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Treatment Outcomes of Asian- and White-American Clients in Outpatient Therapy

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This study was the first to examine extensively the outcomes of Asian-American clients in mental health treatment. The research evaluated the short-term effects of outpatient individual psychotherapy. The focus on short-term outcome was particularly appropriate in view of earlier utilization studies that have consistently found higher premature termination rates and shorter treatment stays for Asian clients relative to White clients. The study used multiple outcome criteria from two different sources: Client self-reports of symptomatology and satisfaction with services and therapist evaluations of client symptomatology and adjustment. To better interpret ethnic effects, client and therapist variables (e.g., social class and pretreatment adjustment) that often have been confounded with ethnicity were accounted for in a multiple regression design. Results indicated poorer short-term treatment outcomes for Asian-American clients. Asian clients were less satisfied than White clients on all five satisfaction indices and reported greater depression, hostility, and anxiety after four sessions of treatment. No ethnic differences were found on the therapist-rated outcome measures, but there was a tendency for therapists to evaluate Asian clients as having lower levels of psychosocial functioning than White clients after short-term treatment. The findings underscore the need for culturally responsive therapies because Asian-American clients are experiencing worse outcomes, and these outcomes cannot be attributed to cultural differences between Asian and White clients that exist prior to treatment.

There is growing concern over the apparent lack of culturally responsive mental health treatment for ethnic minority clients (Abramowitz & Murray, 1983; Atkinson, Maruyama, & Matsui, 1978; Sue, 1977; Sue & Zane, 1987). This concern is especially salient with respect to mental health interventions for Asian-American populations (Lee, 1982; Leong, 1986; Murase, 1977). It is still unclear if mental health practitioners and policy makers have developed mental health services that are effective with this group of culturally diverse peoples. Much of this difficulty can be attributed to the lack of research that directly focuses on how cultural differences affect outcomes in psychotherapy. As Zane and Sue (1991) have noted, some basic clinical outcome-related issues have not been addressed. First, the proposition that Asian-American clients experience less positive outcomes in treatment has developed largely from clinical anecdotal accounts and utilization findings, but a direct empirical test of this notion has not been made. No outcome studies have been conducted that compare the effectiveness

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of psychotherapy with Asian Americans and Whites (Atkinson, 1985; Leong, 1986) Second, even when indirect evidence (e.g., ethnic differences in premature terminatio rates) suggests differential outcomes between Asian and White clients, it is unclear i these can be attributed to ethnic effects. Ethnic variations with respect to treatment out comes may actually result from other treatment-relevant factors such as social class (cf Lorion, 1973). In the case of Asian Americans, differences in language as well as socia class are obviously important. Ethnic differences in premorbid adjustment may also ac count for differences in clinical outcomes. Premorbid adjustment, the individual's genera level of psychosocial functioning prior to treatment, is one of the most consistent predic tors of outcome (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971). It ha been frequently suggested that due both to the stigma of mental illness and t unfamiliarity with mental health care, Asians tend to delay seeking psychological hel such that when they do finally enter treatment, they tend to be more disturbed tha White clients (Lin & Lin, 1978; Tung, 1985). This difference in premorbid adjustmen associated with help-seeking variations may actually account for Asian–White difference in treatment response.

Few studies have examined treatment outcome with respect to Asian American (Wong, 1982). Yamamoto, James, and Palley (1968) found that compared to Whit clients, minority clients were more often discharged or seen for minimal supportiv therapy at a psychiatric outpatient clinic. Because the Asian-American sample was ver small ($n = 5$), the generalizability of findings to this clientele is questionable. In a stud of 17 community mental health centers, Asian Americans and Whites did not differ i the treatment received (as defined in terms of diagnosis, type of personnel seen durin therapy, and type of service received), but the former had poorer outcomes than th latter as suggested by premature termination rates (Sue, 1977). These findings sugge that the treatment experience of Asian Americans is less than satisfactory, but the lac of direct measures of clinical outcome seriously limits interpreting these results as evidenc of culturally unresponsive treatment. Differences in premature termination rates (define as termination after one session) could merely reflect differences in the way in whic ethnic groups make use of psychotherapy. Asian Americans may tend to use menta health services for very short-term, consultation-oriented, problem-solving help whil there may be a greater tendency on the part of White clients to seek therapy for mor long-term, life-style change purposes.

