South Asian American Attitudes Towards Seeking Mental Health Services: An Exploratory Randomly Controlled Trial of Model Minority Myth Internalization, Therapist Culture Matching, and Barriers to Care

By

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Table of Contents

Abstract………………………………………………………………………………… v

CHAPTER I: Study in Brief 1

Dearth of Literature……………………………………………………………. 1

Theoretical Framework……………………………………………………….... 3

South Asian Americans (SAAs)….……………………………………………. 4

Barriers to SAA Research……………………………………………………… 4

Study Focus……………………………………………………………………... 5

Contemporary Literature………………………………………………………… 7

Research purpose……………………………………………………………….. 8

Conclusion……………………………………………………………………………… 9

CHAPTER II 11

Asian Americans in Higher Education………………………………………….. 11

Theoretical Framework…………………………..……………………………… 12

Body of literature………………………………………………………………………. 15

Decolonizing Mental Health……………………………………………………. 15

Pan-Asian Americans…………………………………………………………… 16

Asian Americans in Mental Health……………………………………………… 17

South Asian Americans……………………………………………………….... 18

Therapist/Client Matching……………..……………………………………….. 19

Asian American Attitudes Towards Seeking Mental Health Services………… 23

Seeking Mental Health Services……………………..………………………... 25

The Model Minority Myth…… 29

The Internalization of the MMM…… 31

Statement of Problem, RQs, and Hypotheses…… 34

CHAPTER III: METHODS 39

Design and Statement…… 39

Participants…… 41

Table 1: Participant Descriptives…… 42

Measures…… 45

Procedures…… 48

Recruitment…… 49

Setting…… 50

Procedure Structure…… 50

Procedural Steps and Timing…… 52

Ethical Considerations…… 54

CHAPTER IV: RESULTS 56

Analysis and Interpretability…… 56

First Step Analysis…… 57

Table 2: Total Sample…… 59

Table 3: SAA Therapist…… 60

Table 4: White Therapist …… 61

Moderated-Parallel Mediation…… 62

Figure 1: Moderated-Parallel Mediation Model…… 65

Qualitative Analysis…… 65

Emergent Themes……………………..……………………….............................. 68

"What was that experience like for you?" ……………………...................... 68

"What if your therapist was South Asian American?" ……………………... 69

"What are your thoughts on pursuing therapy?" ………………………......... 73

CHAPTER V: DISCUSSION 75

Examination of Main Study Variables and Research Questions…………………… 75

Racial/Ethnic Match……………………..……………………….................... 75

MMM Internalization and Attitudes Towards Help Seeking Services……… 76

Working Alliance- Bond………………..……………………….…................... 77

Racial/Ethnic/Cultural (REC) Matching……………………...…………… 79

Qualitative Understanding……………………...………………………........ 80

Implications and Limitations……………………...…………………….............. 80

Decolonized Understanding to "Benefits" of Therapy……………………...... 80

Research Implications……………………...……………………….................. 82

Clinical and Training Implications………...……………………...………..… 83

System Implications……………………...……………...…………...………… 84

Limitations……………………….....……………………...………………….. 86

Conclusions……………………..……………………...………………………... 87

References…………………………………………………………………………. 90

Table 5: Participant Themes and Illustrative Statements…………………………... 103

Appendix A: Asian American Values-Multidimensional (AAVS-M)…...………….. 105

Appendix B: Working Alliance Inventory (WAI)……………………….………… 107

Appendix C: Inventory of Attitudes Towards Seeking Mental Health Services…... 109

Appendix D: Internalization of the Model Minority Myth Measure (IM-4)...…….. 111

Appendix E: Mock Session Template…………………………………..…………. 113

Appendix F: Demographics Questionnaire……………………………………... 114

Abstract

In 2014, Inman et al., published a three-decade long content analysis on the psychological literature of South Asian Americans (SAAs). Between 1980 and 2012, only 133 empirical articles focused specifically on SAAs in psychology, with only 10.53% (roughly 14) solely recruiting from college campuses and only 15.73% (roughly 21) focusing on psychological health (Inman et al., 2014). As such, this study adds to the paucity of literature focusing on SAA undergraduate students while laying a foundation for future research to build upon. To understand what systemic structures may inhibit SAA undergraduates' well-being, this study addressed the effects of the therapist-client racial/ethnic matching, the internalization of the model minority myth, and their relationship regarding attitudes towards seeking mental health services.

Using a psychosociocultural (PSC) approach (Gloria & Rodriguez, 2000) to study how racial/ethnic matching of SAA therapists informs the internalization of the MMM and attitudes towards seeking mental health services, the study took an exploratory, concurrent triangular mixed methods approach (Crewswell & Plano Clark, 2007) to understanding the internal processes of SAA undergraduates. Recognizing that many college students use mental health services through their university providers and ensuring that our findings are understood within the context of predominantly White institutions, this study was conducted as a regional study at a large Mid-Western University.

Our study takes a mixed methods pre-post treatment approach to answer our main research questions (RQ) and sub-research questions (SRQ).

RQ1: How does the racial/ethnic relationship between counselor and client inform internalized attitudes of the model minority myth and one's attitudes towards seeking mental health services for SAA undergraduates?

RQ2: Will the internalization of the model minority myth act as a mediator between therapist racial/ethnic match and one's attitudes towards seeking mental health services for SAA undergraduates?

RQ3: What are the experiences of SAA students who meet with racial/ethnically matched therapists versus those that do not?

SRQ1: How will bond influence other study variables?

SRQ2: Will "cultural match" act as a moderator between significant variable relationships?

To answer the research questions, 13 SAA undergraduates were recruited to take a pre-post treatment survey composed of four empirically validated instruments and one demographic questionnaire. The four surveys consisted of the Asian American Values Scale-Multidimensional (AAVS-M) (Kim et al., 2005), the *bond* subscale of the Working Alliance Inventory (WAI) (Horvath et al., 1989), the IM-4 (the Internalization of the Model Minority Myth Measure (IM-4) (Yoo et al., 2010) and the Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS) (Mackenzie et al., 2004). The study used a pre-post treatment format, where participants completed a pre-session survey (AAVS, IM-4, and IASMHS) prior to meeting with a study team member for a mock session. During the mock session, participants met with either a SAA or White identifying study team member for 35-45-minutes. Due to the exploratory nature of the study, all mock sessions were recorded and transcribed for follow-up analysis. For the main study analysis, the primary focus of the mock session was the interaction between the study

team “therapist” and the participant, rather than the content of the session. At post session, participants completed a second survey (IM-4, the bond subscale of the WAI, and IASMHS) and met with another study team member for a brief semi-structured interview (5-10 minutes) about their experience in the study, their attitudes towards help seeking services, and their thoughts about having a SAA or White identifying therapist. Following the semi-structured interview, participants partook in a debrief and given information related to study purpose and mental health services. Ensuring that racial/ethnic matching is not the only measure of identity match, the AAVS was used to assess for cultural/values match. Capturing a person-environment approach to psychological, social, and cultural constructs, study results provide insights towards SAA attitudes towards seeking mental health services, and direction for mental health professionals and university personnel alike.

Chapter I

Study in Brief

In the following chapter, a brief overview of the study is presented. Specifically, this chapter outlines the paper's main topics including the dearth of literature on South Asian American (SAA) populations, theoretical approach, barriers related to SAA research, and the study's focus. Lastly, an overview of the contemporary literature on SAAs and how it informs the research purpose is presented.

Dearth of Literature

Within the mental health and educational literature, there remains a dearth of research focusing on Asian Americans. In fact, in 2009, Musues reported that within the five most frequently read higher education journals, less than 1% specifically focused on Asian Americans. Whereas the literature on Asian American mental health has increased over the years, Sue and colleagues (2012) noticed a trend of Pan-Asian focused literature and called for a more specified approach to Asian American research. As such, this paper responds to Sue et al's., (2012) call, by studying SAA undergraduates. Specifically, SAAs are one of the fastest growing demographics within the United States (AACAJ, 2011), yet with a lack of literature focusing specifically on the experience of SAAs within higher education (DeVitre et al., 2021), this study focuses on the internalized, social, and cultural experiences of SAA undergraduates.

A "Forgotten" Group

In part due to their high degree of academic attainment (PEW Research Center, 2021), SAAs (such as Indian Americans) have been omitted from the literature to such a degree, that four decades ago, they were referred to as "forgotten Asians" (Hess, 1974, p. 576). Two decades later, they were still noted as an Asian ethnic group that were largely missing from the literature

(Rocher, 1995). Most recently, DeVitre and colleagues (2021) called for a redress of the exploration of Asian Indian American experiences within higher education and mental health literature as there still remained relatively little research.

The Model Minority Myth

Attending to the call put forth by Sue and colleagues (2012), while also focusing on systemic issues (e.g., the Model Minority Myth and SAA representation) this study aims to understand the experiences of undergraduate SAAs in relation to presumed assumptions and expectations placed upon students via the model minority myth (MMM). The MMM, a stereotype created to further the divide between racial/ethnic minorities in the U.S., is a myth that posits Asian Americans are high achieving academics who have high economic success given their tenacity and hard work (Lee et al., 2009). This myth further stereotypes that Asian American groups have "made it" and do not struggle with the issues of other racial/ethnic groups such as finances, stability, and mental health. As a result, the MMM holds influence over treatment seeking patterns, and has been attributed to the underreporting and minimization of mental health difficulties (Leong et al., 2011). With the internalization of positive Asian stereotypes being a predictor of less favorable attitudes towards seeking mental health services (Gupta et al., 2011), this study takes an in-depth approach to understanding what factors influence the internalization of the MMM (i.e., positive Asian stereotypes) for SAA undergraduates.

How To Help an Invisible Population

With a call to increase focus on the "how" and the "why" different therapeutic interventions are effective (American Psychological Association, 2006), understanding why/how different racial/ethnic groups respond to mental health treatment is warranted (American

Psychological Association, 2006). As a field, which has a strong focus on social justice and equity (DeBlare et al., 2019), Counseling Psychology still lacks the diversity of research needed to counsel adequately SAAs. Though not addressing all facets to fill the dearth of literature, this study serves as a starting point to understand the internalized processes of SAAs and the barriers they face seeking and while in mental health services.

Theoretical Framework

Attending to a more holistic process involving social and cultural concepts, this study uses the psychosociocultural (PSC) framework (Gloria & Rodriguez, 2000). Through this approach, understanding the various aspects of SAA undergraduates' well-being while obtaining an increased understanding to their internal processes is possible. The PSC approach takes a holistic understanding by focusing on person-environment constructs (psychological, social, and cultural) and aggregates them into one complete construct. It has been used to show how college students' well-being and campus experiences do not stem from purely individual constructs, but rather are a result of the individual, social, and cultural factors which a university environment helps to cultivate (DeVitre et al., 2021; Gloria & Rodriguez, 2000). Utilizing the PSC framework will help researchers, counselors, and university personnel, understand the interpersonal and cultural dynamics related to attitudes towards seeking mental health services, and what systemic and social barriers to care SAA students face within the university setting.

South Asian Americans (SAAs)

Among numerous calls to increase SAA representation within the mental health and educational literature, SAAs continue to be a forgotten population (DeVitre et al., 2021; Inman et al., 2014; Musues, 2009 Sue et al., 2012). With a paucity of research relating to SAA mental health or their educational experience, there is little known beyond resorting to Pan-Asian

American literature. Fortunately, contemporary research has taken note of the dearth of literature relating to the SAAs and are pushing for an increased understanding of SAA mental health. As such, we start with the foundation of SAA research and obtain an understanding of the factors such as representation and MMM internalization contribute to SAA invisibility in mental health services.

Barriers to SAA Research

A Need for Novelty and Representation

In 2020, DeVitre and Pan noted how Asian American internalized values informed attitudes toward seeking mental health services. In their study, they called for more individualized and mixed method approaches to studying Asian Americans' mental health and attitudes towards seeking mental health services. Specifically, DeVitre and Pan (2020) argued that understanding Asian American values was just the first step in understanding attitudes towards seeking help services and that novel approaches were needed.

Contemporary Asian American research has pointed to a common problem within the literature, a focus on Pan-Asian American issues, thus erasing the nuance and experiences of Asian American subgroups (Sue, et al., 2012). Still however, few researchers have posited theories as to *why* even amongst the specified Asian American literature, there remains an erasure of SAA narratives. Speculatively, the dearth of literature focusing on SAAs is partially because the field of psychology lacks SAA representation. Currently, Asian Americans make-up roughly 7% of the U.S. population (Pew Research Center, 2021) and 5% of the psychology workforce. Even with SAAs being one of the largest growing racial/ethnic demographics within the United States (Asian American Center for Advancing Justice, 2021; Pew Research Center, 2021; SAALT, 2019) no data exists examining Asian American sub-group demographics within

the field of psychology, including number of psychologists or type of work (e.g., academia, private practice). Whereas research is trending towards the dismantling of Pan-Asian narratives, in practice, the field of psychology still erases SAA narratives (Inman et al., 2014). Recognizing that SAAs in mental health may be casualties of hermeneutical injustice, or "the injustice of having some significant areas of one's social experiences obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource" (Fricker, 2007, p. 155), understanding what systemic barriers SAAs face, in and outside of the mental health field, and how those barriers influence various pathways, is warranted.

Study Focus

This paper serves to further the directives put forth by DeVitre and Pan (2020) and Sue et al., (2012) (i.e., specified Asian American approach to understanding attitudes towards help seeking services), by drawing awareness to SAA undergraduates' person-environment narratives. Focusing on the effects of the MMM, attitudes towards seeking mental health services, and therapist racial/ethnic matching, this study looks to further the understanding of such constructs related to SAA undergraduates.

Justification of Focus

Previous psychological literature focusing on the effects of racial/ethnic therapist matching found that although, amongst clients, there is typically a preference for a therapist who has similar racial/ethnic identification, racial/ethnic matching has not improved immediate client outcomes (Cabral & Smith, 2011). This phenomenon, however, has not been studied with SAAs, in relation to one's internalization of the MMM nor their attitudes towards seeking mental health services.

As many undergraduate students, attending college may be their first time living away from home, understanding what barriers undergraduates encounter is warranted. Specifically, understanding which negative psychological, social, and cultural barriers that SAA students encounter, thus negatively impacting their psychological well-being (DeVitre et al., 2021), may help university systems to better help their SAA students. Furthermore, this study serves as a launching point for other areas of SAA student research, opens pathways to study unexplored domains, and helps SAA groups not remain "forgotten Asians" (Hess, 1974, p. 576).

Justification Within Counseling Psychology Values

Historically, psychology has been one of the more progressive/social justice-oriented fields within academia (DeBlaere, 2019). As a field, which has an intentional focus on social justice and systemic related concerns, counseling psychology has historically held a specified direction on how to further multiculturalism in practice, education, and research (DeBlaere, 2019). This research attends to the American Psychological Association's (APA) directive, in their ethical guidelines, that cultural competency is not something one can finish obtaining but rather is a continued growth (APA, 2016).

In similar adherence to this growth, and in part due to a lack of focus on Pan-Asian American issues, the Asian American Psychological Association (AAPA) was created in 1972 (Leong & Okazaki, 2009). Since then, Asian American researchers have paved the way to increase Asian American mental health awareness, understanding, and dissemination of information. Fifty years later however, the field of psychology has yet to attend fully to further Asian American narratives by often leaving SAAs out of their conversation (Inman et al., 2014). As such, this paper serves as a means of attending to the APA's call to increase multicultural practice, education, and research, by lifting up the narratives and experiences of SAAs.

Contemporary Literature

Mental Health Service Utilization

Asian American attitudes' towards seeking mental health services has been heavily documented within the Pan-Asian American literature. There is, however, dearth of literature focusing on the factors inhibiting Asian Americans from actively accessing mental health services (Lee et al., 2009). Despite previous studies focusing on cultural factors as inhibiting positive attitudes towards seeking mental health services (DeVitre & Pan, 2020; Kim & Omizo, 2003), there is also a push to understand what other nuanced variables inhibit help seeking attitudes (DeVitre & Pan, 2020). As SAA mental health research is scant within the empirical literature (Inman et al., 2014), this study takes a much-needed specified approach to understanding SAA undergraduates' mental health, in relation to the MMM, and specifically looks to address nuanced cultural *and* systemic related barriers.

The Model Minority Myth

The model minority myth (MMM) has perpetuated the stereotype that Asian Americans, in this case, SAAs, have high educational attainment, high fiscal stability, and high mental health stability (Wing, 2007). The MMM has also been found to predict poor psychosocial health and less favorable attitudes towards seeking mental health services (Gupta et al., 2011). A less studied facet of the MMM, is the effects of the internalization of the MMM on SAAs. As such, this study takes a focused lens on the MMM, attitudes towards seeking mental health services, and additional inhibiting factors effect SAA undergraduates.

Therapist Racial/Ethnic Matching

In 2011, Cabral and Smith published a study focusing on therapist effects in relation to racial/ethnic matching. The findings indicated that although clients reported feeling more

congruent when matched with a therapist of the same racial/ethnic background, their treatment outcomes were not significantly different. As such, a narrative taken from this study, is that therapist racial/ethnic matching may not have the "desired" effect that previous researchers may have hypothesized. The Cabral and Smith (2011) study, however, failed to examine the cultural nuances of racial/ethnic minorities such as SAAs, other factors that could be related to therapist racial/ethnic matching (i.e., attitudes towards seeking mental health services or the internalization of the MMM), and neglected to take a culture-specific approach to understanding the "benefits" of therapist racial/ethnic matching (i.e., collectivistic approaches). As such, knowing that cultural congruency has a significant effect on SAA undergraduates' well-being (DeVitre et al., 2021), and that racial/ethnic matching may yield benefit for marginalized communities (beyond immediate treatment outcome), this study takes a more in depth look at the factors relating to identity match.

SAAs in the University Setting

Novel literature focusing on SAA groups (such as Indian Americans) posit that university experiences account for their overall psychological well-being (DeVitre et al., 2021, Rastogi, 2001). This is important when taking into consideration that social factors are partially constructed via university systems (e.g., feeling value as a student, perceived university values of marginalized populations). As such, understanding what systemic factors within the university setting may influence SAA undergraduates' psychological well-being and their access to seeking help, is warranted.

Research Purpose

To center SAA undergraduates' narratives, this study's purpose was to provide nuanced insight into *why* SAA undergraduates may be less likely to seek mental health services and what

influences those attitudes. With few licensed psychologists identifying as Asian American, and with the number of licensed psychologists being SAA unknown, the study findings provided valuable insight related to the systemic barriers that SAAs encounter. Lastly, knowing that various factors of the MMM are predictors of poor psychosocial health (Parks & Yoo, 2016; Yoo et al., 2015), obtaining additional insight related to what factors may affect the internalization of the MMM is warranted.

