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Psychotherapy Presenting Concerns and Utilization Trends
Among Latino-American and International Latino
Students in a University Counseling Center

Jessica Ann Kirchhoefer

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

Psychotherapy Presenting Concerns and Utilization Trends Among Latino-American and International Latino Students in a University Counseling Center

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Doctor of Philosophy

This study examines current trends of university counseling center utilization among Latino students at a large, private, western university. We examined counseling center data for Latino (n=1,231) and European American (EA) (n=18,125) students who presented for counseling services from 1996-2013. Latino students were divided into three subgroups, U.S. born Latino students (USB), international Latino students (IB), and Latino students who were born internationally but who are now U.S. citizens (IBUS). These three subgroups were compared with the EA student group on multiple variables; therapy utilization, length of treatment, Outcome Questionnaire (OQ) score at intake, OQ change, therapy usage by gender, and intake responses to the Family Concerns Survey and Presenting Problems Checklist. IB students presented for treatment with significantly higher levels of distress than any other group. EA students were more likely to attend therapy than any Latino subgroup. EA students also did not endorse any familial concerns or presenting problems at higher rates than any Latino subgroup. Further research is needed to understand why Latino subgroups are experiencing more distress and attend less treatment than EA counterparts and to look more in depth at resources for IB students, who appear to be the most at-risk Latino subgroup.

Keywords: Latino, counseling center, international student

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DESCRIPTION OF DISSERTATION

This dissertation, *Psychotherapy Presenting Concerns and Utilization Trends Among Latino-American and International Latino Students in a University Counseling Center*, is written in a hybrid format and is a journal-ready manuscript. The preliminary pages of this dissertation reflect the requirements for submission from Brigham Young University. The thesis report is presented as a journal article, and conforms to length and style requirements for submitting research reports to academic research journals. The literature review is included in Appendix A. The list of tables includes statistical information regarding the results of this study. This dissertation format contains two reference lists. The first reference list contains references included in the journal-ready article. The second list includes all citations used in Appendix A entitled “Review of the Literature.”

Introduction

Every year, millions of young adults in the U.S. seek higher education through full time attendance in a college or university setting (National Center for Education Statistics, 2013b). The number of students who seek higher education has increased in recent years, as half of the young adult population is enrolled in some type of college or university (Snyder & Dillow, 2012). With the increase of students attending college, the demand for accessible mental health services has also grown. Nine percent of college students utilize college counseling centers, a number that has remained steady since 2004 (Gallagher, 2005; Kim, Park, La, Chang, & Zane, 2015).

Over the last few years, the severity of presenting concerns for college counseling center clients has increased significantly (Watkins, Hunt, & Eisenberg, 2012). Concerns of depression and anxiety are on the rise in counseling centers along with complaints of more serious mental health issues (Benton, Robertson, Tseng, Newton, & Benton, 2003). In 2000, 77% of college counseling centers cited serious mental health issues as major concern (Gallagher, Gill, & Sysco, 2000). One possible reason for this surge is that today, students who previously would not have been able to attend college can now do so because they have access to mental health resources and medication (Watkins et al., 2012).

Demand for services at college counseling centers is escalating as more clients seek help and the severity of their psychological issues also increase. Recognizing the increase in demand for services, most colleges and universities have worked to find resources to allow counseling centers to expand to meet these needs. As a result of these expansions, students have better access to care and the mental health stigma on campus decreases (Watkins et al., 2012). Other benefits from students taking advantage of counseling center resources include a decrease in

psychological distress (Minami et al., 2009), an increase in positive academic outcomes (Choi, Buskey, & Johnson, 2010), and a lower likelihood of dropping out of school (Wilson, Mason, & Ewing, 1997).

While counseling centers have expanded their services and are reaching more students with mental health needs than ever before, minority and specifically Latino students and their unique needs have historically been overlooked (Kearney, Draper, & Baron, 2005). A lack of awareness of multicultural issues can lead minorities to utilize counseling services at lower levels, resulting in more severe and unregulated emotional and academic issues (Choi et al., 2010; Minami et al., 2009). Today, there are more ethnic minorities attending higher education than at any previous time (National Center for Education Statistics, 2013a). We can predict that as more minority students continue to attend college, more minority students will also attend college counseling centers, making it increasingly important for counselors to give more attention to unique minority student needs.

Despite the increasing number of minority students attending post-secondary education, racial and ethnic minority students typically utilize mental health services at lower rates than their EA counterparts both in community and university samples (Alegria et al., 2002; McMiller & Weisz, 1996; Ramos-Sanchez, 2015; Sullivan, Ramos-Sanchez, & McIver, 2007). Some factors that may contribute to lower levels of minority utilization include institutional barriers, acculturation, lack of culturally appropriate treatment methods, fears of stigma, ethnic composition of counseling staff, and preference for keeping personal information within the family unit (Hayes et al., 2011; Sullivan et al., 2007).

Although minority groups utilize counseling services less, to really understand the barriers to and patterns within mental health treatment it is imperative to look at each ethnic/racial minority individually. For the purposes of this project we will focus on Latinos.

In the United States, Latinos are one of the fastest growing minority groups. The U.S. Department of Health and Human Services (2001) has predicted that by the year 2050 Latinos will account for 25% of the total population. While Latinos have typically been underrepresented on college campuses, the number of Latinos in universities has recently grown and is expected to continue to increase (Gonzalez, 2015).

Most research on Latino utilization of mental health services has shown lower Latino utilization rates than EA counterparts even when a need and/or desire for services is present (Alegria et al., 2002; Alegria et al., 2007). Community sample research shows that barriers such as a low number of bilingual clinicians, value conflicts, limited access to care, and lower recognition of mental health problems dissuade Latino individuals from attending therapy (Alegria et al., 2002; Alegria et al., 2007). With lower levels of psychotherapy utilization, Latino college students drop out at rates 10% greater than their EA counterparts (Atkinson, Casas, & Abreu, 1992; Sue, 1977) and have the lowest session attendance of any minority (Kim, et al., 2015).

Emotional and academic stressors that go untreated due to lower levels of counseling service utilization could possibly be one of the reasons why Latinos are currently the least educated ethnic group in the US (Constantine, Gloria, & Baron, 2006; Gandara, 1995; Gloria & Rodriguez, 2000; Reyes, 2012). In addition, Latinos are more likely to drop out during their first two years of college (Constantine et al., 2006; Reyes, 2012), resulting in only 9.6% of all Latinos obtaining degrees (Constantine et al., 2006; Gloria & Rodríguez, 2000; Jimenez, 2012; Reyes,

2012). While all students see barriers in adjusting to college, minority students see greater negative experiences and are affected more adversely than their EA counterparts, even when minority students are the majority of a student body (Aguirre & Martinez, 1993; Gloria & Rodriguez, 2000; Lopez, 2005; Rodriguez, 1995; Smith, Chesin, & Jeglic, 2014). U.S. born Latinos experience a number of stressors including gender role conflicts, academic struggles, racism, discrimination, acculturation, poverty, and isolation (Duarte, 2003; Romero, 2009; Sue & Chu, 2003).

International Latino students face the same challenges as U.S. born Latinos when coming to the United States for college. However, because of the unique situation of international study, college attendance also encompasses additional obstacles such as language barriers, immigration documentation, guilt about being away from family, homesickness, learning a new culture, conflicts with identity or culture norms, and financial and academic concerns (Arredondo, 1991; Atkinson, Casas, & Abreu, 1992; Romero, 2009; Sue & Chu, 2003; Wilton & Constantine, 2003). In the 2013-2014 academic year 6.9% or 61,439 of all international students came from Latin American countries to study in U.S. schools (Institute of International Education, 2014). With the growing number of Latino international students (Institute of International Education, 2014) and the emotional and academic stressors felt by this group while attending school, it seems vital for counseling centers to expand their services to better assist this population.

First-generation, Latino, U.S. citizens who reside with parents or family that migrated to the US during the student's lifetime, face additional barriers that are encountered when enrolled and even before enrollment in a post-secondary institution. Some of these include secondary school and university employees' lack of knowledge of college financial assistance programs specifically for Latinos, educational gaps that occurred during primary education, and guardians

who are unaware of post-secondary education opportunities (Bohon, Macpherson, & Atilas, 2005; Ruiz-del-Velasco & Fix, 2000). These barriers play a role in hindering students from attending college as well as adding greater financial and academic concerns once there.

One of difficulty providing the best counseling services to Latino students is that the diversity within the Latino population has historically been ignored. Even though the presenting concerns and barriers faced by Latino and international Latino students differ, the general trend in the current literature is to lump these two groups together. When this is done we lose vital information that could help in understanding utilization trends and roadblocks to Latinos seeking mental health services; as possible predictive themes like acculturation, gender roles, expectations of therapy, and background differ between these groups. Sue (1998) notes that dynamic sizing, the idea of “knowing when to generalize and be inclusive and when to individualize and be exclusive,” (p. 446) is an essential element in cultural competency, emphasizing the importance of within-group differences. Treating diverse Latino student subgroups as one limits the information about differences between international Latino students (IB) and U.S. born Latino students (USB), and potentially leaves out valuable information of a third group; Latino students who were born internationally but who have obtained U.S. citizenship (IBUS). While there is scant information on this third group, we can assume that college stressors differ somewhat from the other two subgroups that may play a role in counseling utilization. As far as we know, no research has taken these three subgroups (IB, USB, and IBUS) and compared their counseling center usage side by side. If we are to better understand the differences and similarities among these subgroups in their college counseling center attendance, they need to be directly compared. Doing so will provide information that

will potentially help counseling centers know how to best provide services and reach out to each of these unique subgroups and better address the needs of the individuals within them.

We see that minorities and that community samples of Latinos show higher rates of early termination in therapy (Alegria et al., 2007; Sullivan et al., 2007). But, understanding how early termination rates and utilization trends differ among Latino students and IB, USB, and IBUS subgroups would likely improve treatment for these subgroups in college counseling centers. Additionally, looking at these issues in comparison to a EA student sample will assist clinicians in better understanding the differences of Latino students' experience in presenting for and utilizing counseling services. We decided to compare IB, USB, and IBUS to EA students because EA students made up the majority population of students at the university from which we obtained our data.

While differences between subgroups has not been addressed in the current literature, there is some research looking at differences among psychotherapy usage by gender among Latinos. But the findings in the existing research are inconsistent. Some research states that women receive services more often than men (Chiang, Hunter, & Yeh, 2004; Shibazaki, 1999), while others say that, regardless of gender, services are underutilized (Duarte, 2003; McMiller & Weisz, 1996; Sanchez & King, 1986). Still other research has been inconclusive, finding no differences in gender use but citing reasoning and evidence that may suggest that there are gender differences that need further research to uncover (Sullivan et al., 2007). Looking at differences among male and female Latino clients in this current study may help to clarify the current dissonance in the literature.