Without empirical investigations that assess the actual clinical impact of service developed to improve treatment, a serious knowledge gap exists in Asian-American men tal health research. Fairweather, Sanders, and Tornatzky (1974) have described hov research can be used to develop innovative programs as solutions to mental health prob lems. Their approach involves (1) defining the target problem by means of literatur review, feedback from the consumer population, and naturalistic observation; (2 generating different solutions to the problem; (3) experimentally evaluating the adequac of the solution in the community; (4) assessing outcomes over time; (5) selecting th best solution; and (6) implementing this solution. Asian-American mental health researc has developed a sophisticated array of possible approaches that address the problen of unresponsive treatment (Zane, Sue, Castro, & George, 1982). As Fairweather et al (1974) indicate, the next process requires the empirical testing of these solutions. Studie often cited when discussing clinical outcome with respect to Asian Americans have tende to evaluate entire service delivery systems (e.g., Sue & McKinney, 1975) and emplo only single or indirect measures of outcome. What remains to be considered is the

assessment of individual programs within those systems using direct, multiple outcome criteria to obtain a comprehensive evaluation of treatment impact.

The present study utilized this approach in examining the treatment outcomes of Asian and non-Asian Americans. The research evaluated the short-term effects of outpatient individual psychotherapy and used multiple indices of clinical outcome. The focus on short-term outcome was particularly appropriate for examining the clinical experience of Asian Americans. Earlier studies have consistently found that relative to White clients, Asian clients had higher premature termination rates and shorter treatment stays. This suggests that problems are likely to occur in the early stages of treatment for Asian Americans. The study assessed outcome from two different sources. Outcome data were obtained from clients and their respective therapists. To better interpret ethnic effects, client and therapist characteristics (e.g., social class and premorbid adjustment) that often have been confounded with ethnicity were accounted for in a multiple regression design.

Method

Overview

The study focused on possible ethnic variations in short-term treatment outcomes as a result of treatment in outpatient psychotherapy. Only English-proficient Asian-American clients (i.e., those who chose to use English in their treatment sessions) were included in the study. This was done to isolate ethnic effects from the obvious effects of language and to avoid the complex effects introduced by the use of interpreters in therapy for many non-English-speaking clients. Outcomes were assessed from both client and therapist perspectives by administering these measures at either pretreatment or post-first session and readministering these measures immediately after the fourth treatment session. Client-rated outcomes included experiences of specific symptoms (e.g., anxiety) and evaluations of general well-being (e.g., happiness). Therapist-rated outcomes included judgments of the client's symptoms (e.g., depression, adjustment problems) and evaluations of the client's overall level of psychosocial functioning. Client expectations for therapy and the therapist's initial reactions to the client were also assessed to test hypotheses that have been proposed (e.g., Sue & Morishima, 1982; Zane & Sue, 1991) to account for the early termination of Asian-American clients in psychotherapy and their apparent lack of responsiveness to treatment.

Clients

A total of 85 outpatient clients (20 Asian Americans and 65 White Americans) participated in the study. All the clients were receiving individual psychotherapy treatment. The Asian-American sample primarily consisted of Chinese clients with 1 Japanese, 1 Thai, and 2 Filipino clients. All Asian-American clients were bilingual. The majority of the sample (63%) was female, single (55% with 19% married), had completed high school (53%), and had some type of part-time or full-time employment (61%). Clients tended to be young adults with close to three fourths (73%) of the sample being 35 years old or younger. Many of the clients lived with family members or other relatives (63%), but a significant number lived alone (27%). In terms of socioeconomic status, most of the clients were from either middle- (41%) or lower- (31%) class backgrounds, respectively. Most of the clients were not psychotic, but many reported significant emotional problems. One half or more of the sample indicated on 14 of the 30 symptoms assessed by the Symptom Check List that these were "moderately" to "extremely" bothersome

prior to the first session. In addition, over two thirds of the clients reported that they were "not too happy" (73%) and that, in general, life was "not very satisfying" (68%).

Treatment Setting and Personnel

Data were collected from a community-based outpatient clinic serving a mental health district of San Francisco. Approximately one half of the clientele is Asian American, which is representative of the ethnic composition of the district. Only about 30% of the Asian-American clients at the clinic report being proficient in English. Given this distribution, the study sample is quite representative of the English-speaking client population at this clinic. The mental health clinic has developed services specifically for a multicultural, multi-ethnic population of which the majority are Asian Americans. Special efforts are made to make services culturally responsive as evidenced by the employment of bilingual, bicultural staff, use of multilingual materials, and the implementation of extensive outreach efforts. Besides individual therapy, outpatient services include group therapy, couples therapy, and family therapy.

The treatment personnel who provided services included 5 psychologists, 3 psychiatrists, 6 social workers, 13 psychology interns, 3 social work interns, 2 vocational rehabilitation interns, and 2 marriage and family counselor interns. Nineteen were females and 15 were males. Slightly over three fourths (76%) of the therapists were 26 to 35 years old. With respect to ethnicity there were 10 White, 9 Chinese, 2 Filipino, 5 Japanese, 3 Koreans, 1 Vietnamese, 2 Japanese/Chinese, 1 Filipino/White, and 1 Japanese/White American therapists. Most of the therapists (85%) reported using primarily psychodynamically oriented short-term treatment approaches in their work, and the remainder used primarily cognitive-behavioral treatments.