The Present Research

Attending to the call to have a more specified approach to understanding Asian American help seeking services (DeVitre & Pan, 2020), this study implements a PSC framework. This is done by studying the internalization of the MMM for each participant, having each participant meet with a "therapist," and partake in a semi-structured interview. Through this methodology, the study's findings will speak directly to the systemic factors that may impact the SAA undergraduate community. Framing the study as a randomized multi-time dual participant mixed methods (RMDPM) approach, this study looks to further understand the relationship between SAA undergraduates racial/ethnic therapist match and bond, and their relationship to the internalization of the MMM and attitudes towards seeking mental health services. Based on the limited literature, we expect significant relationships between racial/ethnic matching and attitudes' towards seeking mental health services and the internalization of the MMM, respectively. Further discussion regarding the study's research questions and hypotheses are explored in Chapter 2.

Conclusion

With a paucity of literature surrounding SAA college students' mental health (Inman et al., 2014), and with previous literature supporting a need for increased understanding/specified

approach to Asian American's attitudes towards seeking mental health services (Devitre & Pan, 2020), this study takes a multi-time dual participant approach to understanding the internalized processes of SAA undergraduates and their attitudes towards seeking mental health services. Focusing on therapist match, bond, internalization of the MMM, and attitudes towards seeking mental health services, this study's findings add to the counseling, public health, and educational discourse related to SAA undergraduates. This study also opens a more nuanced discussion related to systemic concerns (such as SAA representation) within the field of psychology.

Chapter II

The following chapter reviews the literature pertaining to the counseling experiences and attitudes towards seeking mental health services, of South Asian Americans (SAAs) through the lens of the psychosociocultural (PSC) framework (Gloria & Rodriguez, 2000). In particular, a review of the literature focusing on the model minority myth (MMM) internalization and how it manifests within university settings is explored. Due to a history of such literature having a Pan-Asian focus, with a dearth of literature specifically on SAA mental health (Inman et al., 2014), much of this chapters' review draws from the greater "Pan-Asian" literature. The importance of this study and its literature review are informed by the paucity of literature focusing on SAA undergraduate well-being. As such, there will first be a discussion of how this topic fits within the values and literature of counseling psychology such as the ideals of social justice, decolonization, and multiculturalism. Next, a review of the major study variables including ethnic identity, attitudes towards seeking mental health services, SAAs in higher education, therapist effects, and the MMM are presented in leading up the study's research questions and hypotheses.

Asian Americans in Higher Education

Asian Americans hold higher post-secondary graduation rates than any other racial/ethnic group (de Brey et al., 2019). This high educational attainment and the absence of Asian American undergraduate research has contributed to the myth that Asian Americans are a universally successful group/problem free minority, which has inhibited their ability to advocate for their needs and well-being (Museus & Maramba, 2010; Museus & Park, 2015). As a result, Asian Americans have become one of the most misunderstood populations within higher education (Museus & Park, 2015). This invisibility is stressed in predominantly White

universities where colonized values are built within the fabric of the institution (Guthrie, 2004) and racial/ethnic minority groups must choose to either assimilate to the campuses' cultural climate or find programs, organizations, and events which help them attend to cultural congruity (Museus & Maramba, 2010). With cultural congruity (i.e., one's individual and cultural values fit within the context of the university environment, Gloria & Robinson Kurpius, 1996) being a predictor of well-being for SAA groups (DeVitre et al., 2021), universities are responsible in cultivating settings where SAA groups may achieve cultural congruity rather than experiencing negative well-being or having to fit into White campus culture by committing "cultural suicide" (Tierney 1999, p. 82). To help facilitate this process, additional research focusing on how campus climates can be adjusted to better suit SAAs is warranted.

Theoretical Framework

Within the higher education setting, college student well-being is traditionally measured by cognitive outcomes such as grade point average, retention, and graduation rates (Swanbrow Becker et al., 2017). That is, whether a student graduates from college, the final outcome is equated to well-being of persistence or overall adjustment, yet the processes of students' experiences within the university on the way to graduation is of equal importance (Castellanos & Gloria, 2007). Ultimately, addressing person-environment considerations and non-cognitive processes with diverse student populations is recommended (Castellanos & Jones, 2003; Tinto, 2012). Yet, how contextual considerations, such as campus climate (i.e., social/cultural constructs) are non-cognitive predictors of psychological adjustment and well-being for students of color (DeVitre et al., 2021; Santos et al., 2007), are not fully or expansively considered within the educational discourse.

Addressing the non-cognitive aspects of college student well-being (i.e., person-environment), this study utilizes the psychosociocultural (PSC) framework (Gloria & Rodriguez, 2000) as a basis of understanding. The first dimension, psychological, relates to one's attitudes, perceptions, and self-beliefs. Next, the social dimension includes environmental influences such as connection, relationships, representation, and peer networks. Lastly, the cultural dimension, accounts for culturally relevant constructs such as values congruence, meaningfulness, and validation (Castellanos & Gloria, 2007; Gloria & Rodriguez, 2000). As a meta-theory, the PSC dimensions inform one another by working independently and collectively (Gloria & Rodriguez, 2000). For example, where psychological processes help to understand the internalized cognitions that one may experience (e.g., coping, anxiety), it can also be informed by social interactions with peers, educators, family, and more. Similarly, the cultural dimension can be informed by internal and environmental factors that inform one's sense of culture. Worth noting, is that similar constructs can fit different dimensions of the PSC framework, depending on how they conceptualized to a specific student group and inform one another. For example, where cultural representation on a university campus may seem like a cultural dimension, it can also inform the model as a social dimension if that representation also informs social aspects (e.g., peer interactions). Thus, instead of focusing on cognitive outcome data (e.g., grade point average, retention, and graduation rates), this study takes a person-environment approach, via the PSC framework, to understand the holistic experience of SAA undergraduates.

Utilized as a holistic approach, the PSC framework is also used to understand the specific constructs that account for variable difference. A core tenet of the PSC framework is that each dimension is individually yet collectively informative within the specific educational context. Within this study, the *psychological* dimension accounts for one's held beliefs and self-

perception. The *social* dimension accounts for the relationships and social perception that one holds with others (e.g., peers, educators) within the university setting. Lastly, the *cultural* dimension accounts for cultural values that one holds and cultural congruity that one may feel within the context of higher education. With the dimensions' ability to be differently conceptualized based on the questions, for this study, the internalization of the MMM is examined as a psychological variable, therapist match as cultural, and bond as social. The construct of therapist match, however, can also be broken into two dimensions: social (racial/ethnic match) and cultural (culture/values match). Thus, depending on the observed hypothesis, racial/ethnic match is conceptualized as a social dimension when contextualizing it as a means of connectivity and relationship to the university experience.

The PSC approach has been used to conceptualize the experience of different Asian American undergraduate populations such as Pan-Asian Americans (Gloria & Ho, 2003), Korean Americans (Gloria et al., 2008), Hmong Americans (Sengkhammee et al., 2017), Chinese Americans (Guan et al., 2020), and most recently Indian Americans (DeVitre et al, 2021). Used as a framework to help understand individual, social, and cultural aspects within the lives of SAA undergraduates, the PSC dimensions have collectively accounted for well-being, with the psychological and social constructs accounting for the largest amount of variance of well-being, respectively (DeVitre et al., 2021). As such, the PSC framework helps attend to the wholeness of a student while simultaneously providing insight into how different constructs inform one another, within the context of the university system (i.e., systemic/environmental barriers). Through the PSC framework, the study attends to the social justice narratives built within the values of counseling psychology by removing the "responsibility" from SAAs and placing the

onus on the academic context by instead asking “what are the university based systemic barriers that SAAs face?”

Body of Literature

Decolonizing Mental Health

The field of psychology is constantly trying to learn, grow, and generate new information related to how researchers, institutions, and mental health professionals may assist those in need. In fact, the American Psychological Associations’ mission statement is “to advance the creation, communication and application of psychological knowledge to benefit society and improve people’s lives.” (APA, 2013, para. 1). To attend to this mission, it is important that the history of the field is contextualized. Psychology is a historically Euro-centric field based in dominant White culture (Guthrie, 2004). That is, what we know can be altered, looked at differently, and/or adjusted when viewed through a multicultural lens. Doing so, means continually striving to understand various cultural nuances and implications. For this study in particular, the narratives add to an otherwise non-existent literature based and attends to the true essence of multicultural psychology (i.e., to learn continually).

Social Justice Perspectives

The field of counseling psychology is historically social justice-oriented and tends to hold specialized knowledge on constructs such as environmental/situational influences (i.e., how culture can shape one’s experiences and concerns; DeBlaere, 2019). Albeit the focus on social justice has been more evident within the recent years, it is important to remember that, like the educational discourse, many groups are overlooked and understudied. As such this research attends to the specified focus of counseling psychology by meeting the call of past researchers to have a more nuanced approach to Asian American studies via the intentional inclusion of Asian

American subgroups (Sue et al., 2012). Thus, this research helps to inform counseling psychology practices and mental health professionals' understanding(s) of how to best help their SAA clients. Furthermore, this research helps university systems assist their SAA students by increasing awareness and understanding of what systemic factors inhibit SAA attitudes towards seeking mental health services.

Representation of SAAs in Higher Education

In 2016, 70% of all SAAs over the age of 25 held a bachelor's degree or higher, with the next highest being Pan-Asians (54%) and White (35%) (de Brey et al., 2019). Similarly in 2016, higher than any other non-Asian racial/ethnic demographic, the average college enrollment rate for SAAs was 68% with White students holding the next highest enrollment (42%, de Brey et al., 2019). Even with such high enrollment rates, SAAs are invisible within the higher education system. With universities primarily focusing on constructs, such as graduate rates, as a metric of college student well-being (Swanbrow Becker et al., 2017), SAAs are disregarded as not needing attention within university systems and comprise less than 1% of the focus within the most frequently read journals of higher education (Museus, 2009).

As such, this study attends to the call put forth by DeVitre et al., (2021) to challenge the invisibility of Asian ethnic specific groups within higher education settings and to no longer let SAA groups go as "forgotten Asians" (Hess, 1974, p. 576). To do this, gaining more in-depth understandings of the barriers SAAs face and how university systems may help to ameliorate those concerns is warranted. Doing so, leaves SAA undergraduates at an increased capacity to attend to their well-being and assists in addressing the erasure of SAAs on university campuses.

Pan-Asian Americans

Pan-Asian Focus

The continent of Asia contains 48 different countries and 3 territories. Psychological research on Pan-Asian American narratives, however, often focuses on East, South, and Southeast Asia, and otherwise specified regions (i.e., Middle East vs Asia). Even amongst the wide range of Asian American countries, almost all Asian Americans, can trace their roots to 19 countries in the East, South, and Southeast Asian regions (Pew Research Center, 2021).

Within the multicultural psychological literature, various terms are used when speaking about Asian American cultures. Within the mental health literature, if the terms "Asian American" or "pan-Asian" are used, the studies rarely differentiate between Asian American cultures (i.e., Indian American vs Chinese American). Until the early 1970s, Asian Americans were not commonly discussed within the psychological research. As a result, researchers used the umbrella term "Asian American" to start the dialogue related to Asian American groups (Leong & Okazaki, 2009). It was not until recently when the psychological community started to break away from Pan-Asian narratives and publicly recognize that grouping all people from Asian American backgrounds was not an accurate depiction of the varying cultural values, norms, and internal processes between groups. In fact, it was not until the last decade that the field made an intentional call for researchers to disaggregate Pan-Asian narratives and to start focusing on different sub-groups of Asian Americans (Sue et al., 2012).

Asian Americans in Mental Health

Whereas Asian Americans have been an integral part of the United States since the 1800s, Asian Americans were not brought into the psychological narrative until the mid 1960s (Leong & Okazaji, 2009). Fighting for civil rights regarding prejudice immigration laws, the 1960s marked one of the earliest moments within psychology that Asian Americans were being discussed as a separate entity. Even so, it was not until December of 1972 that the Asian

American Psychological Association (AAPA) was founded (80 years after the foundation of the American Psychological Association (APA). Alongside its emphasis on equality and attention to multiculturalism, the foundation of the AAPA marked an important shift within the field of psychology. Throughout those years, the AAPA had increased foci on attending to Asian American research and mental health both within the APA and in within the public eye. As a result, the mental health field saw an increase of literature being published with a specified focus on Asian Americans (Kiang et al, 2016).

A few decades later, Asian American researchers noted the lack of Asian American sub-groups being studied, naming that much of the literature focused on the larger "Pan-Asian" narrative. As such, in 2012 Sue and colleagues made a call to action for Asian American researchers to increase efforts to focus on different sub-populations of the Asian American community. Even after the call, SAAs were still relatively invisible and lacked representation within the psychological *and* Asian American psychological discourse. For example, until recently, 50 years after its foundation, AAPA had never had a SAA identifying president. As such, continuing to attend to Sue and colleagues (2012) call to action, this study serves to ensure that SAAs no longer continue to be the "forgotten Asian" (Hess, 1974, p. 576) within the national, educational, and psychological discourse.

South Asian Americans

Indian Americans comprise roughly 20% of the Asian American population within the United States and are the fastest growing Asian American group (Pew, 2021). Within the SAA psychological literature, roughly 61.53% of published articles have a specified focus on Indians Americans, with the next highest singular focused group being Pakistani and Bangladeshi (1.5%) (Inman et al., 2014). Thus, recognizing that as a fast-growing Asian American population the

study's focus could be primarily on Indian Americans, to ensure other SAAs are not left out of the literature, this study will include those who identify as SAA. Countries of which are considered to be within the SAA umbrella are India, Pakistan, Bangladesh, Nepal, Bhutan, the Maldives, and Sri Lanka.

Dearth of SAA Psychological Literature

In Inman et al's (2014) content analysis of psychological research on SAAs, only 133 empirical articles were published between 1980 and 2012. Presumably because Indian Americans are the fastest growing Asian American demographic within the United States (Pew, 2021), a majority of the 133 articles had a specified focus on Indian Americans (61.53%). Inman and colleagues (2014) also found that only 15.7% of the 133 published articles focused on factors related to psychological health, with 3% focusing specifically on the topics of psychotherapy and cultural/values conflict, respectively. The most frequently addressed topics focused on acculturation (14.2%), generational status (10.15%), and interpersonal dynamics (e.g., parenting, family) (14.72%).

Noticeably missing from the SAA discourse, were articles related to environmental and social constructs and specified foci on college students. Only 10.5% of the articles specifically recruited from college student samples; however, the percent of studies which had a specified college student focus is unknown (Inman et al., 2014). As such, the likelihood of empirical literature focusing on the psychological well-being of SAA college students is low, when compared to other racial/ethnic and Asian American groups.

Therapist/Client Matching

Racial/ethnic matching can often be misinterpreted as a face value construct. Where some studies (Cabral & Smith, 2011) utilize racial/ethnic matching from a phenotypical point of view,

this study takes the understanding that racial/ethnic matching is used as a representation of identity match. The below sections highlight the nuances of racial/ethnic and cultural/value matching and how although different, they are often used synonymously. For this study, racial/ethnic vs cultural/values matching is conceptualized in a similar vein of Asian American vs SAA (i.e., racial/ethnic matching is to Asian American as culture/values matching is to SAA). Albeit there are many overlaps, they are not synonymous and, without context, should not be treated as such. Specifically, the section delineates how the study uses racial/ethnic *and* cultural/value match as measures of shared identity.

Colonized Lens to Implications of Racial/Ethnic Matching

When discussing racial/ethnic matching, much of the literature has focused on the individual effects (i.e., treatment outcomes, cultural congruency, or length of stay). Such narratives feed into the belief that, although racial/ethnic matching may prove beneficial, there is no quantifiable benefit to such constructs. Such narratives, however, hold a colonized lens to mental health and diminish the “benefits.” As a result of an individualistic approach, such narratives imply that outcome data related to presenting concerns are the primary benefit of counseling (Cabral & Smith, 2011). This approach, however, neglects the community benefits (i.e., de-stigmatization) that can accompany longer stays in services. For example, individualistic approaches ignore important facets of racial/ethnic therapist matching, such as access to mental health services through trust of the system and de-stigmatization from within the community. As such, when discussing the findings/implications of studies that focus on racial/ethnic match, it is recommended that they are contextualized in relation to community benefit (i.e., understanding of mental health and de-stigmatization).

Racial/Ethnic Matching

Racial/ethnic matching is a topic showing mixed reviews within the psychological literature (Ibaraki & Hall, 2014). Whereas some research findings suggest that racial/ethnic matching does not significantly impact treatment outcome (Cabral & Smith, 2011; Shin et al., 2005) it has also been recognized that racial/ethnic matching significantly increases treatment stay, reduce one-session attrition, and increase cultural congruency amongst racial/ethnic minority clients (Cabral & Smith, 2011; Ibaraki & Hall, 2014). Such research, however, fails to recognize the systemic level effects of therapist and client matching.

Knowing that the matching of therapist and client may not increase immediate well-being outcomes, but rather may lead to increased attrition, it is imperative that researchers increasingly attend to the systemic implications of such findings. The narrative that identity matching does not significantly affect well-being outcomes, and thus is not an important notion of focus, is an individualistic approach that disregards the importance of attrition and increased number of therapy sessions (i.e., helping to break the stigma within community). Focusing on the latter, serves to decolonialize the "identity matching" narrative by focusing on the benefit towards the individual *and* their cultural community.

Another important distinction is the reconceptualization of racial/ethnic matching. When racial/ethnic matching is used, it is most beneficial when used in a responsible and non-discriminatory fashion (i.e., understanding *why* racial/ethnic matching can be beneficial instead of simply pairing together clients and therapists who share racial/ethnic identities) (Cabral & Smith, 2011; Sue, 1998). Ibaraki and Hall (2014) explained how, when understood and used correctly, racial/ethnic matching is less about the effects of matching individuals based on phenotypical expression but rather that phenotype expression is a shortcut and proxy to shared cultural backgrounds, attitudes, values, and beliefs. As such, they argued that racial/ethnic

matching studies can be viewed as studies of cultural match instead of purely racial/ethnic matching.

Culture/Value Matching

Understanding that although racial/ethnic matching is often used as a proxy for culture/values matching, and that at times the two constructs may overlap, they should not be assumed to be synonymous. Therefore, though the study design relies heavily on the notion of racial/ethnic matching, it also looks to differentiate the two constructs. Doing so, helps to understand racial/ethnic matching in a culturally responsible manner and contextualizes different empirical findings related to racial/ethnic matching. For example, one of the benefits of racial/ethnic matching is not that a therapist and client will attend to or even share similar values and/or beliefs, but rather one's therapist can understand the cultural nuances with which their client presents (Ibaraki & Hall, 2014). This is increasingly important when focusing on groups who are either not actively written about within the psychological literature (thus making cultural understanding more difficult amongst non-racially/ethnic matched pairs) and/or groups who have lower rates of seeking mental health services, in part due to distrust of the system (such as Asian Americans) (Leong et al. 2011). As understanding multiculturalism is a growing construct and highly nuanced, so is understanding racial/ethnic matching.