Statement of the Problem

Institutions of higher education across the United States are seeing an increase in Latino students attending their institutions. However, many Latino students are unable to complete school through graduation. Research has shown that university counseling center utilization is associated with a decrease in early college dropout. It therefore seems reasonable to conclude that Latinos' high dropout rates may be ameliorated by improving their historically low counseling center utilization rates. There is currently a dearth of literature examining Latinos' lower levels of utilization of counseling services even though they tend to experience more stressors than their EA counterparts.

To date, no research has been conducted that looks at lower levels of utilization and other counseling trends by comparing subgroups such as IB, USB, and IBUS students. Without such research, it is difficult to understand the reasons why these trends are occurring, how trends and experiences differ among subgroups, and what measures can be taken to increase accessibility to Latino college students. The goal of the current research is to help provide an understanding of the reasons for lower counseling center usage and other utilization trends in order to establish a starting place for figuring out how to best provide counseling services to Latino college students who need them.

Statement of Purpose

The purpose of this research is to better understand intake information, attrition, distress level, and usage patterns that occur in a university counseling center among IB, USB, and IBUS subgroups in comparison to EA counterparts.

Research Questions

This study will address the following research questions:

1. What percentage of IB and USB Latino students have sought counseling services in the sample period compared to the percentage of EA students?
2. What are the differences among Latino and EA students in counseling attendance in terms of number of sessions attended and treatment duration while accounting for age, gender, and initial OQ-45 score?
3. What are the differences among IB, USB, IBUS, and EA students in terms of self-report on the Family Concerns Survey?
4. What are the differences among IB, USB, IBUS, and EA students in terms of level of distress and duration of presenting problems as measured by the Presenting Problems Checklist?
5. What are the differences among intake distress level as well as changes between intake and termination distress level in terms of OQ-45 scores among IB, USB, IBUS, and EA students while accounting for number of sessions attended?
6. Are there gender differences among Latino students within the counseling center in terms of presenting for treatment and number of sessions attended?

Method

Following is a discussion of the participants, setting, instruments, procedure, research design, research limitations, and the statistical analyses that will be employed for this study.

Given the archival nature of the data collected through this university counseling center, we used the informed consent forms signed by the clients upon intake which indicated their willingness to engage in future research that examined their responses to intake information, outcome data, and

treatment utilization. Approval for this informed consent was provided by this university's Institutional Review Board (IRB) to ensure ethical practices.

Participants

Participants for this study came from a predominantly EA, private, religious university counseling center in the west. The data came from information gathered upon intake at the university counseling center as well as assessments taken throughout the course of treatment. Only data from clients who signed the informed consent form were included. This data came from the years 1996 to 2013. The demographic information included variables such as gender, age, marital status, year in school, U.S. citizenship status, country of origin, and religious affiliation

In this study two large groups of participants were included, those of Latino ethnicity and those of EA ethnicity. To be included in the Latino group a student's country of birth or citizenship records needed to be from a country considered to be Latino (Argentina, Bolivia, Brazil, Chile, Columbia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Spain, Uruguay, or Venezuela). A professor of Latino history at this university reviewed the list and confirmed that it was comprehensive and that the aforementioned countries are considered Latino (I. Garcia, personal communication, January 21, 2016). Additionally, the client must have endorsed either Hispanic or Latino as their primary ethnicity on their intake demographic assessment. All participants from the Latino student sample were then placed in a subgroup based on the criteria listed below.

U.S. Born Latino Students (USB). Clients who endorsed U.S. citizenship and the United States as their country of birth as well as Latino ethnicity were placed in the U.S. born Latino student category.

International Latino Students (IB). Clients who endorsed being a non-U.S. citizen, international student status, and a Latino country of birth were placed in the Latino international student subgroup.

Internationally Born U.S. Citizen Latino Students (IBUS). Clients who endorsed U.S. citizenship and a different country of birth were placed in the internationally born, U.S. citizen, Latino student subgroup.

We examined the gathered information to look at differences among these three subgroups.

As a comparison group, we gathered a sample of EA students to represent the general population of this predominantly EA, private, religious university.

European American Students (EA). Clients who endorsed European American as their race on their intake demographic assessment were placed in the EA student subgroup.

Setting

The data collected for this survey came from the years 1996 to 2013 from one university counseling center. The university is a large, private, religiously-affiliated institution in the western United States. This counseling center is funded by the university and offers services such as biofeedback and individual, couples, and group psychotherapy at no cost to full-time students. When students come to the counseling center for individual therapy services, they are assigned to the first available psychologist, intern, or doctoral student unless severity levels at intake are significant, in which case they are assigned a staff psychologist or experienced intern or student. Additionally, students can be referred to biofeedback services or one of over 20 psychotherapy groups (ranging from psycho-educational to process-oriented) held each semester.

Instruments

A variety of instruments were included in this study: three that gathered intake data and a distress level measure that was administered prior to each counseling session. These are the same measures that were utilized by Allen et al. (2016) in their study of Polynesian American college students' counseling utilization.

Demographic Questionnaire (DQ). This measure gathers general demographic information such as gender, age, ethnicity, and citizenship. It also collects data on experiences and attendance in previous counseling.

Family Concerns Survey (FCS). The Family Concerns Survey is designed to assess the prevalence of traumatic family history events in the student's past that may be contributing to current mental health concerns (Kearney et al., 2005). Students are asked to indicate whether certain events happened in their family prior to adulthood, and they are given the following instructions: "Below is a list of experiences which may occur in families. Read each experience carefully. Some of these may have been true at one point in your life but not true at another point. Think about your childhood and your adolescence. If the experiences never happened in your family, please fill in the bubble mark for 'No.' If you are unsure whether or not the experience occurred in your family at some time, please fill in the middle bubble mark for "Unsure." If the experience happened in your family during either of these periods, either during your childhood or adolescence, please fill in the bubble for 'Yes.'"

The list of 18 family experiences includes possible traumatic events such as parental divorce or permanent separation, death of a parent, parents with drinking/drug problems, physical or sexual abuse, rape/sexual assault, attempted or completed suicide by family members, and family members with criminal activity. There are no subscales in the 18-item

assessment, and it is ranked on a 0-2 scale (0=no, 1=unsure, 2=yes). For this measurement, there is no reliability or validity data available.

The Presenting Problems Checklist (PPC). This measure was developed by the University of Texas at Austin Counseling and Mental Health Center (Draper, Jennings, & Baron, 2003) and assesses the degree to which students experience distress in several areas of life functioning. This checklist is used by the university counseling center to assess the presenting concerns of students upon intake. Items are a list of various problems and clients respond to each item twice, once using the stem, “Indicate the extent to which the problem is currently causing you distress” and another time using the stem, “For how long have you had the problem.” A Likert scale of 0 (representing “none”) to 4 (representing “extreme”) was employed for the first stem, and a Likert scale of 1 (representing “Less than a week”) to 6 (representing “More than 3 years”) was employed for the second stem.

Items in the instrument measure a variety of topics such as academic stress, college life adjustment, and emotional distress (Draper et al., 2003). Clinicians receive this information for each item along both dimensions mentioned in the instructions. The total scale shows a Cronbach alpha of .90 (Draper et al., 2003).

The Outcome Questionnaire-45 (OQ-45). The OQ-45 is a self-report measure designed to provide a global assessment of client distress (Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994). The 45 items are rated on a five-point Likert scale from “never” to “almost always.” For example, item four reads, “I feel stressed at work/school,” to which students respond on the given Likert scale. Questions range from current functioning of relationships to suicidal ideation. Higher scores indicate greater levels of distress. Typically, a score above 63 represents a clinical population (Kadera, Lambert, & Andrews, 1996). The

standard deviation for this measure is 15 points, and 14-point increases or decreases indicate a reliable change. Prior research indicates that the OQ-45 has excellent internal reliability (alpha at .93), test-retest reliability (.84), concurrent validity with other instruments, and sensitivity to change ($r = .58$ to $.84$; Kadera et al., 1996; Lambert & Finch, 1999).

Procedure

Clients of the university counseling center signed consent forms and completed demographic, intake, and distress level surveys and measurements before receiving any services in the center. The information from these tools was depersonalized to protect the identities of the students. Students who provided information that did not meet inclusion criteria were not included in the study.

We then used a series of statistical analyses to find the answers to the research questions listed above (see statistical analysis below). From the results of these analyses we are able to see how utilization and intake trends differ between the two main groups of Latino and EA students as well as the IB, USB, and IBUS subgroups.

Research Design

A quantitative design was chosen for this study as the data utilized was archival and numerical in nature and would allow a basic knowledge basis for the differences among the groups and subgroups being studied. This method is appropriate for this study as it allows for recognition as to where these groups are similar in the areas being studied and where they differ. This was done in order to provide a base to know where future research would be needed. It additionally provides needed information to understand what subgroups are at the highest risk for underutilizing services, why this is the case, and what can be done to better understand Latino students' experience in utilizing and presenting for counseling services.

Statistical Analysis

In order to determine if there were discrepancies or lower levels of counseling service utilization between Latino subgroups and EA students, we ran an odds ratio formula for each year data was collected to find the likelihood of each group attending therapy. We did this by comparing the proportion of students of each respective subgroup who attended therapy to the total number of students attending the university in each subgroup. These results were then aggregated which then indicated if there was a significant difference between the usage of these two groups. For this question, we ran analyses solely among EA, IB, and USB groups. The IBUS group was combined with the USB group, as the information required (country of birth and citizenship documentation) to separate the IBUS group out was unavailable for the total university sample from the 17-year period.

To understand if there were differences present among Latino and EA students concerning number of sessions attended and days enrolled in treatment, survival curves with Cox Regression were utilized to compare utilization across the subgroups. This was chosen to account for differences among subgroups while avoiding the weight of present outliers in the variable of number of sessions attended.

A Kruskal-Wallis one-way analysis of variance was employed to see the differences at intake among IB, USB, IBUS and EA student groups in terms of the distress levels and duration of endorsed presenting problems. This non-parametric measure allows for analysis of the individual ordinal data variables on the two PPC Likert scales across multiple groups. This research question poses the issue of a higher probability of making a type one error due to running multiple statistical tests on the dataset. This was accounted for by utilizing the statistical Bonferroni correction as well as Cohen's *d* to look at the effect sizes.

A chi square test of independence was used to determine if IB, USB, IBUS, and EA student groups responded significantly differently in terms of the items on which they responded “YES” on the Family Concerns Survey.

We evaluated gender differences among the whole Latino sample in terms of the number of sessions attended and the frequency of presenting for treatment. The sample was not divided into subgroups for this question as the sample sizes were too small to provide accurate statistical analyses. An independent samples t-test was utilized to find gender differences among number of sessions attended as well as a Mann-Whitney U to account for extreme outliers. A Z-test was also utilized to find if there were gender differences in presenting for treatment.

We employed a one-way analysis of variance and a one-way analysis of covariance to examine whether there were differences in distress levels at intake among IB, USB, IBUS, and EA groups while accounting for age, gender, and number of sessions attended. The resulting p values allowed us to know if there were statistically significant differences among subgroups in the level of distress experienced at intake that may have contributed to the students presenting for services.

