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# **Integrating a Psychoeducational Program with Short-term Therapy for Asian International College Students: A Randomized Controlled Clinical Trial**

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## **ABSTRACT**

*Mental health challenges significantly affect Asian international college students in the U.S., who often underutilize mental health services. This study evaluated the effectiveness of combining psychoeducation with short-term individual therapy, delivered via SFBT and CBT, psychodynamic, and integrated approaches, to improve outcomes in this population. The participants (n = 44) completed preintervention assessments, including the DASS-21, AIS, Rating of Distress, ATSPPH, and MAKS. They were then randomized to receive either psychoeducation plus therapy or therapy alone, with both groups completing eight therapy sessions. The postintervention results indicated that the psychoeducation plus therapy group presented improvements in anxiety, sleep quality, and distress levels and more positive attitudes toward mental health treatment than did the therapy alone group. These findings highlight the benefit of culturally sensitive psychoeducation integrated with therapy to enhance mental health outcomes among Asian international students in university counseling settings.*

**Keywords:** Asian international college students, psychoeducation, psychotherapy, treatment outcomes

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## INTRODUCTION

International students represent a vital segment of the U.S. college student population, accounting for 5.6% of total enrollment in 2023 (National Center for Education Statistics, 2023). Among this population, Asian international students constitute a substantial proportion, with approximately 39% originating from East Asia (e.g., China, Japan, South Korea) and 30% from South Asia (e.g., India, Pakistan, Bangladesh) and Southeast Asia (e.g., Vietnam, Thailand, the Philippines) (NCES, 2023). This demographic distribution underscores the significant presence of Asian international students within the broader international student population at U.S. colleges.

College students face a wide range of challenges, including financial stress, academic pressure, and uncertainty about future careers (Xu, 2024). Among these concerns, mental health issues have emerged as especially critical. In the Healthy Minds Study, which surveyed more than 350,000 students across 373 campuses from 2013--2021, over 60% of the students reported experiencing mental health problems in 2020—an increase from previous years (Lipson et al., 2022). Alarming, students of color, including many international students, demonstrated the lowest rates of treatment-seeking behavior, further exacerbating their mental health concerns (Lipson et al., 2022).

Asian international students are particularly vulnerable to mental health challenges, with depression and anxiety being the most prevalent disorders (Han et al., 2013). Depression commonly manifests as persistent low mood, fatigue, and loss of interest in activities, which can negatively impact both academic performance and social integration. Prior research has documented high rates of depressive symptoms among Asian international students, with more than one quarter of participants scoring above the CES-D clinical depression cutoff (Ma, 2021). Academic stressors, such as language barriers, are significantly correlated with higher levels of depression in this group (Kim, 2020). Acculturative stress—resulting from the demands of adapting to a new culture environment—further exacerbates these symptoms. Additionally, adherence to traditional Asian values, emotional suppression, and feelings of shame have been identified as contributing factors to depression (Liw et al., 2022). Maladaptive perfectionism, characterized by excessively high personal standards combined with self-critical evaluations, is another factor linked to depressive symptoms and is often driven by strong familial and cultural expectations (Huang & Mussap, 2016).

Anxiety disorders are also highly prevalent among Asian international students. In a survey of 1,881 Chinese international students across 21 U.S. universities, 20.7% reported moderate to severe anxiety on the basis of GAD-7 scores ( $\geq 10$ ), indicating widespread symptoms (Lin et al., 2022). In addition to academic and acculturative stress, rigid and demanding cultural and family expectations contribute significantly to anxiety. Jun et al. (2022) reported that among 190 Asian international students from 16 countries, maladaptive, perfectionistic family environments significantly increased the risk of anxiety disorders. These environments—characterized by high academic expectations, limited encouragement, and frequent criticism—were linked to elevated stress and anxiety levels in their findings.

Sleep problems are another major concern because of their strong link to physical and mental health. Disrupted sleep can worsen psychological functioning and contribute to both emotional and cognitive impairment (Allison et al., 2016). Among Asian international students, poor sleep quality is common. A study of 260 Chinese international students revealed a significant correlation between higher anxiety and lower sleep quality (Huang et al., 2022). These sleep issues, often driven by stress and cultural adjustments, are associated with reduced academic performance and greater psychological distress.

Despite elevated mental health risks, Asian international students often underutilize available mental health services (Liu et al., 2020). Cultural values play a central role in this reluctance (Yin et al., 2024). Many Asian families prioritize collective harmony and view mental illness as shameful, discouraging professional health in favor of traditional family-based coping strategies (Gee et al., 2020). Institutional barriers also persist. Most universities offer only short-term counseling, which may not meet the needs of students requiring longer-term care (Cohen et al., 2020). Limited awareness of mental health resources and a lack of cultural responsiveness further hinder access (Chen et al., 2020).