Contemporary Research

In recent years, contemporary literature has started to take a more nuanced approach to understanding the effects of therapist cultural matching. Unlike earlier studies (Cabral & Smith, 2011) which took a "direct" approach to understanding therapist client match (i.e., outcome ratings of racial/ethnic identity match), contemporary studies examine what constructs related to therapist/client cultural matching may inform various processes. For example, where studies

such as Cabral and Smith (2011) sought to understand the direct effects of phenotypical matching and their effect on the individual/therapy space (i.e., treatment effects and stay), recent studies focusing on Asian American cultural matching explore constructs such as self-disclosure (Zany & Ku, 2015), expectations of counseling success (Kim et al., 2005), therapist credibility (Presley & Day, 2019), and retention/dropout (Meyer et al., 2011).

Asian American Attitudes Towards Seeking Mental Health Services

Working Alliance

Working alliance is a combination of three related components (tasks, bonds, and goals) which assists clients to accept and follow treatment (Bordin, 1979; Horvath & Greenberg, 1989). Tasks are defined as "in-counseling behaviors and cognitions that form the substance of the counseling process" (Horvath & Greenberg, 1989, p. 224). Bonds involve various aspects of the counseling relationship such as acceptance, mutual trust, and confidence (Bordin, 1979; Horvath & Greenberg, 1989). Lastly, goals are defined by the mutually agreed upon outcome that one wishes to obtain from therapy (Bordin, 1979; Horvath & Greenberg, 1989). With working alliance being a strong facilitator of treatment outcome and rapport (Bordin, 1979), understanding what factors influence working alliance, is warranted.

In their 2005 study, Kim et al., noted how working alliance is a strong predictor of therapy outcome and one's likelihood to continue services. Instead of focusing on phenotypical racial/ethnic matching, Kim et al., (2005) focused on perceived similarity between Asian values vs. European American values. Their findings evidenced a significant positive association for working alliance and clients who had values-matched therapists. These findings imply that one's immediate outcomes and adherence to therapy may increase for Asian Americans if they are to match with a therapist of whom shares values. With identity value match leading to increased

working alliance, and subsequently continued services, focusing on what systemic factors (i.e., SAA representation) inhibit identity match is warranted.

Experiential Similarities

Literature focusing on Asian American mental health discrepancies shows that some of the biggest concerns occur early in treatment, often lead to poor retention rates, and incompletion of services (Meyer, et al., 2011). To understand what these processes are, Meyer et al's (2011) study explored what psychological processes are occurring for Asian Americans who racially/ethnically match with their therapists. They concluded that for those who matched with their therapist, there were higher perceived rates of experiential similarity (i.e., perceptions of match in values and lived experience). Whereas there was no relationship between racial/ethnic matching and rates of therapist credibility, there was a positive relationship between experiential similarity and therapist credibility. Taking into consideration that perceptions of similarity are positively related to higher psychological outcomes (Meyer et al., 2011), these findings grant further support that although racial/ethnic matching may not singerly increase outcome variables, there may be numerous mediating or moderating effects stemming from racial/ethnic match.

Lack of SAA Focus

Studies focusing on racial/ethnic match for Asian American clients, rarely include SAA participants. For those that do, the SAA participants were less than 3% of the total sample size (Kim et al., 2005, Meyer et al., 2011; Presley & Day, 2019). Recognizing the importance of such literature and the contribution to Asian American psychology, drawing attention to the erasure of SAAs within the Asian American narrative is warranted. To our knowledge, no peer reviewed empirical literature has focused specifically on the effects of racial/ethnic therapist matching with SAA populations. As such, this study aims to provide insight regarding racial/ethnic

matching and to stress the importance of representation as a construct to help break the mental health stigma for SAAs.

To do so, an untraditional approach is taken to understanding access to mental health services. Access to mental health services often takes a literal meaning (e.g., if one can afford services), this study views access to mental health services from a community standpoint. Specifically, this study views access and attitudes towards seeking mental health services as similar constructs in relation to systemic barriers (i.e., representation).

Seeking Mental Health Services

Asian Americans

Asian Americans have one of the lowest attending rates and attitudes towards seeking mental health services when compared to other racial/ethnic populations (Chu & Sue, 2011). Traditionally, Asian American attitudes towards seeking mental health services have differed generationally (i.e., lower positive attitudes for first generation Asian Americans) yet it persists among all age ranges (Chu & Sue, 2011). For example, in many Asian American cultures, seeking mental health services has been thought of and/or only used as a last resort that is either brought on by a crisis or heavily insisted upon by a family member or friend (Chandra et al., 2015).

Study findings reveal that adherence to Asian American values is associated with less positive attitudes towards seeking mental health services and adherence to European American values is associated with positive attitudes towards seeking mental health services (DeVitre & Pan, 2020). Amongst Asian values, constructs such as saving face and the fear of “losing face” directly correlate with one’s attitudes towards seeking mental health services (Leong et al., 2011). Similarly, specified values such as emotional self-control also decrease Asian Americans’

attitudes towards seeking mental health services (Chaudry & Chen, 2019). Recognizing that Asian American attitudes towards seeking mental health services goes beyond individualized values, DeVitre and Pan (2020) called for more specified, mixed methods approaches to understanding this phenomenon.

Asian American Undergraduates

Asian American undergraduates are less likely to seek mental health services when compared to other racial/ethnic minorities, are roughly 26% less likely to seek services when compared to White students (Lipson et al., 2018), and show less favorable attitudes towards seeking mental health services than higher status students (i.e., juniors and seniors; Shea & Yeh, 2008). University support, accessibility of resources, support from social environment, and greater visibility of resources are all factors which effect attitudes towards seeking mental health services (Dong et al., 2020). Unknown however, is *how* such constructs effect help seeking attitudes. For example, older students more favorable attitudes towards seeking services (Shea & Yeh, 2008) could because of time availability, understanding of resources, navigation of university systems, etc. As such, further exploration into such constructs is warranted. Another unexplored area of research is whether constructs such as greater resource availability and/or university support also are representative of visibility of cultural values and personnel (i.e., Asian American identifying faculty/staff).

South Asian Americans

Congruent with the Pan-Asian American literature, SAAs are also less likely to seek mental health services, in part due to cultural values and stigma (Loya et al., 2010). Amongst these cultural values, one of the more studied constructs has been interdependent self-construals, or the degree to which one views themselves as being fundamentally connected to other people

(e.g., family, community, friends) (Chaudhry & Chen, 2019). When looked at as within-group construct for SAAs, it was found that interdependent self-construals decreased courtesy stigma (stigma that affects those who are close to the person or persons that are stigmatized) (Chaudhry & Chen, 2019). These findings may be a result of strong familial ties and community membership often found within SAA cultures. For those who may have high interdependent self-construals (thus less courtesy stigma), they may hold more positive attitudes towards seeking mental health services, but also may be the least likely to "need" traditional mental health services, due to large amounts of community/familial support. As such, instead of focusing solely on what cultural constructs inform attitudes towards seeking mental health services, understanding what systemic level practices account for such seeking patterns is warranted.

Systemic Barriers

Literature related to Asian American attitudes towards seeking mental health services has focused on the "issues" related to Asian Americans' culture (values, stigma, etc.) but neglect a specified focus on the systemic changes needing to be made to increase trust and understanding within Asian American communities. Much of the literature that has focused on the systemic constructs related to Asian Americans attitudes towards seeking mental health services have focused on increased attention to multiculturalism and how therapists can increase multicultural competencies within the therapy setting (APA, 2010; Leong et al., 2011; Yang et al., 2020). Missing from such literature, however, is what precedes the actual act of therapy (i.e., seeking out services). From this standpoint, this research serves two purposes: 1) to gain an increased understanding related to how therapist identity matching effects one's attitudes towards seeking mental health services and 2) to bring increased attention to how to create systemic level changes to increase service utilization and attrition for SAA populations.

From a systemic level, increased understanding into the nuances of different Asian American cultures is warranted. Often, mistrust of the system and/or the narrative that "western" therapists do not understand the Asian American experience and/or culture, has led to a lack of attenuation to seeking mental health services (Leong et al., 2011). For example, having a therapist who is not aware of the importance of the different forms of cultural connection on well-being for SAAs (Mehra, 2003), can be detrimental to rapport and overall effect of therapy for a SAA client, especially if the receiving message feels more individualistic and less rooted in SAA cultural saliency. Another example is how racial/ethnic matching facilitates a higher stay in therapy and a higher completion of therapy rate for Asian Americans (Presley & Day, 2019). While racial/ethnic matching may not directly affect immediate treatment outcome (Cabral & Smith, 2011), attention to stay and completion of treatment, with populations in which therapy is highly stigmatized, may improve therapy stigma on a community-based level.

Knowing what factors affect seeking mental health services, such as increased attention to changing the educational processes around multiculturalism, is warranted. Doing so, may change how SAAs view westernized mental health/therapy while also addressing SAAs representation within the field. Through understanding such constructs, systems level changes can be made, and SAA may start to get the help they need.

The Model Minority Myth

The Origin of the MMM

The Model Minority Myth (MMM) is a construct which posits that, in comparison to other racial/ethnic groups, those of Asian descent are the "model minority" and thus are characterized as hard working, high achieving, and highly intellectual (Yi & Museus, 2015). The MMM is a stereotype that has shaped the perceptions of Asian American groups since the 19th

century. Starting with the comparison of Chinese railroad workers to their Black counterparts, and later emerging during World War II when Japanese Americans were pressured to be seen as model citizens or risk interment (Yi & Museus, 2015). The MMM however, was widely popularized in the 1960s when a *Time Magazine* article came out with a story titled "Success Story, Japanese American Style" and boasted Japanese Americans as a success story in comparison to other "problem minorities" (Yi & Museus, 2015). The article articulated how unlike other racial/ethnic minorities, Japanese Americans were able to rise above prejudice, discriminatory experience, and succeed. This narrative also led critics of civil rights movements to then further promote the model minority as an example that systemic disadvantages are not what lead to poverty, job acquisition, etc. but rather personal perseverance (i.e., "justify and maintain racial order") (Yi & Museus, 2015). This narrative was again bolstered by popular media in 1987 when *Time Magazine* published a cover story titled "Those Asian-American Whiz Kids," which again, furthered the narrative that Asian Americans were an inherently hard working, intellectually superior racial/ethnic minority.

Negative Impacts of the MMM

Whereas many saw the MMM narrative as a positive factor for Asian Americans, it is a false stereotype that inhibited many Asian Americans from being able to express self-and/or community narratives of being disadvantaged, struggling, or needing assistance (Kim & Lee, 2014) Such narratives also affected Asian American youth by increasing the likelihood that they would receive different treatment from educators (i.e., holding higher expectations), were more likely to be harassed by peers (i.e., being labeled "nerd" or "geek"), and threatened one's social identity development (Lee, 1996; Qin et al., 2008). Similarly, throughout the years, the MMM developed other narratives related to mental health (i.e., Asian American's do not suffer from

mental health disparities and/or need assistance for mental health related concerns) and, as a result of societal treatment) started to become internalized by members of various Asian American communities (Yoo et al., 2010).

With little literature focusing on the internalization of the MMM and its effects on well-being, much of the literature available focuses on a Pan-Asian narrative. To attend to a more specified approach, this study's goal is to focus on Asian American sub-groups and specified populations (i.e., college students) within their specific context (i.e., university setting). With our goal is to obtain a more in-depth understanding regarding SAAs and the internalization of the MMM, due to limited research, we take a pan-Asian American understanding to our review of the MMM literature.

MMM Within the University Setting

As with any myth surrounding a racial/ethnic group, the MMM is one which critics point to and posit that although the MMM may be an over exaggeration, that there is some "truth" within the myth. Often pointing to statistics such as high educational attainment within secondary education and higher college admission scores (Kim, 2018), left out of the narrative is how the "truth" in the MMM gets left behind once students enter college, with many Asian American student struggling more than their peers (Dmitrieva et al., 2008). Whereas in secondary education, Asian Americans average higher educational attainment than their European American counterparts, upon entering post-secondary institutions, Asian American students perform worse on constructs such as grade point average (Dmitrieva et al., 2008).

Previous literature has posited this reversal is due to delayed autonomy and that separation from strict parental households are what lead to the reversal of MMM upon entering college (Dmitrieva et al., 2018). These narratives, however, are laden with Asian American

stereotypes and neglect discussion related to systemic issues. Specifically, such narratives ignore whether the lack of academic performance in post-secondary education may be a result of poor mental health and/or lack of belonging within university systems. For example, when studying peer interactions of Asian American and White college students, it was found that White students who were more likely to believe in the MMM were also more likely to treat Asian Americans as perpetual foreigners, hold negative racial attitudes towards Asian Americans, and endorse anti-Asian sentiment (Parks & Yoo, 2016). Park and Yoo (2016) stressed the importance of understanding the MMM from a university system and social perspective. For these reasons, this study focuses on how social/university constructs effect factors that inhibit academic performance, such as mental health and seeking mental health services.

The Internalization the MMM

When considering different psychological outcomes and how they can be affected by one's comfort level and/or disclosure within therapy, Zane and Ku (2015) examined the effects of racial/ethnic match and "face concern" on self-disclosure. "Face concern is a culturally salient construct on social representation that may be particularly important in the understanding of distress among Asians" (Mak & Chen, 2006, p.144). Face concern can be measured by how those from Asian/Asian American cultures attend to constructs such as "saving face" for themselves or others.

Interestingly, Zane and Ku (2015) found no significant relationship between racial/ethnic match and self-disclosure but found that face concern was significantly negatively related to constructs related to self-disclosure (i.e., privacy habits, sex life, close relationships, and personal values/feelings). Adding important information related to face concern and mental health relationships to the literature, our goal is to further the findings of Zane and Ku (2015) and

understand how such processes may be related to the internalization of the MMM, and what factors influence that relationship.

Impacts of the Internalization of the MMM

The MMM has been discussed within many subject areas such as law, sociology, humanities, business, government and more (Yoo et al., 2010). Congruent with the Asian American narratives however, the implications of the internalization of the MMM on the psychological well-being of Asian Americans have been sparse (Yoo et al., 2010). Of the contemporary literature, studies have indicated that the internalization of MMM is related to higher levels of psychological distress and inhibit help-seeking behaviors (DeVitre & Gloria, 2023; Gupta et al., 2011; Inman & Yeh, 2007; Lee et al., 2008). In fact, Asian Americans who attended predominantly Asian high schools are less likely to internalize the constructs of the MMM when compared those who do not attend predominantly Asian American schools (Atkin et al., 2018). These findings suggest that the upward mobility construct of the internalization of the MMM (that Asian Americans have unrestricted upward mobility), has a negative impact on psychological well-being constructs (e.g., depression and anxiety) for those attending predominantly Asian American schools but decreased stress for those attending non-predominantly Asian American schools (Atkin et al., 2018).

These findings provide insight into the constructs of the MMM and how they are related to well-being, but also lack understanding about how or why these relationships exist. Worth noting, is these findings were specifically related to unrestricted upward mobility in high school, which may be social advantageous for the setting, but also may lead to negative psychological impacts as they turn to adulthood (Atkin et al., 2018). Helping to explain this phenomenon, we draw from Helm's (1995) ideology that "people of color must recognize and overcome the

psychological manifestations of internalized racism" (p. 189), indicating that the students attending predominantly White schools may have to adjust to the negative implications of the MMM to defend against the negative psychological impacts.

The MMM and SAAs

When compared to other Asian ethnic groups, SAAs are more dispersed across the United States (i.e., there is less likelihood of having a predominantly SAA school) (Alvarez, 2009), it is important to consider the social implications of SAAs not living in areas with high rates of SAA community membership. Consistent with Bronfenbrenner and Morris's (2006) bioecological theory, one's level of MMM internalization appears to be heavily influenced by their social context (Atkin et al., 2018). As such, when compared to other Asian American groups, if SAAs are more likely to be placed in non- predominantly SAA areas, they may be more at risk for the internalization of the MMM. However, the construct of internalization of the MMM is relatively unexplored amongst Asian American sub-groups.

In literature focusing on the dismantling of the MMM, much of the narrative points out the discrepancies between other Asian ethnic groups and the myth (e.g., family income, educational attainment) while also making note of the higher levels of educational achievement of Indian Americans compared to overall U.S. population. Though a correct analysis, such descriptions without the context of SAA immigration regulations, can be misleading. From 1917 until 1965, the United States had placed immigration quotas on South Asian regions and placed regulations that immigrants must first pass literacy tests to qualify for immigration into the United States. As such, the only immigrants from South Asian countries who gained entry to the United States, between the years of 1917 and 1965, were those who either had pre-existing relatives within the United States or were already established professionals (Samip, 2015).

Whereas many SAAs do hold higher income and educational degrees when compared to other Asian American ethnic groups (de Brey et al., 2019), it is suggested that the selective immigration policies, which shaped the SAA experience, contextualizes this narrative. If such constructs are accurately taught and contextualized, the internalized attitudes of the MMM may be lessened for SAA communities. Paired with societal pressures/narratives and surface level confirmatory information (i.e., "higher levels of educational attainment"), we make the argument that many SAA individuals are placed at a high risk for the internalization of the MMM with little assistance dismantling the myth.

Statement of Problem, RQs, and Hypotheses

Based on the review of the literature, several themes related to SAA mental health are identified. Firstly, there is an erasure of SAA narratives within the Pan-Asian literature, with many published articles using the term "Asian American" in their title, yet either have extraordinarily low SAA participation rates or not having SAA participants at all. Other emergent themes are: 1) the lack of overall literature focusing on SAA mental health, 2) singularly focused research on Asian American attitudes towards seeking mental health services, 3) little empirical research on the effects of the MMM within SAA populations, and 4) lack of understanding surrounding the benefits of therapist racial/ethnic matching within SAA populations. As such, the contemporary research guides the study questions and design. Specifically, with contemporary research positing that SAA groups' (i.e., Indian Americans') internalization of the MMM serves as a partial mediating effect towards attitudes towards seeking mental health services, in relation to psychological openness and help seeking patterns, as well as serves as a full mediating variable in relation to help-seeking stigma (DeVitre & Gloria, 2023), this study took a nuanced understanding related to different factors relationships

to the internalization of the MMM. As such, building off DeVitre and Gloria (2023), this study examined how therapist racial/ethnic match is related to the internalization of the MMM and attitudes towards seeking mental health services. Doing so, provides a means to understanding how racial/ethnic representation can influence one's attitudes toward seeking mental health services and their own attitudes towards stereotype buy ins. Further, it provided the next step in understanding systemic related, community, and personal concerns related to SAA attitudes towards, and utilization of, mental health services. As such, this study took a mixed methods approach to address the following research questions:

RQ1: How does the racial/ethnic relationship between counselor and client inform internalized attitudes of the MMM and one's attitudes towards seeking mental health services for SAA undergraduates?