Measures

The treatment questionnaires for both clients and therapists assessed a great deal of information as part of a larger study. Only those instruments relevant to the outcome focus of this study are reported. The measures assessed three domains: (a) demographic characteristics, (b) initial expectations and reactions to therapy, and (c) clinical outcomes.

Demographic variables. Clients were asked for the following demographic information: age, gender, ethnic background, place of birth, primary language spoken, numbers of years in the United States since immigration, living arrangements, residence ownership (i.e., renting or owning residence), highest level of education, employment status, approximate yearly income, and occupation. Occupation was used to determine the general level of the client's socioeconomic status according to Duncan's Socioeconomic Index (Hauser & Featherman, 1977). Using this index, socioeconomic status was categorized into five levels (1 = lower class, 5 = upper class). A number of demographic variables such as income and years living in the United States were not included in the subsequent analyses because each had a large number of missing cases. Therapists provided similar types of demographic information.

Client attitudes toward treatment and therapist. At times, the confirmation of client expectations about what should happen in therapy has been associated with clinical outcome (Dukro, Beal, & George, 1979). It has also been suggested that Asian clients have expectations about therapy and the type of help needed that differ from what is usually provided in the initial stages of therapy (Atkinson et al., 1978; Yuen & Tinsley, 1981). The Client Expectation Questionnaire (CEQ) is a 6-item measure that assesses the type of help clients preferred to receive from therapists (e.g., "expect the person you see to

give advice and suggestions" or "expect to be given any medications and prescriptions"). Clients indicated on a 5-point scale ranging from "yes, definitely" to "definitely not" the strength with which they held these preferences. The CEQ was administered to clients prior to their initial session.

Therapist attitudes toward clients. Therapists' attitudes toward their clients formed early in treatment have been found to be predictive of treatment outcome, particularly in brief or short-term therapy (Ehrlich & Bauer, 1967; Stoler, 1963). The Therapist Evaluation Questionnaire (TEQ) is an 8-item measure that assesses the therapist's initial impressions of the client in terms of interpersonal attraction (e.g., "Is this patient likeable?" "Are you comfortable with this patient?") and capabilities that may facilitate treatment (e.g., "Does this patient understand therapy?" "Do you consider this patient to be insightful?"). Therapists responded to the items on a 6-point scale ranging from "yes, most definitely" to "no, most definitely not" reflecting the degree of agreement with each attitudinal statement. Therapists completed the TEQ after their first session with a client.

Client-rated outcomes. Client ratings of outcome were obtained using the following measures. The Symptom Check List (SCL-30) is a 30-item measure assessing symptoms commonly presented by psychiatric outpatients. Clients rated the amount of distress experienced with respect to specific psychiatric symptoms including somatic problems, anxiety, role performance difficulties, and depression. Clients rated the degree to which each symptom had bothered them during the past week on a 5-point severity scale from "a little bit" to "extremely." The SCL-30 is a revised and shortened version of the SCL-90 developed by Derogatis and his associates (Derogatis, Lipman, & Covi, 1973). The original measure demonstrated good reliability and validity (Derogatis et al., 1973). The SCL-90 and shorter versions of it have been used with various Asian groups (Mollica, Wyshak, & Lavelle, 1987; Yamamoto et al., 1983), and these studies reported adequate internal consistency and concurrent validity for the measures. The SCL-30 was administered to clients at pretreatment and after their fourth sessions. The Client Satisfaction Questionnaire (CSQ) is a 19-item questionnaire that measures the client's satisfaction with service (e.g., "How would you rate the quality of the service you received?" "If you wanted services again, would you come back to the Center?"), the treatment (e.g., "How satisfied are you with the amount of help you received?"), the characteristics of the services ("How convenient is the location of the Center?"), and the mental health personnel (e.g., "How well did your therapist understand your situation and how you felt about it?"). Degree of satisfaction was assessed using a 4-point response format. In addition, clients rated how happy they were and how satisfied they were with their lives on 3-point scales (3 = "Very Happy" or "Very Satisfied," 1 = "Not Happy" or "Not Satisfied"). The two items were summed to obtain a measure of general well-being. Clients completed the CSQ and the general well-being measures after their first and fourth sessions.

