REPORTING BEHAVIOR PROBLEMS AS A FUNCTION OF REPORTING METHOD IN A PRIMARY CARE SETTING AMONG FEMALES OF ASIAN, PACIFIC ISLANDER, AND WHITE DESCENT IN HAWAI'I

A THESIS SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAI'I IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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By

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ACKNOWLEDGMENTS

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ABSTRACT

Objective: To determine the degree to which the rate and severity of reporting behavior problems by female patients of Asian, Pacific Islander, and White descent in a primary care setting are affected by the method of reporting (written vs. oral).

Methods: Female primary care adult outpatients at a university health clinic were screened for behavior problems by either a written or interview method using the three scales (Morale, Global Impairment, and Global Symptoms) of the Health Dynamics Inventory—Self Report Form (Saunders & Wojcik, 2004). Data were collected on 316 participating, eligible patients (132 females of Asian descent, 51 females of Pacific Islander descent, and 133 females of White descent).

Results: A 3 x 2 ANOVA analyses indicated significant main effects for group, method of reporting, and group by method interaction of female patients reporting behavior problems. Additional post-hoc procedures found a significant difference in the method of reporting among female patients of Asian descent in the Global Impairment Scale in which the written self-report scores of this group were significantly higher than the face-to-face oral interview format in reporting behavior problems. There was also a significant difference in Global Impairment Scale scores between the written method of reporting behavior problems by female patients of Asian descent and the interview method by female patients of White descent.

Conclusions: This study suggests the level of reporting behavior problems by female patients in a primary care setting may depend on the self-identified racial group of the patient and the context in which the information is collected.
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Introduction

Behavior Problems in Primary Care Settings. Only a minority of people with behavior problems who go to their primary care physicians receive treatment for these problems (Ansseau et al., 2004; Goodrick, Kneuper, & Steinbauer, 2005; Liu, Mann, Cheng, Tjung, & Hwang, 2004; Rucci et al., 2003; Young, Klap, Sherbourne, & Wells, 2001). Young et al. (2001) found that the majority of adults (80.8%) with a probable depressive disorder, anxiety disorder, or both disorders ($n = 833, n = 314, n = 439$, respectively) sought care from their primary care providers but that appropriate treatment was received by only about 19% of the patients.

Behavior Problems Among Persons of Asian and Pacific Islander Descent. Lack of treatment for behavior problems may be a particular problem for persons of Asian and Pacific Islander descent, who have been found to have more behavior problems than Whites\(^1\) (Abe & Zane, 1990; Chang, 1996; Gratch, Bassett, & Attra, 1995; Gregersen, Nebeker, Seely, & Lambert, 2004; Lai & Linden, 1993; Mokuau, 1990; Okazaki; 1997, 2000; U.S. Department of Health and Human Services, 2001; Zane, Sue, Hu, & Kwon, 1991). For example, when comparing college students of Asian and Pacific Islander descent with established student norms (primarily White) using the Outcome Questionnaire—45 (Lambert, et al., 1996), a self-report inventory to evaluate psychological functioning and symptomatic distress, the total scores for the students of Asian ($d = 0.8$) and Pacific Islander ($d = 0.4$) descent were significantly higher than the

\(^1\) Racial categories are those used by the U.S. Census Bureau, which conform to the revisions of the standards for the classification of federal data on race and ethnicity promulgated by the Office of Management and Budget in October 1997. These racial categories have no biological or anthropological bases of categorization but are sociopolitical constructs (OMB, 1997). They are commonly used as a social category (e.g., inferring common heritage among groups but are not necessarily markers for "ethnicity") for demographic purposes (e.g., census data) or to facilitate research. For this study, these categories reflect self-identified racial designations by the participants.
normative sample (Gregersen, Nebeker, Seely, & Lambert, 2004), possibly indicating greater emotional and behavioral distress. The Surgeon General’s Report (U.S. Department of Health and Human Services) disclosed in their 2001 supplement to mental health elevated depressive symptoms among Asian Americans compared to White Americans. The Native Hawaiian Data Book (Office of Hawaiian Affairs, 2002) reported the mean percentage comparison for mentally unhealthy days and activity limitation days during the past 30 days between Native Hawaiians and the rest of the State of Hawai'i population as 2.7 compared to 2.3, respectively.

Unfortunately, there is a paucity of research on behavior problems of persons of Asian and particularly of Pacific Islander descent in the United States (U.S. Department of Health and Human Services, 2001). The Surgeon General’s Supplement to Mental Health (U.S. Department of Health and Human Services, 2001) on mental health care for persons of Asian and Pacific Islander descent concluded that more research on these populations is necessary, including research on strategies to promote mental health within these populations.