Psychoeducation is grounded in multiple theoretical models across therapy approaches (Kürümlüoğlugil & Tanrıverdi, 2021; Gervis & Goldman, 2020). These models use psychoeducation to increase disorder-specific knowledge, reduce stigma, improve coping skills, and promote engagement in therapy. Pretherapy psychoeducation, specifically, plays a crucial role in preparing clients for treatment by fostering psychological readiness and addressing barriers such as stigma and misinformation (Maeshima & Parent, 2020). This framework supports the integration of psychoeducation with individual therapy to better serve populations facing unique cultural and systemic barriers, such as Asian international students.

Although psychoeducational interventions for Asian international students have gained attention (Kim et al., 2021), few studies have examined their individual effects when they are implemented prior to short-term therapy. Existing programs often emphasize specific diagnoses (Lam et al., 2017) or focus on individuals already engaged in treatment (Kumar & Gupta, 2015). Public-facing interventions, such as Fung et al. (2021), offer general psychoeducation mental health information but lack actionable guidance on navigating therapy (e.g., how to find a therapist or set expectations).

In response, this study introduces a culturally responsive, pretherapy psychoeducation program designed to improve therapy outcomes for Asian international students. Rooted in a contemporary understanding of psychoeducation as a collectivized and culturally adaptable process (Magill et al., 2021), the intervention provides practical tools for engaging with therapy and managing common mental health concerns. This study investigated whether students receiving psychoeducation prior to short-term individual therapy show greater improvements in depression, anxiety, stress, and sleep quality than those receiving therapy alone. By addressing the gap in targeted, preparatory psychoeducation, this research aims to inform culturally sensitive practices in university counseling services and improve access to and outcomes for Asian international students.

## **METHOD**

This study addressed two primary research questions:

- 1) Do Asian international students who receive psychoeducation in addition to short-term therapy show greater improvement in treatment outcomes than those who receive therapy alone?
- 2) Are there differences in mental health knowledge and attitudes between the two groups?

### **Participants**

Forty-four full-time Asian international students holding F1 visas participated in the study (Table 1). Most were recruited from a northeastern university's student counseling center and five additional counseling centers across New York State. International student offices and psychology departments also distributed flyers and survey links via email. The inclusion criteria required participants to (a) be at least 18 years old; (b) be enrolled full-time as international students (e.g., F-1 visa, OPT); (c) self-identify as Asian; (d) report experiencing depression, anxiety, or stress in the past two weeks; (e) have no prior psychological treatment; and (f) be able to attend at least 7 of 8 therapy sessions.

Four therapists—doctoral students in their third year of clinical psychology or PsyD programs (2 female, 2 male)—provided therapy under licensed supervision. Two were Asian international students in the U.S., and two were Asian immigrants. One therapist treated six participants via a combination of solution-focused brief therapy (SFBT) and cognitive behavioral therapy (CBT). Two therapists treated ten participants via a psychodynamic approach, exploring underlying psychological processes and past experiences. The fourth therapist worked with 27 participants via an integrative approach, combining multiple modalities to tailor treatment to individual needs.

**Table 1: Demographic** characteristics of the participants (n = 44)

	Social-demographic characteristics	Psychoeducation + Therapy	Therapy
Gender	Men	8	2
	Women	16	18
	Nonbinary/prefer not to say	0	0
Age group (years)	18-22	10	4
	23-26	7	6
	27-30	3	9
	30+	3	2
Education Level	Undergraduate	8	3
	Graduate	12	16
	Other	3	2
Ethnicity	China	18	17
	India	3	2
	Korea	1	1
	Thai	1	1
Years in U.S.	Less than a year	7	2
	1 year	3	6
	2 years	2	3
	4 years	2	0
	5 years	3	3
	6 years	5	3
	8 years	2	0
	9+ years	0	3
Major	Architecture and Related	1	1
	Business	3	4
	Computer	4	3
	Education	1	0
	History	2	0
	Human Resource	0	1
	Liberal Arts	4	2
	Math	1	1
	Multi/interdisciplinary	2	0
	Philosophy	1	0
	Psychology	2	6
	Social Science	1	1
	Visual and Performing Arts	1	0
Previous Diagnoses		0	0
Previous Treatment		2	4

## **Procedures**

Institutional review board approval was obtained for this study. After providing informed consent and completing eligibility screening, the participants were assigned a unique ID and completed a preintervention assessment measuring depression, anxiety, stress, sleep quality, attitudes toward mental health, and mental health knowledge. The participants were then randomly assigned to either the psychoeducation plus therapy group or the therapy alone group. Both groups received eight weekly individual therapy sessions from psychologists-in-training and were supervised by licensed psychologists.