The last test that was used was a split plot analysis of covariance. This was employed to look at whether the four groups differ in their changes in distress levels over the course of treatment. The test allowed us to compare students’ OQ-45 scores at intake to their OQ-45 scores at their last session. This test also controlled for the effect of the number of sessions attended, age, gender, and initial OQ-45 score which could have impacted results. These changes over treatment were then compared across subgroups to see if the p value showed statistically significant differences among OQ change for the four groups being studied.

Results

Data for these analyses were gathered from a university counseling center over a 17-year period. Clients provided this information as well as consent to use information gathered throughout the time they received counseling center services. We compared the counseling center data from four different subgroups (USB, IB, IBUS, and EA) to see how their therapy experiences differ.

Treatment Utilization

Presenting for treatment. We utilized Odds Ratio analyses to assess the likelihood that IB, USB, and EA students would attend therapy. We excluded IBUS students from this question as the data needed for this subgroup (birthplace data) was not available for the general university sample, and it was not possible to separate members of this group from the USB group without that information. For this question, we included IBUS student data in the USB group. We performed an Odds Ratio for each year data was collected for each subgroup as well as the total 17-year period (see Table 1). We did this by comparing the proportion of students from each of the aforementioned groups (EA, USB, and IB) who attended therapy to the proportion of the total number of students from each of these groups attending this university. Overall, during the time period of the collected data there was an average of roughly 28,800 students on campus on any given year. Of that, roughly 1,300 were of Latino heritage. Of those 1,300 Latino students about 73 began to attend therapy each year. On average, every year there were 46 USB students, 22 IB students, and 4 IBUS students (who were added to the USB group) who began to attend counseling.

The odds ratio for the overall sample of Latino and EA students attending counseling services had a coefficient of 1.52 with a 95% confidence interval (1.44, 1.61). This shows that

EA students were 50% more likely to attend counseling services than Latino students during the 17-year period. The overall model is significant ($p < .001$) according to the chi-square statistic with a critical value of 209.13 ($df=1$).

The odds ratio for the overall sample of EA students compared to USB students attending counseling services had a coefficient of 1.76 with a 95% confidence interval (1.65, 1.89). This shows that EA students were 76% more likely to attend counseling services than USB students during the period of the study. The overall model is significant ($p < .001$) with a critical value of 272.22 ($df=1$). Throughout the 17-year period there was a gap between EA and USB students attending therapy, with EA students attending at higher rates than USB students for every year measured. However, this gap became smaller as time progressed. In 1996 (the first year and year of greatest difference), EA students were 121% more likely to utilize counseling services than USB students given their respective proportions at the university but in 2013 (the last year and year of least difference) EA students were only 19% more likely to attend therapy than USB students.

The odds ratio for the overall sample of EA students compared to IB students attending counseling services had a coefficient of 1.18 with a 95% confidence interval of (1.07, 1.31). This shows that EA students were 18% more likely to attend counseling services than IB students during the 17-year period. The overall model is significant ($p = .001$) according to the chi-square statistic with a critical value of 11.18 ($df=1$). The comparison of EA and IB students was the only comparison pair that had years in which the group that attended therapy most often switched in different years. EA students were more likely to attend therapy in 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2006, 2007, 2008, 2010, 2011, and 2012. IB students were more likely to attend therapy in 1996, 1999, 2005, 2009, and 2013. When comparing the overall models

with each Latino comparison group (USB and IB), EA students were more likely to attend therapy than their counterparts.

The odds ratio for the overall sample of IB students compared to USB students attending counseling services had a coefficient of 1.48 with a 95% confidence interval (1.32, 1.68). This shows that IB students were 50% more likely to attend counseling services than USB students during the studied period. The overall model is significant ($p < .001$) according to the chi-square statistic with a critical value of 42.27 ($df=1$). This comparison group also generally trended downward. The year of greatest difference was 1999 when EA students were 158% more likely to attend therapy than USB counterparts, the year of least difference was 2001 when EA students were only 2% more likely to attend therapy more often. While both Latino subgroups generally attended therapy at lower rates than EA students, IB students were more likely to attend services than their USB counterparts, leaving the USB group as the least likely subgroup to attend therapy.

Duration of treatment. In order to have a better understanding of dropout and treatment termination rates among Latinos and EA students we utilized two Cox Regression survival curves, one for the number of sessions attended and one for the number of days in treatment. In the initial model for number of sessions attended, age ($p = .025$), gender ($p < .001$), and initial OQ score ($p < .001$) were all significant covariates. For the typical client in a college population, 12 sessions tend to be the suggested length of treatment (Anderson & Lambert, 2001; Kadera et al., 1996) and in this data set, it was also the mean number of sessions attended ($M = 11.64$). Twelve sessions were used as a cutoff point to avoid the effects of outliers, the greatest being 512 sessions. This number was also selected because the majority of this sample (69%) fell at or below this point.

In the Cox Regression analysis (Table 2), ethnicity was not a significant predictor of the duration of treatment when looking at number of sessions attended ($\chi^2=2.67$ $df=1$ $p=.10$).

Overall, the model was significant ($df=4$ $p<.001$) and the covariates of initial OQ score ($p<.001$) and gender ($p=.008$) reached statistical significance.

A separate Cox Regression analysis was conducted to investigate the number of days that clients remained in treatment. Ethnicity was not a significant predictor ($\chi^2=2.49$ $df=1$ $p=.11$) of the number of days enrolled in treatment. However, the overall model was significant ($df=4$ $p<.001$) and the covariates of initial OQ score ($p<.001$), age ($p<.001$), and sex ($p=.004$) all reached statistical significance. However, it is interesting to note that EA students attended a greater number of sessions, while Latino students were in treatment for a greater number of days.

Intake Measurements

Family concerns. The FCS is categorical in nature, thus we used a Chi-Square test of independence to look at potential differences between USB, IB, IBUS, and EA students. Responses of “No”, “Yes”, and “Unsure” were not compared to one another, but subgroups were analyzed on an item by item level. Post-hoc analyses were conducted to look at the proportional differences among subgroup responses. Table 3 provides the percentage of each subgroup that endorsed each response, with subscripts indicating proportionately significant differences at the .05 level. If a cell is marked with subscript a, it denotes that there is no proportionately significant difference in comparison to the other subgroups. If a cell is marked with subscript b, it denotes that the item was endorsed at a rate that was proportionally higher at a statistically significant level than the comparison subgroup. If a cell is marked with subscript c it denotes that the item was endorsed at a rate that was proportionately lower at a statistically significant

level than the comparison subgroup. Participants in the four subgroups differed proportionately at statistically significant rates from one another on every question of the 18-item survey.

The USB group responded “Yes” more frequently at a statistically significant level on more items than any other group, totaling 14 of the 18 items possible. The most frequently endorsed questions dealt with hostile arguing, parental unemployment, parental divorce, and frequent moving. The IBUS group responded “Yes” at statistically higher levels on 10 items. The questions with the most endorsement included those dealing with parental divorce, frequent moving, and parental unemployment. They did not endorse any family concerns at statistically lower rates.

The IB group endorsed family concerns at higher statistical rates on seven of the items when compared to all other groups, including hostile arguing, frequent moving, and parental unemployment. This group was also the only Latino subgroup to endorse “Yes” at a statistically significant lower rate when compared to USB and IBUS counterparts, which it did on three items concerning family members with issues of mental health disorders, criminal activity, and eating problems. It also was the only Latino subgroup to endorse “No” at a statistically higher rate, which it did on one item dealing with familial mental health disorder diagnosis.

EA students did not respond “Yes” to any of the items at statistically significant, higher rates than any Latino subgroup, but did respond “Yes” at significantly lower rates on four items. These items concerned hostile arguing, parental divorce, physical abuse, and parents with a drinking problem. Overall, EA and Latino students differ in multiple areas of familial concerns, and subgroups also differ from one another in multiple areas.

Presenting problems. All four subgroups were compared to one another in how they responded to the 42 item PPC questionnaire on an item by item level on both measurements of

duration and distress of presenting concerns. A Kruskal-Wallis one-way analysis of variance was employed to find where EA, IB, IBUS, and USB groups gave responses that differed from one another at statistically significant levels. Due to the high number of statistical analyses run, we used the Bonferroni correction and found that items needed to reach a p value of .001 in order to reach statistical significance. After the Bonferroni correction, there were significant differences between at least two of the EA, IB, IBUS, and USB groups on 18 of the 42 distress items on the PPC. There were significant differences between at least two of these groups on the duration measure on 13 of the 42 items. Table 4 shows where those differences among groups were and whether groups endorse each item more or less than comparison groups. Tables 5 and 6 show the effect sizes of each significant item on the distress and duration measures respectively.

Post hoc analyses of USB students indicated significantly higher levels of distress than EA students on 9 items which included: academics/study skills, adjustment, discrimination, finances, relationships, and body image. USB students reported significantly higher levels of distress than IB students on one item concerning familial relationships. On the duration measurement, USB students reported significantly higher levels of duration than EA students on four items including adjustment, discrimination, study skills, and academic anxiety. There were no items on which USB students reported significantly higher levels of duration than IB and IBUS students. USB students scored lower than IB students on seven distress items and nine duration items, while they scored lower than IBUS students on only one duration item.

In the post hoc analyses of IB students, we found that they reported significantly higher levels of distress than EA students on 16 items dealing with problems in the areas of academics, discrimination, anxiety, finances, and sexual identity. IB students reported significantly higher

levels of distress than USB students on seven items including adjustment, anxiety, discrimination, and performance anxiety, and significantly higher levels of distress than IBUS students on two items; discrimination and homesickness. In the duration measurement, IB students reported significantly higher levels of duration than EA students on 12 items which included areas of academics, adjustment, discrimination, making friends, problem pregnancy, and study skills. IB students reported significantly higher levels of duration than USB students on eight items including adjustment, discrimination, perfectionism, study skills, and performance anxiety, and significantly higher levels of duration than IBUS students on three items which were discrimination, homesickness, and performance anxiety. IB students only reported a significantly lower score on one item overall, which was a distress item when compared to USB students.

In the post hoc analyses of IBUS students, we found that they reported significantly higher levels of distress than EA students on two items which were academics and time management. IBUS students did not show higher levels of distress than USB or IB students on any item. In the duration measurement, IBUS students reported significantly higher levels of duration than EA and USB students on the same item which was problem pregnancy. They reported significantly higher levels of duration than IB students on no items. IBUS students also scored lower than IB students on two distress items and two duration items, which in both cases were discrimination and homesickness.

When compared to each subgroup separately on both distress and duration measures, EA students did not score higher than any other subgroup on any measure on any item. After running Cohen's *d* effect sizes, there were 22 instances in which distress values qualified as a small effect size. There were 14 instances in which duration values qualified as a small effect

size. There was also one instance in which a value qualified as a moderate effect size, which compared IB to EA students when asking about the duration of ethnic/racial discrimination as a presenting problem. It is important to note that while the covariates were significant, due to the large sample size these effects remain very small.

Distress

We used the OQ-45 to measure distress. Clients completed this measure both at intake and before every session attended. Distress was measured among subgroups to see potential differences across initial distress upon intake as well as change in distress level over the course of treatment.

