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Exploring the Moderating Role of Therapist Approaches in Short-Term Therapy Outcomes for Asian International Students

Diyue Dou
King's College London, UK

Han Wang
Northwestern University, USA

Yuanruo Xu
Adelphi University, USA

ABSTRACT: *This secondary data analysis of Xu and Wang (2025) examined whether a therapeutic approach moderated the effects of a pretherapy psychoeducation program on short-term psychotherapy outcomes among Asian international college students. Forty-four participants were randomly assigned to either a psychoeducation-plus-therapy group or a therapy-alone group. The psychoeducation program aimed to enhance mental health literacy, reduce stigma, and increase readiness for therapy. All participants received eight-week individual therapy sessions delivered by doctoral trainees using one of three approaches: psychodynamic, SFBT + CBT, or an integrated approach. Outcomes were assessed using the DASS-21, AIS, ATSPPH, MAKS, and a self-rated distress scale. Multilevel modeling showed that the therapeutic approach moderated changes in DASS-21 scores, with SFBT + CBT and integrated approaches associated with greater reductions in psychological distress and stress than psychodynamic therapy. No significant moderating effects were found for attitudes. The findings suggest that goal-oriented approaches may be effective in interventions for Asian international students.*

Keywords: Asian international college students, psychoeducation, psychotherapy, therapeutic approach, treatment outcomes

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INTRODUCTION

Asian international students in Western countries often experience multiple barriers when engaging in mental health treatment, including high levels of stigma, unfamiliarity with psychotherapy processes, and misalignment between cultural norms and therapeutic models. Despite elevated levels of psychological distress, this group tends to underutilize mental health services and demonstrates lower treatment retention rates compared to domestic student populations (Hovey et al., 2006; Mori, 2000).

Cultural stigma plays a particularly influential role in shaping help-seeking behaviors. Studies have consistently found that Asian international students endorse more negative attitudes toward mental health services, often viewing emotional difficulties as personal weaknesses or family burdens (Shea & Yeh, 2008). These attitudes contribute to delayed service use, premature dropout, and poor therapeutic alliance development (Sue et al., 1991; Zhang & Dixon, 2003).

Psychoeducation has been proposed as a culturally sensitive strategy to reduce stigma, increase mental health literacy, and improve treatment outcomes. Psychoeducational interventions, especially when tailored to the cultural needs of specific populations, have been shown to enhance understanding of psychological symptoms, normalize the therapy process, and foster more positive attitudes toward seeking help (Kim et al., 2023; Wei et al., 2012). A prior randomized controlled trial (Xu & Wang, 2025) demonstrated that Asian international students who received pretherapy psychoeducation showed greater reductions in anxiety and distress, improved sleep quality, and more positive attitudes toward help-seeking than those who received therapy alone. To support this intervention, a structured psychoeducation program was developed to prepare Asian international students for short-term individual therapy. The program aimed to increase mental health knowledge, normalize help-seeking behaviors, and enhance readiness for therapeutic engagement.

While these results support the effectiveness of psychoeducation, they do not account for the potential influence of therapist-level variables. Research on the role of therapist characteristics in cross-cultural interventions remains limited. Therapeutic approaches, defined as the theoretical frameworks guiding treatment delivery, may significantly shape how clients respond to therapy, particularly in cross-cultural contexts where alignment between client expectations and therapy approach is critical. For instance, cognitive behavioral therapy (CBT) is a practical, structured approach that helps individuals recognize and change

unhelpful thought patterns and behaviors contributing to emotional distress (Beck, 2011). Often delivered over a short period, it is goal-oriented and works well for those seeking clear strategies for symptom relief. In contrast, solution-focused brief therapy (SFBT) encourages clients to focus on their strengths and envision preferred futures, emphasizing quick, solution-building conversations over in-depth problem analysis (de Shazer et al., 2021).

Alternatively, psychodynamic therapy invites clients to explore unconscious processes, past experiences, and internal conflicts that may shape their current difficulties. This approach is typically less structured and more reflective, often unfolding over a longer duration (Shedler, 2010). Integrated therapy blends elements from multiple approaches, enabling therapists to tailor interventions to the unique needs, preferences, and cultural contexts of each client (Norcross & Goldfried, 2005).

Taken together, structured and collaborative approaches such as CBT and SFBT may align more closely with the expectations of many Asian international students because they emphasize clarity, concrete strategies, and problem-solving goals (Chang & Berk, 2009; Wang & Kim, 2010). In contrast, psychodynamic approaches, which often rely on introspection and emotional exploration, may feel less familiar for students from collectivist cultural backgrounds (Sue & Sue, 2012).