**Persons of Asian and Pacific Islander Descent in Hawai'i.** Persons of Asian and Pacific Islander descent are the fastest growing racial groups in the United States (U.S. Census Bureau, 2000). With a 0.7 million population of persons of Asian descent, Hawai'i has the third largest population of persons of Asian descent in the United States (behind California and New York, 4.2 million and 1.2 million, respectively), and a reported 58% of the state’s total population are persons of Asian descent (i.e., Japanese, Filipino, Chinese, Korean, Vietnamese, Asian Indian, or other Asian) (U.S. Census Bureau, 2000). Hawai'i also has the largest population of persons of Native Hawaiian
and other Pacific Islander descent in the United States, in which 9.4% comprise its total state population (U.S. Census Bureau, 2000). Persons of Native Hawaiian and other Pacific Islander descent include Hawaiians, Guamanians, Samoans, and other people of Polynesian, Micronesian, and Melanesian cultural backgrounds. Hawai‘i has the largest percentage (21.4%) of persons in the United States indicating “Two or More Races” (U.S. Census Bureau, 2000). Of these, approximately 96% designated themselves to be part Asian, Native Hawaiian or of other Pacific Islander descent (CensusScope, 2000).

**Utilization of Mental Health Services.** Up to 90% of persons of Asian and Pacific Islander descent with behavior problems are believed to receive no services for these problems (Chow, 2002). Leong (1994) reported significant differences among racial groups’ (White, Chinese, Filipino, and Japanese) utilization of inpatient mental health facilities in Hawai‘i. Post-hoc comparisons between persons of White descent and persons of Asian descent determined that persons of Asian descent (i.e., Chinese, Filipino, and Japanese) do not utilize inpatient mental health facilities relative to their proportion in the population. Using an epidemiological data comparison approach (number of actual cases divided by the number of all possible cases, then multiplied by 100), Leong determined mental health facilities’ utilization by these different racial groups. His results showed that for inpatient mental health facilities, the utilization percentage for persons of White descent was 0.7%, while the utilization percentage for persons of the Asian descent groups ranged between 0.2-0.3%.

Significant differences were also found between the same racial groups in the utilization of outpatient mental health facilities in Hawai‘i. Post-hoc chi-square tests between persons of White descent and persons of Asian descent again determined that
persons of Asian descent do not utilize outpatient mental health facilities relative to their proportion in the population (Leong, 1994). The same epidemiological data comparison approach applied to outpatient mental health facilities showed a utilization percentage of 0.41% for persons of White descent compared to 0.11% of persons of Chinese descent, 0.23% of persons of Filipino descent, and 0.14% of persons of Japanese descent.

Possible Explanations. The Surgeon General’s supplemental report on mental health (U.S. Department of Health and Human Services, 2001) reported possible explanations as to why persons of Asian descent do not utilize mental health services as much as persons of White descent: Treatment is often sought only when behavior problems become severe, and families of Asian descent tend to discourage treatment until individuals with these problems become unmanageable (U.S. Department of Health and Human Services, 2001; Ja & Aoki, 1993; Lin & Cheung, 1999; Snowden & Cheung, 1990; Wynaden et al., 2005). Shin’s (2002) qualitative study found that mental health services are oftentimes sought only when the individual with the behavior problems is brought in for treatment involuntarily and/or sometimes near death.

Additional reasons have been offered for less utilization of services for behavior problems among persons of Asian descent compared to persons of White descent. One barrier may be the culturally associated stigma attached to behavior problems (Harris, 2004; Narikiyo & Kameoka, 1992; Shin, 2002; Sue, 1994; Takeuchi, Leaf, & Kuo, 1988; U.S. Dept. of Health and Human Services, 2001; Wynaden et al., 2005; Yamashiro & Matsuoka, 1997). Gross and John (1998) identified additional barriers to less utilization of mental health services for behavior problems among persons of Asian descent compared to persons of White descent. They reported that persons of Asian descent had
significantly less confidence in their expressive skills and made significantly more attempts at masking their feelings than did persons of White descent ($d = -0.36$ and $d = -0.38$, respectively). Additionally, the acculturation level of a person of Asian descent was not found to be associated with their degree of emotional expression. High-, medium- and low-acculturated Canadians of Asian descent were found to be significantly less emotionally expressive than Canadians of White descent ($d = -0.4$, $d = -0.5$, and $d = -0.7$, respectively) (Lai & Linden, 1993).