Based on the literature which posits that racial/ethnic matching may increase adherence to therapy, in part due to cultural understanding (Meyer et al., 2011), it was posited that participants who are racially/ethnically matched with a therapist would show an overall decrease in the internalization of the MMM and increased attitudes towards seeking mental health services.

Hypothesis1$_{Ho}$: Participants with a therapist who share racial/ethnic variables will show no difference in the internalization of the MMM nor attitudes towards seeking mental health services).

Hypothesis1$_{H1:}$ Participants with a therapist who share racial/ethnic variables will have decreased rates of MMM internalization as well as more positive attitudes towards seeking mental health services.

The research related to Asian American therapeutic outcomes and racial/ethnic matching posits that Asian Americans are less likely to have increased therapy retention (in part due to cultural misrepresentation and/or understanding), (Meyer et al., 2011) but also are more likely to increase therapy stay when paired with a therapist of similar racial/ethnic identity (Cabral & Smith, 2011). As such, it was predicted that participants paired with White therapists would show increased rates of internalization of MMM and less positive attitudes towards seeking mental health services.

Hypothesis 2_{Ho}: *Participants with a White therapist will show no difference in the internalization of the MMM nor attitudes towards seeking mental health services).*

Hypothesis 2_{H1}: *Participants with a White therapist will show increased rates of the internalization of the MMM as well as less positive attitudes towards seeking mental health services.*

RQ2: Will the internalization of the model minority myth act as a mediator between therapist racial/ethnic match and one's attitudes towards seeking mental health services for SAA undergraduates?

Contemporary literature supports the notion that the act of going to therapy can behave as a variable of which helps to de-stigmatize seeking mental health services, regardless of racial/ethnic match (Kalkbrenner & Neukrug, 2018). As such, controlling for such variables, it was predicted that the internalization of the MMM would act as a mediating variable between therapist racial/ethnic matching and attitudes towards seeking mental health services.

Hypothesis 3_{Ho}: *The internalization of the MMM will not have a mediating effect on therapist racial/ethnic match and one's attitudes towards seeking mental health services.*

Hypothesis 3H1: The internalization of the MMM will act as a mediating variable between therapist racial/ethnic match and attuites towards seeking mental health services.

RQ3: What are the experiences of SAA students who meet with racial/ethnically matched therapists versus those that don't?

Lastly, recognizing that the literature contains mixed results on the benefits of therapist racial/ethnic matching (Carbral & Smith, 2011), it was predicted that emergent themes would differ between groups.

Hypothesis $4_{Ho:}$ *There will not be any difference in emergent themes between participants groups.*

Hypothesis $4_{H1:}$ *There will be differences in emergent themes between participants groups.*

In addition to the main research questions, the study also examined other variable relationships to help answer sub-research questions (SRQ).

SRQ1: How will bond influence other study variables?

The study used only the bond construct within the working alliance while also recognizing that factors contributing to bond (i.e., comfort in therapy) are predictors of help seeking patterns (Ibaraki & Hall, 2014; Presley & Day, 2019). As such, it was predicted that bond would mediate the relationship between the internalization of the MMM and attitudes towards seeking mental health services while also having a significant relationship with variables such as therapist match, help seeking services, and culture match.

Hypothesis $5_{Ho:}$ *Bond will have no significant relationship with any of the other study variables.*

Hypothesis $5_{H1:}$ *Bond will have a significant relationship with other study variables.*

SRQ2: Will "cultural match" act as a moderator between significant variable relationships?

Recognizing that one may racially/ethnically match with their therapist but not feel cultural congruity (Ibaraki & Hall, 2014) it is predicted that cultural/values matching will moderate the relationships (internalization of the MMM, therapist racial/ethnic match, and bond) related to attitudes towards seeking mental health services.

Hypothesis $6_{Ho:}$ *Culture/values match will not act as a moderator between any study variables.*

Hypothesis $6_{H1:}$ *Culture/values match will act a moderator between the internalization of the MMM and attitudes towards seeking mental health services, therapist racial/ethnic match and attitudes towards seeking mental health services, and/or bond and attitudes towards seeking mental health services.*

CHAPTER III

Methods

Knowing that one's internalization of the MMM 1) partially mediates towards attitudes towards seeking mental health services, in relation to psychological openness and help seeking patterns and 2) fully mediates help-seeking stigma (DeVitre & Gloria, 2023), understanding how therapist effects can impact the internalization of the MMM is warranted. As such, this exploratory study served as an initial understanding of how cultural/racial representation can influence one's attitudes toward seeking mental health services and stereotype internalization. This chapter outlines the methods including design and statement, participant information, and measures. Next, the procedure for the study is explained in sequential order, starting with recruitment, setting, procedure structure, procedural steps, and ethical considerations.

Design and Statement

With SAA attitudes towards seeking mental health services being affected by the internalization of the MMM (DeVitre & Gloria, 2023), this study looked to understand what additional factors affect SAAs attitudes towards seeking mental health services and what factors are related to SAAs internalization of the MMM. Taking the first step in understanding how racial/ethnic matching affects SAAs attitudes towards seeking mental health services, this study also took a decolonized approach by understanding what systemic factors inhibit SAAs utilization of and attitudes towards seeking mental health services.

Previous studies focusing on Asian American identity matching have taken different approaches to studying the effects. Where some studies used mock sessions (Kim et al., 2005), others implemented participant observation of mock sessions, with participants providing ratings on constructs (such as working alliance) through third party observation (Meyer et al., 2011).

Kim et al's (2005) use of mock sessions yielded significant results and higher external validity than audiovisual/questionnaire-based studies. While they noted the limitations of a single mock session, Kim et al., (2005) still recommended the use of a single session approach to proxy for therapy. Kim et al's (2005) study design yielded fewer limitations than Meyer et al's., (2011) study approach, which did not have participants directly involved with the session, thus limiting their ability to capture fully being in a therapy space with a similarly identifying therapist.

As such, to address how the internalization of the MMM and one's attitudes towards seeking mental health services may be affected by therapist racial/ethnic match for SAA undergraduates while also recognizing the paucity of randomized controlled trials amongst Asian American groups, this study took a randomized pre-post treatment approach. Taking previous literature into consideration, two different constructs were examined as main independent variables, therapist racial/ethnic match, and cultural/values match.

To address these constructs, this study took a randomized multi-time dual participant mixed methods approach (RMDPM) approach to studying the effects of therapist culture match, values, internalization of the MMM, and attitudes towards seeking mental health services. Therapists' racial/ethnic match served as the main variable of study within the design, with Asian American values serving as potential moderating variable to study cultural identity match. Participants were given four different measures in total. Before their mock sessions, participants took the Internalization of the Model Minority Myth measure (IM-4), the Asian American Values Scale-Multidimensional (AAVS-M), and Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS). After their mock session, participants took the IM-4 and the IASMHS again as well as the *bond* subscale within the Working Alliance Inventory (WAI). After all measures are completed, participants met with a study team member for a brief semi-

structured interview and debrief. Prior to the study, therapists also took the AAVS-M so that culture/values match could be assessed. This mixed-methods approach provides insight into SAAs' attitudes toward seeking mental health services within a psychosociocultural context.

Mock Session

Although the content of the mock session was not a part of the study, the session's purpose helped to build rapport and to proxy a racial/ethnic matching therapy session in a controlled environment. The mock session was used to create a more realistic way to measure the effects of racial/ethnic matching, apart from asking a population sample who have either not had first-hand experience in a therapeutic environment and/or experienced therapy with a SAA identifying therapist. Additional information about the mock session is described in "Procedures."

Participants

In total, 72 participants started the study of which 21 were excluded due to likely poor reliability and validity of results (as dictated by a completion time of less than five minutes). Of the 51 remaining study responses, 37 completed the survey to 100% with 29 deciding to schedule a mock session interview. Of the 29 scheduled interviews, 16 either cancelled or did not show up for their scheduled appointment, resulting in a total of 13 participants completing the study.

A total of 13 South Asian American undergraduates (10 Indian American, 2 Pakistani American, and 1 Nepalese American) completed the entirety of the study. The students were primarily 2nd generation South Asian Americans and ranged in age from 19- 22 (average = *20*, *SD* = .93) (See Table 1 for overview of participant descriptives). Being that the mock session was the manipulated variable within the study (i.e., assessing for effects of therapist racial/ethnic matching), participants who completed initial survey information but do not complete the mock

session or their post-session surveys were be excluded from the final data analysis. To minimize missing data via participant drop-out, post-session surveys and debriefings took place immediately after the mock session. In total, 51 participants started the study process but did not schedule a mock session, of the 51, 23 scheduled a mock session with 10 of those 23 eventually no-showing or canceling. In addition to reminder emails, if participants "no-showed" their session, they were contacted, via email, up to two more times with an open invention and instructions with how to reschedule.

Table 1: *Participant Descriptives*

Participant ID	*Therapist Identity*	*Age*	*Gender Identity*	*Cultural Origin*	*Student Standing*	*Generation to U.S.*	*Generation to College*
1	SAA	22	Female	Indian	Fourth Year	2nd	2nd+
2	SAA	20	Male	Indian	Third year	2nd	2nd+
3	SAA	21	Female	Indian	Fourth Year	2nd	2nd+
4	SAA	20	Female	Indian	Third Year	1st	2nd+
5	SAA	20	Female	Pakistani	Second Year	2nd	2nd+
6	SAA	19	Female	Nepalese	Second Year	1st	1st
7	SAA	19	Male	Indian	Second Year	1st	2nd+
8	White	20	Female	Indian	Third Year	2nd	2nd+
9	White	20	Female	Indian	Third Year	2nd	2nd+
10	White	21	Female	Pakistani	Fourth Year	2nd	2nd+
11	White	19	Female	Indian	Second Year	1st	1st
12	White	21	Female	Indian	Third Year	1st	2nd+
13	White	21	Female	Indian	Fourth Year	1st	2nd+

Inclusion Criteria

For our study, the inclusion criteria were those who self-identify as SAA undergraduates at "Large Mid-Western University." Participants had to be between the ages of 18-26 years old and be currently enrolled students at "Large Mid-Western University".

Exclusion Criteria

Any persons who are not enrolled undergraduates at "Large Mid-Western University," outside the ages of 18-26 (i.e., younger than 18 year of age and older than 26 years of age), and/or do not identify as SAA. Due to the researcher's role at "Large Mid-Western University" working within a clinical capacity with marginalized students on campus, as well his direct involvement with the mock session, a statement was made acknowledging the PIs position within the university. Specifically, if any potential participants currently previously worked with study team members in a clinical capacity, they were considered ineligible for the study due to the boundaries set forth by the APA code of ethics (APA, 2010). Lastly, any participants who endorsed risk to self or others will be excluded from continuing in the study. Though exclusion procedures were placed, no participated met exclusion criteria by the end of the study. Procedures for supporting students who endorsed risk is addressed below.

SAA vs International Participants

Due to systemic and cultural barriers (e.g., dearth of literature on SAA groups, recruitment in a predominantly White area, SAA mental health stigma), we studied SAAs broadly instead of specified SAA regions (e.g., Indian American). Focusing on SAAs, broadly, put the study at an increased capacity to observe separate groups and ensures that other SAAs are included within educational discourse. Similarly, to ensure that the study specified South Asian *Americans,* international students were not automatically be ruled out as a part of the recruitment criteria, but rather specify that inclusion criteria is for those who identify as South Asian

American. Doing so, attended to systemic related issues, and ensured that those who may have resided within the United States for multiple years but may not have acquired citizenship could be included within the study.

"Therapists"/Participants

Due to the dual participant methodology of this study, the "therapists" were also a part of the study factors. In addition to being a part of the study's team as "therapists" (who were briefed/taught about the study goals, aims, and session material) they also took a values-based questionnaire (see AAVS-M in "Measures") before meeting with any participants. The purpose of this was to measure racial/ethnic match from a phenotypical and a culture/value match perspective. To ensure reliability across therapists, only two therapists/team members were selected for the study. With only two study team members/therapists, team members alternated being a "therapist" and the one who conducts the debrief session (see "Procedures"). To decrease therapist effects (i.e., biases and assumptions based on clothing), "therapists" also wore the same outfits for each interaction, both wearing similarly styled pants, shoes, and a department sweater. Therapists also alternated debrief sessions to ensure participants were less likely to save face when asked questions related to their experiences within the mock sessions.

To ensure credibility, trustworthiness and administrator reliability, "therapists" were given a semi-structured interview form of which they learned and practice prior to seeing participants (see "Team Training" under "Procedures"). To ensure that "therapists" had the base skills required to conduct a therapy session/create the space of a therapy session, "therapists" were two counseling psychology doctoral students. Both "therapists" hold M.S. degrees in a mental health related field, were in their 2nd year of doctoral training or beyond, and were currently undergoing supervised clinical work at the same clinical training site. Albeit, the

content of the session was not important, we wanted to ensure that therapist effects were minimized so that racial/ethnic matching was the content of study.

Measures

Demographics Questionnaire

The first portion of the survey included a demographics form including questions that focused on personal, cultural, and educational domains. Personal questions included questions such as age, gender, and hometown. Cultural questions included U.S. generation status and ethnic/cultural identification. Lastly, educational questions include major and student status (i.e., first-year, sophomore, junior, senior).

Internalization of the Model Minority Myth

The Internalization of the Model Minority Myth measure (IM-4) (Yoo et al., 2010), is a "15-item self-report measure of the extent to which individuals believe Asian Americans are more successful than other racial minority groups based on values emphasizing achievement and hard work and belief in unrestricted mobility towards progress" (Yoo et al.,2015, p. 239). The scale consists of two subscales: Achievement Orientation (10 items) and Unrestricted Mobility (5 items). Items are based on a 7-point Likert type scale, ranging from 1 (*Strongly disagree)* to 7 (*Strongly agree*) with higher scores indicating greater internalization of the model minority. A sample Achievement Orientation item is "Asian Americans are more likely to persist through tough situations" whereas a sample Unrestricted Mobility item is "Asian Americans are less likely to experience racism in the United States." In the confirmatory study of the scale with 187 self-identified Asian American undergraduates, Yoo et al. (2010) reported internal consistencies of .91 (Achievement Orientation) and .75 (Unrestricted Mobility), respectively. Being that the IM-4 has shown good internal consistency ($\alpha = .92$) when used with a SAA population (DeVitre

& Gloria, 2023) this study utilized the IM-4's total scale score as the primary measure while also looking at various sub-scales. Within this study, the IM-4 showed strong internal consistency, pre, post, and total with Cronbach's alpha ranging from α =.89-.95. Within the subscales, the achievement subscale showed a greater range of internal consistency (pre, post, and total) ranging from α = .92-.97. Though lower, the mobility subscale still indicated good internal consistency (pre, post, and total) ranging from α =.75-.82.

Values

The Asian American Values Scale-Multidimensional (AAVS-M) is a 42- self-report assessment of one's attachment with Asian American values (Kim et al., 2005). The scale includes five subscales: Collectivism (7 items), Conformity to Norms (7 items), Emotional Self-Control (8 items), Family Recognition Through Achievement (14 items), Humility (6 items). A sample Achievement item is "One's academic and occupational reputation reflects the family's reputation," whereas a sample Self-Control item is "One should not express strong emotions." There are 13 recoded-items, with statements based on a 7-point Likert type scale ranging from 1 (*Strongly Disagree*) to 7 (*Strongly Agree*). Higher scores reflect higher levels of enculturation to values. Used with Asian American populations, the scale has been reported to have high internal reliability (α = .90, Kim et al., 2005). In another Pan-Asian study comprised of both East and South Asian American participants, the AAVS-M showed good internal reliability (α = .89. DeVitre & Pan, 2020). The AAVS-M also has shown good internal consistency for use with SAA populations, α = .89 (DeVitre & Gloria, 2023). The AAVS-M held consistent within this study, indicating strong internal consistency, α = .91

We elected to utilize the AAVS-M versus the more commonly utilizes Asian Values Scale (AVS) due to the AAVS-M's increased attention to Asian *American* values, thus taking into consideration different cultural constructs between Asian Values and bicultural values.

Attitudes Towards Seeking Mental Health Services

The Inventory of Attitudes towards Seeking Mental Health Services (IASMHS) is a 24-item self-report measure of what attitudes one might hold towards seeking mental health services (Mackenzie et al., 2004). Comprised of three factors (8 items each), the scale includes psychological openness ("There are certain problems which should not be discussed outside of one's immediate family"); help-seeking propensity ("If I believed I were having a mental breakdown, my first inclination would be to get professional attention"); and indifference to stigma ("Important people in my life would think less of me if they were to find out that I was experiencing psychological problems"). Items are based on a 5-point Likert scale ranging from 0 (*Disagree*) to 4 (*Agree*); higher scores reflect more positive attitudes towards seeking mental health services. In the validation study, Mackenzie et al. (2004) reported an acceptable Cronbach's alpha ($\alpha = .87$) with 293 undergraduates and two-week test-retest reliability with 23 student volunteers ($r = .85$, $p < .01$). Study of Asian American attitudes towards seeking mental health services indicated the acceptable internal reliability ($\alpha = .70$) when conducted with a sample population comprised of both East and South Asian Americans (DeVitre & Pan, 2020). Given previous use with SAA populations that showed adequate internal consistency ($\alpha = .78$) (DeVitre & Gloria, 2023), we elected to utilize the IASMHS rather than other well-known inventories such as the Attitudes Toward Seeking Professional Psychological Help Scale.

Within the context of this study, the IASMHS, and its subscales, indicated good internal consistency pre, post, and total. As a full inventory, the IASMHHS's internal consistency ranged

from α = .90-.95. All but one subscale indicated good internal consistency (pre, post, and total) with both psychological openness and indifference to stigma ranging between α = .77-.93. The only noteworthy internal consistency was the pre-test for help-seeking propensity (α = .64), for post and total, the help-seeking propensity subscale indicated good internal consistency α = .78-.82.

Working Alliance

The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986) is a 36-item self-report measure with three sub-scales that measure client and therapist perceptions on goals, tasks, and quality of the personal bond. Typically, the WAI has two scales utilized to measure working alliance, the client version (assessing the quality of alliance from the perception of the client) and the therapist version (assessing the therapist's perspective about how the client's perception of the quality of alliance) (Horvath & Greenberg, 1986). Only the WAI client -version will be utilized. The WAI is set on a 7-point Likert Scale ranging from 1 (*Rarely*) to 7 (*Always*) and asks questions such as "___and I understand each other" and "I was confident in ___'s ability to help me." The WAI has also been used and validated with Asian American university students with high internal reliability (α = .95) for total scores and acceptable to high ranges for the subscales of task (α = .90), bond (α = .84), and goals (α = .88) (Erdur, 2000). Recognizing that the study design did not include multiple sessions, thus not require goal and task setting, only the 12 questions related to the *bond* construct were utilized. As such, we use the term "bond" a reflection of the bond construct within the WAI. Focusing only on the *bond* construct the WAI showed strong internal consistency (α = .90) within the study. To our awareness, no study has been published which has a specified focus on the WAI and SAAs.

