences on the Symptom Distress subscale were between Asian Americans and Caucasians ($p < .01$) and African Americans and Asian Americans ($p < .01$). Likewise, a post-hoc test (Scheffe) demonstrated that the significant differences on the Social Roles subscale were between Asian Americans and Caucasians ($p < .01$), Asian Americans and Hispanics ($p < .01$), and African Americans and Caucasians ($p < .01$). The mean differences across ethnic groups on OQ45 total and subscale scores at intake is shown in Table 4 (see Table 4).

Symptomatology at termination. A univariate ANOVA indicated significant differences between the groups on the OQ45 total scores at termination [$F(3, 510) = 5.92, p < .01$]. Again, the post-hoc test demonstrated that the differences were greatest between Caucasians and Asian Americans ($p < .01$), with Asian Americans reporting the greatest symptomatology. An ANOVA was conducted to determine if there were any significant differences between the subscale scores by ethnic group. The Symptom Distress subscale score differences [$F(3, 510) = 4.0, p < .01$], the Social Roles subscale score differences [$F(3, 510) = 9.83, p < .01$], and the Interpersonal Issues subscale score differences [$F(3, 510) = 4.44, p < .01$] were each significant. The post-hoc test (Scheffe) revealed significant differences between Caucasians and Asian Americans only for the Symptom Distress subscale ($p < .05$). This same pattern was also seen on the Interpersonal Issues subscale with the post-hoc test revealing a significant difference between Caucasians and Asian Americans only ($p < .01$). However, the post-hoc test for the Social Roles subscale demonstrated that the differences were significant between Asian Americans and all other groups ($p < .05$) and that Hispanics differed significantly from Caucasians ($p = .05$). Table 4 shows the mean breakdown of the termination OQ45 scores and subscale scores (see Table 4).

Therapeutic outcomes. To test for significant differences in outcome, the researchers ran another ANOVA to determine if there were differences in the amount of OQ score change the clients indicated between intake and termination. The result was not significant [$F(3, 510) = 1.02, p = ns$]. Covariates were examined that would account for the fact that there were significant

differences in first and last session OQ45 scores and numbers of sessions, but not a significant difference in OQ45 change score. An ANCOVA was run to examine the differences between the groups' last-session OQ score, while controlling for the number of sessions and the OQ score at intake. The results for the total score were not significant [$F(3, 461) = 1.62, p = ns$]. To follow up, a MANCOVA was run to determine if there were any significant differences among ethnic groups on OQ subscale scores at termination after controlling for number of sessions attended and OQ score at intake. The differences on the Symptom Distress subscale [$F(3, 461) = .87, p = ns$] and the Interpersonal Issues subscale [$F(3, 461) = 1.50, p = ns$] were not significant. However, the differences on the Social Roles subscale [$F(3, 461) = 4.02, p < .01$] were significant after controlling for intake OQ and number of sessions.

Discussion

In confirmation of our original hypotheses, Caucasians did attend significantly more sessions than African American, Asian American, and Hispanic individuals. Caucasians attended the most sessions, while Hispanics attended the fewest number of sessions. This supports prior findings that suggest that minority individuals attend fewer counseling sessions than Caucasians, which indicates that the needs of minority students may not be satisfied through current therapy approaches. Therapists in university populations, as in community agencies, are thereby called to provide more culturally sensitive modes of therapy for their clients. Likewise, continuing education concerning multicultural issues may be one method of increasing such awareness, as well as an expansion in the hiring of therapists with backgrounds that prepare them to serve the diverse needs of particular university populations.

Further, significant differences were found between the racial/ethnic groups at intake, with Asian Americans presenting with the most distress and Caucasians with the least distress. However, differences between the groups at the last session were not significant when controlling for the number of sessions and OQ score at intake. Since minority students are indicating greater overall distress at the time of intake, counseling centers must provide culturally relevant services to meet this need. These findings may indicate that minority students are having greater difficulty acclimating to university campuses because of specific concerns, such as social alienation and concomitant lack of social support. Another possible explanation of this discrepancy is the existence of racial discrimination on campuses across the country. Racism and hostile environments may cause more stress in the lives of ethnic minority students leading to greater distress at intake (Aponte & Crouch, 1995). However, differences between the groups at the last session were not significant when controlling for the number of sessions and OQ score at intake. These findings suggest that marked improvements can be made if minority students were to return for more sessions, which might occur with an increase in multicultural awareness and sensitivity in university counseling centers.