Despite substantial research documenting help-seeking barriers among Asian international students, including stigma, limited mental health literacy, and unfamiliarity with Western counseling models (Shea & Yeh, 2008; Leong & Kalibatseva, 2011), few studies have examined how these challenges intersect with the therapeutic approaches students encounter in short-term treatment settings. Existing scholarship emphasizes the importance of cultural alignment in the counseling process and highlights that therapist behaviors, communication styles, and relational responsiveness can significantly shape outcomes for Asian clients (Chang & Berk, 2009; Wang & Kim, 2010). Research in college counseling centers also demonstrates that short-term interventions can be effective for culturally diverse student populations when they are delivered in a consistent and accessible format (Kim et al., 2023). Integrating these strands of research reveals a critical gap. Little is known about whether the therapeutic approach itself moderates the effects of psychoeducation for Asian international students who receive brief therapy. The present study addresses this gap by examining how different therapeutic modalities influence treatment outcomes following psychoeducation.

To address these gaps, the present study examines whether the therapeutic approach moderates the effects of a pretherapy psychoeducation program on short-term psychotherapy outcomes among Asian international college students. Building on findings from Xu and Wang (2025), this study focuses on understanding how structured, integrative, or psychodynamic approaches shape students' responses to therapy following psychoeducation. Guided by this aim, we pursued the following research questions:

1) RQ1: Does participation in pretherapy psychoeducation lead to improved psychological outcomes compared to therapy alone?

2) RQ2: Does the therapeutic approach (SFBT + CBT, psychodynamic, or integrated) moderate treatment outcomes over time?
3) RQ3: Is there an interaction between psychoeducation and therapeutic approach such that the effectiveness of psychoeducation differs depending on the therapy modality used?

METHOD

This study is a secondary analysis of data collected in a previously reported randomized controlled clinical trial (Xu & Wang, 2025) that examined whether pretherapy psychoeducation improved treatment outcomes for Asian international students engaged in short-term individual therapy.

This extended study investigates the potential influence of the therapist approach on previous study findings that pretherapy psychoeducation combined with short-term therapy leads to greater reductions in psychological distress and anxiety, as well as improvements in sleep quality and attitudes toward seeking psychological help, among Asian international students compared to short-term individual therapy alone. Institutional Review Board approval was obtained for the study.

Participants

Forty-four Asian international students who met eligibility criteria after providing informed consent and completing eligibility screening were included in the analysis. Participants were assigned unique identification numbers and completed preintervention assessments measuring symptoms of depression, anxiety, stress, sleep quality, attitudes toward seeking psychological help, and mental health knowledge. All participants received eight weekly individual therapy sessions delivered by Asian doctoral-level psychologists-in-training under licensed supervision in New York State.

Therapists and Therapeutic Approaches

Four bilingual (English and Mandarin Chinese) Asian therapists (two female, two male) were recruited for the study. They were all third-year doctoral students, with three enrolled in PhD programs in clinical psychology and one in a PsyD program.

Regarding their immigration status, two therapists were international students in New York State, and the other two were Asian immigrants. They provided short-term psychotherapy in English under weekly individual supervision by clinical psychologists licensed in New York State.

Therapists employed one of three therapeutic approaches. The SFBT + CBT group (n = 6) received a structured, goal-directed approach integrating solution-focused brief therapy and cognitive behavioral therapy. The Psychodynamic group (n = 10) focused on exploring underlying psychological processes and past experiences contributing to participants' present mental health concerns. The

Integrated Approach group (n = 27) drew from multiple therapeutic modalities, allowing therapists to flexibly adapt treatment to individual participants' needs.

Measures

All participants completed a set of validated self-report measures at both baseline and posttreatment. The Depression Anxiety Stress Scales–21 (DASS-21; Henry & Crawford, 2005) was used to assess symptoms of depression, anxiety, and stress. Sleep quality was evaluated using the Athens Insomnia Scale (AIS). Help-seeking attitudes toward mental health problems were measured with the Attitudes Toward Seeking Professional Psychological Help Scale–Short Form (ATSPPH-SF; Fischer & Turner, 1970), which covers four dimensions (Need, Stigma, Openness, and Confidence). The Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010) was used to assess both stigma-related and condition-specific mental health knowledge. Finally, self-rated distress was measured through a single-item Likert scale, where participants rated their current level of emotional distress on a scale from 0 ("no distress") to 10 ("extreme distress"). These measures were used to compare the effects of psychoeducation plus therapy versus therapy alone.