Procedures

Recruitment

Participants were randomly recruited from clubs, organizations, and classrooms across a "Large Mid-Western University's" campus via online and in person solicitation. In total, 21 organizations, clubs, and departments were contacted. Online solicitation included an emailed flyer which was passed through different on campus department listservs (e.g., psychology, engineering, ethnic studies). The PI also conducted in-person solicitation by going to club/organization meetings and talking about the study with potential participants, providing clubs/organizations paper and digital flyers containing study information. Potential participants were given information regarding inclusion and exclusion criteria, scope of participant involvement, and information regarding participants' compensation ($25.00 gift card). Study team members were recruited via the Counseling Psychology department at the "Large Mid-Western University" and were contacted about recruited via in-person solicitation.

Participant Incentive

With a maximum total 80-minute study involvement, participants were offered a $25.00 gift card to compensate for their time and participation. Participants were emailed a link containing a $25.00 gift card upon the completing of study data collection.

Recruitment Considerations

While recruiting for this study, considerations were given to the practical recruitment of SAAs from a predominantly White institution. Specifically, with systemic related considerations resulting in poor recruitment for previous studies at the same university with a similar population (DeVitre & Gloria, 2023), the study recruitment procedures contextualize the difference between a statistically significant sample size versus a practical one. For example, practical recruitment considerations include availability of SAA undergraduate populations, SAA stigma towards

seeking mental health services (Loya et al., 2010), lack of university resources to help recruit SAA participants (DeVitre & Gloria, 2023), and participant time commitment. Other studies using a pre-post treatment method with 12-30 Asian American participants as their total sample size, have yielded efficacious results (Hinton et al., 2004; Hinton et al., 2009; Otto et al., 2003; Pan et al., 2011) thus providing support for a practical sample size of 13.

Setting

The study was conducted in a Counseling Psychology Training Clinic (TC) at the "Large Midwestern University." The TC is a community-based clinic with private counseling spaces, equipped with two-way mirrors for observation and an on-call licensed psychologist for safety. The head researcher obtained permission to use the TC during their closed hours as well as IRB and TC permission to use recording equipment. Using this space helped ensure that participants and clients of the TC did not have interactions, thus maintaining confidentiality. The study team set up a "front desk" in the hallway next to the "mock session' therapy room where participants could check in for their session. Of the participants who scheduled an interview, the majority (N=19) scheduled times in the late afternoon (3:00-4:00pm) or early evening (8:00pm). Of the 13 participants who completed the study, nine completed their mock sessions in late afternoon (3:00-4:00pm), early evening (8:00pm) and four were schedule morning mock sessions (9:00am.

Procedure Structure

Utilizing a RMDPM approach, participants completed paperwork twice (pre- and post-), engaged a mock session with a "therapist", and met with a study team member for follow-up questioning and study debrief. Combining the time of the pre-session surveys, scheduling, post-session surveys, semi-structured interview, and debrief, the average amount of time for participants' involvement was roughly 61.5 minutes.

Components

The study procedures had four main components: 1) Pre-meeting surveys (8 minutes), 2) "Mock Session" (35-45 minutes), 3) Post-meeting surveys (6 minutes), and 4) Semi-structured interview/debrief (5-10 minutes). Prior to meeting their "therapist," participants were given paperwork (i.e., surveys) to complete. The initial "paperwork" consisted of the three scales (i.e., AAVS-M, the IM-4, and the IASMHS). After survey completion, participants were randomly assigned to either Group A (racial/ethnic matched therapist) or Group B (non-racial/ethnic matched therapist) and partook in a mock session (see "*Step 2*" for more information). Following the mock session, participants partook in a short semi-structured interview and debrief with a study team member, to obtain more information relating to their experience within the study, and relay their impressions of their session (i.e., if they believed meeting with a differently identifying therapist would affect their thoughts on pursuing mental health services).

Team Training

With the primary variable of the mock session being therapist racial/ethnic match, the mock session was crafted as a semi-structured interview (mimicking an "intake interview") as to minimize other therapist variables/effects. The mock-session template also included questions that are theoretically based within the PSC framework (Gloria & Rodriguez, 2000). To help minimize therapist effects, team members were presented and trained with a mock-session template (see *Appendix E*). Specifically, each study team members partook in a series of three, one-hour meetings/trainings, and documented one hour of "out of meeting" practice time so that they may better memorize the study script/procedures and minimize therapist effects. During training meetings, team members practiced being the "therapist" *and* the participant so that they

may provide feedback to the team member practicing as "therapist" if they felt the questions being asked were leading (e.g., meaning making or hypothesis testing).

Procedural Steps and Timing

Step 1

After study solicitation, participants signed up for the study via a Qualtrics link/QR code which included informed consent and the "paperwork" (mock session, demographics questionnaire, AAVS-M, IASMHS, & IM-4) with the end of the survey containing a link to schedule their mock session. One week prior to their mock session (and again the day of), participants received an email reminder confirming their mock session appointment, with detailed directions regarding location and a brief overview of what to expect from their participation. If participant and PI had increased communication due to constructs such as scheduling conflicts, that participant was then placed into the group with the White "therapist" as the relationship between the SAA "therapist" would not be equitable across other participants.

Step 2

Once onsite, participants were met by a member of the study team, who briefed them on what to except. Participants were then escorted to a nearby private counseling room where they met with their "therapist" in a mock session for roughly 35-45 minutes, addressing topics such as their social relationships/connection on campus, culture, and their experience with mental health services (see *Appendix E*). For the mock session, standard procedure included informed consent and standard safety and confidentiality considerations. To help cultivate a space that feels like therapy, "therapists" employed intervention techniques such as micro skills (e.g., open ended questions and reflection). Being that one's benefit from therapy may not only be via direct skill-based intervention (e.g., coping skills) but also process based interventions (i.e., intentionally

used micro-skills informed by a theoretical orientation) (Ridley, et al., 2011), questions focusing on PSC dimensions were asked throughout the mock session. As such, serving as an intervention technique at each step, asking questions through a PSC driven theoretical approach provided the participants with a beneficial therapeutic experience while also informing the studies' theoretical framework. "therapists" also ensured that although they were creating/cultivating a space that may feel like therapy, that the mock sessions should not be used in place of therapy and that if participants wish to pursue services, they may ask more questions to the study team member during the debrief. All sessions were audio recorded for both safety (i.e., endorsement of risk) and for follow-up analysis, if necessary.

Step 3

After the mock session, the "therapist" provided participants with "post-session paperwork" (IM-4, IASMHS, and bond measure), on an electronic tablet, to complete. The "therapist" informed participants that they (the "therapist) would leave the room to provide the participant with privacy, and once the participant had finished their paperwork to notify the member of the study team (who they at the beginning of Step 2) who was sitting outside of the mock session room.

Step 4

Immediately following Step 3 (i.e., once the participant had notified the study team member that they had finished their "post-session paperwork"), Step 4 served as the qualitative portion of the study. To gain increased context, following post-session paperwork, participants stayed in the same room while they engaged in a 10-minute brief interview which acted as an exploratory method to gain an increased understanding of SAA experiences of therapist racial/ethnic match. The questions from the interview included three questions related to their

experiences:1) "What was that experience like for you?", 2) "How do you think your experience would be different if your therapist was (SAA or White)?", and 3) Based on this experience, what are your thoughts about pursuing therapy in the future?"

Step 4.5. Following questions asked in Step 4, participants were debriefed and given more information related to the study, such as study purpose. Specifically, the interviewer re-affirmed that the participants are partaking in a study, and thus the mock session was not to be used as therapy nor would "continuation" of services be provided by members of the study team. Participants were, however, provided information regarding available on campus mental health services and how to initiate services, in case they wish to pursue services. Lastly, participants were asked if they have any final questions about the study and/or mental health services.

Protocol Adjustments

Minor changes were made to the initial interview script such as changing "how would you feel if your therapist was White/SAA" to "how would you feel this would differ if the person who you just spoke to was White/SAA". This change was implemented after the first mock session to decrease potential participant confusion about viewing research team members as the assigned interviewer (i.e., "your therapist").

Ethical Considerations

Recognizing that themes related to risk may be brought up by the participants, a licensed psychologist was on call for consultation during the entirety of the mock sessions. By the conclusion of the study, no participants endorsed risk. Furthermore, contextualizing that the study's methods sought to create an experience or "feeling" of therapy, without actually receiving services, and that the mock session may leave participants wanting to continue services (potentially with their "therapist"), the participants were reminded of the study's purpose, scope,

and provided campus resources. A list of campus resources was provided at the end of the mock session (Step 2) and referred to during the study debrief (Step 4). Participants were given resource materials regardless of if they endorsed wishing to pursue services.

Data Collection and Confidentiality

All participant meetings were conducted in a secure counseling environment, providing confidentiality of mock session information, increased anonymity, and feeling of “real” counseling. Furthermore, all participant information collected prior, during, and after the mock session were immediately transferred to a secure online data base and any identifying and/or sensitive information collected on paperwork was immediately shredded upon electronic data entry.

CHAPTER IV

Results

Analysis and Interpretability

The following chapter outlines the study's data analyses to help answer the aforementioned research questions. Specifically, we used a concurrent triangular mixed methods design (Crewswell & Plano Clark, 2007) as a method which has shown frequent use in cultural psychological literature and within SAA populations (Bartholomew & Brown, 2012; Sharma, et al., 2007). This design uses quantitative and qualitative data as independent constructs which can be used to collectively inform one another in the pursuit of nuanced research questions (Bartholomew & Brown, 2012). Specifically, the data sets are merged to support the independent findings of each respective data set (Bartholomew & Brown, 2012).

First, management of missing data is discussed prior to the first step analyses for tests of normalcy (tests of assumptions, skew, and kurtosis) and correlations (multicollinearity). Next, the first step (regression) of the main quantitative analysis was conducted to observed mean differences and test the main RQs related to mediating variables. Lastly, using LeCompte's (2000) five-step approach to qualitative analysis, the information gathered during the semi-structured interview was analyzed for emergent themes.

Lastly, due to the nature of the study (e.g., experimental, sample size) the following results are contextualized within an understanding of interpretability and feasibility. Specifically, quantitative results are interpreted with a focus on practical significance, group mean differences, and effect sizes. Concurrent triangular design was used to bolster and further understand quantitative findings while also providing evidence to the support the feasibility of protocol, analysis, and interpretation when doing such research with SAA populations.

How does the racial/ethnic relationship between therapist/client inform MMM internalization and attitudes towards seeking mental health services?

First Step Analysis

Prior to data analysis, a review of the data revealed that all scales were within normal limits of skewness and kurtosis (+/- 1 and 2, respectively), indicating normal distributions. All research questions and analyses were addressed using, data software “R” (R Core Team, 2021). Specified analyses included correlation, regression, mediation, and moderation. Additionally, tests of internal consistency (i.e., Cronbach’s alpha) were conducted for each variable. To understand the relationships between study variables, correlation analyses were also conducted for the 1) total sample, 2) SAA therapist, 3) White therapist (*Table 2, 3, 4, respectively)*. Results imply negative correlational relationships, across groups, between participants attitudes towards seeking mental health services, and internalized traditional values (as measured by AAVS). Results highlight the relationship between bond and therapist racial/ethnic matching and working alliance and the culture/values matching (see *Figure 1*).

Furthermore, group mean differences found within the correlation indicated overall decreases in MMM internalization for participants meeting with a SAA identifying therapist, and overall increased MMM internalization for participants meeting with a White identifying therapist. To further observe this trend, a post-hoc Welch’s two sample t-test was run to confirm if significant differences between groups existed. No significance was found between groups when measuring MMM internalization or bond at confidence level of 95%. Taking into consideration a smaller sample size, however, a 90% confidence interval was used to better represent potential group mean differences. As such, the post-hoc analysis indicated group mean differences between the overall change in MMM internalization ($t = 1.85$, 90 %CI [.031, .892],

bond (t = 1.89, 90% CI [.023, .901], and overall change in attitudes towards seeking mental health services (t =2.68, 95% CI [.103, .819].

Assessing how each dimension of the psychosociocultural (PSC) framework accounted for attitudes towards seeking mental health services, a three-step hierarchical regression was conducted. Due a smaller sample size, results were not statistically significant, $R2_{adj.,}$ (-.17), *F* (4, 6) = .63, *CI*= [-.34, 1.63.]. Firstly, the psychological dimension (MMM internalization) was entered into the equation, $R2_{adj.,}$ (-.067), *F* (1, 11) = .247, *CI*= [-.73, .44]. The social dimension (bond) was entered second, ($\Delta R2_{adj.,}$ (-.155), ΔF (2, 8) = .158, *CI* = [-.72, .67] followed by the cultural dimension (therapist-client match) $\Delta R2_{adj.,}$ (.048), *F* (4, 6) = .540, *CI* = [-.34, 1.63].

Table 2: (Total Sample)

Means, standard deviations, and correlations with confidence intervals.

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11
1. BOND	5.95	0.83											
2. AAVS	3.34	0.71	-.72* [-.92, -.21]										
3. IM4_pre	3.54	1.09	-.54 [-.86, .09]	.66* [.17, .89]									
4. IM4_post	3.39	1.25	-.37 [-.79, .29]	.63* [.12, .88]	.81** [.47, .94]								
5. IASMHS_pre	3.52	0.77	.55 [-.07, .87]	-.76** [-.92, -.36]	-.47 [-.81, .11]	-.33 [-.74, .27]							
6. IASMHS_post	3.86	0.69	.68* [.13, .91]	-.75** [-.92, -.33]	-.42 [-.79, .17]	-.32 [-.74, .28]	.90** [.69, .97]						
7. PsychOpen_pre	3.63	0.81	.54 [-.09, .86]	-.82** [-.94, -.49]	-.48 [-.82, .10]	-.41 [-.78, .18]	.92** [.74, .98]	.81** [.47, .94]					
8. HSP_pre	3.49	0.60	.22 [-.44, .72]	-.64* [-.88, -.14]	-.57* [-.85, -.02]	-.45 [-.80, .13]	.79** [.42, .93]	.62* [.10, .87]	.70** [.25, .90]				
9. Stigma_pre	3.61	1.13	.65* [.09, .90]	-.66* [-.89, -.18]	-.39 [-.78, .20]	-.17 [-.66, .42]	.94** [.82, .98]	.90** [.68, .97]	.84** [.53, .95]	.58* [.05, .86]			
10. PsychOpen_post	3.81	0.77	.45 [-.21, .83]	-.87** [-.96, -.61]	-.41 [-.78, .19]	-.42 [-.79, .17]	.75** [.35, .92]	.81** [.48, .94]	.83** [.53, .95]	.53 [-.03, .84]	.69** [.23, .90]		
11. HSP_Post	3.92	0.66	.45 [-.20, .83]	-.30 [-.73, .30]	-.28 [-.72, .32]	-.15 [-.65, .44]	.70** [.24, .90]	.79** [.42, .93]	.53 [-.03, .84]	.54 [-.01, .84]	.70** [.24, .90]	.37 [-.23, .76]	
12. Stigma_post	3.84	0.96	.77** [.33, .94]	-.70** [-.90, -.25]	-.38 [-.77, .22]	-.24 [-.70, .36]	.84** [.54, .95]	.95** [.84, .99]	.71** [.26, .91]	.53 [-.03, .84]	.89** [.67, .97]	.70** [.23, .90]	.71** [.26, .91]

Note. *M* and *SD* are used to represent mean and standard deviation, respectively. Values in square brackets indicate the 95% confidence interval for each correlation. The confidence interval is a plausible range of population correlations that could have caused the sample correlation (Cumming, 2014). * indicates $p < .05$. ** indicates $p < .01$. Variables 7-12 are subscales of IASMHS. HSP = "help-seeking propensity".

Table 3 (SAA Therapist)
Means, standard deviations, and correlations with confidence intervals.

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11
1. BOND	5.99	1.04											
2. AAVS	3.06	0.78	-.83* [-.97, -.22]										
3. IM4_pre	3.30	1.30	-.67 [-.95, .17]	.81* [.13, .97]									
4. IM4_post	2.74	1.30	-.47 [-.90, .44]	.64 [-.22, .94]	.83* [.20, .97]								
5. IASMHS_pre	3.62	0.83	.78* [.06, .97]	-.92** [-.99, -.53]	-.80* [-.97, -.11]	-.54 [-.92, .36]							
6. IASMHS_post	4.04	0.70	.88** [.36, .98]	-.96** [-.99, -.73]	-.82* [-.97, -.17]	-.51 [-.91, .40]	.91** [.50, .99]						
7. PsychOpen_pre	3.88	0.78	.83* [.20, .97]	-.87* [-.98, -.32]	-.69 [-.95, .14]	-.43 [-.89, .48]	.94** [.65, .99]	.87* [.35, .98]					
8. HSP_pre	3.64	0.77	.29 [-.59, .86]	-.60 [-.93, .27]	-.65 [-.94, .20]	-.45 [-.90, .46]	.82* [.17, .97]	.57 [-.32, .93]	.66 [-.19, .94]				
9. Stigma_pre	3.55	1.21	.93** [.58, .99]	-.92** [-.99, -.56]	-.80* [-.97, -.12]	-.51 [-.91, .40]	.94** [.66, .99]	.97** [.79, 1.00]	.94** [.63, .99]	.60 [-.28, .93]			
10. PsychOpen_post	4.12	0.62	.82* [.18, .97]	-.95** [-.99, -.67]	-.75 [-.96, .00]	-.53 [-.92, .37]	.78* [.06, .97]	.95** [.71, .99]	.74 [-.03, .96]	.39 [-.51, .88]	.87* [.32, .98]		
11. HSP_Post	4.04	0.57	.65 [-.20, .94]	-.70 [-.95, .11]	-.78* [-.97, -.06]	-.31 [-.86, .58]	.84* [.24, .98]	.84* [.24, .98]	.77* [.05, .96]	.71 [-.09, .95]	.85* [.27, .98]	.67 [-.17, .95]	
12. Stigma_post	3.95	1.06	.91** [.51, .99]	-.98** [-1.00, -.86]	-.77* [-.96, -.05]	-.54 [-.92, .36]	.91** [.48, .99]	.98** [.89, 1.00]	.89** [.44, .98]	.52 [-.38, .92]	.97** [.79, 1.00]	.95** [.71, .99]	.75 [-.01, .96]

Note. *M* and *SD* are used to represent mean and standard deviation, respectively. Values in square brackets indicate the 95% confidence interval for each correlation. The confidence interval is a plausible range of population correlations that could have caused the sample correlation (Cumming, 2014). * indicates $p < .05$. ** indicates $p < .01$. Variables 7-12 are subscales of IASMHS. HSP = “help-seeking propensity”.

Table 4 (White therapist)

Means, standard deviations, and correlations with confidence intervals.