Therapist-rated outcomes. Therapists' judgments of their clients' symptomatology and functioning were obtained by the Brief Rating Scale (BRS), a shortened version of the Brief Psychiatric Rating Scale (BPRS) devised by Overall and Gorham (1962). The BRS is a 9-item measure that obtains therapist ratings of the client's general symptoms (e.g., somatic complaints, anxiety or tension, depression, disturbance of thought) and adjustment problems (e.g., interpersonal/marital/social problems, job-related difficulties). Ratings are made on a 7-point severity scale ranging from "not present" to "extremely severe." The measure can be used with a wide range of clients including

those who are severely disturbed. A short interview was conducted to obtain information for the ratings, and was usually completed in 20 minutes. Numerous validation studies using contrasting groups, concurrent measures approaches, cross-cultural comparisons, and factor analysis have supported the reliability, validity, and sensitivity to change of the original BPRS (Hedlund & Vieweg, 1980; Overall & Hollister, 1982). This shortened measure has demonstrated adequate reliability and concurrent validity in an assessment study on Asian-American clients in San Francisco (Wang, 1993). Therapists also evaluated the client's overall level of psychosocial functioning by means of the Global Assessment Scale (GAS). The GAS is a 100-point scale representing a hypothetical continuum from mental illness to mental health (Endicott, Spitzer, Fleiss, & Cohen, 1976). The GAS rating reflects the client's overall level of psychosocial functioning during the past week. The rating is based on face-to-face interviews and relies on behavioral markers as evidence of impairment. The GAS is the most widely used measure of psychosocial adjustment and has demonstrated adequate reliability and validity (Endicott et al., 1976; Sohlberg, 1989). Therapists completed the BRS and GAS after the first and fourth sessions.

Data Reduction

To determine the dimensional structure of each multiple-item measure, a factor analysis of each measure was conducted followed by a varimax rotation to generate orthogonal factors. Each multiple-item measure was administered twice in the study, but the results of the separate factor analyses tended to be invariant across the two time periods. Consequently, only results of the factor analyses for the measures administered at the initial assessment period are presented. Measures subjected to factor analysis included the Client Expectation Questionnaire, the Symptom Check List-30, the Client Satisfaction Questionnaire, the Therapist Evaluation Questionnaire, and the Brief Psychiatric Rating Scale.

Factor analysis of the Client Expectation Questionnaire yielded two factors that accounted for 64% of the total variance. The first CEQ factor accounted for 45% of the total variance and was defined by items involving problem-solving advice and prompt help. The item content (e.g., "expect . . . advice and suggestions to solve problem" and "expect to get immediate or quick help") tended to reflect a preference for an approach directed toward rapid problem resolution. This factor was labeled "Immediate Solutions." The second CEQ factor accounted for 19% of the total variance, and its items involved expectations for medication and regular appointments suggesting a "Medication" factor. Reliability alpha coefficients for the Immediate Solutions and Medication factors were .74 and .65, respectively.

Factor analysis of the SCL-30 resulted in three factors that accounted for 52% of the total variance. The first factor accounted for 35% of the total variance and was defined by such symptoms as sad mood, excessive worry, tension, self-derogation, low energy, and apathy. This factor was labeled "Depression" because the item content reflects many of the cognitive, affective, and somatic symptoms associated with this clinical syndrome. The second factor accounted for 10% of the total variance. Symptoms loading on this factor included panic, trembling, and heart pounding. The item content suggested an "Anxiety" factor. The third factor accounted for 7% of the total variance and was associated with symptoms involving aggressive urges, temper outburts, and frequent arguments. These items appeared to represent a "Hostility" symptom dimension. The three symptom dimensions were internally consistent with alpha reliability coefficients of .92, .85, and .81 for Depression, Anxiety, and Hostility, respectively.

Five factors were extracted from the Client Satisfaction Questionnaire, and they accounted for 67% of the total variance. The first factor accounted for 34% of the variance and was saturated with items referring to the quality of service, overall satisfaction with services, client's decision to return for services or recommend them to a friend, and match of type of service with what the client wanted. The items tended to emphasize the client's general evaluation of services so that this factor was labeled "Service Satisfaction." The second factor accounted for 11% of the variance and included items concerning the client's perceived improvement in her or his problems, amount of help given by the therapist, relevance of help in dealing with the client's problems, and degree to which the client's needs were met. This factor was called "Treatment Satisfaction" given the substantial item content reflecting the extent to which clients felt they had improved as a result of treatment. The third factor accounted for 9% of the variance and was defined by items reflecting attitudes toward the center's staff, particularly the client's therapist. Accordingly, this factor was designated as "Therapist Satisfaction." The fourth factor accounted for 7% of the variance and included items concerning satisfaction with appointment times and the convenience of the center's location. This factor was labeled "Access Satisfaction." The fifth factor accounted for 6% of the variance and was associated with items that referred to the cost of services. This final factor was called "Fee Satisfaction." The alpha coefficients for the Service, Treatment, Therapist, Access, and Fee Satisfaction factors were .85, .84, .64, .70, and .32, respectively. The internal consistency of Fee Satisfaction was low, but it was included in the subsequent analyses because it appeared to assess an important dimension of client satisfaction.