Procedure

Participants were then randomly assigned to either a psychoeducation + therapy group or a therapy-alone group. Participants in the psychoeducation + therapy group completed a structured, self-guided psychoeducation program before beginning therapy. The program consisted of four thematic modules: (1) Introduction to Mental Health, covering key concepts and treatment types; (2) Therapeutic Alliance, focusing on building effective therapist-client relationships and preparing for therapy; (3) Cultural Factors in Therapy, highlighting cultural competence in multicultural settings; and (4) Accessibility, outlining mental health resources available in New York City. To ensure comprehension, participants were required to complete a 20-item multiple-choice quiz and score at least 80% before progressing to therapy.

All participants in both conditions then received eight weeks of weekly individual therapy delivered by psychologists-in-training under licensed supervision in the U.S. Postintervention assessments were conducted at the final session and again at a 90-day follow-up. Subsequently, psychoeducation materials were emailed to all participants, who then rated their experience with the program, while both participants and therapists evaluated the therapy process.

Data Analysis

Participants were nested within therapists, and the distribution of caseloads was uneven, with one therapist treating a disproportionately large share of participants. To address this, we used multilevel modeling (MLM), which is appropriate for unbalanced nested data and does not require equal numbers of

cases per cluster. MLMs therapist-level variance while estimating group and time effects, thereby reducing the likelihood that caseload imbalance would distort fixed-effect estimates. Nonetheless, the substantial imbalance remains a methodological limitation and may affect the precision of parameter estimates. This issue is further discussed in the Limitations section.

Data were analyzed using multilevel modeling (MLM) in IBM SPSS. Treatment outcomes were compared between groups (Psychoeducation + Therapy vs. Therapy-Alone) with therapeutic approach (SFBT + CBT, Psychodynamic, Integrated) included as a fixed effect. All possible two-way interactions (Group × Time, Group × Approach, Time × Approach) and the three-way interaction (Group × Time × Approach) were tested. For outcomes with significant interaction effects ($p < .05$), Tukey-adjusted pairwise comparisons were conducted to compare estimated marginal means while controlling for familywise error at $\alpha = .05$.

RESULTS

Multilevel Model Main Effects

Before interpreting the results, it is important to note that in multilevel models, treatment efficacy is reflected in the Time × Group interaction rather than in the main effect of Group. Thus, the main effects reported below only describe overall trends across participants.

Multilevel models (MLM) were first used to examine the main effects of time, group, and therapeutic approach across all outcome variables. As shown in Table 1, significant main effects of Time were observed for several measures, indicating overall pre–post improvements across participants regardless of treatment condition or therapeutic approach. Specifically, significant time effects emerged for the DASS-21 total score [$F(1, 37) = 9.98$, $p = .003$] and Anxiety [$F(1, 37) = 8.57$, $p = .006$] and Stress [$F(1, 37) = 11.57$, $p = .002$] subscales. Time effects were also significant for overall attitudes toward seeking professional help, ATSPPH total [$F(1, 37) = 4.72$, $p = .036$], and the Need [$F(1, 37) = 5.09$, $p = .030$] and Openness [$F(1, 37) = 4.95$, $p = .032$] subscales. No significant time effects were observed for sleep quality (AIS), distress ratings, or mental health knowledge (MAKS total or its subscales).

In contrast, no significant main effects of Group were found for any outcome, indicating that when collapsing across time and therapeutic approach, the psychoeducation + therapy and therapy-alone groups did not differ in overall levels of symptoms, sleep, distress, or help-seeking attitudes. Although the Group effect reached significance for the ATSPPH Need subscale [$F(1, 37) = 4.37$, $p = .043$], this effect did not persist across related subscales and should be interpreted cautiously.

The therapeutic approach also did not show significant main effects for most outcomes, with the exception of the MAKS stigma-related knowledge subscale

Table 1: Multilevel Model Main Effects on Treatment Outcomes

Measure (N)	Effect	F	*p*
DASS-21	Time	9.98	.003*
(N = 43)	Group	0.06	.800
	Approach	0.06	.942
DASS-21 (Depression)	Time	2.40	.130
(N = 43)	Group	0.04	.836
	Approach	0.20	.817
DASS-21 (Anxiety)	Time	8.57	.006*
(N = 43)	Group	0.06	.805
	Approach	0.02	.977
DASS-21 (Stress)	Time	11.57	.002*
(N = 43)	Group	0.37	.545
	Approach	0.25	.777
AIS	Time	3.45	.071
(N = 43)	Group	0.01	.940
	Approach	2.05	.143
Distress	Time	0.04	.852
(N = 41)	Group	1.75	.195
	Approach	1.41	.258
ATSPPH	Time	4.72	.036*
(N = 43)	Group	2.53	.120
	Approach	1.47	.243
ATSPPH (Need)	Time	5.09	.030*
(N = 43)	Group	4.37	.043*
	Approach	1.66	.204
ATSPPH (Stigma)	Time	1.38	.246
(N = 43)	Group	1.17	.286
	Approach	0.92	.409
ATSPPH (Openness)	Time	4.95	.032*
(N = 43)	Group	0.95	.336
	Approach	0.58	.563
ATSPPH (Confidence)	Time	3.62	.065
(N = 43)	Group	1.51	.227
	Approach	2.10	.137
MAKS	Time	1.10	.302
(N = 43)	Group	0.56	.457
	Approach	2.97	.063
MAKS (Stigma)	Time	1.32	.259
(N = 43)	Group	0.02	.902
	Approach	4.73	.015*
MAKS (Conditions)	Time	0.58	.449
(N = 43)	Group	1.13	.295
	Approach	1.04	.362