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11
1. BOND	5.88	0.39											
2. AAVS	3.67	0.48	.04 [-.96, .96]										
3. IM4_pre	3.82	0.82	.69 [-.81, .99]	.08 [-.78, .84]									
4. IM4_post	4.14	0.66	.40 [-.91, .98]	.02 [-.81, .82]	.92** [.42, .99]								
5. IASMHS_pre	3.41	0.76	-.58 [-.99, .86]	-.55 [-.94, .47]	.25 [-.70, .88]	.26 [-.70, .89]							
6. IASMHS_post	3.65	0.66	-.61 [-.99, .85]	-.27 [-.89, .69]	.51 [-.52, .93]	.59 [-.43, .95]	.90* [.32, .99]						
7. PsychOpen_pre	3.35	0.81	-.58 [-.99, .86]	-.74 [-.97, .19]	-.00 [-.81, .81]	.01 [-.81, .81]	.93** [.48, .99]	.69 [-.27, .96]					
8. HSP_pre	3.31	0.30	-.77 [-.99, .74]	-.61 [-.95, .40]	-.01 [-.82, .81]	.10 [-.77, .84]	.92** [.45, .99]	.79 [-.05, .98]	.94** [.57, .99]				
9. Stigma_pre	3.67	1.15	-.58 [-.99, .86]	-.50 [-.93, .52]	.32 [-.67, .90]	.35 [-.65, .90]	.99** [.91, 1.00]	.94** [.54, .99]	.87* [.21, .99]	.89* [.29, .99]			
10. PsychOpen_post	3.44	0.81	-.37 [-.98, .92]	-.81* [-.98, -.01]	.21 [-.73, .87]	.30 [-.68, .89]	.82* [.01, .98]	.68 [-.30, .96]	.89* [.29, .99]	.87* [.20, .99]	.77 [-.10, .97]		
11. HSP_Post	3.79	0.80	-.75 [-.99, .76]	.35 [-.65, .90]	.43 [-.59, .92]	.37 [-.63, .91]	.58 [-.43, .95]	.76 [-.15, .97]	.30 [-.68, .89]	.40 [-.61, .91]	.63 [-.37, .95]	.10 [-.78, .84]	
12. Stigma_post	3.71	0.90	-.43 [-.98, .90]	-.18 [-.86, .74]	.56 [-.46, .94]	.70 [-.25, .96]	.74 [-.18, .97]	.94** [.53, .99]	.47 [-.55, .93]	.62 [-.39, .95]	.82* [.04, .98]	.51 [-.51, .93]	.70 [-.26, .96]

Note. M and *SD* are used to represent mean and standard deviation, respectively. Values in square brackets indicate the 95% confidence interval for each correlation. The confidence interval is a plausible range of population correlations that could have caused the sample correlation (Cumming, 2014). * indicates $p < .05$. ** indicates $p < .01$. Variables 7-12 are subscales of IASMHS. HSP = “help-seeking propensity”.

Moderated-Parallel Mediation

Mediation

To address the study's Research Questions: 1) "How does the racial/ethnic relationship between counselor and client inform internalized attitudes of the MMM and one's attitudes towards seeking mental health services for SAA undergraduates?" 2) "Will the internalization of the model minority myth act as a mediator between therapist racial/ethnic match and one's attitudes towards seeking mental health services for SAA undergraduates?" a moderated-parallel mediation model (see *Figure 1*) was conducted. Originally, the model was to be run via Baron and Kenney's (1968) three-step approach to mediation. Recognizing however, that the Baron and Kenny approach was not suited for allowing simultaneous comparison of mediating pathways, the Hayes Macro (Hayes, 2022) was used instead. This approach, run via "R" allows for simultaneously mediation and moderating effects of hypothesized mediators and moderators. Using Hayes Macro, model 8, (Hayes, 2022) the effects between therapist match and attitudes towards seeking mental health services and the potential mediating effects of that direct relationship (i.e., internalization of the MMM and bond) were observed. Recognizing a sample size of 13 would not yield statistically significant results, the results of the parallel mediation are understood within a "practical significance" and were used in tandem with subsequent quantitative and qualitative analyses.

Using effect sizes (β) as a measure of strength between variables (Nieminen, 2022), the parallel mediation model (see *Figure1*) revealed that therapist racial/ethnic match yielded a small positive effect with attitudes towards seeking mental health services (β = .126), a large negative effect with MMM internalization (β = -.583), and a negligible negative effect with bond (β = -.02). MMM internalization (mediator one) indicated a medium negative effect towards attitudes

towards seeking mental health services ($\beta = -.332$), which suggests that the lower the MMM internalization, the higher likelihood to have more positive attitudes towards seeking services. Lastly, working alliance-bond (mediator two), indicated a negligible negative effect with positive attitudes towards seeking mental health services, $\beta = -.07$.

Moderation

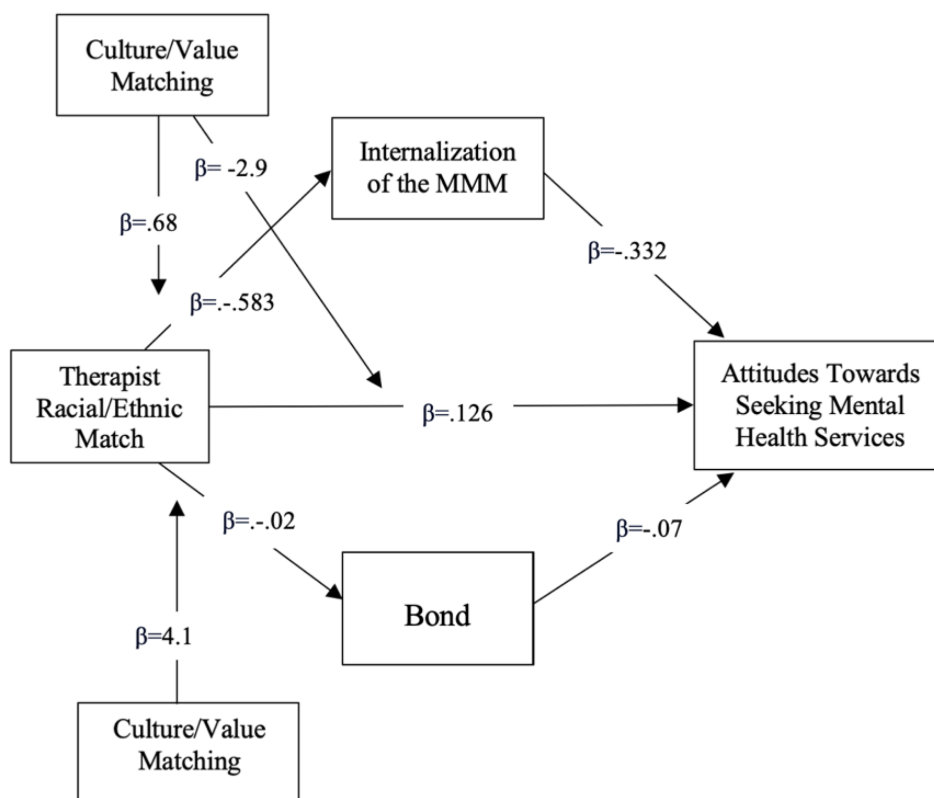
Lastly, to account for culture/value match, instead of relying only on racial/ethnic effects, a moderation analysis was run as part of the parallel mediation to determine if and how culture/value matching impacts the relationship between variables. Specifically, the moderation was run to address sub research questions one and two: 1) “How will bond influence other study variables?” and 2) “Will culture/values match act as a moderator between significant variable relationships?”

Worth noting, is that culture/value match was utilized even with contextualizing practical significance, there remains however, a difficultly of measuring whether a client is aware of culture/value match. Specifically, after one meeting with a therapist, measuring such an effect undertakes two challenging steps; 1) novelty of quantitative measurements for internalized value and 2) client awareness of internalized match (see discussion/implications for further details). To our awareness, no study has attempted to measure the degree of cultural match/mismatch based on measurements taken by two groups (e.g., participants and “therapists”). As such, because the variable of interest was cultural match/mismatch *not* one’s level of enculturation, the analysis looked at collected data to determine significant amount of cultural match/mismatch between groups. The purpose for this analysis, rather than using data from prior studies’ which have utilized the AAVS-M, was because cultural match/mismatch may be dependent on variety of variables (e.g., geographical location, age, generation to US, generation to college).

Before conducting the moderation, the first step was to create an index of strengths of relationships between therapist-client internalized values. As such, Kendall's Tau was used as a metric of agreement between values. This method was used over hierarchical cluster via Euclidian distancing as the latter would require one to create meaningful match scores (i.e., high, medium, low) for a non-defined construct. Being that this method is ascribing "match" to a fluid construct (i.e., values), having a pre-determined scale (i.e., Kendall's Tau and correlation strengths metrics) help to craft more statistically sound findings.

Similar to the mediation, this analysis used effect sizes (β) as a measure of strength between variables and did not yield statistical significance. Though the moderation did not yield statistical significance, the findings serve as first step in understanding how to measure internalized cultural match as an individual yet moderating variable to racial/ethnic matching. The findings suggest that internalized cultural match may strengthen the negative relationship between racial/ethnic match and MMM internalization ($\beta = -.68$), strengthen the negative relationship between racial/ethnic match and bond ($\beta = 4.1$), and weaken the relationship between racial/ethnic match and bond ($\beta = -.07$) with effect sizes ranging from large to negligible (See *Figure 1*).

Figure 1: Moderated-Parallel Mediation Model
Note. Inventory of Attitudes Towards Seeking Mental Health Services = Attitudes Towards Seeking Mental Health Services. Asian American Values Scale-Multidimensional = Culture/Value Matching. IM-4 = Internalization of the MMM. Working Alliance Inventory-Bond Subscale = Bond



Qualitative Analyses

Statement of Researcher Positionality

Addressing researcher positionality and ensuring its minimization of influence within the qualitative analyses, Holmes' (2020) was used as a framework of finding, understanding, and addressing researchers' positionality. Holmes (2020) identifies positionality within three constructs "1) the subject under investigation, 2) the research participants, and 3) the research context and process" (pg. 2). With the head researcher having a "fixed aspect of positionality" or racial/cultural similarities with the participants (i.e., identifying as SAA), he informed the

research team of the cultural biases that he had in relation to the qualitative narratives. Specifically, he informed the team of his own attitudes towards seeking mental health services if paired with SAA vs White therapist, having a therapist that understands his cultural background, and his anticipated findings.

As such, he also informed the team that although he believes in the individual and community benefits of mental health services, he also believes that as a SAA, he would face backlash and be stigmatized if members of his community were aware that he was seeking services. Furthermore, he believes that his own attitudes towards seeking mental health services would improve if he had access to a SAA identifying therapist.

Knowing the head researcher may also find additional meaning in participant statements, by understanding cultural nuances that are not discussed within the literature (i.e., a true representation of how stigma manifests in SAA families). As such, the head researcher and study analysis team members (i.e., head researcher and PI) came to a consensus when creating emergent themes from participants' narratives. Conversely, the head researcher ensured to consult team analysis members specifically regarding his relationship with SAA culture and how it may leave him more susceptible to "areas of unawareness" and/or biases within participant narratives.

Approach to Data Analyses

For the study's qualitative portion, LeCompte's (2000) multi-step content analysis was utilized to discover emergent themes. The 5-step analysis identified emergent themes, subthemes, and constructs. The first step took place after transcription in which the study lead cleaned the data and de-identify constructs such as names, programs, or clubs/orgs that students identified. Secondly, units of analyses were identified via line-by-line coding. Following unit

identification, units were grouped, and items were categorized to form taxonomies for each set. In the fourth step, the study lead determined patterns and emergent themes which determined how the taxonomies could be put together to form patterns. Lastly, the study lead formed "meta-themes" to create a description of participants' narratives.

Data Trustworthiness

To ensure data trustworthiness, the study team members, comprised of head researcher, "therapist" two, and dissertation chair/study PI, attended to Lincoln and Guba's (1985) four elements of trustworthiness: truth value (internal validity), applicability (external validity), consistency (reliability), and neutrality (objectivity). To establish *truth value* ("the 'truth' of the findings of a particular inquiry") (Lincoln & Guba, 1985, p. 290), and *applicability* (determining how applicable the findings of inquiry are), a data source triangulation methodology was utilized by the study analysis team (i.e., head researcher and PI). A data source triangulation strategy can be utilized to test truth value and applicability by converging information from multiple interviews (Carter et al., 2014). To adhere to *consistency*, how findings can be repeated if they are replicated within a similar context (e.g., participant, setting), study team members (i.e., study "therapists") adhered to the specified study protocol such as interview protocol and transcription of interviews via audio (refer to "Therapists"/Participants" section for additional information). Lastly, to establish *neutrality*, (the degree to which the findings are determined by participants' responses and not via study team biases), investigator triangulation (having multiple team members analyzing/observing the data) (Carter et al., 2014) was used. Throughout this process, study analysis team members addressed how personal experiences and presumed participant experience may influence data interpretation, while maintaining discussions related to literature and cultural knowledge.

Emergent Themes

An overview of the study's themes and subthemes by core question and therapist identity (i.e., White vs SAA) with supportive illustrative statements are presented in Table 5. As a part of the study debrief, participants were asked three questions relating to their study experience 1) "What was that experience like for you?" 2) "How do you think your experience would be different if your therapist was (White or SAA)" 3) "Based on this experience, what are your thoughts on pursuing therapy in the future?" Illustrated below are the emergent themes from participant response, by question, and differentiated based on the racial/ethnic/cultural background of their therapist.

"What was that experience like for you?"

Recognizing one's experience in therapy is a contributing factor to outcome processes such as return to services, working alliance, and treatment outcome (Wampold & Imel, 2015), the first question was asked to gauge how participants felt about the mock therapy experience. Participants shared five main themes regardless of therapists' identity: 1) An enjoyable experience which was made better by 2) having a space to talk about and reflect on self, including 3) a sharing/processing of experience such as 4) sharing of culture which made the space feel 5) safe. For example, when asked about their experience of the session, one participant stated:

> "I think umm, I feel you rarely get to explain South Asian experience, especially with someone like outside of the community, but also like outside of just my friends. So, it was cool being able to explain what I've experienced with someone other than a friend."

Questions within the interview protocol also had culturally oriented questions. As such, another noteworthy theme across experiences was enjoying being able to share cultural experiences, with one participant sharing:

> "[It was] a really good experience talking about culture and how it relates to my mental health and my experience with the college campus and the college atmosphere."

Participants were also asked how their experiences in session would have differed based on the identity of their therapist (i.e., White or SAA).

"What if your therapist was South Asian American?"

When asked about how they believe their experiences would have differed if their therapist was White or SAA identifying, participants gave varying responses depending on their therapist. In total, five emergent themes were found.

Would have felt more (or less) comfortable.

For participants who had a White therapist, participants noted that, though they believe the experience would be the same (i.e., the "good" feeling), they also believe they would have felt more comfortable working with a SAA identifying therapist. This theme was also seen for those working with a SAA therapist. When asked about how they would feel the experience would differ if working with a White therapist, a similar theme (e.g., similar experience but varying comfort level) emerged, with the differentiating factor being participants stating they would feel less comfortable talking about the topic(s) discussed if paired with a White therapist. Specifically, one participant who was originally paired with a White therapist stated:

> "Like for example, a common thing that really comes up in our conversations with me and my friend group about mental health is, a person of an American or like a Eurocentric American background, might suggest like 'oh, if so and so family member is really toxic and really causing stress in your life you should cut them off'. But like for, a lot of our cultures or in a lot of Desi cultures, that's not a feasible option. Like, maybe religiously, culturally, like you can't go about cutting people off like you can't cut off a whole tree. So, maybe things like that. Like maybe, umm, a person of color or a similar or the same background maybe they would understand that kind of factor more."

Being able to relate

A theme of relatability also emerged throughout the findings. Specifically, participants revealed a feeling that they would be able to relate more with a SAA identifying therapist as opposed to White identifying therapist. For example, when asked about how their experience would have differed if paired with a SAA instead a White identifying therapist, one participant stated:

> "I think they might have been able to relate. I got like, empathetic vibes from him [White therapist], so I feel like it was fine, but I feel like if it was somebody else I think they might have understood a little bit more"

Recognizing that feeling understood or "seen" as a client can impact both one's experience in therapy, thus influencing their likelihood to return, to have positive experiences, and more (Cabral & Smith, 2011; Wampold & Imel, 2015), this important contextualization highlights the power of visibility within the field of psychology, and more specifically, within the counseling setting.

Differing responses

Another emergent theme was one's response style. When asked about how they believe their experiences may differ based on having a SAA or White identifying therapist, participants noted that they believed their response style, (i.e., what they chose to speak about) would change. Specifically, participants named feeling more comfortable disclosing information relating to culture when working with a SAA identifying therapist as well as noted feeling that having a White identifying therapist would inhibit their ability to talk about culture, and that the therapist himself would ask less questions relating to cultural experiences. This was illustrated with two participants stating:

> "… some of the questions would have been different…just because they were so many like South Asian American based. I'm assuming that all the questions would [not] have been so heavily related towards that."

"I don't think I would have been able to say that stuff to a White person"

One of the most important facets of therapy, is a client's ability to self-disclose and feel at capacity to be open and honest within the therapy space (Wampold & Imel, 2015). Thus, the finding that participants reported feeling inhibited in disclosing cultural elements about themselves and their experiences to a White therapist raises concern relating to trust, continuation of services, and treatment outcome. Specifically, even *if* SAA identifying clients enter therapy services, unless there is a trust between themselves and their therapist, they will be less likely to be honest about their lived experience(s).

Not wanting to offend their therapist.

A final shared theme within this question was participants feeling as if they did not want to offend their therapist. Specifically, participants noted that if they had a White identifying therapist, they would not want to offend them while talking about experiences that they've had with White people/students on campus. For example, two participants, each paired with a different therapist, stated:

> "Somethings can be offensive if like you had a certain experience with like umm…like maybe like White people."

> "…it feels like when I'm talking about specific people I feel like I'm attacking them, so I would feel a little less comfortable sharing this information."

Lastly, though this participant identified as South Asian American, they specifically identified as a 1st-generation SAA and spoke specifically to feeling "more judged" by 2nd generation SAAs, thus calling attention to the nuanced cultural differences between SAAs who were born in the U.S., and those who immigrated. In particular, this participant stated:

> "But on the other hand, because a South Asian interviewer would know what I'm talking about, I also might have bit my tongue a bit more, I may have been a bit more inhibited, not because anything in inherent about South Asians, but because you know you're probably going to have a better idea about what I'm talking about and what I'm saying may

> be perceived as a bit more controversial by a South Asian person than a non-South Asian person…As a 1st generation immigrant, I do think that I'm better than 2nd generation immigrants and I know that most SAAs are 2nd gen immigrants so I probably would not have said that to a south Asian interviewer"

Contextualizing this participant's experience is important as they are highlighting a similar narrative as previous participants (i.e., not wanting to offend their therapist) but rather is focusing on the cultural biases they hold in relation to SAA umbrella term. Thus, providing additional evidence to support the importance of understanding one's narrative, illustrating the heterogeneity that exists within the term "South Asian American", and how disaggregated even "subfields" of Asian American Psychology need to be. Furthermore, this provides evidence to support the importance of the "C" in the REC matching model in that internalized cultural values can and ought to be attend to when thinking about therapist/client match.