Intake distress. A one-way analysis of variance showed that the effect of subgroup (EA, USB, IB, or IBUS) on the OQ-45 distress score upon intake was significant, $F(3, 20338) = 19.79, p = .000$ with the IB population experiencing significantly more distress ($M = 77.74, SD = 26.17$) than the USB population ($M = 69.78, SD = 23.92, p < .001$), the IBUS population ($M = 69.51, SD = 28.110, p = .02$), and the EA population ($M = 68.85, SD = 22.77, p < .001$). The IB student group is the only subgroup to experience more distress at intake than every other subgroup.

A one-way between subjects ANCOVA was also calculated to examine the effect of subgroup on OQ-45 distress score at intake while controlling for the effects of gender, age, and number of sessions attended. Gender ($F[1, 19184] = 310.600, p = .000$), age ($F[1, 19184] = 6.620, p = .010$), and number of sessions attended ($F[1, 19184] = 200.427, p = .000$) were all significantly related to intake distress. There were still significant differences between subgroups in terms of intake distress $F(3, 19184) = 21.754, p = .000$ after eliminating the effect of gender, age, and number of sessions attended.

Distress change. We utilized a split-plot analysis of covariance to examine the effect of subgroup on change in distress level over the course of treatment while controlling for the number of sessions attended, initial OQ score, age, and gender. A significant time x number of sessions attended interaction was present $F(1, 13894) = 227.39, p = .000$. A significant time x subgroup interaction was present $F(1, 13894) = 646.47, p = .017$. The main effect for time, was also significant $F(1, 13894) = 18549.13, p = .000$. The main effect for subgroup was significant $F(3, 13894) = 8.99, p = .000$, while the main effect for number of sessions attended was not significant $F(1, 13894) = 5.07, p = .024$. USB, IBUS, and EA groups generally trended together in the change in OQ over the course of treatment. IB students, who began treatment with higher OQ scores, saw a significantly steeper drop in OQ scores than other subgroup counterparts over the course of treatment while controlling of the number of sessions attended.

Gender Differences

Presenting for treatment. Latino students were not divided into subgroups for this question, as dividing the sample into subgroups and then into gender groups would create unreliably small sample sizes. We ran a Z test for this question in comparing rates of attending treatment between male and female Latino students. Data for this question was only available from 1997 as opposed to 1996, giving a 16-year span of data from 1997-2013. Presenting for treatment was found to be statistically significant when dependent on gender. During the sample period 15,531 male Latino students attended the university with 541 of those students presenting for treatment. Simultaneously, 15,588 female Latino students attended the university with 756 presenting for treatment. Female Latino students were significantly more likely to present for treatment than male Latino students $z=-6.031, p=.001$.

Number of sessions attended. We ran an independent samples t-test and Mann-Whitney U to see if the number of sessions attended was dependent on gender. This question was also not divided into subgroups as the Latino sample size would be too small if divided again into gender groups. The independent samples t-test showed no statistically significant difference between males ($M = 9.89$, $SD = 12.66$) and females ($M = 10.45$, $SD = 16.05$) in terms of number of sessions attended; $t(1315) = -0.684$, $p = .494$. Neither males nor females attended services for a duration that was significantly higher or lower than the other.

To account for the skewness of the data (males = 3.16, females = 5.62), a Mann-Whitney U was also utilized. It also indicated that number of sessions attended was not significantly different for males ($Mdn = 6.00$) or females ($Mdn = 6.00$), $U = 208,814.50$, $p = .768$.

The results from multiple statistical analyses show that there are significant differences between Latino and EA students in counseling, which supports current literature. It also shows that there are significant within-group differences among the Latino population when looking at USB, IB, and IBUS groups.

Discussion

Researchers examining Latino students' utilization of counseling services have typically lumped all Latino students together. In order to explore the differences that occur between Latinos based on a variety of factors, we divided the sample size employed for this study into three subgroups IB, USB, and IBUS. This allowed for a better understanding of how these groups differ in terms of intake measurements, treatment length, treatment utilization, and change in distress over time in a college counseling center setting.

Treatment Utilization

Overall, ethnicity did not appear to have a significant impact on the length of treatment when comparing Latino and EA students or when looking at number of sessions attended and days enrolled in treatment by EA and Latino students. The idea that there is no significant difference as far as length of treatment is concerned when accounting for ethnicity contrasts previous research. This research cites that Latino students are presented with more barriers in attending sessions consistently. These potential barriers that could make it more difficult to attend counseling regularly have been shown in previous research to include institutional barriers, acculturation, feeling that it is not acceptable to attend counseling, language barriers, limited number of bilingual counselors, limited culturally appropriate treatment methods, ethnic composition of counseling staff, academic struggles, poverty, isolation, racism, discrimination, stigma, gender role conflicts, belief in *familismo* or keeping concerns within the family as opposed to going to an outside source for help, and other cultural conflicts (Alegria et al., 2007; Duarte, 2003; Hayes et al., 2011; Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015; Paniagua, 2014; Romero, 2009; Sue & Chu, 2003; Sullivan et al., 2007).

When looking at the little difference in length of treatment between EA and Latino students in this study, it is difficult to pinpoint why results of this study differ from the results of previous research. One possibility is that the college counseling center in this study is doing something or a number of things that assisted in overcoming the aforementioned barriers and increased the likelihood of Latinos continuing treatment. It could also mean that EA students were not attending treatment as regularly as the sites used in previous research.

Additionally, when looking at general differences among Latino and EA students, there were no significant differences in treatment utilization based on gender when looking at the

number of sessions attended. However, there were significant differences when looking at differences between male and female Latino clients in presenting for treatment with female students presenting for treatment more often. This finding contrasts previous research that suggests that Latina students attend counseling services less often than male counterparts (Chiang et al., 2004; Shibazaki, 1999) as well as the work of Sullivan et al. (2007) who report that there is no difference in utilization by Latinos based on gender. Future research may be needed in this area to clarify whether true differences between Latino and Latina students exist when looking at treatment utilization.

When comparing the utilization of Latino to EA students, results suggest that EA students were 50% more likely to attend therapy than Latino counterparts, which supports current research that Latinos are less likely to attend therapy than EA students (Alegria et al., 2002; Alegria et al., 2007; Kim et al., 2015). EA students are also more likely to attend therapy than both USB and IB subgroups when compared to each group individually.

Generally, this could suggest that EA students are experiencing more stressors than Latino students. However, after reviewing the differences among subgroups in this study while also looking at similar findings in other research (Kearney et al., 2005), it is more likely that Latino students experience greater amounts of stressors than EA students and, as a result, we can assume that Latinos experience significant barriers to attending counseling services. However, when IB and USB groups are compared to one another, it appears that IB students endorsed higher levels of distress on the OQ-45 as well as a greater amount of presenting problems on the PPC. They also attended therapy more often than USB counterparts who endorsed fewer stressors. Even though IB students attended therapy at greater rates than USB students, it

appears that IB students may be waiting longer to seek help, because when they do attend services their distress rates are significantly higher.

This data also shows general downward trends among the difference in likelihood of counseling attendance. During this 17-year period, the gap between counseling attendance among EA, IB, and USB students has grown smaller. This could be occurring for a number of reasons. One possibility is that as the number of IB and USB students attending the university has increased over the time period of the study, creating a greater network of other Latinos on campus who may assist other students in overcoming barriers of attending services or even lessen the impact of potential issues such as stigma. Another possible explanation could be that the university over time has done a better job at doing outreach to minority populations or advertising services to be more accessible to the student body. It is also possible that, over time, service providers have become more culturally sensitive, providing better services with more culturally relevant treatment, which in turn would ideally encourage clients to return for future appointments.

Initial Concerns

Outcome Questionnaire-45. When presenting for treatment, all students complete the OQ-45, a measurement for distress level. Students continue to complete the OQ-45 at the beginning of every attended session. Upon presenting for treatment, IB students come in experiencing much higher levels of distress than any other Latino subgroup or EA students. This could mean that IB students generally face more distress than national students, and/or that IB students are waiting to attend therapy until their distress is much higher than other student groups. It could also indicate that IB students may be interpreting the questions differently than the other subgroups. Previous research points to some potential stressors that cause IB students

to wait longer before seeking treatment including English language proficiency, adjusting to a new education system, adjusting to a new culture, employment restrictions, financial issues, lack of knowledge about available resources, homesickness, and guilt about leaving and not confiding in family (Arredondo, 1991; Gloria & Rodriguez, 2000; Miranda et al., 2015; Romero, 2009; Sue & Chu, 2003; Thomas & Althen, 1989). Language barriers become a greater area of concern, as not knowing English fluently can lead to acculturative stress, which leads to negative orientation to help-seeking behaviors (Stanton-Salazar, Chavez, & Tau, 2001). This, coupled with a low number of bilingual counselors, could be providing significant deterrents to attending counseling (Alegria et al., 2007) for all Latino students, and especially for IB students, who may experience these stressors at greater rates, which may explain why distress levels are higher for this subgroup upon entering services.

While the data suggests that IB students come in with higher levels of distress, there also appears to be a greater difference when comparing IB students and other subgroups as far as change in distress level over time. So, while IB students experience more distress initially, they also see a significant drop in distress scores over time in comparison to subgroup counterparts. This could mean that while IB students present with higher levels of distress upon intake, distress scores are responding to treatment at faster rates for this group than the distress scores of other Latino and EA students.

Family Concerns Survey. The main finding of the FCS is that EA students self-report experiencing familial concerns at much lower rates than Latino students when presenting for counseling. It appears that the three Latino subgroups had many similarities in their self-reporting, in that all three subgroups trended the same way on one third of the questions.

At first glance, the data suggests that USB students experience more familial issues than IBUS or IB groups. This contrasts the results discussed both above and below, which suggest that IB students generally experience greater stressors. While USB students endorsed more distress with familial concerns, a closer look at the specific responses seems to show that different subgroups responded to the survey in different ways for a variety of reasons. For example, USB students endorsed “Unsure” at significantly higher levels on multiple questions, including parents divorced or separated, sexual abuse, rape or sexual assault, or family member committed suicide. This seems to suggest that cultural factors may affect how students understand or classify events, as they appeared unable to define or uncomfortable defining whether these events did or did not occur.

IB students also endorsed “No” at significantly higher levels for a question that asked if a family member was diagnosed with a mental health disorder. While it is possible that IB students have less familial experience with mental health disorders, it seems more likely that, as has been noted in previous research (Alegria et al., 2002), Latinos tend to recognize fewer psychological problems as mental health disorders. These responses suggest that cultural factors play into how familial concerns are interpreted, understood, and reported.

Presenting Problems Checklist. On every item of the PPC where we found a significant difference among groups, all Latino subgroups endorsed experiencing more presenting problems at greater rates than EA counterparts. On a few questions, Latino subgroups trended together in their responses when compared with the EA group.

Questions concerning academic work and school grades were significant in our results. All Latino student subgroups reported greater distress in these areas than their EA counterparts.