It is interesting that there was a statistically significant difference on the Social Roles subscale, even after controlling for first session score and number of sessions attended. Again, the major difference lay between Caucasians and Asian Americans. This difference may reflect the great emphasis placed on academic achievement in Asian American families, as this particular subscale taps into stress related to academic work. Asian Americans have been shown to spend twice as much time on academics as non-Asians (Eaton & Dembo, 1997) and often report the greatest fear of academic failure. It may be that such vast differences between Asian Americans and Caucasians in academic expectations and pressure can not be overcome in a time-limited therapeutic setting, common to many university counseling centers. Further, this difference also implies that although counseling may be helpful for some, it may not effectively address the specific situations of Asian Americans, perhaps due to the differences between Asian American culture and those of the psychotherapists (Sue, 1994; Sue, et al., 1991). For example, counseling practices have been characterized as containing White values such as individualism, autonomy, and individual responsibility (Atkinson, et al., 1997; Highlen, 1996), which may contradict Asian American values. Additionally, counselors who emphasize process oriented therapy rather than more problem solving approaches may alienate Asian American clients who may wish to have more concrete problem solving resolutions as the focus of therapy (Root, 1998). Thus, Asian American clients may leave therapy sooner before receiving the benefits which might help decrease stress related to academic performance.

While each group appeared to receive some benefit from therapy, as noted by the decrease in symptomatology, no group met the criteria for clinically significant change as established by previous research. Thus, since the amount of change indicated by the OQ45 was not significantly different across the groups, all groups appeared to benefit equally from counseling services, with those having the lowest severity at intake also exhibiting the least symptomatology at termination. These findings are promising in that they offer some hope that university counseling centers, with their greater emphasis on multicultural awareness, may be providing better treatment for ethnic minority students than would be received in community health centers, where such training for therapists is not emphasized. Unfortunately, because the study did not include information about the multicultural training therapists had received, conclusive evidence that this is the case cannot be found in this particular study.

Future Research

However, we hope that future researchers might look into these variables in college counseling centers to see if multicultural counseling training is connected with better therapeutic outcomes in ethnic minority student populations. With the American Psychological Association's greater emphasis on multicultural education for therapists both in training programs and training sites, it is of vital importance to determine if such education influences therapeutic outcomes. Thus, future researchers are encouraged to assess therapeutic outcomes

for ethnic minority clients with therapists who have had such training in comparison to those who have not.

Future research should also be directed toward studying the utilization of counseling services by minority students to address reasons for the discrepancy found between Caucasians and other ethnic groups in the number of sessions attended. Given that the amount of average change for each group was not significant, it may be that the outcomes were due to the passage of time rather than counseling effects. Another study might utilize a short-term control group of students not attending therapy to determine if there are differences between treatment and non-treatment conditions across ethnic groups. Further, studies should strive to identify why minority students are reporting greater amounts of distress in university settings, and how their perceptions of the counseling process may be influencing decisions to terminate counseling earlier than their Caucasian counterparts.

Limitations

In conclusion, the findings of this study strongly suggest the need for greater multicultural sensitivity by therapists in providing counseling services. The naturalistic quality of the study enhances the generalizability of these particular results to other counseling center populations since it captures the real world nature of clinical work at university counseling centers. However, while the sample is quite large and diverse in nature, there are some factors regarding the sample which must be addressed. As in other studies involving minorities, the number of participants for some ethnic groups is smaller than desired. Specifically, a larger number of African American and Asian American students would have been beneficial. Further, because counseling centers tend to use short-term models of therapy, the numbers of sessions were limited. Thus, the findings regarding severity at termination may have been quite different if looking exclusively at university centers implementing longer-term therapy models. The sample may also be biased in favor of those willing to participate in the study. It is unclear how many clients who are members of minority groups declined to participate in the study.

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Acknowledgements

Thanks are expressed to Judy Jennings and Steve Fitzpatrick of the Measurement and Evaluation Center, and Carolyn Hanna of the Counseling and Mental Health Center, for their assistance with various phases of the research. We also wish to express appreciation for the suggestions and valuable comments from Jill Rader and Ingelore Gillian.