Patients of Asian descent may also communicate differently than their physicians, thereby decreasing both their ability to attain help and a physician’s ability to detect problems (Ngo-Metzger, Legedza, & Phillips, 2004). Patients of Asian descent have been found to be more indirect in their style of communicating symptoms because of influences associated with their cultures (Harris, 2004; Ngo-Metzger et al., 2004) compared to patients of White descent. For example, Harris (2004) stated that culture can influence how patients report depressive symptoms by presenting somatic complaints (e.g., having weakness or tiredness) instead of with direct communication of symptoms (e.g., feeling sad or depressed).

Indirect, culturally associated paralinguistic communication, such as nodding and smiling, can also affect treatment decision-making between patients and their doctors. Ngo-Metzer et al. (2004) found that different communication styles may explain why persons of Asian descent reported that their doctors did not involve them in their health care decision-making process as they would like: While persons of Asian descent nod and smile as a sign of respect for their doctor, the doctor may in turn regard this as
agreement with the treatment plan, although the patient may feel otherwise and feel it not appropriate to openly disagree with the doctor.

McLaughlin & Braun (1998) also suggested that cultural values affect how patients of Asian and Pacific Islander descent communicate with their physicians, which can result in underreporting their behavior problems. These authors suggested that these groups place high value on harmony in relationships, which can result in the tendency to communicate to their physicians what they believe the physicians want to hear. McLaughlin & Braun (1998) also suggested that patients of these groups may also think it not appropriate to disclose their feelings with strangers. In a study in which patients rated their primary care physicians, Murray-Garcia et al. (2000) found that patients of Asian and Pacific Islander descent rated their physicians significantly lower than did Whites, Blacks, and Latinos in communication style ($p < .001$). These ratings included adequacy of the physician’s explanations, time spent with the patient, and interpersonal style (i.e., courtesy, respect, and sensitivity). These barriers of stigma, possession of less expressive skills, masked feelings, and communication style conflicts present problems for primary care providers who often depend on their patients to verbally communicate their health issues, which include behavior problems.

Additionally, cultural differences may influence whether primary care providers, such as physicians, can recognize behavior problems with persons whose ethnicity differs from their own (Borowsky et al., 2000). This may be another reason why persons of Asian and Pacific Islander descent are less likely to receive help from their physicians than persons of White descent (Murray-Garcia, Selby, Schmittdiel, Grumbach, & Quesenberry, 2000; Ngo-Metzger, 2004). Physicians may also stereotype some ethnic
minorities, such as persons of Asian descent, as “model minorities” who possess few health problems or negative health habits (Chen & Hawks, 1995; Smedley, Stith, & Nelson, 2003).

**Primary Care Providers and Their Role.** Primary care providers play an important role in the identification, treatment, and/or referral for their patients’ behavior problems. Using the National Institute of Mental Health Epidemiologic Catchment Area study (U.S. Department of Health and Human Services, 1992) with a sample of 20,291 adults treated for some mental or addictive disorder, Regier et al. (1993) estimated that in one year primary health care providers rendered mental or addictive disorder services to the largest proportion of persons (43%) compared to other mental health sectors, such as the specialty mental health and addictive disorders sectors, self-help groups, family, friends, and other human services professionals.

Persons of Asian descent have been found to seek help for behavior problems most often from their primary care providers, such as general practitioners, family practitioners, internists, and gynecologists (Ng, 1997; Shin, 2002; Yeung, Chang, Gresham, Nierenberg, & Fava, 2004), because of their tendency to focus more on the physical than behavior components of their problems (Lin et al., 1999; Yeung et al., 2004). Given the many impediments to persons of Asian and Pacific Islander descent receiving needed mental health services, one solution may be to assist primary health care providers (e.g., physicians, nurses) who are major sources of services for individuals with behavior problems.

The facts that persons of Asian and Pacific Islander descent have a higher rate of behavior problems, underreport these problems, and seek help less often than persons of
White descent, suggest that primary care providers can help to detect and identify behavior problems among their primary care patients from these populations.

Method of Reporting Behavior Problems. The method of reporting behavior problems by patients to their primary care providers may affect identification of these problems, which in turn can affect the delivery of appropriate services for this group. A study by Okazaki (2000) found that persons of Asian descent reported lower rates of depressive symptoms in the interview format compared to the written questionnaire format. Additionally, when the written format was used, participants were found to report feeling more depressed or lonely than in the interview format.