An explanation for this may be that many Latino students are the first generation in their family to attend college, which can lead to greater vulnerability to achievement stress (Jimenez, 2012).

Two Latino subgroups, IB and IBUS trended together on multiple items including feeling more anxiety, nervousness, and perfectionism, as well as having issues with reading and study skills, test and speech performance, time management, and concentration. In the case of IB students, this may be explained by additional academic policies that depend on academic success. For example, international students who are academically suspended face losing visa status, and must return home in a short period of time and may possibly not be able to receive another academic visa once the suspension is lifted. IB students are also legally required to take a minimum of 12 credits each semester, even if they feel overwhelmed. It is possible that the greater endorsement of stressors relating to academic performance could be occurring because of IB students added academic stressors or the extra stressor of adjusting to a different educational system (Constantine, Wilton & Caldwell, 2003; Reyes, 2012).

While there are some potential explanations as to why IB students are endorsing these stressors at greater rates, there are fewer answers to explain why IBUS students are having similar experiences to IB students. We expected that these two subgroups would experience things differently, as IBUS students do not have the added distress of extra academic policies or facing a major adjustment to the university, as IBUS have obtained U.S. Citizenship. However, it appears that even though IBUS students are more removed from these specific stressors, they are still significantly affected by these stressors. While we are not sure why this is occurring, it is essential to note that lumping and separating people into groups could lead to a loss of important information that would otherwise be assumed to apply or not apply to an individual.

All Latino subgroups endorsed significantly greater distress and duration of distress resulting from racial discrimination than EA counterparts. It is interesting to note that in both categories IB students report these experiences more often and are more distressed by them than IBUS or USB groups. This is interesting as IBUS students were also born internationally, with the major difference of having obtained US citizenship. If we assume that IB students have spent less time in the country than USB or IBUS counterparts, then it appears that the more time spent in the U.S., the less likely a student will endorse feelings of discrimination and homesickness. It is possible that the IB group could be experiencing these problems more often due to acculturation issues, language barriers, and increased feelings of isolation. The increased amount of concerns endorsed by Latino students could potentially be impacting students in various areas including academic achievement (Lockard, Hayes, Graceffo, & Locke, 2013; Vasquez-Salgado, Greenfield, & Burgos-Cienfuegos, 2015), social interactions (Jimenez, 2012), and emotional distress (Ramos-Sanchez, 2015), creating a disadvantage for these students in a university and a greater need for counseling services.

Study Limitations

One potential limitation of this study is that it was conducted at a private, religiously affiliated university in which the majority of students identify as Latter-day Saints (98.6% in 2013). It is likely that our sample is not representative of students at other universities. Additionally, there may be religious and/or cultural factors that played a role in the experiences of students in this study that may not be present at other institutions. One potential implication could be that the presence of a shared Latter-day Saint culture among students may have an impact on the expression of other cultures, or it may act as a unifying agent across other differing cultures.

Another potential limitation is that levels of acculturation play a significant role in a student's experience in a US college. We were unable to account for acculturation in the collected data as there were no measures utilized to look at acculturation. If this proved to be a significant factor, this lack of information could result in potentially losing important information on the impacts of acculturation on students' experiences within colleges and college counseling centers. Additionally, we were unable to account for other variables which could have impacted our results, such as proficiency of the English language and socio-economic status.

Generally, the IBUS subgroup was not significantly different from the other subgroups or EA students the results of the IBUS subgroup were not significant. While these results may be reflective of the presenting issues and counseling service utilization of this subgroup, a possible limitation is that the sample size of this subgroup was small ($n=71$). In comparison to the other subgroups, this was the smallest n . Future research should explore and look at these subgroups with larger samples. This would allow for more clarity about where any differences between the IBUS and other subgroups lie.

This study aimed to break down groups that have traditionally been lumped together. However, this still results in the limitation that in the process other groups were lumped together. For example, an international student from Spain will have a different experience than an international student from Mexico. This lumping could cause important information about individual experience to be lost.

Nearly all the measures used in this study were created by and for EA clients. These measures were also normed on EA samples. This presents another limitation, as the measures

that we accessed and employed were not created for or normed on a Latino population. The result of this could be that certain information could be lost or misrepresented.

Lastly, the study was done at a university with students of college age ($M=22.59$). Because of this, it would be inappropriate to assume that these results are representative of Latinos of different age groups. In fact, it is likely that presenting problems, duration of problems, and family concerns would change for different age groups, as different stages of life can be accompanied by different types and severity of stressors than those felt during early adulthood.

Implications for Future Research

This study has shown that there are differences among Latino subgroups when it comes to therapy. As there is no other research that has delved into these differences, this is an area that needs to be explored further. We know that there are differences, but this study only looked at a few areas associated with therapy utilization and presenting concerns. More research is needed generally to look at other areas where Latino subgroups may differ when it comes to therapy utilization and mental health. Looking more closely at the IBUS subgroup as well as understanding Latino student subgroups' perceptions of therapy and the stressors they face are just a few of the areas where more information is needed.

While this study looked at many variables, in understanding the complexity of intersectionality it should be noted that numerous other variables could have a significant impact on the results as well as the experience of individuals. It would be beneficial for further research to examine other variables such as SES, language proficiency, acculturation, and variables in treatment utilization, to name a few. As future research builds on the information presented in this study, clinicians will have greater insight into the specific needs and experiences of Latino

clients. However, it is important to note that regardless of how many variables are analyzed it still cannot fully describe the unique experience of individuals.

Implications for Practice

Attendance at a college or university is stressful for every student, but the findings of this study suggest that Latino students experience a greater number of stressors than EA students. Among the Latino subgroups we investigated, IB students report experiencing the most stressors. This information reinforces the idea that it is imperative for practitioners to be competent in multicultural aspects of counseling. It also is clear that practitioners need to understand that vital information is lost about an individual when they are lumped into a group, or it is assumed that their experience will be similar to that of others of the same ethnicity. This research calls for special attention to the needs of international students, who likely experience a multitude of challenges while attending a university in the U.S., far above and beyond the normal stressors that college students typically face. These challenges vary significantly among students. Therefore, it is essential to note that even within subgroups, the mosaic of individual differences creates a unique experience for each student. It is advantageous for practitioners to check potential stereotypes and work to know the individual, thus paying attention to these individual differences as opposed to assuming universal experience.

Our results show that IB students present for counseling services with higher levels of distress than any other subgroup. This has significant implications for how clinicians should approach counseling for IB students. Being aware that distress levels are higher upon intake for this subgroup, clinicians should take the opportunity to be more conscientious of assessing each individual for the need do more crisis work during the first session. Making changes in counseling center services to be more accessible to minority and international students' needs to

become a priority, as these student groups appear to be more at risk, and yet access services at lower rates. Adaptations such as specific outreach to minority and international students, having more Spanish-speaking counselors, as well as becoming more culturally sensitive as a counseling center may allow greater accessibility to services by minority and international students.

Lastly, results showed that in this research Latino students remained in treatment at similar rates when compared to their EA counterparts, the opposite of previous research. Research shows that more sessions with a therapist are more beneficial than fewer sessions with a therapist (Erekson, 2013). In order to continue to assist Latino students in accessing needed mental health resources, it may be beneficial for therapists to emphasize the importance of attending sessions often and consistently to achieve the greatest benefit. It also may be helpful for clinicians to make an extra effort to follow up on missed appointments to allow students every opportunity to attend as many sessions as they feel are needed.

Conclusion

Previous research that has looked at Latino utilization of treatment and presenting concerns has generally lumped all Latinos together, purporting that experiences of all Latinos, and specifically Latino college students, are similar. This research aimed to look at how different backgrounds of Latino students emerged as a factor in how Latino students' experiences differ with treatment in order to better understand where these differences lie and what clinicians need to know to best help Latino student clients. We utilized data from a college counseling center from 1996-2013 and looked at treatment utilization, intake, and distress measurements of Latino subgroups of USB, IB, and IBUS students in comparison to EA students.

By looking at general trends, Latino students attend therapy at lower rates than EA counterparts, and within subgroups, IB students are more likely to attend therapy than USB students. When IB students do attend therapy, they present with much greater levels of distress than EA, IBUS, or USB groups. Intake assessments revealed that all Latino subgroups experience past familial concerns and presenting problems at greater levels than EA counterparts. Subgroups show that USB students endorse more familial concerns than IB or IBUS students, while IB students endorse greater duration and distress of presenting concerns than USB or IBUS students, specifically with racial discrimination.

This research adds to the ongoing research of Latino studies by showing that there are significant differences among Latino subgroups when college counseling is considered. While experiences of Latino students generally differ from those of EA students, important differences are lost when subgroups are lumped together. This information should encourage clinicians and practitioners to be aware of the differences of these subgroups, by understanding that IB students come into therapy with greater levels of distress and are experiencing more racial discrimination and other presenting problems, whereas a USB student may have overcome significant stressors to even come to treatment as they are the least likely to attend and typically have significant familial concerns. These differences from this research are very general and are just barely revealing how these subgroups differ. More research is needed to better understand specific experiences of Latino college students in order to fully comprehend what information is critical for clinicians to understand to offer the most beneficial services to this population.

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Tables

Table 1

Odds Ratio

Year	Comparing EA and USB		Comparing EA and IB		Comparing IB and USB	
	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE
1996	2.21	0.28	0.89	0.05	2.49	0.53
1997	1.49	0.27	1.16	0.36	1.29	0.45
1998	2.03	0.18	1.22	0.31	1.67	0.35
1999	1.96	0.18	0.76	0.34	2.58	0.38
2000	1.81	0.16	1.11	0.26	1.64	0.30
2001	1.54	0.17	1.49	0.22	1.03	0.27
2002	1.31	0.17	1.23	0.23	1.07	0.28
2003	1.34	0.16	1.28	0.19	1.05	0.25
2004	1.92	0.14	1.48	0.17	1.29	0.21
2005	1.65	0.14	0.97	0.21	1.70	0.25
2006	1.58	0.14	1.25	0.20	1.27	0.24
2007	1.94	0.14	2.14	0.14	1.81	0.24
2008	1.82	0.13	1.15	0.20	1.58	0.23
2009	1.76	0.13	0.83	0.20	2.12	0.24
2010	1.59	0.13	1.06	0.21	1.51	0.24
2011	1.73	0.12	1.11	0.16	1.70	0.23
2012	1.90	0.11	1.75	0.17	1.09	0.19
2013	1.19	0.15	0.85	0.24	1.40	0.28
Total	1.76	0.03	1.19	0.05	1.49	0.06

Note. Odds Ratios by year comparing therapy utilization rates among international Latino (IB), US born Latino (USB), and European American (EA) students. The n for each group varied each year. When comparing each group, an odds ratio greater than 1 indicates a greater treatment utilization rate among the first group being compared and is based on the proportion of students from each group attending therapy compared to the proportion of the total number of students from each group attending this university.