Cultural Competency

The final emerging themes within the second debrief question was found only with those paired with a White therapist when asked about how their experience would change if they had a SAA identing therapist. Specifically, participants mentioned that they trusted their White therapist because the study's focus was on SAA students, thus they could assume that their therapist has exposure, experience, and knowledge relating to the SAA experience. This is highlighted with one participant stating:

> "I think, honestly just knowing that it's part of the study. Assuming [therapist name] has spoken with other students, South Asians, I think in that respect having a therapist who at least understands the South Asian experience would be helpful."

Again, this finding showcases the importance of cultural competency, specifically in relation to SAA clients. With little literature focusing on SAA student experiences/mental health (DeVitre et al., 2021, Inman et al., 2014, Museus 2009) and with the first textbook focusing on the Indian

American diaspora in mental health being recently published (Amin & Bansal, 2023), this asks the question “how do we ensure therapists are culturally aware/component when working with SAA identifying individuals?”

“What are your thoughts on pursuing therapy?”

When asked about their thoughts on pursuing therapy in the future (based on the experience of the study), participant themes were categorized into three sections: 1) shared themes regardless of therapist identity, 2) themes found when working with SAA therapist, and 3) themes found when working with a White therapist.

Shared themes

Regardless of therapist identity, a shared theme across participants when asked their thoughts on if they would pursue therapy in the future (based on “this experience”) participants noted three major themes all relating to “openness” to therapy. 1) Openness based on clarity of what therapy is, 2) openness based on the experience/how it felt, 3) psychological openness (e.g., “If I needed to go, I would be more open to it”). Such themes highlight an important aspect of attitudes towards seeking services, one exposure to what therapy *can* look like for SAA clients, can increase access to services by decreasing community stigma and misinformation about therapy services (which are frequented within the SAA community) (Amin & Bansal, 2023). Another theme found, and consistent with contemporary literature, is that SAA students are open to the idea of the pursuing therapy services, but an inhibiting factor being feeling like they “need it” (i.e., psychological openness and willingness “if needed”) (DeVitre & Gloria, 2023).

With SAA therapist

When working with a SAA identifying therapist, one prominent theme emerged cross participants: an increased wiliness to pursue therapy in the future (if they had a SAA identifying therapist). Highlighting the importance of REC match, one participant stated:

> "Umm, I'd say I've always been very open to therapy. Umm…it's more so finding a therapist that like matches the identity that's more difficult…"

With White therapist

Lastly, for those who worked with a White identifying therapist but were debriefed by a SAA identifying therapist, two themes emerged: 1) An increased willingness to but inhibited by cultural stigma and a want for cultural awareness, 2) system-based considerations (i.e., telehealth and waitlists). These themes provide insight into two specified areas, one being content itself, which is congruent with the literature stating SAA are less likely to seek services as result of mistrust in the system and cultural/family stigma (Amin & Bansal, 2023, DeVire & Pan, 2020). This was highlighted in one participant's response who stated:

> "…it can be helpful to talk to a professional. But when I voiced that in the past like maybe I/they should seek professional help it's all just brushed off and not taken seriously and that's just so consistent and I just feel like, maybe talking to a professional might help validate some of my feelings of being so brushed off by my family"

The second area of which these emergent themes provide insight into, was the way in which participants were willing to disclose the information. Consistent with the themes of the previous responses (e.g., increased willingness to disclose/talk about cultural considerations with SAA therapist), participants only shared these themes when being debriefed by the SAA study team member.

CHAPTER V

Discussion

Using a multi-time, dual participant, mixed methods approach, this study sought to further the psychological communities' understanding of therapist-client match and to assist in decolonizing the understanding of match, therapy outcome variables, and methods of improving access to services, with a specified focus on stigma within and outside South Asian American (SAA) communities. To contextualize and understand the study findings, characteristics and relationships between study variables are described below. Using a concurrent triangular mixed methods design (Crewswell & Plano Clark, 2007) via a moderated parallel-mediation and correlational analyses contextualized by qualitative narratives, the study findings are understood within the context of the study hypotheses. Lastly, study limitations and implications for future research on therapist-client Racial/Ethnic/Cultural (REC) matching are explored.

Examination of Main Study Variables and Research Questions

Racial/Ethnic Match

Limited literature has focused on the effects of therapist-client REC match in relation to one's attitudes towards seeking mental health services (DeVitre & Gloria, 2023, Inman et al., 2014). Specific to Asian/South Asian American undergraduates, who are less likely to seek mental health services at lower rates than any other racial ethnic group (Chu & Sue, 2011, Lipson et al., 2018), the first research question was made to address what systemic factors may inhibit SAA attitudes towards seeking mental health services, specifically, therapist match.

With a pre-posttest screening of attitudes towards seeking mental health services and a mock session intervention with either a SAA or White identifying therapist, study participants (N = 13) indicated more favorable post-session attitudes towards seeking mental health services

when paired with a SAA identifying therapist than when compared to a White identifying therapist (see tables 3 & 4). Similarly, one's internalization of the MMM increased when paired with a White identifying therapist and decreased when paired with a SAA identifying therapist. A post-hoc analysis also revealed significant group mean differences between MMM internalization, bond, and one's attitudes towards seeking mental health services. Such findings provide evidence supporting a more in-depth understanding to the benefits of therapist-client REC matching. Contextualization of findings in relation to MMM internalization, and one's attitudes towards seeking mental health services are discussed below.

MMM internalization and Attitudes Towards Help Seeking Services

MMM internalization negatively impact various facets of SAA's attitudes towards seeking mental health services (i.e., psychological openness) (DeVitre & Gloria, 2023). Looking at nuanced factors, the study findings suggest that whether one is paired with a therapist who shares their REC identity impacts their levels of MMM internalization. Important to contextualize, although MMM internalization may not directly inform traditional "immediate" therapeutic outcomes (e.g., depression, anxiety), the study findings suggest that MMM internalization can and should be contextualized as an immediate outcome variable, which can be addressed and attended to via shared cultural knowledge. As such, when looking at the effects of MMM internalization, our analyses addressed two of the study's pivotal points: 1) will MMM internalization mediate the relationship between therapist-client match and one's attitudes towards seeking mental health services? and 2) will MMM internalization be impacted by therapist-client match?

Bolstered by correlational (Tables 3 & 4) and qualitative narratives, the mediation (*Figure 1*) findings indicated trending data to support the hypotheses that MMM internalization

is impacted by therapist-client match *and* mediates pathways between therapist-client match and one's attitudes towards seeking mental health services. Specifically, these results corroborate the findings from DeVitre & Gloria (2023) that lower levels of MMM internalization increase SAA undergraduates' attitudes towards seeking mental health services, and that MMM internalization may be influenced by specified university factors (e.g., cultural representation).

With the findings suggesting that MMM internalization mediates the relationship between therapist-client match and attitudes towards seeking services, this provides a new understanding to the influence of the MMM and what factors may affect one's MMM internalization. Specifically, the findings suggested that if SAA undergraduates were to be paired with a SAA identifying therapist, they may have lower rates of MMM internalization, more positive attitudes towards seeking mental health services, and subsequent factors which stem from the aforementioned (e.g., decreased depressive and anxiety related symptoms).

These findings grant additional support for the hiring of SAA identifying therapists within university counseling centers. Recognizing that the MMM is less likely to be internalized on predominantly Asian American campuses (Atkin et al., 2018), contextualizing how representation within campus systems, specifically within mental health systems is warranted. Doing so, may have the potential to impact MMM internalization rates (and subsequently attitudes towards seeking mental health services) and provide less barriers to care for SAAs who are questioning whether to seek services. Knowing that an inhibiting factor for Asian Americans seeking services is mistrust of the system, availability to SAA mental health providers may be the first step in assisting the large discrepancy seen in various racial/ethnic groups attitudes towards seeking mental health services.

Working Alliance-Bond

Another study variable, bond, was observed to understand the relationship between therapist-client match, bond, and attitudes towards seeking mental health services. In attempt to further understand the role of therapist/client match, the mediation model findings did not align with the study hypothesis and suggested that those paired with a REC matched therapist may have lower rates of bond, and subsequently attitudes towards seeking mental health services. To understand this trend, the researchers took a post-hoc review of data response trends which indicated that some participants may not have understood the scoring system of the working alliance inventory-bond scale, and thus reported their responses within a reverse score fashion. This hypothesis may also explain correlational findings that suggested only those paired with a SAA identifying therapist had significant correlations between bond and positive attitudes towards seeking mental health services (see table 3 & 4). Furthermore, Table 4 corroborates the post-hoc hypothesis that the aforementioned response style may have been with participants who were paired with a White identifying therapist, due to negative correlational trends in bond and attitudes towards seeking mental health services. As such, a focus on the data trends with SAA identifying therapist are discussed.

With a sole focus on participants paired with a SAA identifying therapist, the findings are contextualized within previous literature which posits that constructs such as "traditional outcome variables" (e.g., depression, anxiety) are influenced by common factors such as working alliance (Horvath, et al., 2011; Wampold & Imel, 2015). This anticipated finding was welcomed as previous literature suggests that, though outcomes such as depression and anxiety are not directly impacted by therapist racial/ethnic match, clients often have higher perceived competence, longer stay, and preference for a racial/ethnically matched therapist (Cabral &

Smith, 2011; Ibaraki & Hall, 2014). This finding also provides a new understanding and reason to further look at the benefits of therapist-client match.

With factors such as working alliance and perceived competence being predictors of better psychotherapy outcomes, as they increase therapy "buy in" (Cuijpers et al., 2019; Wampold & Imel, 2015), re-addressing the pathways of "benefits" is warranted. Specifically, as racial/ethnic therapist-client match influence constructs such as working alliance, contextualizing these effects grants even more support for more intentional and inclusive hiring practices within university systems.

Racial/Ethnic/Cultural (REC) Matching

Recognizing that previous literature has used therapist-client racial/ethnic match as a proxy for cultural match (Ibaraki & Hall, 2014; Smith, 2011; Sue, 1998), this study piloted a method of quantifying therapist-client match as it pertains to internalized values. This was done to observe how internalized values match may impact and/or strengthen the relationship between various pathways (e.g., racial/ethnic match and attitudes towards seeking mental health services) while simultaneously piloting a new method of understanding therapist-client match. Due to the statistical power (i.e., using the measure of internalized match as a moderator), it is difficult to draw conclusions from the moderating impacts of internalized cultural match. Nonetheless, the findings suggest that such constructs *are* measurable via differing statistical techniques. Thus, it is suggested that future researchers continue to contextualize therapist-client match within the context of internalized values. Such understandings provide additional pathways into more in-depth research relating to therapist-client match while also relying less on assumptions to measure cultural constructs (i.e., racial/ethnic match as a proxy for culture). Lastly, when analyzing REC matching, additional consideration given towards clients' awareness of

internalized values matching (i.e., if a client can recognize internalized values matching) is warranted.

Qualitative Understanding

The qualitative element of this study served multiple purposes in understanding the study's main research questions. Primarily, given that constructs such as attitudes towards help seeking services are not often considered to be "outcomes" of therapy in the same context as decreases in more acute mental health concerns (e.g., depression, anxiety), the narratives from participants provide insight as to *why* and *how* one's attitudes towards seeking mental health services should be considered a therapeutic outcome variable. Next, knowing one's trust, rapport, and perceived empathy from their therapist are factors which predict traditional outcomes variables (Cuijpers et al., 2019; Prihi et al., 2019; Wampold & Imel, 2015), participant narratives further contextualize how intentional REC matching, within SAA populations, is a worthwhile venture. Specifically, when understanding previous narratives that therapist-client match does not lead to improved treatment outcomes (Cabral & Smith, 2011), the study findings suggest our understanding of therapist-client match needs to be contextualized and understood within the context of specified populations. Lastly, recognizing the study's focus on practical versus statistical significance, the qualitative themes found within participants' narratives help to further contextualize *and* bolster the study's quantitative findings. Specifically, narratives which posit one's MMM internalization and attitudes' towards seeking mental health services are impacted by REC matching variables.

Implications and Limitations

Decolonized Understanding to "Benefits" of Therapy

Historically, "benefits" to therapy have been constructs related specifically to mental health from a diagnostic perspective (e.g., depression and anxiety) (Cabral & Smith, 2011). As a result, communities who are at high risk of mental health distress but also less likely to seek services (i.e., SAAs) are systemically not included within the conceptualization of therapeutic benefits. With constructs such as bond, MMM internalization, and attitudes towards seeking mental health services all having emerged as factors influenced by therapist-client REC matching (Cuijpers et al., 2019; Horvath et al., 2011; Prihi et al., 2019; Wampold & Imel, 2015), re-conceptualizing how the psychological community understands psychotherapy benefits is warranted. Specifically, taking a community-based approach to understanding therapy benefits and how it can improve retention, re-entry, and de-stigmatization within SAA communities is suggested.

Decolonized Lens to Understanding Retention

Lastly, though study retention is traditionally understood within a methodological context, a further contextualization within this study is warranted. With a total of 37 participants finishing the study pre-surveys, 29 electing to schedule a session, and 13 showing up to their session, the study retention rate holds research, clinical/training, and system implications. Specifically, understanding the nuance of conducting research with populations who traditionally hold negative attitudes towards mental health systems and less positive attitudes towards seeking mental health services (e.g., SAAs) is warranted. As such, future study should contextualize expected retention (i.e., research implications), an understanding of SAAs relationship with mental health services and mental health stigma (i.e., clinical and training implications), and the ability of study protocols to promote trust, safety, and anonymity (i.e., system implications)

within SAA populations. Further implications and suggestions for future research, practice, and system understanding are made below.

Research Implications

Research focusing on therapist-client match has often been conceptualized with only within the context of phenotypical matching and have used singular marginalized populations of color as the baseline for understanding all forms of therapist-client racial/ethnic match (Ibaraki & Hall, 2014 & Cabral & Smith, 2011). As a result, colloquial teachings of therapist-client match have posited that a focus on such constructs is not warranted, and do not lead to immediate treatment benefits. Contrary to the aforementioned however, the findings of this study provide evidence supporting that therapist-client matching may impact outcomes of therapy, and also has community-based considerations. To do this, it is suggested that future research focusing on therapist-client match take into consideration cultural matching as an inclusive variable with an additional focus on decolonized understandings of treatment effects. Though not perfected, this study provides a glimpse into the possibility to studying REC matching and a new method of understanding the impact of cultural match.

A focus on the "C" (culture) of REC matching, encourages researchers not to put cultural implications as a limitation/afterthought but rather as a focused variable of such research. Doing so helps ensure that cultural factors (e.g., differences between/within cultures) can be understood within a systems-based lens and held as a competency for researchers and clinicians alike. Lastly, recognizing the practical considerations for studying racial/ethnic as opposed to REC matching (e.g., knowing if a client can "see" a match) finding ways to help clients "see" cultural match is warranted. This can be done by studying REC matching over various time-points (e.g.,

three or more sessions) and noting differences in therapist-client awareness of cultural match//understanding.

Overall, the study findings support the feasibility and initiative to conduct similar intervention-based studies with SAA populations. Within a feasibility framework, this study illustrates how, though mental health stigma within SAA populations exists, there is an increased want for mental health research, understanding, and competency within SAA populations. Even with factors inhibiting study completion, such as community/cultural stigma and student education considerations (e.g., finals, anticipated time commitment, in-person vs online engagement), the study findings evidence strong community interest in SAA mental health and provides justification to continue such research. Furthermore, the use of a concurrent triangular mixed methods design (Crewswell & Plano Clark, 2007) supports how traditional (i.e., quantitative) and decolonized approaches (i.e., qualitative) should be used for intervention studies for SAA populations. Specifically, this methodology promotes contextualized feedback of datapoints, thus also replicating an ideal form of competent multicultural therapy (e.g., contextualizing cultural differences within the larger narrative) (Thakkore-Dunlap et al., 2022).

Clinical and Training Implications

The findings of this study put forth a variety of clinical and training implications. Namely, the qualitative findings suggest that participants reported feeling comfortable with a therapist who *the client* knew held similar cultural understanding/knowledge. As such, a focus on how to build trust and understanding between therapist-client (in particular, as it relates to cultural knowledge) is warranted. Knowing that trust and rapport are major factors in therapy effectiveness (Prihi, et al., 2019; Wampold & Imel, 2015), increased focus on multicultural competency as a core competency within psychological training is suggested. Beyond direct

clinical implications, training programs may benefit from increased attention focused on the multicultural *and* clinical implications of therapist-client match, with a specified focus on cultural match. Doing so, promotes novel advancements in the field while teaching understandings of how a focus on culture and values promotes decolonized approaches to treatment.

Clinicians are required to hold competency in the treatment of mental health conditions (e.g., depression and anxiety). As such, the advancement of increased cultural knowledge as it pertains to specified cultural groups, is warranted as it appears as an emergent theme of what helps to strengthen trust and rapport. This can be done with a more specified attention to base competencies, including coursework and professional development which focuses on the decolonization, historical contextualization, and historical understanding of SAA populations. As such, the findings grant support for the crafting of more specialized courses such as specified Asian American psychology courses at both undergraduate and graduate levels. Doing so, frames REC modeling not as an “addition” to psychotherapy, but rather an understanding of what can assist SAA population needs (e.g., community-based benefits). To address such clinical implications however, it is also suggested that university personnel address the systems-based concerns which can encourage such suggestions.

System Implications

SAA are one of the fastest growing racial/ethnic populations within the United States (Pew, 2021), yet there remains a dearth of literature within mental health *and* higher education focusing on SAA experiences (DeVitre et al., 2021; Inman et al., 2014; Museus, 2009). With the first textbook focusing on SAAs in mental health not being published until late October 2022 (Thakore-Dunlap et al., 2022), the dearth of understanding relative to SAA mental health is

evident. Though stemming from many contributing factors, the results of this study help to highlight a commonality: a lack of representation. Paired with systemic barriers, the pathway to becoming a mental health practitioner as an SAA is riddled with cultural stigma and expectations. University environments which lack SAA representation in mental health (e.g., psychological faculty/staff, course offerings) further contribute to MMM-based narratives that SAA students do not suffer from mental health concerns and careers related to such subjects (e.g., psychology) and are not viable options for them or their culture. Such narratives may contribute to MMM internalization and subsequent mental health concerns for SAAs in and outside of the field.

For many SAAs, pursuing a career in mental health often takes going against cultural norms, knowledge, and expectations (Thakore-Dunlap, et al., 2022), a challenge which takes much sacrifice. If done, many SAAs continue to face barriers within higher education/mental health relating to their belongingness in the field. A dearth of literature, paired with a misunderstanding of the needs of SAAs can lead to SAAs feeling like they do not belong in the field. For example, being that many graduate programs admit scholars based on match of research or clinical interests, SAA individuals may be systemically excluded from admission, salient research topics, and other aspects which contribute to the advancement of SAA teachings in mental health.