In another study, two groups of persons of Korean descent were found to report higher levels of behavior problems on a written self-report questionnaire than when the same questions were given in face-to-face interviews ($F=24.75$, $p=.001$ and $F=21.94$, $p=.001$) (Park, Upshaw, & Koh, 1988). These findings, that the rate of symptom reporting depends on the type of assessment method, suggest a disparity between the interview and self-report responses of at least one group of persons of Asian descent (in this particular study persons of Korean descent).

Females and Behavior Problems. Lastly, males and females differ in their rate of self-reported behavior problems (Jarett, Yee, & Banks, 2007). The Office of Research on Women’s Health (ORWH; 2004) reported that depression affects females about twice as much as males and that anxiety disorders, such as anxiety, panic, and phobic disorders, are two to three times more common in females than in males. Females also make up the vast majority of cases involving eating disorders and are more likely than males to
attempt suicide (ORWH, 2004). For these reasons, the female gender was another focus, and female primary care patients were utilized for this study.

**Goals.** The goals of this study were to determine the degree to which the rate and severity of self-reported behavior problems of female patients in a primary care setting were associated with the method of reporting (written vs. oral) and self-identified racial group (Asian, Pacific Islander, and White descent).

**Method**

**Study Site.** This study was conducted in the patient waiting area at the University Health Services Mānoa, an outpatient primary care clinic at the University of Hawai'i at Mānoa. Data was collected at this site over 14 days between October and December of 2007. Health care at the University Health Services Mānoa is provided to students of the University of Hawai'i at Mānoa (freshman, sophomore, junior, senior, and graduate students), students from the University of Hawai'i community colleges, and the university's faculty, staff members, conference attendees, and other visitors.

**Selection of Subjects.** Participants were 340 female subjects—132 females of Asian descent, 51 females of Pacific Islander descent, 133 females of White descent, and 24 females from other racial descents\(^2\)—18 years or older, who came for services with a primary care provider at the facility. Additional inclusion criteria were first-time participants in the study and those who were without health impairments serious enough to preclude participation (e.g., apparent physical injuries; too ill to read and fill out or verbally answer questionnaires). Participant selection was by a convenience sample of eligible female patients upon checking in or after their primary care visit while waiting for their prescriptions to be filled by the clinic's pharmacy in the same patient waiting area.

\(^2\) For purposes of this study, results of females of “other” descent groups are not reported.
area during open clinic hours. Six female participants were not included in the data analyses—one was too ill to finish the questionnaires, one had to attend class after her visit, one refused to complete the demographic questionnaire because selection of a racial category was required, one refused because her questionnaire was to be orally administered, and two participants did not exit through the front waiting area after their visit to complete their questionnaires.

**Questionnaires.** The demographic survey (Appendix A) included information regarding sex, age, status (e.g., student, faculty), racial descent, and marital status. Presence of behavior problems was assessed using the Health Dynamics Inventory—Self-Report Form (HDI-S; Saunders & Wojcik, 2004) (Appendix B).

The HDI-S is a brief questionnaire that takes 5-10 minutes for respondents to complete and is a screening tool that was developed to assess mental health status in a primary care setting. It consists of three major scales (Morale [the opposite of distress], Global Impairment, and Global Symptoms) to evaluate aspects of mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994).

The Morale or distress Scale has a score range of 4 to 20 and measures a patient’s level of mental health, distress, contentment, and happiness over their last two weeks (Saunders & Wojcik, 2004). The Global Impairment Scale has a score range of 12 to 49 and measures a patient’s general functioning or impairment in occupational, social

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3 The HDI-S was altered for purposes of the study—the rewording of a question in the Morale Scale was changed from “How distressed have you been in the past two weeks because of the problem for which you are seeking treatment” to “How much distress have mental or emotional problems caused you in the last two weeks”; two questions in the Morale Scale were omitted because they implied the existence of behavior problems; items in the Global Symptom Scale addressing substance abuse were omitted as required by the university health clinic.
relationship, and self-care roles (Saunders & Wojcik, 2004). The Global Symptoms Scale has a score range of 28 to 140. This scale measures global symptomatic distress and categorizes symptoms into subscales that measure depression, anxiety, attention problems, psychotic thinking, eating disorder, and behavior problems (Saunders & Wojcik, 2004).