Table 2

Cox Regression Analysis

Variable	Sig.	Exp(B)	SE
Ethnicity	0.10	0.95	0.03
Initial OQ	0.01	0.99	<0.01
Age	0.16	1.00	<0.01
Gender	0.008	0.96	0.02

Note. Cox Regression Analysis comparing the likelihood of discontinuance of therapy between European American (EA) and Latino Students (n=15,064) when controlling for number of sessions (12), gender, age, and initial OQ score.

Table 3

Family Concern Survey

Question	Value	df	Yes				No			
			USB	IB	IBUS	EA	USB	IB	IBUS	EA
1. Parents divorce or permanently separated before you were 18 years old.	213.57	6	27% _{ob}	25% _{ob}	41% _{ob}	13% _{oc}	71% _{oc}	72% _{oc}	58% _{oc}	85% _{oa}
2. Family frequently moved.	55.92	6	25% _{ob}	29% _{ob}	40% _{ob}	19% _{oa}	72% _{oa}	65% _{oc}	54% _{oc}	76% _{oa}
3. Parent(s) unemployed for an extended period of time.	110.58	6	26% _{ob}	26% _{ob}	38% _{ob}	17% _{oa}	66% _{oc}	68% _{oc}	51% _{oc}	78% _{oa}
4. Frequent, hostile arguing among family members.	112.06	6	48% _{ob}	44% _{ob}	60% _{ob}	33% _{oc}	43% _{oc}	47% _{oc}	34% _{oc}	58% _{oa}
5. Death of parent(s) before you were 18 years old.	19.79	6	4% _{oa}	5% _{ob}	8% _{ob}	2% _{oa}	95% _{oa}	94% _{oa}	91% _{oa}	96% _{oa}
6. Parent(s) with a drinking problem.	271.57	6	13% _{ob}	16% _{ob}	11% _{ob}	4% _{oc}	84% _{oc}	80% _{oc}	84% _{oa}	94% _{oa}
7. Parent(s) with a drug problem.	62.42	6	6% _{ob}	1% _{oa}	7% _{ob}	2% _{oa}	91% _{oa}	95% _{oa}	92% _{oa}	96% _{oa}
8. Parent(s) with a gambling problem.	61.59	6	2% _{ob}	0.8% _{oa}	1% _{oa}	1% _{oa}	93% _{oa}	96% _{oa}	95% _{oa}	97% _{oa}
9. Physical abuse in your family.	147.40	6	20% _{ob}	19% _{ob}	20% _{ob}	9% _{oc}	73% _{oc}	74% _{oc}	72% _{oa}	85% _{oa}
10. Sexual abuse in your family.	30.28	6	8% _{oa}	7% _{oa}	12% _{ob}	6% _{oa}	85% _{oa}	87% _{oa}	84% _{oa}	90% _{oa}
11. Rape/sexual assault of yourself or family member.	30.65	6	13% _{ob}	9% _{oa}	15% _{oa}	9% _{oa}	81% _{oa}	85% _{oa}	81% _{oa}	87% _{oa}
12. Family member hospitalized for emotional problems.	16.89	6	17% _{ob}	11% _{oa}	21% _{oa}	13% _{oa}	76% _{oa}	83% _{oa}	71% _{oa}	81% _{oa}
13. Family member diagnosed with a mental disorder.	58.05	6	24% _{oa}	11% _{oc}	15% _{oa}	25% _{oa}	65% _{oa}	82% _{ob}	70% _{oa}	65% _{oa}
14. Family member attempted suicide.	25.60	6	14% _{ob}	10% _{oa}	25% _{ob}	11% _{oa}	76% _{oa}	82% _{oa}	68% _{oa}	81% _{oa}
15. Family member committed suicide.	16.94	6	4% _{ob}	2% _{oa}	4% _{oa}	2% _{oa}	94% _{oa}	95% _{oa}	95% _{oa}	96% _{oa}
16. Family member with a debilitating illness, injury, or handicap.	15.76	6	18% _{ob}	12% _{oa}	18% _{oa}	15% _{oa}	78% _{oa}	82% _{oa}	74% _{oa}	81% _{oa}
17. Family member prosecuted for criminal activity.	60.81	6	15% _{ob}	4% _{oc}	12% _{oa}	8% _{oa}	80% _{oc}	92% _{oa}	81% _{oa}	88% _{oa}
18. Family member with an eating problem.	14.79	6	16% _{oa}	10% _{oc}	15% _{oa}	16% _{oa}	74% _{oa}	82% _{oa}	72% _{oa}	74% _{oa}

Note. Family Concern Survey (FCS) analyzed for significant differences using Pearson Chi-Square Test with U.S. born Latino (USB)(n=775) International Latino (IB) (n = 380), Internationally born U.S. citizen Latino (IBUS) (n=70) and European American (EA) (n = 18,118) students. Each difference in subscript letters in the Yes and No categories denote proportionately significant differences (at the .05 level) between the different groups of interest. No, Yes, and Unsure categories were not compared to one another. If a cell is marked with subscript a, it denotes that there is no proportionately significant difference. If a cell is marked with subscript b it denotes that the item was endorsed at a rate that was proportionally higher at a statistically significant level. If a cell is marked with subscript c it denotes that the item was endorsed at a rate that was proportionately lower at a statistically significant level.

Table 4

Presenting Problems Checklist

Question	Distress					Duration				
	Sig.	USB	IB	IBUS	EA	Sig.	USB	IB	IBUS	EA
1. Academics or school work or grades	<0.001	2.2 _a	2.4 _a	2.6 _a	2.0 _b	<0.001	1.5 _e	1.7 _{e, f}	1.7 _e	1.4 _{e, g}
2. Adjustment to the university	<0.001	.9 _a	1.2 _b	.8 _{a, b, c}	.7 _c	<0.001	.8 _e	1.1 _f	.8 _{e, f, g}	.7 _{g, h}
3. Alcohol or drugs	0.037					0.040				
4. Anxiety, fear, worries, or nervousness	0.001	1.9 _a	2.2 _b	1.9 _{a, b, c}	1.9 _{c, a}	0.085				
5. Assertiveness	0.626					0.144				
6. Breakup/loss of a relationship	<0.001	.9 _a	1.2 _{a, b}	.9 _a	.9 _{a, c}	0.202				
7. Concentration	<0.001	1.7 _a	2.0 _b	1.9 _{a, b, c}	1.5 _c	<0.001	1.1 _e	1.3 _{e, f}	1.5 _e	1.1 _{e, g}
8. Confusion about beliefs or values	0.006					0.033				
9. Dating concerns	0.301					0.053				
10. Death or impending death of a significant person	0.043					0.072				
11. Decisions about career or major	0.884					0.548				
12. Depression	0.011					0.142				
13. Developing independence from family	0.113					0.359				
14. Ethnic/racial discrimination	<0.001	.2 _a	.5 _b	.2 _{a, c, d}	.0 _d	<0.001	.1 _e	.5 _f	.1 _{e, g}	.0 _g
15. Eating: bingeing, vomiting, dieting, laxatives, etc.	0.090					0.143				
16. Fasting or avoiding food	0.254					0.474				
17. Finances	<0.001	1.5 _a	1.7 _{a, b}	1.5 _{a, b, c}	1.3 _c	0.469				
18. Homesickness	<0.001	.5 _a	.9 _b	.6 _a	.5 _a	0.000	.5 _e	.9 _f	.5 _{e, g, h}	.5 _{e, g, h}
19. Irritability, anger, or hostility	<0.001	.9 _a	1.1 _{a, b}	1.2 _a	.8 _{a, c}	0.057				
20. Making friends	0.003					0.001	.5 _e	.8 _f	.5 _{e, f, g}	.6 _{e, g}
21. Perfectionism	0.005					<0.001	.5 _e	.7 _f	.5 _{e, f, g}	.5 _{e, g}
22. Physical health problems (ie: headaches, etc.)	0.010					0.015				
23. Problem pregnancy	<0.001	.0 _a	.1 _{a, b}	.1 _a	.0 _{a, c}	<0.001	.0 _e	.0 _{e, f}	.1 _{f, g}	.0 _{e, h}
24. Procrastination or getting motivated	0.001	1.8 _a	1.9 _{a, b}	1.9 _a	1.7 _{a, c}	0.003				
25. Rape, sexual assault, or unwanted sex	0.034					0.937				
26. Reading or study skills problems	<0.001	1.2 _a	1.5 _b	1.2 _{a, b, c}	.9 _c	<0.001	.8 _e	1.1 _f	.9 _{e, f, g}	.7 _g
27. Relationship with family, parents, or siblings	<0.001	1.2 _a	.9 _b	1.2 _{a, b, c}	.9 _{b, c}	0.007				

28. Relationships with friends, roommates, or peers	0.200					0.506					
29. Relationship with romantic partner or spouse	0.141					0.538					
30. Religious or spiritual concerns	0.679					0.572					
31. Self-esteem or self-confidence	0.735					0.169					
32. Sexual concerns	0.085					0.062					
33. Sexual identity or orientation issues	<0.001	.2 _a	.3 _{a, b}	.2 _a	.2 _{a, c}	0.476					
34. Sexually transmitted disease(s)	0.024					0.807					
35. Shyness, being ill at ease with people	0.007					0.076					
36. Sleeping problems	0.002					<0.001	.8 _e	.9 _{e, f}	1.0 _e	.7 _{e, g}	
37. Stress management	<0.001	1.5 _a	1.7 _{a, b}	1.9 _a	1.4 _{a, c}	<0.001	1.0 _e	1.2 _{e, f}	1.1 _e	.9 _{e, g}	
38. Suicidal feelings or thoughts	0.069					0.178					
39. Test, speech, or performance anxiety	<0.001	.8 _{a, c}	1.1 _b	.9 _{a, b, c}	.7 _{a, c}	<0.001	.5 _e	.8 _f	.4 _{e, g}	.4 _{g, h}	
40. Time management	<0.001	1.4 _a	1.6 _a	1.8 _a	1.2 _b	<0.001	.9 _e	1.2 _f	1.1 _{e, f, g}	.8 _{e, g}	
41. Uncertain about future or life after college	0.183					0.165					
42. Weight problems or body image	<0.001	1.3 _{a, b}	1.3 _b	1.3 _b	1.1 _b	0.093					

Note. Significantly different averaged means for (USB) (n = 779), (IB)(n=381), (IBUS) (n=71) and (EA) (n = 18,125) students on the Presenting Problems Checklist (PPC). PCC Distress and Duration subscales are reported. Differences between these three groups were analyzed using a Kruskal-Wallis One-way ANOVA and the Sig. column indicates p-values that reached statistical significance between groups at the .001 level due to the Boneferroni correction. Each difference in subscript letters denotes a significant difference at the .001 level after the Boneferroni correction. If a group has a subscript that is a different letter than a comparison group in its respective distress/duration category, it denotes a statistically significant difference. If there were no statistically significant difference between groups, they would all have the same subscript. If the question had no significant differences, the group means were not included on the table. Distress and duration categories were not compared to one another. Thus, the column examining differences in distress responses uses the subscripts a, b, c, and d. The column examining differences in duration responses uses the subscripts e, f, g, and h.