Note. $^*p < .05$.

[F(2, 37) = 4.73, p = .015]. This suggests that, independent of time and treatment condition, participants working with different therapist orientations varied modestly in stigma-related mental health knowledge.

Taken together, these main effects indicate that participants generally improved over time, but neither psychoeducation nor therapist approach produced overall differences when time was not considered. Thus, the key treatment-related effects lie in the interaction terms.

Interaction Effects

Multilevel models were next used to examine interaction effects among time, group, and therapeutic approach. Because the primary effect of psychoeducation is reflected in differences in pre–post change rather than in static posttreatment group differences, the Time × Group interaction was treated as the main test of treatment efficacy. Additional two-way and three-way interactions were examined to assess whether the therapeutic approach moderated the treatment response.

Effect of Psychoeducation (Time × Group)

The time × group interaction was not significant for any outcome except distress ratings, indicating that the psychoeducation + therapy group did not improve significantly more than the therapy-alone group on most measures of psychological distress, sleep, attitudes toward seeking help, or mental health knowledge (see Table 2). For self-rated distress, however, a significant interaction emerged [F(1, 35) = 5.16, p = .029], indicating greater reductions in self-reported distress among participants who received psychoeducation prior to therapy. No other outcomes showed differential changes between groups over time.

Effects of Therapeutic Approaches (Time x Approach)

In addition to the primary focus on psychoeducation and its impact on treatment outcomes, the MLM results also examined whether therapists' therapeutic approaches had a significant effect on outcomes.

A significant time x approach two-way interaction was found for the overall DASS-21 score [F(2, 37) = 3.81, p = .031] and its stress subscale [F(2, 37) = 3.56, p = .038]. A follow-up post hoc Tukey test (see Table 3), with a familywise error rate set at $\alpha = .05$, revealed that both the Integrated Approach group [T(1, 25) = -2.69, p = .011] and the SFBT + CBT group [T(1, 4) = -3.25, p = .003] showed significant improvement in overall DASS scores. Both groups also demonstrated a significant reduction in stress symptoms: the Integrated Approach group [T(1, 25) = -2.30, p = .027] and the SFBT + CBT group [T(1, 4) = -3.37, p = .002]. In contrast, clients who worked with Psychodynamic therapists did not show significant pre–post change on these measures.

While no significant differences were observed in attitudes toward seeking professional psychological help, the Mental Health Conditions Knowledge

subscale of the MAKS reported a significant Time × Approach interaction effect [F(2, 37) = 4.91, p = .013]. A further post hoc Tukey test indicated that participants in the Integrated Approach group had a significant change between pre- and posttest scores [T(1, 25) = -4.29, p < .001].

Group × Approach and Three-way Interactions

Neither the Group × Approach interaction nor the three-way Group × Time × Approach interaction reached significance for any outcome. These results suggest that the moderating effects of therapeutic approach were consistent across both treatment conditions and did not depend on whether participants received psychoeducation.

Table 2: Multilevel Model Interaction Effects

Measure (N)	Interaction	F	*p*
DASS-21	Time × Group	0.14	.712
(N = 43)	Group × Approach	0.54	.589
	Time × Approach	3.81	.031*
	Group × Time × Approach	3.00	.062
DASS-21 (Depression)	Time × Group	0.06	.807
(N = 43)	Group × Approach	0.26	.771
	Time × Approach	1.89	.165
	Group × Time × Approach	0.91	.411
DASS-21 (Anxiety)	Time × Group	0.00	.992
(N = 43)	Group × Approach	0.08	.927
	Time × Approach	2.85	.071
	Group × Time × Approach	2.69	.081
DASS-21 (Stress)	Time × Group	1.40	.245
(N = 43)	Group × Approach	1.51	.233
	Time × Approach	3.56	.038*
	Group × Time × Approach	3.07	.058
AIS	Time × Group	0.63	.433
(N = 43)	Group × Approach	1.70	.196
	Time × Approach	0.84	.438
	Group × Time × Approach	1.33	.276
Distress	Time × Group	5.16	.029*
(N = 41)	Group × Approach	0.19	.827
	Time × Approach	0.83	.443
	Group × Time × Approach	0.20	.816
ATSPPH	Time × Group	1.25	.271
(N = 43)	Group × Approach	0.32	.726
	Time × Approach	0.24	.788
	Group × Time × Approach	1.21	.311
ATSPPH (Need)	Time × Group	1.07	.307
(N = 43)	Group × Approach	0.23	.794