Three factors accounted for 72% of the total variance in the Therapist Evaluation Questionnaire (TEQ). The first TEQ factor explained 42% of the variance and was saturated with items that referred to likability of the patient, comfort with the patient, degree of patient's potential for benefiting from therapy, and therapist's preference for treating this type of patient. The items focused on the interpersonal evaluation of the client so that it was designated as the client's "Likability." The second TEQ factor accounted for 18% of the variance and was defined by items that measured the therapist's appraisal of the client's ability for insight and for understanding therapy. This factor appeared to reflect the therapist's judgment of the client's affinity for brief psychotherapy and was identified as the client's "Therapy Suitability" factor. Alpha coefficients for the Client attraction and suitability factors were .83 and .82, respectively.

Factor analysis of the Brief Rating Scale yielded three factors accounting for 62% of the total variance. The first factor accounted for 31% of the total variance and had defining items such as inappropriate affect and disturbance of thought. These symptoms are ones associated with schizophrenia so that the factor was labeled "Schizotypal Problem." The second factor accounted for 17% of the variance and was defined by affective and somatic symptoms of depression (e.g., disturbance of sleep or appetite). The third factor accounted for 14% of the variance and included items that referred to interpersonal and job problems suggesting an "Adjustment Problem" factor. The internal consistencies of the Schizotypal and Depression factors were adequate (alphas of .70 and .64, respectively), but the internal consistency for adjustment problems was somewhat low (alpha = .46).

Data Analyses

Researchers often have suggested that Asian-American clients enter treatment with attitudes and expectations that differ from White-American clients and that these

differences may account for differential outcomes in treatment (e.g., Leong, 1986; Zane & Sue, 1991). On the other hand, therapists (particularly in cases of ethnic mismatches) may differ in the ways that they initially respond to Asian-American clients compared to White-American clients, and these differences may impact the outcomes of treatment (Sue, Zane, & Young, 1994). A set of regression analyses was conducted to determine if there were ethnic differences in client pretreatment attitudes while controlling for certain demographic variables that covaried with client ethnicity. Similarly, an analogous set of regression analyses was conducted to examine ethnic differences in initial therapist attitudes toward the client.

The primary purpose of this study was to examine if differences occurred in treatment outcomes between Asian- and White-American clients. Moreover, it was important to examine these ethnic effects independent of possible demographic confounds as well as client and therapist attitudinal variables that often have been associated with treatment outcomes. Regression analyses were conducted to determine the effects of client ethnicity on each outcome measure (e.g., client-rated depression, therapist-rated adjustment problem) while controlling for the effects of other demographic characteristics, premorbid adjustment, and the pretreatment attitudes of clients and therapists. For example, to examine ethnic differences in anxiety outcomes, a regression analysis was conducted on client anxiety after the fourth session with client ethnicity, SES, pretreatment client anxiety, client preferences for immediate solutions and medication-type treatment, and therapist attitudes concerning client likability and suitability for therapy as the predictors.

Results

Ethnic Group Comparability

Asian and White client groups were compared on demographic variables including gender, age, marital status, country of origin, years in United States, employment status, type of occupation, years of education, highest degree attained, and SES. Significant ethnic differences occurred with respect to four demographic characteristics. Asian Americans compared to White clients resided in houses versus apartments more frequently (45% and 15%, respectively), $\chi^2(1) = 6.12$, $p < .05$, used English as a first language less frequently (50% and 94%, respectively), $\chi^2(1) = 7.09$, $p < .01$, and originated from foreign countries more frequently (40% and 14%, respectively), $\chi^2(1) = 2.50$, $p < .05$. There was also a tendency for Asians to be lower in socioeconomic status ($M = 2.65$, $SD = 1.14$, and $M = 3.14$, $SD = .95$, respectively), $t(83) = 1.92$, $p < .06$. Socioeconomic status (SES) and residence ownership (i.e., renting or owning residence) were related to pretreatment attitudes (e.g., client expectation for immediate solutions), but only SES was related to any of the treatment outcomes. With respect to demographic characteristics of the clients' therapist, there were no ethnic differences with the exception of therapist ethnicity. All Asian-American clients were seen by Asian Americans (including Asian/Caucasian American) therapists whereas White clients were seen by Asian-American (68%) or White (32%) therapists, $\chi^2(1) = 6.76$, $p < .01$. However, therapist ethnicity was not related to any of the pretreatment attitudes or treatment outcomes. It should be noted that although Asian clients were seen by Asian therapists, the proportion of clients who were actually matched with a therapist from their specific ethnic group (e.g., Chinese client seen by a Chinese therapist) was similar to that for White clients (40% and 32%, respectively). Consequently, degree of client–therapist ethnic match was not confounded with client ethnicity.