The participants in the psychoeducation group completed a 20-item multiple-choice exam to assess their understanding of the program content. A minimum passing score of 16 (80%) was needed, reflecting accepted standards in health education for content mastery (Downing & Yudkowsky, 2009). This ensured adequate comprehension before starting therapy. All participants completed postintervention assessments at the final session and again at the 90-day follow-up visit to evaluate treatment outcomes.

After the postintervention assessments, psychoeducation materials were emailed to all the participants. All participants then rated their experience with the psychoeducational program, and both participants and therapists evaluated the therapeutic process.

## **Psychoeducational Program**

The psychoeducational program was designed to provide participants with a comprehensive understanding of mental health and available treatment options. Informed by findings from prior studies, the program was divided into four key areas: introduction to mental health, therapeutic alliances, cultural factors in therapy, and accessibility of mental health treatment in New York State. Each section was carefully curated to deliver practical knowledge, reduce stigma, and enhance participants' readiness to seek help.

The Introduction to Mental Health section covered fundamental topics, including definitions of mental health, common mental health disorders, and treatment modalities such as psychotherapy, medication, and support groups. The Therapeutic Alliance section emphasized the importance of establishing effective relationships with therapists, introduced various therapeutic approaches (e.g., CBT and psychoanalysis), and offered guidance on selecting a therapist and preparing for sessions. The Cultural Factors in Therapy section addressed the role of cultural competence and sensitivity, particularly for students navigating therapy in multicultural contexts. The Accessibility section provided resources specific to New York City, including available campus-based mental health services and other community resources.

To evaluate participants' knowledge after the psychoeducation program, researchers developed a 20-item multiple-choice quiz on the basis of the program content (available upon request). Each correct response was awarded one point, resulting in possible total scores ranging from 0 to 20.

## **Assessment**

Depression Anxiety Stress Scale-21 (DASS-21): (Henry & Crawford, 2005). The Depression Anxiety Stress Scale-21 (DASS-21) is a 21-item quantitative measure of distress along the three axes of depression, anxiety, and stress. The participants rate how much the statement applies to them on a 4-point scale, with 0 representing “does not apply at all” to 3 “applies to me very much or most of the time.” These subscales are scored by the addition of the total item scores. A higher score indicates greater severity or frequency of negative emotional symptoms. The overall Cronbach’s alpha for the DASS-21 scale of the current sample was 0.89. The DASS-21 subscales had Cronbach’s alpha values of 0.87, 0.68, and 0.78 for depression, anxiety, and stress, respectively.

Athens Insomnia Scale (AIS): (ICD-10). The Athens Insomnia Scale is an 8-item scale that assesses the severity of insomnia using diagnostic criteria set forth by the International Classification of Diseases (ICD-10). The scale evaluates sleep onset, night and early-morning waking, sleep time, sleep quality, frequency and duration of complaints, distress caused by the experience of insomnia, and interference with daily functioning. The participants used 4-point Likert scales to indicate how the severity of certain sleep difficulties affected them during the past month. Scores range from 0, “has not been a problem,” to 3, “more acute sleep difficulties.” The scale is scored by the addition of the total item scores. A higher score indicates more significant sleep difficulties. The developers suggest a cutoff score of 6, distinguishing between controls and insomnia patients. The scale has demonstrated good reliability and validity for screening insomnia symptoms in the Asian population (Jeong et al., 2015; Manzar et al., 2022). The overall Cronbach’s alpha of the current sample was 0.86, indicating excellent internal consistency.

The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF): (Fischer & Turner, 1970). The Attitudes Toward Seeking Professional Psychological Help Scale is a 29-item measure. It consists of four factors: recognition of the personal need for professional psychological help, tolerance of the stigma associated with psychological help, interpersonal openness regarding one’s problem, and confidence in the mental health professional. It is widely used in the U.S. to investigate help-seeking attitudes among various racial and ethnic groups, immigrants, and international students. The participants rated these statements on a four-point Likert scale ranging from “Strongly Agree” to “Strongly Disagree”, with scores ranging from 4 to 1. The total score for each participant is calculated by adding the response points of each item. Eighteen items are reverse scored before a score is computed. A high score indicates a more positive attitude toward mental health treatment. This version of the ATSPPH has demonstrated internal consistency ranging from 0.82--0.84 (Elhai et al., 2008) and has sustained test–retest reliability in Taiwanese undergraduates at two-, four-, and six-week intervals (Han & Chen, 2015). The overall Cronbach’s alpha of the current sample was 0.88. However, the subscales varied in their internal consistency. The Cronbach’s alpha values for need, stigma, openness, and confidence were 0.65, 0.64, 0.49, and 0.74, respectively.