Table 5

Distress

Question	USB compared with EA	IB compared with EA	IBUS compared with EA	USB compared with IB	USB compared with IBUS	IB compared with IBUS
1. Academics or school work or grades	p<.001; .15	p<.001; 0.25*	p<.002; 0.30*			
2. Adjustment to the university	p<.001; 0.16	p<.001; 0.32*		p<.001; 0.23*		
3. Alcohol or drugs						
4. Anxiety, fear, worries, or nervousness		p<.001; 0.19		p<.049; 0.16		
5. Assertiveness						
6. Breakup/loss of a relationship		p<.001; 0.22*				
7. Concentration	p<.001; 0.15	p<.001; 0.40*		p<.001; 0.25*		
8. Confusion about beliefs or values						
9. Dating concerns						
10. Death or impending death of a significant person						
11. Decisions about career or major						
12. Depression						
13. Developing independence from family						
14. Ethnic/racial discrimination	p<.001; 0.34*	p<.001; 0.33*	p<.001; 0.37*	p<.001; 0.40*		p<.001; 0.35*
15. Eating: binging, vomiting, dieting, laxatives, etc.						
16. Fasting or avoiding food						
17. Finances	p<.001; 0.14	p<.001; 0.12				
18. Homesickness		p<.001; 0.46*		p<.001; 0.42*		p<.020; 0.31*
19. Irritability, anger, or hostility		p<.002; 0.22*				
20. Making friends						
21. Perfectionism						
22. Physical health problems (ie: headaches, etc.)						
23. Problem pregnancy		p<.004; 0.12				
24. Procrastination or getting motivated		p<.013; 0.15				
25. Rape, sexual assault, or unwanted sex						

26. Reading or study skills problems	p<.001; 0.20*	p<.001; 0.45*		p<.001; 0.25*
27. Relationship with family, parents, or siblings	p<.001; 0.16			p<.010; 0.18
28. Relationships with friends, roommates, or peers				
29. Relationship with romantic partner or spouse				
30. Religious or spiritual concerns				
31. Self-esteem or self-confidence				
32. Sexual concerns				
33. Sexual identity or orientation issues		p<.001; 0.19		
34. Sexually transmitted disease(s)				
35. Shyness, being ill at ease with people				
36. Sleeping problems				
37. Stress management		p<.002; 0.18		
38. Suicidal feelings or thoughts				
39. Test, speech, or performance anxiety		p<.001; 0.27*		p<.008; 0.19
40. Time management	p<.009; 0.12	p<.001; 0.27*	p<.016; 0.37*	
41. Uncertain about future or life after college				
42. Weight problems or body image	p<.001; 0.15			

Note. As the large n most likely impacted levels of significance, p-values for each pairwise comparison that reach statistical significance and their accompanying Cohen’s d effect sizes are reported for comparisons between groups on the distress measure on the Presenting Problems Checklist between International USB (n =779), IB (n=381), IBUS (n=71), and European American (n =18,125) students. Values marked with a * indicate a Cohen’s d value of .2 which is qualified as a small effect size.

Table 6

Duration

Question	USB compared with EA	IB compared with EA	IBUS compared with EA	USB compared with IB	USB compared with IBUS	IB compared with IBUS
1. Academics or school work or grades		p<.000; 0.23*				
2. Adjustment to the university	p<.006; 0.08	p<.000; 0.31*		p<.003; 0.23*		
3. Alcohol or drugs						
4. Anxiety, fear, worries, or nervousness						
5. Assertiveness						
6. Breakup/loss of a relationship						
7. Concentration		p<.004; 0.17				
8. Confusion about beliefs or values						
9. Dating concerns						
10. Death or impending death of a significant person						
11. Decisions about career or major						
12. Depression						
13. Developing independence from family						
14. Ethnic/racial discrimination	p<.000; 0.19	p<.000; 0.57**	p<.003; 0.23*	p<.000; 0.41*		p<.000; 0.46*
15. Eating: binging, vomiting, dieting, laxatives, etc.						
16. Fasting or avoiding food						
17. Finances						
18. Homesickness		p<.000; 0.36*		p<.000; 0.01		P<.045; 0.34*
19. Irritability, anger, or hostility						
20. Making friends		p<.000; 0.17		p<.005; 0.27*		
21. Perfectionism		p<.000; 0.19		p<.040; 0.13		
22. Physical health problems (ie: headaches, etc.)						
23. Problem pregnancy		p<.026; 0.09	p<.006; 0.14		p<.022; 0.11	
24. Procrastination or getting motivated						

25. Rape, sexual assault, or unwanted sex				
26. Reading or study skills problems	p<.000; 0.14	p<.000; 0.33*	p<.002; 0.19	
27. Relationship with family, parents, or siblings				
28. Relationships with friends, roommates, or peers				
29. Relationship with romantic partner or spouse				
30. Religious or spiritual concerns				
31. Self-esteem or self-confidence				
32. Sexual concerns				
33. Sexual identity or orientation issues				
34. Sexually transmitted disease(s)				
35. Shyness, being ill at ease with people				
36. Sleeping problems		p<.004; 0.17		
37. Stress management		p<.000; 0.20		
38. Suicidal feelings or thoughts				
39. Test, speech, or performance anxiety	p<.038; 0.08	p<.000; 0.33*	p<.000; 0.24*	p<.008; 0.38*
40. Time management		p<.000; 0.25*	p<.017; 0.17	
41. Uncertain about future or life after college				
42. Weight problems or body image				

Note. As the large n most likely impacted levels of significance, p-values for each pairwise comparison that reach statistical significance and their accompanying Cohen’s d effect sizes are reported for comparisons between groups on the duration measure on the Presenting Problems Checklist between International USB (n =779), IB (n=381), IBUS (n=71), and European American (n =18,125) students. Values marked with a * indicate a Cohen’s d value of .2 which is qualified as a small effect size. Values marked with a ** indicate a Cohen’s d value of .5 which is qualified as a moderate effect size.

APPENDIX A

Counseling Center Utilization

Every year, millions of young adults seek out higher education through full time attendance at a college or university setting (National Center for Education Statistics, 2013). The number of students who seek out higher education has increased in recent years, as half of the young adult population is enrolled in some type of college or university (Snyder & Dillow, 2012). However, with the increase in number of students attending college, there is also an increase in demand for student services, including on campus access to mental health care. Students are currently showing a nine percent rate of utilization within college counseling centers, a number that has remained steady since 2004 (Gallagher, 2005; Kim, Park, La, Chang, & Zane, 2015).

Increase in Severity of Concerns

Over the last few years, college counseling center clients have shown a significant increase in the severity of presenting concerns (Watkins, Hunt, & Eisenberg, 2012). Staff within counseling centers have reported an increase in more serious mental health issues, and it has been coupled with the rise of other primary concerns such as depression and anxiety (Benton, Robertson, Tseng, Newton, & Benton, 2003; Blanco et al., 2008). In 2000, 77% of counseling center directors reported that one of the major concerns for their center was the increase in clientele with serious psychological issues (Gallagher, Gill, & Sysco, 2000). Another study found that one in three college students reported that they had been too depressed to function at least one time in the last year (American College Health Association, 2009). Additionally, suicidal ideation is on the rise, as one third of counseling center clients self-reported that they had seriously contemplated suicide in 2013 (Center for Collegiate Mental Health, 2014). One

reasoning that attempts to explain this change, is that today, accessible mental health resources and medication are helping students to attend college who previously would not have had the support or resources to be able to attend a higher education facility (Watkins et al., 2012).

Expansion of services. As the number of clients seeking help increases with the severity of psychological issues, college counseling centers are seeing an escalation in demand for services to meet the needs of students. One of the reasons for the increase of clientele in college counseling centers is that clients have had more exposure to mental health services before attending college than previously. As a result, counseling centers are attempting to expand services, which have been found to lead to a reduction in mental health stigma on campus as well as increased accessibility for students (Watkins et al., 2012).

Counseling centers have grown and expanded to meet demands with the purpose of helping students to work on both academic and emotional needs to become more successful in their schooling. Counseling services provided through college counseling centers have been proven to be effective and correlate with a decrease in psychological distress (Minami et al., 2009), an increase in positive academic outcomes (Choi, Buskey, & Johnson, 2010), and a lower likelihood of dropping out of school (Wilson, Mason, & Ewing, 1997). When counseling centers are prepared to meet the needs of students and students are willing to take advantage of these services, there are positive effects that benefit both the student and the university.

Attention to minority counseling services. As counseling centers work to expand their services to reach all students with mental health needs, more attention needs to be given to minorities within the university setting. Previously, the needs of minorities have been overlooked in the literature and in practice, and research on counseling centers has focused on the center as a whole as opposed to looking at specific ethnic and racial groups (Kearney,

Draper, & Baron, 2005). More recently we have seen a call to pay more attention in research and in practice to ethnic minorities (Bernal & Scharro-del-Rio, 2001) as multicultural issues, or lack of awareness of multicultural issues, can lead to lower levels of counseling service utilization by minorities. From prior research, we can assume that this lower utilization can lead to unmanaged emotional and academic issues, resulting in higher dropout rates of minorities.

Utilization trends of minorities. Currently, racial and ethnic minorities typically utilize mental health services at lower rates than their EA counterparts in both community and university samples. Some factors that may contribute to lower levels of utilization are institutional barriers, acculturation, lack of culturally appropriate treatment methods, fears of stigma, ethnic composition of counseling staff, and keeping personal information within the family unit (Hayes et al., 2011; Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015; Sullivan, Ramos-Sanchez, & McIver, 2007). The number of ethnic minorities in the US is growing. By the year 2050, it is predicted that ethnic minorities will make up 50% of the U.S. population (U.S. Census Bureau, 2000). With such a large percentage of future students being ethnic minorities, it is imperative to understand levels of utilization among this population in order to offer better services.

Latino Utilization Trends

Although we can see that these trends affect minority groups, to really understand the issues at hand it is important to look at each racial or ethnic minority individually to understand common themes that may contribute to lower levels of utilization of counseling services. Within the United States, Latinos are one of the fastest growing minority groups. The U.S. Department of Health and Human Services (2001) is predicting that by the year 2050 Latinos will account for 25% of the total population. While Latinos have typically been underrepresented on college

campuses, the number of ethnic minorities and Latinos in universities has grown (Gonzalez, 2015). Looking at the trend of growth among Latinos in the general population and in universities, we can see that the need for understanding barriers in mental health for this population is important.

Stressors of Latino college students. College presents stressors and difficulties for all students. However, minority students tend to have more negative experiences than do their EA peers, with these negative experiences having greater adverse effects on minority students (Aguirre & Martinez, 1993; Gloria & Rodriguez, 2000; Rodriguez, 1995). These extra stressors could explain the reason why Latinos are currently less likely than their EA counterparts to complete schooling both at the secondary and postsecondary level. Of this ethnic group, Mexican Americans are the least educated subgroup with only five percent having received a college degree (Constantine, Gloria, & Baron, 2006; Gloria & Rodriguez, 2000). The small number of Latinos attending college can be explained by the inordinate number of stressors that they experience. These stressors include, but are not limited to, gender role conflict, academic struggles, racism, discrimination, acculturation, poverty, isolation, and cultural conflicts (Duarte, 2003; Romero, 2009; Sue & Chu, 2003). The result of these psychological stressors leads to a considerable amount of mental health problems among both Latinos and especially international Latino college students (Ramos-Sanchez, 2015).