With less SAA representation and focus on SAA research, knowledge relating to therapeutic practice of SAAs are less likely to occur. As such, the findings of this study also call on university-based psychology departments to make intentional efforts to on-board faculty/scholars of SAA descent and/or with a SAA research focus. Doing so, intentionally addresses the systematic barriers that inhibit SAAs from entering the field of mental health.

Recognizing that REC matching influences both one’s MMM internalization and one’s attuites towards seeking mental health services, and that university factors also influence one’s level of MMM internalization (DeVitre & Gloria, 2023), it is suggested that university counseling centers also put forth additional intentional efforts towards the hiring of and professional development surrounding SAAs.

Limitations

Being the first study of its kind, this study is not without limitations. Namely, being that this is a pilot study which focuses on practical versus statistical significance, the study’s quantitative elements (i.e., moderated parallel mediation model) could be further bolstered with increased study participation. Even though the qualitative element was used to further contextualize the quantitative findings, it is still suggested that future researchers adhere to the mixed-methods design, regardless of sample size, to continue to understand treatment effects, MMM internalization, and one’s attitudes towards seeking mental health services. Another limitation to this study was the availability of participants. Taking place at a predominantly White institution, with a population of which traditionally is less likely to seek mental health services (i.e., SAAs) (Chaudhry & Chen, 2019; Loya et al., 2010), finding undergraduate participants to undergo “mock therapy” made for difficulties with recruitment. This limitation, however, also underscores the importance of the study implications of addressing system-based concerns which impact SAA’s attitudes towards seeking mental health services. Lastly, though therapist effects were accounted for during the mock-therapy trials (see Therapists”/Participants”), future studies could benefit from having additional therapists of different SAA identifying backgrounds (e.g., Indian, Pakistani, Nepalese) as well as additional therapists of White identifying backgrounds. Doing so may help to further decrease therapist

effects while simultaneously providing additional understandings to the impact of REC modeling.

Conclusions

The first of its kind, this study incorporates a randomized multi-time dual participant mixed methods (RMDPM) approach as it relates to SAA undergraduate mental health and attitudes towards seeking mental health services. Being the first of its kind to focus on SAA undergraduate MMM internalization as it relates to therapist-client match, attitudes towards seeking services, *and* to use REC modeling as a new understanding of therapist-client match, this study lays a foundation for future research to build upon. Building off prior research which calls for a more specified approach to understanding Asian Americans' attitudes towards seeking mental health services (DeVitre & Pan, 2020) and more contextualized understanding to SAA mental health within university settings (DeVitre et al., 2021; DeVitre & Gloria, 2023), this study continues to scaffold off previous research while addressing a multitude of constructs within multicultural psychology as they relate to 1) treatment implications, 2) SAA attenuation to services, 3) statistical modeling, and 4) system-based concerns within mental health fields and university settings.

Key study findings including the negative relationship between REC matching and MMM internalization, the positive relationship between REC matching and one' attitudes towards seeking mental health, and contextualized qualitative narratives (e.g., increased trust and rapport) underscores the importance of REC matching within university settings while providing a more nuanced method of understanding therapist-client match and therapeutic outcomes. Specifically, the focus on REC matching challenges previous narratives that therapist-client racial/ethnic matching does not lead to overall outcome changes (Cabral & Smith, 2011). This is

done by providing nuance to understanding "outcomes" of therapy and contextualizes it within a multicultural context.

Recognizing that data presented relating to university counseling centers/therapy is rarely disaggregated amongst racial/ethnic demographics let alone amongst Asian/Asian American groups (AUCCD, 2021), this study provides much needed information relating to the construct of therapist-client matching. Specifically, the findings reveal the importance of contextualizing racial/ethnic disaggregation; as marginalized populations each have various stigmas, cultures, and backgrounds of which cannot be treated as a monolith within the field of psychology. This not only applies to the understanding of one's clients, but also the understanding of university hiring practices.

The study findings point towards a more intentional effort within university and mental health spaces to contextualized SAA attitudes towards seeking mental health services as a systems-based factor. When thinking about hiring practices and the growing effort amongst universities to attend to diversity and inclusion, SAAs are still invisible within the higher education narrative. Though this narrative is often addressed through student-related concerns, rarely addressed is the diversity and attention to SAA (or lack of) staff/faculty. Knowing that SAA attitudes towards seeking mental health services is a factor which is systematically influenced (DeVitre & Gloria, 2023) universities can address this issue by putting forth intentional efforts to onboard more SAA staff/faculty within mental health related fields. Doing so will increase opportunity to address REC matching for SAA students and showcase the field as a viable option for SAA populations (i.e., addressing both staff/faculty and student alike).

Building upon prior literature which focuses on SAA undergraduate mental well-being (DeVitre et al., 2021; DeVitre & Gloria, 2023), the findings highlight the need for increased

focus on a disaggregation of Asian American mental health (DeVitre & Pan, 2020), increased research/literature relating to SAA psychology (Inman et al., 2014), and increased efforts towards inclusion of SAA in mental health. Additionally, the findings challenge colloquial narratives relating to therapist-client matching, bolsters the need for longitudinal studies/mixed method approaches in SAA research, and challenges both university and mental health personal to further expand their knowledge of one of the fastest growing racial/ethnic groups within the United States, SAAs (Pew Research Center, 2021).

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Table 5: *Participant Themes and Illustrative Statements*

Theme	Illustrative Statement for Themes
Question: "What was that experience like for you?	
Enjoyable Experience	"It was nice because he asked me questions that I don't always get the chance to talk about o it's nice just to say them and talk about them
Having Space to reflect on self	"It allowed me to self-reflect a bit, because I don't really do that much."
Sharing processing of experiences	"Whenever I talk to people about therapy, they're like 'oh yea, I unpacked my whole life'. And yea, it doesn't have to be like that. I think it shows it can be helpful without having to get into, everything."
Sharing of Culture	"It was really good experience talking about culture and how it relates to my mental health."
Safe	"He was understanding of the things I was sharing, it made it a very safe space to go through."
Question: "How do you think your experience would have been different if the person interviewing you was SAA/White?"	
Feeling more/less Comfortable working with SAA/White therapist (respectively)	"If I can feel this comfortable White guy, then I'm sure therapy is probably going to be working for me in the future."
SAA therapist would be able to relate	"Because (SAA therapist name) might have experienced some of the things that I had said, it made it easier for us to relate on that level. I have a therapist, and he's White, and talking to him sometimes there's like a disconnect between me and him because he doesn't understand things that are culturally significant to my culture and how people are supposed to act."
Provision of differing	"I probably would have felt a little hesitant talking about

responses	my experience here on campus."
Not wanting to offend their therapist	"I wouldn't want to feel like I offended anybody."
Cultural Competency	"Honestly, just knowing that it's a part of the study. Assuming (White therapist name) has spoken with students, South Asians, I think in that respect having a therapist who at least understands the south Asian experience would be helpful."

Question: "Based on this experience what your thoughts on pursuing therapy in the future?"

Openness because of:	
1) Clarity of what therapy is	"It helped me to understand what that conversation would be like now that I feel like it's more like a regular conversation that opens up some questions that haven't come up."
2) Feeling/Experience	"As he left, I was kind of like 'I'm definitely someone who bottles everything up, so it would be nice to have someone to', you know. I was telling him things I don't even think I've told my parents before, so I think it would be nice."
3) Psychological openness	"I have been wanting to go to therapy for a while, it's just I haven't had time, so I think that this has honestly reassured the fact that it would be helpful."
With SAA therapist: Increased willingness if working with SAA therapist	"I'd say I've always been very open to therapy. It's more so finding a therapist that matches the identity that's more difficult."
With White therapist: Increased willingness but Inhibited by systems	"I heard that (campus counseling centers) are overwhelmed so I've been hesitant of actually seeking [services] because of wait time stuff. He [therapist] said that (campus counseling center) is pretty good at scheduling you in a timely manner so I think that I'll definitely check that out in more detail."

Appendix A
Asian American Values-Multidimensional (AAVS-M)

INSTRUCTIONS: Use the scale below to indicate the extent to which you agree with the value expressed in each statement.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Mildly Disagree
4 = Neither Agree or Disagree
5 = Mildly Agree
6 = Moderately Agree
7 = Strongly Agree

______1. One should recognize and adhere to the social expectations, norms and practices.
______2. The welfare of the group should be put before that of the individual.
______3. It is better to show emotions than to suffer quietly.
______4. One should go as far as one can academically and professionally on behalf of one's family.
______5. One should be able to boast about one's achievement.
______6. One's personal needs should be second to the needs of the group.
______7. One should not express strong emotions.
______8. One's academic and occupational reputation reflects the family's reputation.
______9. One should be able to draw attention to one's accomplishments.
______10. The needs of the community should supersede those of the individual.
______11. One should adhere to the values, beliefs and behaviors that one's society considers normal and acceptable.
______12. Succeeding occupationally is an important way of making one's family proud.
______13. Academic achievement should be highly valued among family members.
______14. The group should be less important than the individual.
______15. One's emotional needs are less important than fulfilling one's responsibilities.
______16. Receiving awards for excellence need not reflect well on one's family.
______17. One should achieve academically since it reflects on one's family.
______18. One's educational success is a sign of personal and familial character.
______19. One should not sing one's own praises.
______20. One should not act based on emotions.
______21. One should work hard so that one won't be a disappointment to one's family.
______22. Making achievements is an important way to show one's appreciation for one's family.
______23. One's efforts should be directed toward maintaining the well-being of the group first and the individual second.
______24. It is better to hold one's emotions inside than to burden others by expressing them.
______25. One need not blend in with society.
______26. Being boastful should not be a sign of one's weakness and insecurity.
______27. Conforming to norms provides order in the community.

______28. Conforming to norms provides one with identity.
______29. It is more important to behave appropriately than to act on what one is feeling.
______30. One should not openly talk about one's accomplishments.
______31. Failing academically brings shame to one's family.
______32. One should be expressive with one's feelings.
______33. Children's achievements need not bring honor to their parents.
______34. One need not sacrifice oneself for the benefit of the group.
______35. Openly expressing one's emotions is a sign of strength.
______36. One's achievement and status reflect on the whole family.
______37. One need not always consider the needs of the group first.
______38. It is one's duty to bring praise through achievement to one's family.
______39. One should not do something that is outside of the norm.
______40. Getting into a good school reflects well on one's family.
______41. One should be able to brag about one's achievements.
______42. Conforming to norms is the safest path to travel.

Key:
Collectivism = 2, 6, 10, 14, 23, 34, 37
Conformity = 1, 11, 25, 27, 28, 39, 42
Emotional Self-Control = 3, 7, 15, 20, 24, 29, 32, 35
Family Recognition Through Achievement = 4, 8, 12, 13, 16, 17, 18, 21, 22, 31, 33, 36, 38, 40
Humility = 5, 9, 19, 26, 30, 41

Appendix B
Working Alliance Inventory (WAI)

Working Alliance Inventory:

Instructions: On the following pages there are sentences that describe some of the different ways you might have thought or felt about your therapist. As you read the sentence mentally insert the name of your therapist in place of _____ in the text.

Below each statement inside there is a seven-point scale:

1= Never
2= Rarely
3= Occasionally
4= Sometimes
5= Often
6= Very Often
7= Always

1. I feel uncomfortable with _____.
2. _____ and I agreed about the things I will need to do in therapy to help improve my situation.
3. I was worried about the outcome of the sessions.
4. What I was doing in therapy gave me new ways of looking at my problem.
5. _____and I understood each other.
6. _____perceived accurately what my goals were.
7. I find what I was doing in therapy confusing.
8. I believe _____ liked me.
9. I wish _____ and I could have clarified the purpose of our sessions.
10. I disagreed with _____ about what I ought to get out of therapy.
11. I believe the time _____and I were spending together was not spent efficiently.
12. _____ did not understand what I was trying to accomplish in therapy.
13. I was clear on what my responsibilities were in therapy.
14. The goals of the sessions were important for me.
15. I find what _____ and I were doing in therapy was unrelated to my concerns.
16. I feel that the things I did in therapy helped me to accomplish the changes that I wanted.
17. I believe _____ was genuinely concerned for my welfare.
18. It was clear as to what _____wanted me to do in those sessions.
19. _____and I respected each other.
20. I feel that _____ was not totally honest about his/her feelings toward me.
21. I was confident in _____'s ability to help me.
22. _____ and I were working towards mutually agreed upon goals.
23. I feel that _____ appreciated me.
24. We agreed on what was important for me to work on.
25. As a result of the therapy I became clearer as to how I might be able to change.
26. _____and I trusted one another
27. _____and I had different ideas on what my problems were.
28. My relationship with _____was very important to me.
29. I had the feeling that if I said or did the wrong things, _____ would stop working with me.

30. _____and I collaborated on setting goals for my therapy.
31. I was frustrated by the things I was doing in therapy.
32. We had a good understanding of the kind of changes that would be good for me.
33. The things that _____ as asking me to do did not make sense.
34. I did not know what to expect as the result of my therapy.
35. I believe the way we were working with my problem was correct.
36. I feel _____cared about me even when I did things that he/she did not approve of.

Key:
Task scale: 2, 4, 7, 11, 13, 15,16, 18, 24, 31, 33, 35
Bond scale: 1, 5, 8, 17, 19, 20, 21, 23, 26, 28, 29, 36
Goal scale: 3, 6, 9, 10, 12, 14, 22, 25, 27, 30, 32, 34

Appendix C
Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS)

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g. psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns, emotional problems, mental troubles* and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

1. There are certain problems which should not be discussed outside of one's immediate family.
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know *everything* about oneself.
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
9. People should work out their own problems; getting professional help should be a last resort.
10. If I were to experience psychological problems, I could get professional help if I wanted to.
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.
12. Psychological problems, like many things, tend to work out by themselves.
13. It would be relatively easy for me to find the time to see a professional for psychological problems.

14. There are experiences in my life I would not discuss with anyone.

15. I would want to get professional help if I were worried or upset for a long period of time.

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circle might find out about it.

17. Having been diagnosed with a mental disorder is a blot on a person's life.

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

20. I would feel uneasy going to a professional because of what some people would think.

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up".

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

Key:
Psychological openness: 1, 4, 7, 9, 12, 14, 18, 21
Help-Seeking propensity: 2, 5, 8, 10, 13, 15, 19, 22
Indifference to stigma: 3, 6, 11, 16, 17, 20, 23, 24

Appendix D
Internalization of the Model Minority Myth Measure (IM-4)

Instructions: Using the scale below, indicate the extent to which you agree or disagree with each item. Please be open and honest in your responding.

In comparison to other racial minorities (e.g., African American, Hispanics, Native Americans)…………………	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
1. Asian Americans generally perform better on standardized exams (i.e., SAT) because of their values in academic achievement.	O	O	O	O	O	O	O
2. Asian Americans are less likely to face barriers at work.	O	O	O	O	O	O	O
3. Asian Americans make more money because they work harder.	O	O	O	O	O	O	O
4. Asian Americans are more likely to persist through tough situations.	O	O	O	O	O	O	O
5. Asian Americans are more likely to be treated as equal to European Americans.	O	O	O	O	O	O	O
6. Asian Americans are more likely to be good at math and science.	O	O	O	O	O	O	O
7. Asian Americans get better grades in school because they study harder.	O	O	O	O	O	O	O
8. Asian Americans are less likely to experience racism in the United States.	O	O	O	O	O	O	O
9. Asian Americans are harder workers.	O	O	O	O	O	O	O
10. Despite experiences with racism, Asian Americans are more likely to achieve academic and economic success.	O	O	O	O	O	O	O
11. Asian Americans are more motivated to be successful.	O	O	O	O	O	O	O
12. Asian Americans have stronger work ethics.	**O**	**O**	**O**	**O**	**O**	**O**	**O**
13. It is easier for Asian Americans to climb the corporate ladder.	O	O	O	O	O	O	O
14. Asian Americans generally have higher grade point averages in school because academic success is more important.	O	O	O	O	O	O	O
15. Asian Americans are less likely to encounter racial prejudice and discrimination.	O	O	O	O	O	O	O

Key:
Achievement Orientation = 1, 3, 4, 6, 7, 9, 10, 11, 12, 14

Unrestricted Mobility = 2, 5, 8, 13, 15

Appendix E
Mock Session Template

- Introductions
  - Welcome
  - Informed consent including confidentiality and risk assessment/screening
- Naming what is counseling/what to expect
  - "What a lot of people may not realize, is that a lot of early-stage counseling can actually be psychoeducation, so if anything comes up that you may have questions about, please feel free to ask"
- Talk about 3 areas
  - Self-beliefs
    - Can you tell me a bit about your experience student?
  - Social connections
    - Tell me about important relationships that you have on campus
    - As a [year in school] what is your campus experience like?"
      - Are there any particular stressors that you're facing?
      - If needing additional prompting: Clubs/orgs, weekend activities
    - "How do you feel SAAs are represented on campus?
  - Cultural processes
    - Tell me about your cultural background
      - If needing additional prompting: Where cultural roots are from, generational status, salient cultural identities
    - Did you grow up with people who shared your cultural identities?
  - Wellness / self-care
    - What do you do to take care of yourself for wellness/self-care?
      - Ask follow-ups
  - ***With 10 mins remaining:*** Provide wellness resources:
    - Wellness wheels
    - Feeling Charts
    - Other examples of how to attend to wellness/self-care
  - Ending: Provide campus mental health resources and how to utilize them and inform participant of next steps
    - Provide forms and remind that meeting with one more study team member

Appendix F: Demographics Questionnaire

- What is your age in years?
- What is your gender identification?
- What school/major are you in?
- Are you a part of any clubs/organizations?
    - If so, which ones?
- Do you live on or off campus?
- Where is your hometown/permanent address?
- Do you work during the academic year?
    - If so, approximately how many hours/week?
- What year are you in school (i.e., first-year, sophomore, junior, senior)?
- Are you a full-time or part-time student?
    - Are you a transfer student?
- What generation to college are you?
- What generation to the United States are you?
- What is your ethnic/cultural identification (India, Pakistan, Bangladesh, Nepal, Bhutan, the Maldives, and Sri Lanka)?
- Have you previously sought professional counseling/mental health services?
    - If so, on or off campus?
    - If so, what was the racial/ethnic identification of your counselor?

- Please use the following scale to answer the next three questions

1= Never
2= Rarely
3= Sometimes
4= Often
5 = Always

1. How often is your identification as a South Asian American brought to mind?
2. How often is your identification as South Asian American brought to mind in a negative or challenging way (whether it's experience microaggression, being the only South Asian American in the room, being on a PWI, etc.)?
3. How often is your identification as South Asian American brought to mind in a positive or celebratory way (whether it's experience microaggression, being the only South Asian American in the room, being on a PWI, etc.)?