Mental Health Knowledge Schedule (MAKS): (Evans-Lacko et al., 2010). The Mental Health Knowledge Schedule (MAKS) is designed to assess knowledge of mental health and covers six stigma-related areas: help-seeking, recognition, support, employment, treatment, and recovery. It also includes six items specific to knowledge of mental health conditions. According to Evans-Lacko's work, higher scores signify a more informed understanding of mental health, potentially including the nature of mental health conditions, recognition of symptoms, and understanding of appropriate treatments and coping strategies. Participants with higher MAKS scores presented a greater degree of knowledge and awareness about mental health issues. The MAKS uses an ordinal scoring scale ranging from 1 to 5, representing the degree of agreement from low to high. Notably, items 6, 8, and 12 are reverse-coded. Pingani et al. (2019) conducted a study to validate the scale and demonstrated moderate reliability. The Mental Health Knowledge Schedule (MAKS) of the current study showed good reliability for the overall scale ( $\alpha = 0.81$ ), indicating high internal consistency. Its subscales had the following reliabilities: Part 1 ( $\alpha = 0.67$ ) with moderate reliability and Part 2 ( $\alpha = 0.73$ ) with high consistency.

Finally, the participants' feedback on the Psychoeducation Program scale exhibited strong internal consistency ( $\alpha = 0.91$ ), indicating high reliability.

## Data Analysis

The data were analyzed via IBM SPSS. Thematic analysis was used for qualitative data, and descriptive statistics were used to summarize the quantitative findings. The internal consistency reliability was calculated for all the scales and subscales. One-way ANOVAs were used to assess group differences in pre- and postassessment scores, with significance set at  $p < .05$  (two-tailed).

## RESULTS

Two-tailed, one-way ANOVA was used to compare posttreatment DASS-21 scores between the psychoeducation plus therapy group and the therapy alone group. A marginal effect was found for anxiety [ $F(1, 41) = 4.03, p = .051$ ], but no significant differences emerged for total DASS-21 scores [ $F(1, 41) = 2.46, p = .125$ ], depression scores [ $F(1, 41) = 1.67, p = .203$ ], or stress scores [ $F(1, 41) = 0.57, p = .456$ ]. Despite their limited significance, both groups showed symptom reduction posttreatment (see Table 2).

For the Athens Insomnia Scale (AIS), a significant effect was observed [ $F(1, 41) = 10.17, p = .003$ ]. The psychoeducation plus therapy group showed reduced insomnia, whereas symptoms increased in the therapy alone group.

A significant difference in self-reported distress was also found [ $F(1, 40) = 8.11, p = .007$ ], with the psychoeducation group reporting a greater reduction ( $M = -1.52, SD = 2.70$ ) than the therapy alone group did ( $M = 0.95, SD = 3.57$ ).

Posttreatment differences in ATSPPH scores were significant [ $F(1, 41) = 4.14, p = .048$ ], with the psychoeducation group showing greater

improvement ( $M = 12.58, SD = 11.21$ ) than the therapy group did ( $M = 2.60, SD = 19.07$ ). Significant effects were also found for the Need [ $F(1, 41) = 4.08, p = .050$ ] and Openness [ $F(1, 41) = 5.97, p = .019$ ] subscales but not for Stigma [ $F(1, 41) = 2.40, p = .129$ ] or Confidence [ $F(1, 41) = 1.88, p = .378$ ].

No significant group differences were found for the MAKS total score [ $F(1, 41) = 1.99, p = .166$ ] or its stigma-related knowledge [ $F(1, 41) = 1.16, p = .288$ ] and mental health conditions knowledge [ $F(1, 41) = 2.26, p = .140$ ] subscales. Notably, both groups showed decreased knowledge posttreatment, contrary to expectations and discussed further below.