Stressors of international Latino college students. While the number of university attendees, and specifically the number of Latino attendees is rising, it is also important to recognize the number of international students from Latino countries. The number of international students has grown by 72% since the year 2000 and makes up four percent of the university population with a total of 886,052 students in the 2013-2014 school year (Institute of

International Education, 2014a). However, Nilsson, Berkel, Flores, and Lucas (2004) reported that only two percent of all international students seek out counseling services. The 61,439 Latino international students (Institute of International Education, 2014b) face many similar stressors as domestic born Latinos, but they are also faced with additional stressors like English language proficiency, isolation from peers, adjusting to a new education system and culture, employment restrictions, financial issues, homesickness, guilt about leaving the family, and separation from family and peers (Arredondo, 1991; Miranda et al., 2015; Romero, 2009; Sue & Chu, 2003; Thomas & Althen, 1989).

Unaddressed subgroups of Latino college students. A third group, students who were born internationally but then became U.S. citizens and attended college, has not been addressed in the literature. Even though we see differences among these groups, the trend in the literature is to group these three subgroups; Latinos born in the US, international Latinos, and Latinos born internationally but who became U.S. citizens later. There is a paucity of research that separates these groups out to better understand their specific counseling needs and the stressors to their treatment in a university setting.

Research Gaps in Latino Student Counseling Utilization

There are a few main points that are seen throughout the literature that expose the gaps in the research and demonstrate the need for separating these three subgroups out as opposed to treating them as one large assemblage and ignoring their differences. Some of the areas that need consideration to better understand counseling utilization among Latinos are acculturation, gender roles, different worldviews, acceptance among peers, and reports on measurement tools.

Acculturation. As expected, there are many differences correlated with differences in acculturation among IB, USB, and IBUS populations. Studies looking at community health

samples show that Mexican Americans born in the US have higher rates of phobias, depression, and lifetime prevalence of these diagnoses than do Latinos who are born in Mexico (Sue & Chu, 2003). Furthermore, among immigrants, longer residence in the US correlates with higher rates of psychiatric disorders (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Since this was found, more research has been done with the purpose of looking at the role of acculturation within therapy (Romero, 2009). For example, Vega et al., (1998, 2004) hypothesized that one of the reasons why mental health issues are positively correlated with time lived in the US among Latinos is due to differences between social expectations in Latino countries versus in the US. The theory states that immigrants have lower expectations concerning income and educational acquisition than do immigrants who have spent more time in the US or than U.S. born Latinos, who may become demoralized and depressed if they are unable to attain the income and educational expectations endorsed by U.S. culture after becoming significantly acculturated to U.S. ideals.

Additionally, issues like language barriers become an obstacle, as low numbers of bilingual counselors as well as low confidence in speaking that language could deter English as a second language students from attending counseling (Alegria et al., 2002; Alegria et al., 2007; Kearney et al., 2005; Sue & Chu, 2003). Stresses of not knowing English fluently while living in the US can contribute to higher levels of acculturative stress (Miranda & Matheny, 2000), and this is correlated with a negative orientation to help-seeking behaviors (Stanton-Salazar, Chavez, & Tau, 2001).

Likewise, the process or act of acculturation in and of itself can be a major stressor to students (Arredondo, 1991; Gloria & Rodriguez, 2000; Miranda & Matheny, 2000), and it correlates with depressive symptomatology and anxiety (Castillo et al., 2015; Crockett et al.,

2007). Other stressors that result from acculturation that affect students include struggles with ethnic identity, implications of being a minority, differing cultural values, homesickness, family distancing, cultural incongruity, subjection to stereotyping, intercultural competence, and psychological distress (Carrera & Wei, 2014; Gloria & Rodriguez, 2000; Leong & Chou, 1994; Miville & Constantine, 2006; Reyes, 2012; Romero, 2009; Wilton & Constantine, 2003). As we look at these struggles it is clear that acculturation and other stressors that we see vary in between and within group differences (Gloria & Rodriguez, 2000). However, a few researchers have reported that findings about acculturation have not been consistent (Romero, 2009; Shibazaki, 1999) which begs for more research on the topic, especially within Latino subgroups, as levels of acculturation change among these groups.

While there are many arguments that more needs to be done to view the within-group differences of acculturation and how it relates to mental health, the majority of these studies have not separated participants into groups based on international status, but rather have lumped these subgroups together. Even though acculturation levels are likely to differ greatly among IB, USB, and IBUS students, which would consequently influence the need for counseling, it has not been discussed in the literature. Furthermore, issues related to second generation Latinos have been neglected (Sullivan et al., 2007) even though it is noted that the differences between first generation parents and second-generation children may have an effect on stigma and issues within therapy.

Gender. As far as cultural backgrounds and experiences are concerned, some researchers have examined gender differences in regards to therapy as well as gender role differences between highly acculturated and less acculturated Latinos. While differences between gender usage of services are prevalent within the literature, it is important to note that

there are many between and within group differences as far as gender roles are concerned. So, being aware of individual differences is important in further research of gender roles, therapy, and Latinos (Gloria & Rodriguez, 2000).

Overall, there has been a good amount of research done on gender differences among Latinos in therapy, although the results appear inconclusive. Some research states that females underutilize therapy and have more overall psychological complaints (Chiang, Hunter, & Yeh, 2004; Shibasaki, 1999). Other research states that regardless of gender Latinos underutilize therapy (Duarte, 2003; McMiller & Weisz, 1996; Sanchez & King, 1986) and that gender has no impact on utilization (Sullivan et al., 2007). While generational status was found to be a significant factor in a few of these studies, there were no studies that looked at citizenship or international status specifically in a college counseling center population or how it relates to gender effects.

Differences in worldviews. Within the Latino community, there are many differences in background, culture, and worldviews. These differences could possibly trend similarly for those of the same subgroup (i.e., IB, USB, or IBUS). It has been theorized that differences among worldviews could play a role in counseling utilization, although there is a paucity of research in this area. For example, it has been hypothesized that one of the reasons why Latinos utilize services at lower rates is due to the idea of *familismo*, which is the ideal of loyalty and trust within the family and the norm that you go to the family with problems and concerns (Paniagua, 2014). Because of this belief, research suggests that for some Latinos it is considered shameful to attend therapy, as one is sharing familial issues with an outsider and insinuating that the family cannot adequately help the individual with their problems (Alegria et al., 2007; Paniagua, 2014). As a result, Latinos are more likely to contact family members as opposed to

professionals for mental health concerns (Constantine, Wilton, & Caldwell, 2003; Kearney et al., 2005; McMiller & Weisz, 1996; Shibazaki, 1999).

Due to Latino cultural ideals of collectivism, it has also been hypothesized that the Latino population may be drawn to group therapy as opposed to individual therapy. It is also theorized that this would be a culturally relevant practice, as it fits better with the collectivist nature of the Latino population (Rivera, Fernandez, & Hendricks, 2014). However, there is little research testing whether Latinos utilize groups at higher rates than their EA counterparts, whether those rates change if the groups offered are on a predominately EA campus, or whether groups are more effective than individual therapy among Latinos and Latino subgroups.

Differing expectations of therapy. Students may all have differing expectations of therapy, but there has been little research looking at how expectations differ among Latinos, and what has been done shows conflicting results. The few studies that exist on this subject suggested that ethnicity as well as time spent in the US and acculturation has an impact on students' expectations of therapy (Kunkel, 1990; Marien, 1998). However, other studies show that across levels of acculturation, there is no difference among expectations (Marien, 1998). Additionally, it has been noted that Latinos have higher expectations for success in multicultural counseling than EA, Asian, or biracial students (Constantine & Arorash, 2001). Other studies report that Latinos believe that services offered are irrelevant to the stressors they are currently facing (Kearney et al., 2005). While there are some studies that have considered differences in counseling expectations among Latinos, there are no clear results. Additionally, there have been no studies that separate USB, IBUS, and IB Latino students.

Social acceptance. The impact of social acceptance plays a significant role in the mental health and well-being of Latino college students (Arredondo, 1991; Capello, 1994; Constantine

et al., 2006; Jimenez, 2012). Social acceptance is the idea of making friends and feeling accepted as part of an in-group. For Latinos, this can be difficult, as sometimes students may feel “stuck” between cultures or struggle with their ethnic identity (Constantine et al., 2006; Lee & Richardson, 1991). This can lead to higher levels of stress resulting from issues within interpersonal relationships (Skowron, Wester, & Azen, 2004). It has also been found that when compared to EA counterparts and after controlling for social class and acculturation, Latinos experience higher levels of social stress in college (Crockett et al., 2007; Rodriguez, Mira, Myers, Morris, & Cardoza, 2003). It is possible that there could be differences between the number of social stressors felt based on international student status, as this would add to other stressors such as making friendships within a new language. While social stress has been noted in the literature, Latinos have typically been lumped together. To date no studies on social stress have looked at this issue in the context of its impact on different Latino subgroups.

Measurement differences. Lastly, among the studies that look at Latino counseling utilization, few examine measurement tools utilized by counseling centers to better understand minority utilization trends. Some studies have looked into the OQ-45 (Kearney et al., 2005; Kim et al., 2015), some have utilized the CCAPS (Kim et al., 2015; Lockard, Hayes, Graceffo, & Locke, 2013) but there is little research that utilizes intake tools like the Family Concerns Survey or Presenting Problems Checklist (Lockard et al., 2013). One possible reason for this is that most measurements utilized by counseling centers today were created by and normed on EA clients, with no measurement tools created or normed on Latino clients. While measurements created for different populations may provide access to important information about Latino clients, it is still important to draw attention to the lack of intake measurements normed for diverse populations.

Looking at the current literature it is apparent that more research needs to be done to better understand minority trends in college counseling centers, as mental health concerns are rising concurrently with enrollment of both U.S. born and international minority students. Considering the high college dropout rate of the Latino population and the positive academic and emotional effects of counseling, understanding the reasons behind lower levels of Latino utilization of services becomes increasingly imperative. Little investigation has been done to understand the differences between Latino subgroups of U.S. born, internationally born U.S. citizen, and international students. Specifically, looking at differences among gender utilization, treatment modality, changes in distress level, and measurement outcome will ideally show how these differences transfer to interpreting trends of therapy utilization. By gaining a clearer grasp of the differences among counseling service utilization trends among Latino subgroups, we can begin to discern why these trends are occurring. We would then have the base information to create appropriate and effective outreach programs to assist each specific subgroup in overcoming barriers to receiving needed mental health services. As clients overcome these obstacles to treatment they are more likely to have the skills to cope with emotional and academic stressors and as a result, continue enrollment in a university setting until their degree is completed.

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