Based on the previous analyses, client SES and residence ownership were included as control variables in the subsequent regression analyses on client pretreatment attitudes and on the initial attitudes of therapists toward their clients. The regression analyses on treatment outcomes included client SES as the only demographic control variable.

Ethnic Differences in Client and Therapist Attitudes

Regression analyses were used to determine if Asian- and White-American clients differed in pretreatment attitudes toward therapy, namely, the extent to which they expected therapy to focus on (a) immediate solutions and problem solving or (b) medication-oriented treatment. Demographic controls included SES and residential ownership. No ethnic effects were found for either one of the client attitudes toward treatment. The beta weights indicated that the lower the client's socioeconomic status was the more the client expected therapy to involve immediate solutions (beta = $-.47$, $p < .001$) and medication-oriented treatment (beta = $-.38$, $p < .001$).

With respect to initial therapist attitudes toward the client, no client ethnicity or SES effects were found on the extent to which therapists liked their client following the first session ($ps > .65$). However, both ethnic and SES effects were found on the extent to which therapists considered clients suitable for therapy after one session. Asian clients were considered to be less suitable for therapy than White clients (beta = $-.23$, $p < .05$), whereas higher SES clients were considered more suitable for therapy than lower SES clients (beta = .40, $p < .001$).

Client-Rated Outcome

Clients judged their outcomes in treatment in terms of anxiety, depression, and feelings of hostility. Table 1 shows summaries of the multiple regression results for each client-rated outcome. Significant beta weights for client ethnicity were found for depression and hostility, and the client ethnicity effect approached significance for anxiety ($p = .06$). Specifically, Asian-American clients reported feeling more depressed, more hostile, and more anxious after four sessions of treatment than White-American clients. These results indicate that even after controlling for socioeconomic status, pretreatment attitudes on the part of clients and their therapists, and pretreatment level of severity, Asian Americans experienced more clinical symptomatology than White clients after short-term outpatient treatment. Other effects on client symptomatology included SES, pretreatment outcome, and client expectations for immediate solutions in therapy. In general, worse outcomes were associated with lower SES, more severe symptoms at pretreatment, and greater expectations for immediate solutions at the beginning of treatment. There were no ethnic differences in treatment outcome associated with client perceptions of general well-being.

Clients also evaluated the treatment experience in terms of their satisfaction with various aspects of service received. As indicated in Table 2, Asian-American clients were less satisfied with progress in treatment, their therapists, the overall service received, access to services, and the fee charged than White-American clients. In other words, Asian-American clients were less satisfied with all aspects of their treatment experience compared to their White-American counterparts. Client ethnicity appeared to be the most important predictor of client satisfaction because most of the other predictors showed no significant effects on any of the satisfaction indices.

Table 1
Beta Weights of Predictors of Client Symptomatology and General Well-Being

Outcome predictors	Depression	Anxiety	Hostility	General well-being
Ethnicity[a]	.20*	.15	.44***	.04
Socioeconomic status	−.23*	−.42***	−.36***	−.05
Pretreatment outcome	.58***	.58***	.50***	.52***
Client expectations for Immediate solution	−.38***	−.35***	−.22*	.12
Medication	.24*	.15	.23*	−.10
Therapist rating of Client's likability	−.26**	−.15	−.27**	.12
Therapy suitability	.07	.02	.12	−.27*
Adjusted R^2	.60***	.68***	.58***	.36***

[a] 0 = White, 1 = Asian.
*$p < .05$; **$p < .01$; ***$p < .001$.

Table 2
Beta Weights of Predictors of Client Satisfaction Indices

Outcome predictors	Client satisfaction with Treatment	Therapist	Service	Access	Fee
Ethnicity[a]	−.29*	−.29*	−.40**	−.36**	−.36**
Socioeconomic status	.09	.04	.11	−.07	.11
Client expectations for Immediate solution	.28	.27	.25	.33*	.28
Medication	−.07	−.26	−.12	−.26	−.27
Therapist rating of Client's likability	.22	.25	.12	.02	−.02
Therapy suitability	.11	.00	.20	−.17	.14
Adjusted R^2	.08	.09	.15*	.18**	12*

[a] 0 = White, 1 = Asian.
*$p < .05$; **$p < .01$; ***$p < .001$.