**Table 2: DASS-21, AIS, Rating Distress, ATSPPH & MAKS scores pre- and postintervention**

Measure	Group	Time	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	<i>d</i>
DASS-21	Psychoeducation + Therapy	Pre	20.17	8.27			
		Post	12.71	10.48	1.66	.211	0.79
	Therapy	Pre	17.20	8.45			
		Post	15.75	10.84	0.80	.383	0.15
	Between Groups				2.46	.125	-0.48
DASS-21-Depression	Psychoeducation + Therapy	Pre	12.00	9.02			
		Post	7.50	9.90	3.32	.082	0.47
	Therapy	Pre	9.80	6.45			
		Post	9.50	9.22	2.01	.174	0.04
	Between Groups				1.67	.203	-0.40
DASS-21-Anxiety	Psychoeducation + Therapy	Pre	12.25	6.33			
		Post	6.50	7.27	2.47	.130	0.84
	Therapy	Pre	10.20	5.94			
		Post	9.60	6.85	0.05	.822	0.09
	Between Groups				4.03	.051	-0.62
DASS-21-Stress	Psychoeducation + Therapy	Pre	16.08	8.31			
		Post	11.42	7.63	1.58	.222	0.58
	Therapy	Pre	14.40	6.73			
		Post	12.40	8.17	0.56	.466	0.27
	Between Groups				0.57	.456	-0.23

Measure	Group	Time	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	<i>d</i>
AIS	Psychoeducation + Therapy	Pre	7.54	4.69			
		Post	4.67	4.27	11.11	.003*	0.64
	Therapy	Pre	3.55	3.90			
		Post	4.80	3.54	1.00	.322	-0.34
	Between Groups				10.17	.003*	-0.98
Distress <sup>a</sup>	Psychoeducation + Therapy	Pre	7.22	3.04			
		Post	5.70	2.89	11.20	.003*	0.54
	Therapy	Pre	7.21	2.87			
		Post	8.16	2.69	0.58	.581	-0.39
	Between Groups				8.11	.007*	-0.87
ATSPPH	Psychoeducation + Therapy	Pre	54.71	10.89			
		Post	67.29	11.95	8.26	.009*	-1.10
	Therapy	Pre	55.95	17.26			
		Post	58.55	9.73	0.14	.718	-0.19
	Between Groups				4.14	.048*	0.62
ATSPPH - Need	Psychoeducation + Therapy	Pre	15.21	3.51			
		Post	18.58	3.56	8.67	.007*	-0.95
	Therapy	Pre	14.85	4.72			
		Post	15.45	3.36	1.81	.195	-0.15
	Between Groups				4.08	.050*	0.62
ATSPPH - Stigma	Psychoeducation + Therapy	Pre	10.58	2.74			
		Post	12.46	2.16	8.08	.009*	-0.76
	Therapy	Pre	11.10	3.35			
		Post	11.00	3.17	0.02	.885	0.03
	Between Groups				2.40	.129	0.48
ATSPPH - Openness	Psychoeducation + Therapy	Pre	11.17	2.47			

Measure	Group	Time	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	<i>d</i>
ATSPPH - Confidence	Therapy	Post	14.58	3.16	5.34	.031*	-1.20
		Pre	11.75	4.22			
	Between Groups	Post	12.45	2.50	0.29	.598	-0.20
		Pre	17.75	4.35			
	Psychoeducation + Therapy	Post	21.67	4.65	5.26	.032*	-0.87
		Pre	18.25	6.23			
	Therapy	Post	19.65	3.18	0.18	.674	-0.28
		Pre	19.65	3.18			
	Between Groups	Post			1.88	.378	0.57
		Pre					
MAKS	Psychoeducation + Therapy	Pre	45.17	6.37			
		Post	37.92	10.60			
	Therapy	Pre	38.90	10.70	0.57	.459	0.83
		Post	37.45	12.36			
	Between Groups	Post			1.10	.308	0.13
		Pre					
Psychoeducation + Therapy	Post	18.29	6.31	4.81	.039*	0.56	
	Pre	19.10	4.78				
Therapy	Post	18.50	5.47	0.02	.886	0.12	
	Pre	18.50	5.47				
Between Groups	Post			1.16	.288	-0.33	
	Pre						
MAKS Part 1	Psychoeducation + Therapy	Pre	21.29	4.22			
		Post	18.29	6.31			
	Therapy	Pre	19.10	4.78	4.81	.039*	0.56
		Post	18.50	5.47			
	Between Groups	Post			1.16	.288	-0.33
		Pre					
Psychoeducation + Therapy	Post	19.63	5.63	0.00	.954	0.84	
	Pre	19.80	6.68				
Therapy	Post	18.95	7.16	4.02	.060	0.12	
	Pre	18.95	7.16				
Between Groups	Post			2.26	.140	-0.46	
	Pre						

*Note.* *N* = 44 (*n* = 24 for psychoeducation + therapy, and *n* = 20 for therapy).