	Time × Approach	0.18	.833
	Group × Time × Approach	0.29	.752
ATSPPH (Stigma)	Time × Group	1.27	.268
(N = 43)	Group × Approach	0.53	.595
	Time × Approach	0.50	.608
	Group × Time × Approach	1.36	.268
ATSPPH (Openness)	Time × Group	1.45	.236
	Group × Approach	0.24	.786
	Time × Approach	0.43	.652
	Group × Time × Approach	1.60	.216
ATSPPH (Confidence)	Time × Group	0.52	.476
(N = 43)	Group × Approach	0.42	.659
	Time × Approach	0.33	.723
	Group × Time × Approach	1.07	.354
MAKS	Time × Group	0.77	.387
(N = 43)	Group × Approach	0.28	.756
	Time × Approach	3.11	.056
	Group × Time × Approach	1.02	.369
MAKS (Stigma)	Time × Group	0.04	.843
(N = 43)	Group × Approach	0.32	.725
	Time × Approach	0.99	.382
	Group × Time × Approach	1.30	.286
MAKS (Conditions)	Time × Group	1.93	.173
(N = 43)	Group × Approach	0.16	.857
	Time × Approach	4.91	.013*
	Group × Time × Approach	0.53	.595

Note. *p< .05.*

Table 3: Tukey-Adjusted Post Hoc Comparisons for Significant Time × Approach Interactions

Measure	Approach	N	Mean Δ (Post–Pre)	T	*P*
DASS-21	SFBT + CBT	6	-12.83	-3.25	.003*
	Psychodynamic	10	-0.30	0.21	.832
	Integrated	27	-4.85	-2.69	.011*
DASS-21 (Stress)	SFBT + CBT	6	-10.33	-3.37	.002*
	Psychodynamic	10	-0.20	-0.25	.807
	Integrated	27	-3.48	-2.30	.027*
MAKS (Conditions)	SFBT + CBT	6	-1.67	-0.39	.698
	Psychodynamic	10	2.10	1.30	.200
	Integrated	27	-4.78	-4.29	< .001*

*Note. Mean Δ reflects pre-to-post change (Post – Pre); negative values indicate improvement for DASS and positive change for MAKS. Tukey-adjusted p values control the familywise error rate at α = .05. *p < .05.*

Due to insufficient response rates at the 90-day follow-up assessments, no statistical analyses were conducted for that time point.

In summary, while psychoeducation had a modest direct impact, most notably on self-rated distress, therapist approaches significantly moderated treatment effects. The greatest symptom improvement was observed in participants treated by therapists using either an Integrated or SFBT + CBT approach. No meaningful changes were detected in help-seeking attitudes or sleep, and an unexpected decline in mental health knowledge was found in one group.

DISCUSSION

This study investigated whether therapeutic approaches moderated the effects of a pretherapy psychoeducation program on treatment outcomes among Asian international college students receiving short-term psychotherapy. It builds upon a prior research analysis that explored the distinct contributions of psychoeducation in reducing experiencing depression, anxiety, and stress in this population. While prior results have demonstrated that short-term therapy combined with psychoeducation can be effective, limited attention has been given to the potential influence of therapeutic approaches (Xu & Wang, 2025). The current study expands on that work by analyzing whether accounting for therapeutic approaches affects outcomes among students receiving psychoeducation plus therapy versus therapy alone. Although the significance of the previous findings was limited, this study offers valuable insights into how therapeutic approaches may shape mental health intervention effectiveness in a cross-cultural context.

In the previous study, Asian international students who received psychoeducation prior to therapy showed greater improvements in anxiety, sleep quality, and attitudes toward seeking professional psychological help than those who received therapy alone. These between-group differences suggest that adding psychoeducation may enhance the effectiveness of short-term therapy by addressing cultural and psychological barriers to treatment engagement and response. Although not all outcomes reached statistical significance, the observed pattern indicates the potential value of culturally informed psychoeducation as an adjunct to therapy for this population.