Therapist-Rated Outcome

Table 3 presents a summary of the regression analysis for each treatment outcome as evaluated by the therapists. As expected, SES and pretreatment outcome were significantly related to the various outcomes. In general, lower SES and more severe pretreatment problems were associated with worse outcome. No client ethnicity effects were found on the therapist-rated outcomes, but the ethnic effect approached significance with respect to the client's level of psychosocial functioning ($p = .10$). By the end of the fourth session, therapists tended to evaluate Asian-American clients as functioning less well than White-American clients.

Discussion

This study was the first to examine extensively the treatment outcomes of Asian-American clients in mental health treatment. The research evaluated the short-term effects of outpatient individual psychotherapy provided from a community-based

Table 3
Beta Weights of Predictors of Therapist-Rated Treatment Outcomes

Outcome predictors	Intrapsychic distress	Schizotypal	Interpersonal adjustment	Overall functioning[b]
Ethnicity[a]	.02	.02	−.05	−.14
Socioeconomic status	−.08	−.25*	−.25*	.46***
Pretreatment outcome	.51***	.45***	.62***	.50***
Client expectations for				
Immediate solution	−.01	.02	−.17	.32**
Medication	.13	.08	.09	.00
Therapist rating of				
Client's likability	−.18	−.08	−.17	.29***
Therapy suitability	−.02	−.20	−.07	.04
Adjusted R^2	.29***	.55***	.47***	.64***

[a]0 = White, 1 = Asian.
[b]Global Assessment Scale scores.
*$p < .05$; **$p < .01$; ***$p < .001$.

treatment setting. The investigation focused on short-term outcome because previous utilization studies have consistently found higher premature termination rates and shorter treatment stays for Asian clients relative to White clients (e.g., Sue, 1977). Results indicated poorer short-term treatment outcomes for Asian-American clients. Asian clients were less satisfied than White clients on all five satisfaction indices and reported greater depression, hostility, and anxiety after four sessions of treatment. Also, there was a tendency for therapists to evaluate Asian clients as functioning less well than White clients. In other words, even after controlling for differences in pretreatment severity, social class, and the initial attitudes of clients and their therapists, Asian-American clients experienced worse outcomes than their White-American counterparts. These results tend to corroborate previous research which had suggested that Asian clients were faring less well in treatment than White clients (e.g., Sue & McKinney, 1975). Most of the earlier studies relied on indirect, utilization-based measures of outcome (e.g., premature termination) and/or single, global outcome measures (e.g., the Global Assessment Scale) whereas the current study directly assessed a variety of treatment outcomes from multiple perspectives.

From a psychodynamic perspective, reports of greater depression, hostility, and anxiety may be seen as evidence of effectiveness given the psychodynamic emphasis on the expression and release of emotion during the early phases of treatment. However, this explanation tends to reflect the traditional, long-term, dynamic treatment approach to psychotherapy. As indicated earlier, the clinic's therapists practiced brief, psychodynamic therapy. Therapies with a brief dynamic orientation have tended to focus on specific problems and do have symptom reduction as a primary treatment goal (Crits-Christoph, 1992). Moreover, this explanation fails to account for other findings in the study. First, Asians were less satisfied with *all* aspects of their mental health service experience. Second, even therapists tended to judge Asians as functioning less well in their lives. Third, the psychodynamic explanation would suggest that treatment is *more* effective for Asians than Whites, and this finding would be the opposite of what has been previously found in Asian-American mental health research. Finally, the explanation is inconsistent with the attitudinal results. Asian clients were seen as less suitable

for therapy than White clients. Previous research (e.g., Ehrlich & Bauer, 1967) has suggested that this ethnic difference would result in worse, not better, outcomes for Asians. It appears that an outcome-based interpretation is a more plausible and parsimonious explanation of the pattern of results found in this study.

There was a clear discrepancy between clients and therapists in their assessments of outcome. Ethnic differences occurred when clients evaluated their treatment experiences, but these differrences were not found when therapists judged outcomes, with the possible exception of one measure assessing global psychosocial functioning. The lack of convergence among different sources of outcome evaluation has been a continuing controversy in treatment outcomes research (Cartwright, Kirtner, & Fiske, 1963; Garfield, Prager, & Bergin, 1971; Harty & Horowitz, 1976) and raises the issue of which source may be more valid as an indicator of outcome. In their review of assessment research on psychotherapy outcomes, Lambert and Hill (1994) conclude that therapist-based data have tended to produce larger effect sizes than client self-report data. It is possible that the tendency for therapists to judge clients as improved may have obscured the ethnic differences in outcome. However, rather than argue that one source of data is more valid than another, it is more useful to consider these different sources as reflecting different value orientations and motivations. Strupp and Hadley (1977) have noted that both clients' and therapists' evaluations are legitimate because each represents a valid judgment of functioning but from differing frames of reference. From this perspective, the results strongly suggest that Asian-American clients are *experiencing* treatment as less successful and effective than are White-American clients. The treatment experiences of ethnic minority clients are important to consider, especially as mental health places increasing value on providing effective and culturally responsive care for all people who seek service.