<sup>a</sup> The rating distress *n* is 23 for the psychoeducation + therapy group and 19 for the therapy group because of missing pretest or posttest results.

\**p* < .05, a higher mean indicates greater severity or frequency of negative emotional symptoms or a more positive attitude toward mental health treatment.

### **Participant Feedback**

The participants rated their experience with the psychoeducation program on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

**Table 3: Average Rating for the Psychoeducation Program**

Statement	Average Rating
After taking the psychoeducation program, I have a better understanding of psychotherapy.	4.48
This was an interesting psychoeducation program.	4.43
Each page was well planned.	4.43
The website was well organized.	4.38
In each page the key points were made clear.	4.33
I could understand the relevance of what was on the website.	4.33
The exam related closely to the expected learning outcomes.	4.29
The expected learning outcomes of the psychoeducation program were clear.	4.24
I found the psychoeducation program enjoyable.	4.10
There were times the context made me think deeply about important issues.	4.00
A variety of contexts were used.	3.95
In this website I was exposed to different points of view.	3.90
The amount of content covered was not excessive.	3.81
This was a demanding psychoeducation program, but I learnt a lot from it.	3.76
I found the psychoeducation exam (20 multiple choices) to be challenging.	2.67

Owing to the limited number of completed 90-day follow-up assessments, no data analysis was conducted for the follow-up assessment period.

### **DISCUSSION**

This study examined the distinct contributions of psychoeducation as a standalone pretherapy intervention for Asian international college students experiencing depression, anxiety, and stress. While short-term therapy combined with psychoeducation has been shown to be effective, few studies have explored psychoeducation's independent benefits. The study compared outcomes between students receiving psychoeducation plus therapy and those receiving therapy alone, with a focus on symptom changes, sleep quality, mental health knowledge,

and attitudes. Although not all findings are aligned with expectations, the study provides valuable insights into culturally responsive mental health interventions.

The first research question examined differences in treatment outcomes between Asian international students receiving psychoeducation plus short-term therapy and those receiving short-term therapy alone, as measured via the DASS-21, AIS, and self-rated distress levels. While the overall DASS-21 scores were not significantly different between the groups, the subscale analyses revealed nuanced insights. Compared with the therapy alone group, the psychoeducation plus therapy group demonstrated a marginally significant reduction in anxiety, suggesting that psychoeducation enhances the understanding and management of anxiety-provoking situations by equipping students with mental health knowledge and reducing pretreatment anxiety (Dombou et al., 2023; Morgado et al., 2022). However, no significant differences were observed in the depression or stress subscales, indicating that core therapeutic techniques in short-term therapy may sufficiently address these symptoms or that psychoeducation content may require further tailoring to target depression and stress (Karruri et al., 2021; Tamminga et al., 2023). These findings highlight the potential of psychoeducation to complement therapy, particularly in reducing anxiety.

The significant improvement in sleep quality observed in the psychoeducation plus therapy group highlights the potential role of psychoeducation in addressing sleep-related issues. The program covered key areas, including an introduction to mental health, the therapeutic alliance, cultural factors in therapy, and the accessibility of mental health treatment in New York State. These components likely contributed to improved sleep by increasing awareness of the connection between mental health and sleep, fostering comfort in therapeutic relationships, addressing cultural considerations to reduce stress, and empowering students to navigate the healthcare system effectively.

The reduction in anxiety appears to be the primary driver of improved sleep, as psychoeducation helps lower the level of cognitive and emotional arousal that often disrupts sleep. This aligns with findings from cognitive-behavioral therapy for insomnia (CBT-I), which emphasizes anxiety-reduction strategies to enhance sleep quality (Mirchandaney et al., 2022; Rossman, 2019). By addressing both psychological and practical barriers, the psychoeducation program supported better sleep through an integrated approach to mental well-being.

Additionally, this study examined self-rated distress levels before and after treatment, comparing the effects of psychoeducation plus therapy with those of therapy alone. The participants rated their distress on a scale from 0 to 10. The results revealed that the psychoeducation plus therapy group reported significantly lower distress levels than did the therapy alone group. Notably, distress decreased after therapy in the psychoeducation group but increased in the therapy alone group.