However, when the therapeutic approach was controlled using a multilevel model (MLM), the significant differences observed in the initial one-way ANOVAs were no longer present, except for self-rated distress. This suggests that the therapeutic approach, instead of the treatment condition alone, may have been a more critical determinant of the treatment outcomes. In particular, participants receiving therapy from practitioners using more structured, goal-oriented modalities, such as SFBT combined with CBT or the Integrated Approach, showed greater reductions in overall psychological distress and stress symptoms over time than those in the psychodynamic group.

These findings are consistent with prior research indicating that Asian clients often prefer directive and structured therapeutic formats, which emphasize clear goals, action planning, and symptom relief (Kim & Atkinson, 2002; Chang &

Berk, 2009). Such approaches may better align with cultural expectations around authority, concreteness, and the therapist's active role (Moir-Bussy, 2014). The effectiveness of SFBT + CBT and Integrated Approaches in this context may reflect the compatibility of these modalities with the cultural and psychological needs of Asian international students.

The impact of the therapeutic approach on treatment outcomes is an important factor to consider. Wampold (2015) emphasizes that a therapist's competence, interpersonal style, and the quality of therapeutic alliance often outweigh the specific modality used. This suggests that the therapeutic relationship and the manner in which therapy is delivered may play a more critical role than the content of the intervention itself. It is possible that the therapeutic approach played a significant role in influencing the results, potentially overshadowing the distinct effects of psychoeducation. In this study, one therapist treated over half the sample, which may have disproportionately influenced the results. When this confounding factor was controlled, the distinct effects of psychoeducation appeared diminished.

Moreover, the lack of significant MLM findings may indicate that both treatment types are similarly effective or that any observed differences are tied more closely to how therapy was delivered than to what was delivered. This finding underscores the importance of considering therapist-related variables when evaluating the efficacy of interventions, particularly in culturally diverse settings where therapist-client dynamics play a critical role (Hall et al., 2016). The lack of significant differences in ATSPPH scores further suggests that attitudes toward seeking help may be influenced more by factors other than therapeutic approach, such as individual therapist-client dynamics or cultural considerations (Leong & Kalibatseva, 2011). Future research could further explore these factors to better understand how they interact with therapeutic approaches to shape treatment outcomes.

While the primary focus was on the effect of psychoeducation, multilevel modeling revealed that significant differences in mental health outcomes were associated with the interaction between time and therapeutic approach, independent of group assignment. Specifically, a significant Time × Approach interaction emerged for the overall DASS-21 score and its stress subscale, indicating that certain therapeutic approaches were more effective over time in reducing psychological distress. Post hoc analyses identified the Integrated Approach and SFBT + CBT as particularly effective in improving overall DASS-21 scores, with both groups also showing a significant reduction in stress symptoms. These findings suggest that the approach or combination of therapeutic modalities may play a critical role in enhancing short-term therapy outcomes (Tseng, 2004; Leong & Lee, 2006)

In addition, self-rated distress was the only outcome that remained significantly different between groups even after controlling for therapeutic approach. This finding may indicate that psychoeducation has a unique and direct influence on individuals' subjective experience of emotional discomfort, regardless of therapy style. As a brief and targeted intervention, psychoeducation may enhance self-awareness, normalize symptoms, and provide immediate tools

for reframing distress, which could help students feel less overwhelmed even before deeper therapeutic change occurs. This aligns with prior research showing that increased mental health literacy can reduce distress by improving perceived control and reducing stigma (Gulliver et al., 2012; Rickwood et al., 2005).

The Mental Health Conditions Knowledge subscale of the MAKS also showed a significant Time × Approach interaction. Notably, this change reflected a decline in condition-specific knowledge posttreatment, contrary to expectations. One possible explanation is cognitive overload, where exposure to diverse therapeutic frameworks may have diluted the clarity and retention of key psychoeducational content (Sweller, 1988; van Merriënboer & Sweller, 2005). The broad scope of integrated therapy may have lacked a consistent structure for reinforcing mental health concepts, in contrast to more directive modalities such as CBT.

Alternatively, participants may have undergone a metacognitive shift—becoming more aware of the complexity of mental health conditions and reassessing their prior understanding—resulting in lower self-rated knowledge despite actual gains (Kruger & Dunning, 1999). This possibility is particularly relevant for culturally diverse clients encountering Western models of mental illness for the first time. Finally, variability in therapist communication styles across approaches may also contribute to inconsistent transmission of information (Hill & Knox, 2009). Together, these findings underscore the importance of intentional and structured integration of psychoeducation, especially within flexible or eclectic treatment models.