The hypothesis that Asian clients differ from White clients in their expectations about therapy was not supported. There was some evidence, however, that the initial attitudes of therapists toward Asian clients and toward White clients may differ. Therapists tended to see the former as less suitable for therapy. When these effects of client pretreatment attitudes and the initial attitudes of therapists were controlled, ethnic differences in outcome still persisted. The findings suggest that certain processes, occurring in the early stages of treatment itself, contribute to worse outcomes for Asian-American clients. Previously, the need for culturally responsive interventions has been argued on consumer rights and ethical grounds. The study's results strongly suggest that there is a clear need for culturally responsive interventions because Asian-American clients are experiencing worse outcomes, and these outcomes cannot be attributed to cultural differences between Asian and White clients that exist prior to treatment.

A number of possible events may be occurring in therapy that may account for this ethnic difference in outcome. For example, Chang (1985) has observed that cultures differ in the "language of emotion," the modes and patterns of communication that are used to convey emotions, particularly caring and affection. She notes that people from East Asian cultures tend to rely less on direct, verbal expressions of love and caring but, instead, use gestures (involving the offering of goods or services to meet another person's material needs) and metaphors to convey affection and friendship. It is possible that cultural differences in this language of emotion can adversely affect rapport and/or the development of the working alliance (Kokotovic & Tracey, 1990) in the initial stages of therapy. Sue and Zane (1987) have hypothesized that the critical process is credibility and that cultural differences in three aspects of therapy, problem

conceptualization, preferred means for solving the problems, and treatment goals, contribute to credibility issues between ethnic minority clients and their therapists. On the other hand, Zane (1992) has noted that certain types of interpersonal dynamics may be more salient in one culture than in another. In other words, cultures often differ in the extent to which certain interpersonal dynamics such as autonomy, dependence, loss of face, etc., govern or affect social interactions. He suggests that loss of face (defined as the threat or loss of one's social integrity) may be a key and dominant interpersonal dynamic in Asian social relations (Sue & Morishima, 1982), particularly when the relationship involves help-seeking issues or focuses on stigmatized problems such as mental health disorders (Shon & Ja, 1982). In these contexts, face issues may be especially salient to Asian-American clients but these issues may be overlooked by therapists whose training has seldom focused on such interpersonal dynamics. These and other explanatory models may help stimulate what promises to be new and exciting mental health research on cultural diversity.

Most of the Asian-American clients in the study were Chinese and moderately acculturated (mostly second generation), and all were English speaking. In view of the great heterogeneity among Asian-American populations, it is important that the study be replicated with other Asian-American client groups that utilize various types of mental health services. However, it should be noted that the acculturation level and English proficiency of the sample may have created a conservative test of cultural influences. With a less-acculturated sample whose primary language was not English (which is the more typical case for Asian mental health clients), cultural differences between therapists and clients would have been more marked, and this very likely could have resulted in greater ethnic disparities in treatment outcomes. The study also had other limitations. Therapists could not be randomly assigned or fully crossed with Asian and White clients so that not every individual therapist effect was controlled. However, for therapists who did treat both Asian and White clients, no systematic therapist effects were found on treatment outcome. Although treatment outcomes were assessed from client and therapist perspectives, both of these sources were directly involved with treatment. The use of nonparticipant observer ratings would have provided data independent of any social demands emanating from the treatment experience. Finally, the findings only pertain to the initial, short-term effects of treatment. It is unclear if this ethnic difference in outcomes persists or weakens over the course of therapy.

This study can be viewed as one of the first steps in the development of empirically based evaluation of mental health treatment for Asian Americans. Until subsequent evaluations assess the robust nature of these findings, they must be considered to be applicable only to the specific treatment context and population examined. Nevertheless, the results underscore the need for more outcome-oriented research to design and evaluate various treatment models systematically that may be effective approaches to the mental health problems of Asian Americans. Initially, it would be highly informative to conduct treatment outcome studies that evaluate interventions which have been designed to treat a variety of ethnic minority populations such as those developed by Paul Pedersen (1985) and Derald and David Sue (1990). Without this emphasis on accountability, Asian-American mental health will continue to be mired in an endless discourse of what could be culturally responsive treatment rather than in the actual development of culturally competent mental health care for Asian Americans.

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