The inclusion of psychoeducation likely contributed to these findings by equipping students with foundational mental health knowledge, normalizing their experiences, and reducing stigma, which has been shown to improve treatment outcomes (Amsalem & Martin, 2021; Díaz-Mandado & Periañez, 2021). Practical information about accessing mental health services in New York State further

empowered students, alleviating anxiety and stress related to navigating the healthcare system (Burnett-Zeigler et al., 2018). By addressing these areas, the psychoeducation program prepared students to engage more confidently in therapy, facilitating better management of distress and enhancing overall treatment effectiveness.

Overall, while short-term therapy alone effectively reduces psychological distress among Asian international students, the addition of psychoeducation provides specific benefits, notably in reducing anxiety and improving sleep quality. These findings underscore the value of tailoring psychoeducational content to address specific symptoms, such as anxiety and insomnia, for optimal outcomes in this population.

The second research question explored how changes in mental health attitudes and knowledge differed between Asian international college students who participated in psychoeducation plus short-term therapy and those who did not, using the ATSPPH scale and the MAKS. The results revealed significant differences between the groups in several areas. The psychoeducation plus therapy group demonstrated significantly higher overall ATSPPH scores, indicating improved attitudes toward seeking professional psychological help. Specifically, psychoeducation provided foundational mental health knowledge, normalized help-seeking behaviors, and reduced stigma, aligning with findings from Kim et al. (2023) that psychoeducation enhances mental health literacy and reduces stigmatizing attitudes. By emphasizing the therapeutic alliance, the program also likely fostered openness and confidence in therapy, consistent with the findings of Frieswyk et al. (1986), who noted the importance of a strong therapeutic relationship in mental health treatment.

Addressing cultural factors in therapy further improved attitudes by ensuring that students understood within their cultural context, reducing stigma, and promoting a sense of safety (Rogers-Sirin et al., 2015). Providing information on accessing mental health services in New York State empowered students with practical knowledge, alleviated anxiety and barriers to care, and positively influenced attitudes (Xu, 2024). This aligns with findings by Xu (2023), who identified accessibility concerns as a significant stressor for Asian international students.

Subscale analyses of ATSPPH revealed interesting effects. The Need subscale showed a significant improvement in the psychoeducation plus therapy group, indicating an increased perceived need for professional help, which is consistent with Onnela et al. (2021). The openness subscale also improved significantly, reflecting reduced fears and increased willingness to seek therapy, as corroborated by Bamgbade et al. (2020). However, no significant differences were observed in the stigma subscale, suggesting the need for more targeted approaches to address stigma effectively or that both interventions are equally effective in reducing stigma. The confidence subscale for help-seeking also showed no significant difference between the groups. This may indicate a gap in the practical information and skills delivered during psychoeducation sessions. These elements are essential for empowering students to take proactive steps toward managing their mental health (Qian et al., 2022).

With respect to mental health knowledge, there was no significant difference in overall MAKS scores between the two groups. For the MAKS Part 1 subscale, which measures stigma-related knowledge, no significant group differences were found, which aligns with the ATSPPH stigma subscale findings. However, both groups showed a general decline in MAKS scores postintervention, particularly in Part 2 (knowledge of mental health conditions). This unexpected decrease may reflect a "Dunning-Kruger effect," where students become more aware of the complexities of mental health and reassess their initial confidence in their knowledge (Canady & Larzo, 2022). This finding suggests a need for ongoing education to reinforce and build upon the knowledge gained during the sessions.

In conclusion, psychoeducation combined with short-term therapy enhances attitudes toward seeking professional help, particularly in terms of perceived need and openness. These improvements are essential for promoting engagement with mental health services, which can lead to better long-term mental health outcomes. However, the observed decline in mental health knowledge highlights an area for further research. Future studies could explore strategies such as follow-up sessions or digital tools to sustain and deepen mental health literacy over time (Kutcher et al., 2016).

### **Clinical Implications**

This study highlights the clinical value of integrating psychoeducation with short-term therapy for Asian international students, particularly in reducing anxiety, improving sleep, and fostering more positive attitudes toward help-seeking. On the basis of these insights, we propose a conceptual framework, "Education Before Intervention," which prioritizes foundational mental health knowledge before therapy begins.

Unlike traditional psychoeducation, which focuses on illness-related information (Barker, 2013), this framework introduces core concepts such as how therapy works, basic mental health knowledge, therapeutic alliances, and access to services. These elements are particularly relevant for students unfamiliar with Western mental health systems and may improve engagement by reducing stigma and increasing psychological readiness. This framework—linking pretherapy education to increased readiness and improved outcomes—can aid in implementation in university counseling settings.

