Examining Somatization as a Potential Barrier to Mental Health Care in South Asian College Students in the U.S.

healthyhorns

MHISA
Mental Health Initiative for South Asians

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Introduction

Cultural stigma and collectivist family dynamics impact mental health symptoms and help-seeking among South Asian individuals. For example, beliefs that only biological symptoms are valid may make South Asians more prone to **somatization** – physical manifestations of psychological distress.[1] Additionally, beliefs that mental illness reflects personal weakness and should be handled by the family contribute to lower treatment rates in this population.[1] Despite increased likelihood of experiencing biological *symptoms*, attributing biological *causes* to mental illness is associated with higher shame and lower help-seeking among South Asian college students. Among White students, on the other hand, biological attributions are associated with lower shame and higher treatment rates.[2]

Research on mental health and help-seeking among South Asian Americans is limited as most race/ethnicity reporting standards align with U.S. Census categories and fail to distinguish between Asian ethnic subgroups, obscuring potential differences in mental illness presentation and treatment utilization.[3]

Study Aims

1. Validate a name-based classification algorithm to differentiate between students of South Asian (SA) and non-South Asian (NSA) origin.
2. Investigate differences in mental health symptom presentation and utilization of on-campus health and mental health services among SA, NSA, and white students.

Methods

This study is a secondary analysis of UT Austin Counseling and Mental Health Center (CMHC) and University Health Services (UHS) clinical data (UT Austin IRB Protocol #00005852).

Aim 1. The classification algorithm was validated using a training sample of international students with known countries of origin (*n* = 2,757), achieving classification accuracy of 94%.

Aim 2. The sample included records of students' first mental health diagnosis (MH Dx) at CMHC/UHS from AY 18-19 through 22-23 (n = 1,932; 12.8% SA, 12.6% NSA, 74.6% white), classified into four groups:

1. **CMHC Dx.** Initial presentation + MH Dx at CMHC (*n* = 1,028; 53.2%)
2. **UHS (somatization).** Initial presentation at UHS with a ***potentially* MH-related concern**† (i.e., physical symptom(s) commonly associated with mental health issues) followed by MH Dx within 30 days (*n* = 244; 12.6%)
3. **UHS (direct MH presentation).** Initial presentation at UHS with a ***direct/explicit* MH concern**† followed by MH Dx within 30 days (*n* = 371; 19.2%)
4. **UHS (non-MH presentation).** Initial presentation at UHS with a **non-MH-related concern** followed by MH Dx within 30 days (*n* = 289; 15.0%)

†Potential vs. direct/explicit vs. non-MH concerns classified using UHS appointment reason codes. **Potentially MH-related concern:** Abdominal/stomach pain; asthma/wheezing/shortness of breath; cardiovascular symptoms (high BP, chest pain, palpitations); fatigue, headache, lightheaded, sleep problems; GI problem; numbness/tingling; back/neck/diffuse pain. **Direct/explicit MH concern:** Anxiety/stress; depression; mental health concern.

Results

Figure 1. *Percentages of students within each mental health presentation/diagnosis pattern by race/ethnicity.*

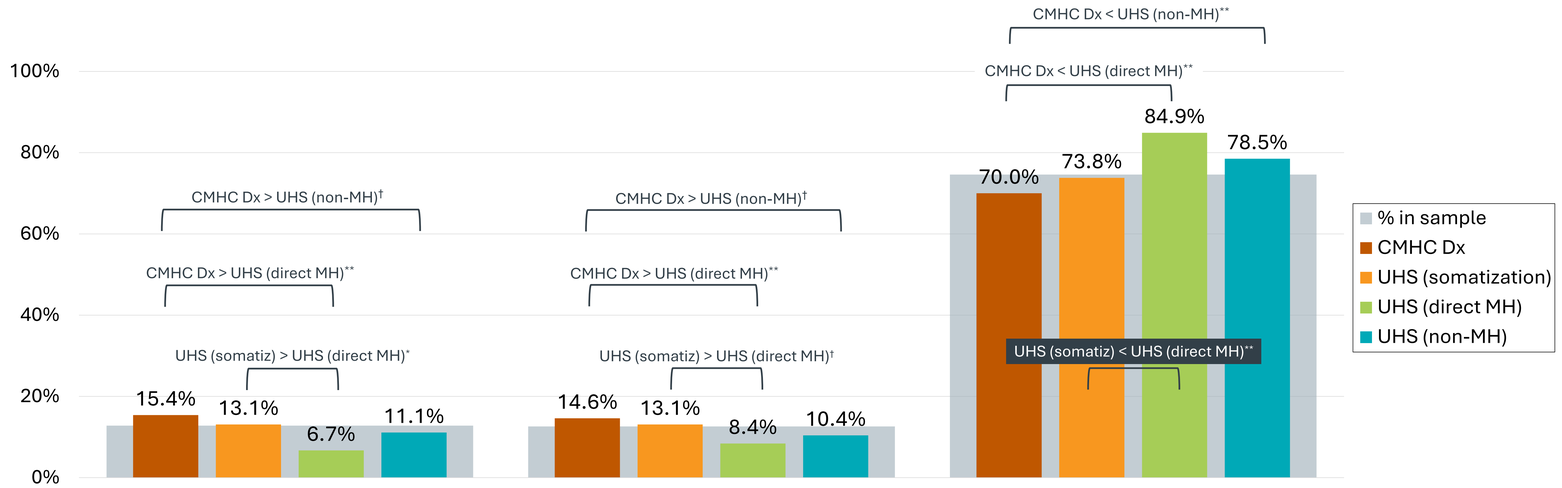

Table 1. *Proportional differences in racial/ethnic breakdown of mental health presentation/diagnosis pattern groups.*

	CMHC Dx vs. UHS (somatization)		CMHC Dx vs. UHS (direct MH)		CMHC Dx vs. UHS (non-MH)		UHS (somatization) vs. UHS (direct MH)		UHS (somatization) vs. UHS (non-MH)		UHS (direct MH) vs. UHS (non-MH)	
	% diff	p-value	% diff	p-value	% diff	p-value	% diff	p-value	% diff	p-value	% diff	p-value
Non-South Asian	+2.3%	.430	+8.6%**	< .001	+4.3%†	.082	+6.4%*	.012	+2.0%	.556	-4.3%*	.049
South Asian	+1.5%	.634	+6.2%**	0.003	+4.2%†	.081	+6.2%†	.077	+4.2%	.398	-2.0%	.373
White	-3.7%	.283	-14.9%**	< .001	-8.5%**	.006	-11.1%**	< .001	-4.8%	.234	+6.4%*	.034

Note. Proportional differences tested using Z-tests comparing two proportions. **p < .01. *p < .05. †p < .10.

Discussion

- Slightly over half of Asian students in our sample were of South Asian descent, underscoring the importance of disaggregating Asian American groups in healthcare research to examine potential heterogeneity among Asian ethnicities.
- Among students who presented to an on-campus clinic seeking mental health care, Asian students were over-represented among those who sought care at CMHC, whereas White students were over-represented among those who sought care at UHS. This may reflect a more limited understanding of the scope of UHS (i.e., physical health only) among Asian students. Due to lower family stigma,[4] White students may enter college with more familiarity with mental health service delivery options, including primary care. Finally, biological attributions for mental illness that promote help-seeking among White students[2] may also make them more likely to seek treatment in medical settings.
- Findings highlight the need for better communication around the scope of healthcare services, importance of holistic approaches to health, and stigma reduction among Asian student populations.

References

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