Taken together, while initial analyses suggested that psychoeducation may offer added benefits, further analysis controlling for therapeutic approach tempers this conclusion. The current findings highlight that the therapeutic approach is not a neutral backdrop but a dynamic factor influencing treatment efficacy. They suggest that matching therapeutic modalities to client needs and ensuring that psychoeducation is delivered in a coherent and digestible format may be essential for optimizing both symptom improvement and knowledge acquisition.

Implications for International Student Services (ISS) and Higher Education Settings

As the Journal of International Students serves a multidisciplinary readership, including educators, academic advisors, counseling center clinicians, student affairs practitioners, and institutional policymakers, it is important to consider how the current findings translate into campuswide practices that support Asian international students' mental health. Prior research has documented that international students often underutilize available mental health resources due to stigma, unfamiliarity with services, and lack of culturally attuned support structures (Mori, 2000; Leong & Kalibatseva, 2011). The present study contributes to this broader literature by highlighting how structured interventions and culturally aligned therapeutic approaches may enhance engagement and treatment outcomes.

International Student Services as a Gateway to Mental Health Literacy

ISS offices serve as one of the earliest and most trusted points of contact for international students. Embedding mental health-related psychoeducation within prearrival information, advising processes, and transition programming can help reduce stigma and normalize help-seeking. These are factors repeatedly shown to influence service engagement among Asian international students (Shea & Yeh, 2008; Kim et al., 2023). The present findings suggest that early exposure to clear, structured information about mental health and therapy expectations may reduce distress and increase readiness to engage with counseling services.

Counseling Centers and Alignment with Cultural Expectations

The study's observation that structured modalities (e.g., SFBT + CBT, integrative approaches) produced the greatest reductions in distress aligns with the literature showing that Asian clients often respond well to directive, goal-oriented interventions (Kim & Atkinson, 2002; Chang & Berk, 2009). Counseling centers may therefore benefit from incorporating culturally responsive intake procedures, offering goal-focused brief therapy pathways, and training clinicians in culturally informed case conceptualization (Wang & Kim, 2010). These steps may increase engagement and reduce early dropout, a known challenge in counseling with international students.

Orientation and Transition Programs as Universal Prevention Platforms

Orientation programs can serve as nonstigmatizing mechanisms for mental health education. Research indicates that proactive psychoeducation can reduce help-seeking stigma and improve mental health literacy for international students (Wei et al., 2012; Kim et al., 2023). Incorporating sessions that clarify the therapy process, provide coping strategies, and normalize adjustment challenges may address barriers before they escalate into acute distress. In line with the study's findings, such interventions could improve readiness for treatment and facilitate smoother transition into counseling services.

Academic Departments and Faculty Engagement in Early Identification

Faculty often serve as important observers of student distress but may feel underprepared to respond to culturally influenced patterns of help-seeking. Training faculty to recognize culturally shaped distress expressions, understand stigma in Asian student communities, and make warm referrals to support services aligns with broader recommendations for holistic campus mental health systems (Hall et al., 2016; Leong & Kalibatseva, 2011). Strengthening these capacities can expand the network of early responders for Asian international students.

Cross-unit Collaboration and Seamless Referral Pathways

Universities can improve student outcomes by fostering integration across counseling services, ISS offices, academic units, and student support programs. Research on culturally adapted interventions emphasizes that multisystem collaboration increases accessibility and cultural responsiveness (Hall et al., 2016). Shared mental health literacy initiatives, coordinated outreach, and referral systems may reduce fragmentation and ensure that students receive timely, culturally appropriate services.

Policy Implications for Culturally Responsive Campus Mental Health Initiatives

At the institutional level, policies that expand resources for bilingual counseling, culturally specific outreach, and structured psychoeducation may enhance the accessibility of services for Asian international students, as they are groups known to face systemic and cultural barriers to care (Mori, 2000; Leong & Kalibatseva, 2011). Embedding pretherapy psychoeducation as part of counseling intake or offering culturally adapted short-term therapy tracks may also support improved engagement and outcomes.

Campus-wide Climate and Mental Health Culture

Finally, efforts to promote campus climates that normalize mental health discourse and reduce stigma, such as peer-led programs, inclusive messaging, and culturally diverse testimonials, complement the benefits of psychoeducation and structured therapy. Research repeatedly shows that reducing perceived stigma and increasing mental health literacy improves help-seeking among Asian international students (Shea & Yeh, 2008; Kim et al., 2023).

Taken together, these implications highlight how institutions can translate the study's findings into multilevel, culturally responsive strategies that support the mental health of Asian international students. Rather than viewing mental health support solely as a clinical concern, this study underscores the importance of coordinated campus systems in addressing cultural, structural, and psychosocial barriers to care.