### ***Education Before Intervention Framework***

The "Education Before Intervention" framework offers a structured, culturally responsive approach to improving therapy outcomes among Asian international students. It emphasizes delivering targeted psychoeducation before therapy begins to address common barriers such as stigma, unfamiliarity with therapy, and limited knowledge of mental health.

**Core Components.** Mental Health Foundations: Introducing students to basic mental health concepts (e.g., stress, anxiety, and depression) to normalize

emotional experiences and reduce stigma. This foundational understanding increases psychological readiness and contributes to improved outcomes, particularly anxiety and sleep-related symptoms.

**Therapeutic Process Orientation:** Explains how therapy works, including the role of the therapist, session structure, confidentiality, and the therapeutic alliance. This fosters realistic expectations, strengthens engagement, and builds trust—key predictors of treatment adherence and satisfaction.

**Navigation of Services:** Offers practical guidance on accessing counseling services, including where and how to seek help, what to expect in intake processes, and how to manage follow-up. This increases perceived accessibility and empowers students to take initiative in help-seeking.

**Implementation Steps for Clinicians.** Assess Knowledge and Readiness: Brief interviews or tools (e.g., MAKS or ATSPPH) are used to identify gaps in students' understanding of mental health and therapy.

**Deliver Culturally Tailored Psychoeducation:** Provide brief, structured sessions addressing specific gaps via culturally relevant examples, language, and analogies.

**Reinforce Engagement Principles:** Emphasize that therapy is collaborative, strengths-based, and nonjudgmental. Actively challenge internalized stigma by normalizing help-seeking behaviors.

**Follow-up and support:** Psychoeducational content should be reinforced throughout therapy to promote retention and application. Questions should be encouraged, and misconceptions should be addressed as therapy progresses.

By operationalizing psychoeducation as a pretherapy intervention, this framework contributes a novel, actionable model that bridges the cultural and knowledge gaps that Asian international students face. It is distinct from general psychoeducational practices in that it focuses on preparatory, engagement-enhancing content and structured implementation, making it adaptable for university counseling settings.

## **Limitations**

This study offers valuable insights into the role of psychoeducation in treating Asian international college students; however, several limitations should be acknowledged. First, the sample size was relatively small, which limits the statistical power and generalizability of the findings. Additionally, the absence of follow-up assessments restricts conclusions about the long-term effects of the interventions.

The study relied exclusively on self-reported measures, which may have introduced bias due to social desirability or recall inaccuracies. Therapist effects also emerged as a potential confounding variable, as one therapist treated more than half of the participants, potentially influencing the outcome. Furthermore, language factors were not fully explored. Because most students and therapists are nonnative English speakers, the language used during therapy sessions may

have influenced alliances, treatment outcomes, and the effectiveness of psychoeducation.

Finally, the psychoeducation program may not have adequately accounted for the diverse cultural backgrounds of Asian international students. This limitation could have reduced the program's relevance and effectiveness across various subgroups within this population.

### **Future Research**

To expand upon the findings of this study, future research should include larger and more diverse samples that include students from various Asian countries to better capture cultural nuances. Employing longitudinal designs with follow-up assessments would help clarify the sustainability of treatment outcomes and identify any delayed effects. The use of both self-reported data and objective assessments, such as clinician ratings, is recommended to increase the validity and reliability of future studies. Additionally, distributing participants more evenly across therapists would help disentangle treatment outcomes from therapist-related variables and allow for an examination of how different therapeutic approaches may influence results.

Future studies should also investigate the impact of language use in therapeutic settings and consider the development of multilingual psychoeducational materials to improve accessibility and program effectiveness. Moreover, tailoring psychoeducational content to reflect the specific cultural contexts of Asian international students is essential. Integrating this content directly into therapy sessions may enhance alignment between therapist and client expectations, strengthen therapeutic engagement, and ultimately lead to more effective interventions.

### **CONCLUSION**

The current study demonstrates that integrating culturally responsive psychoeducation prior to short-term therapy offers distinct benefits for Asian international college students. While both treatment groups experienced symptom reduction, those who received psychoeducation reported greater improvements in anxiety, sleep quality, self-rated distress, and attitudes toward seeking professional help. These findings support the value of equipping students with foundational mental health knowledge, enhancing engagement, and addressing cultural and systemic barriers to care.

The proposed "Education Before Intervention" framework offers a practical and scalable model for implementing pretherapy psychoeducation in university counseling settings. By targeting psychological readiness, clarifying the therapeutic process, and improving service navigation, this framework addresses the unique needs of Asian international students. This study contributes to the growing literature on culturally informed interventions and presents a novel pathway to improve mental health outcomes in this underserved population.

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