Clinical Implications

What this suggests clinically is that when working with Asian international student populations, practitioners should consider integrating structured and culturally appropriate psychoeducation early in the therapy process. Interventions that clarify treatment expectations, normalize mental health concerns, and emphasize symptom management may enhance engagement and reduce early dropouts. These findings reinforce the Education Before Intervention framework developed in the previous study.

The Education Before Intervention framework (Xu & Wang, 2025) presents a structured and culturally responsive strategy for enhancing therapy outcomes

among Asian international students. Providing targeted psychoeducation prior to the start of therapy aims to reduce common barriers such as stigma, limited mental health literacy, and unfamiliarity with the therapeutic process. Its core components include mental health foundations, therapeutic process orientation, and navigation of services. Through this framework, therapists can increase psychological readiness and foster realistic expectations in Asian international students.

Furthermore, the therapeutic benefits of culturally tailored psychoeducation may be amplified when paired with structured, goal-oriented therapy modalities such as CBT or SFBT. This synergy fosters early trust, clearer expectations, and active participation—particularly important for culturally diverse students who may approach therapy with hesitancy or uncertainty.

Future research should continue to disentangle how specific therapeutic approaches interact with psychoeducation, particularly in culturally diverse populations. Additionally, future studies should recruit a more balanced sample across therapists to determine whether psychoeducation has a distinct, measurable impact beyond standard therapy.

Limitations & Future Research Implications

This study had several limitations. First, the sample size was relatively small, limiting the statistical power and generalizability of the findings. Future research should aim to recruit a larger and more diverse sample to increase statistical power and enhance the generalizability of findings.

Second, there was an unbalanced distribution of participants across therapists and therapy approaches. One therapist treated 27 participants, over half the sample, raising concerns about the potential influence of that individual therapist on overall outcomes. Although a multilevel model was used to control for therapeutic approach, this disproportionate caseload may have confounded the results. Efforts in future studies should be made to distribute participants more evenly across therapists and therapeutic approaches to better isolate treatment effects from therapist-specific influences.

Moreover, while some therapy sessions were conducted in English, this may have introduced subtle barriers to expression and understanding for some participants, particularly those who may have been more comfortable processing emotional content in their native language. Language mismatch has been shown to affect therapeutic alliance, emotional nuance, and treatment outcomes, particularly in multicultural contexts (Kim et al., 2002). Future studies should consider offering therapy in participants' preferred language and explore whether bilingual therapy enhances engagement and effectiveness.

Finally, one limitation of the present study is the absence of follow-up data, as an insufficient number of participants completed the 90-day post-treatment assessment. As a result, the evaluation of the longer-term sustainability of treatment effects was unavailable. Therefore, future studies should incorporate longitudinal follow-up assessments to evaluate the durability and delayed effects of psychoeducation and therapy on mental health outcomes.

CONCLUSION

This study highlights the nuanced role of the therapist approach in shaping short-term psychotherapy outcomes for Asian international college students and suggests that psychoeducation alone may not account for observed treatment effects. While psychoeducation appeared to reduce self-rated distress, its impact was modest when therapist variables were accounted for. Notably, structured and integrative therapeutic approaches (e.g., SFBT + CBT and the Integrated Approach) were associated with greater improvements in psychological distress and stress symptoms over time. This emphasizes the importance of considering both intervention content and delivery context. Future studies should continue to examine how culturally responsive psychoeducation interacts with therapist characteristics to optimize treatment outcomes.

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- [X] *None*
- ☐ *Some sections, with minimal or no editing*
- ☐ *Some sections, with extensive editing*
- ☐ *Entire work, with minimal or no editing*
- ☐ *Entire work, with extensive editing*

This article does not incorporate content generated by artificial intelligence (AI) tools.

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Author bios

HAN WANG, MA, is a master's student in health analytics at the School of Professional Studies, Northwestern University. With her background in psychology and healthcare data, her research interests focus on mechanisms and the evaluation of interventions to improve psychotherapy quality and outcomes across diverse populations. Email: hanwang2027@u.northwestern.edu

DIYUE DOU, MSc, graduated from the Institute of Psychiatry, Psychology & Neuroscience (IOPPN), King's College London. With her background in Psychology, her research interests are on mental health mechanisms and psychotherapeutic processes, particularly cognitive–behavioral therapy (CBT), culturally informed approaches to psychotherapy, and evidence-based treatments for mental health disorders. Email: dia.dou@kcl.ac.uk

YUANRUO XU, PhD, graduated from the Gordon F. Derner School of Psychology, Adelphi University. Her research focuses on attitudes toward mental health and the impact of psychoeducation in short-term psychotherapy for individuals from diverse cultural backgrounds, with an emphasis on multicultural and language considerations in psychotherapy.
Email: yuanruoxu@mail.adelphi.edu