The HDI-S has been found to be a reliable and valid screening measure. Previous research with mental health outpatients and inpatients and nonpatient volunteers have indicated that the HDI-S is reliable, with internal consistencies of its major scales and subscales ranging between .69 and .95 and Guttman split-half reliability coefficients ranging between .70 and .91 (Saunders & Wojcik, 2004). Validity was also supported in the same study by patients (mental health outpatients and inpatients) scoring significantly higher than non-patients on all scales as well as by significant correlations between patients' reports and clinicians' ratings.

**Procedures.** Patient participation was conducted during open clinic hours. After a female patient arrived at the clinic and checked in, or while she was waiting for her prescription from the clinic pharmacy after completing her visit with a primary care provider, one of two female researchers of Asian descent approached the patient to request participation in the study, assuming the patient did not appear to have any serious health impairments as noted above. Patients who met the inclusion criteria for the study were assigned a number and given a letter of invitation to participate (Appendix C for the written method and Appendix D for the oral method) and a brief description of the study and consent form (Appendix E for the written method and Appendix F for the oral method) by the researcher. Participants were also informed that the researcher was
conducted research by collecting data for a master's thesis, and the participant was assured of her anonymity as stated in the consent form.

Each participant reported the severity and frequency of her behavior problems in response to items from the HDI-S presented in either the written questionnaire or interview method. If the patient was selected for the written method and agreed to participate in the study after reading the study description and consent form, the participant was given an envelope packet that contained a demographic questionnaire and the HDI-S, which were attached to a clipboard with a pen. The patient was then instructed to fill out the two questionnaires, place them back into the envelope after completion, and keep the study description and consent form. The participant was also informed that the researcher was available in the clinic waiting area to answer any questions the participant may have while completing the forms and asked to return the packet, clipboard, and pen after completion.

If the participant was selected to be administered the HDI-S questionnaire by the interview format, the patient was asked to read the study description and informed consent. If the patient agreed to participate in the study, she was asked to go with the researcher to a secluded section in the clinic away from other patients and was given the demographic questionnaire, which was attached to a clipboard with a pen. She was instructed to complete the questionnaire and to place it into its corresponding numbered envelope. The participant was then orally administered the HDI-S by the researcher. The patient was allowed to use the questionnaire as a visual aid by looking at the choices listed on the questionnaire to respond to a question or statement. For example, to rate how often the patient had been bothered by a symptom, the patient looked at the choices
listed on the questionnaire to select one of five options (from "not at all" to "several times per day or more"). Upon completion of the interview, the researcher placed the HDI-S into its corresponding numbered envelope, and the participant was given a copy of the study description and consent form.

If the participant was called in to the examination room by the nurse before completing the questionnaires, the participant was asked if she was willing to complete them on the way out after the office visit; if not, the participant’s data was not used in the study. Patients did not take any questionnaires from this research into the clinic examination rooms and were instructed that the questionnaires were for research purposes only, that they were not part of the health service procedures, and that health service providers would not see the results of their surveys.

Training and Monitoring of Research Assistants. Prior to initiation of the study, a female research assistant of Asian descent was trained in recruitment procedures, how to obtain informed consent, how to conduct the written and oral screening sessions, and how to conduct the debriefing session. (A female of Asian descent was selected as a research assistant since the principal investigator for this study, who was also collecting data, is a female of Asian descent.) Training consisted of discussion, demonstrations, and role play. To insure fidelity, the research assistant was monitored on site by the principal investigator.

Results

Data Analyses. The means and standard deviations for each of the three HDI-S scales (Morale, Global Impairment, and Global Symptoms) and for each of the three subject groups (females of Asian, Pacific Islander, White descent) and the two methods of
reporting (written and interview) are presented in Table 1. Correlation coefficients among the three scale scores by method are shown in Table 2, which indicate significant correlation between scales.

Table 1.
Scores of HDI-S Scales as a Function of Reporting Method for Participants of Asian, Pacific Islander, and White Descent

<table>
<thead>
<tr>
<th>Scale</th>
<th>Group</th>
<th>Written Method (n=162)</th>
<th>Interview Method (n=154)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Morale (Distress) Scale</td>
<td>Asian (n=132)</td>
<td>9.41</td>
<td>3.07</td>
<td>8.86</td>
</tr>
<tr>
<td></td>
<td>Pacific Islander (n=51)</td>
<td>8.63</td>
<td>2.76</td>
<td>10.63</td>
</tr>
<tr>
<td></td>
<td>White (n=133)</td>
<td>9.15</td>
<td>2.62</td>
<td>8.73</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>9.06</td>
<td>2.82</td>
<td>9.41</td>
</tr>
<tr>
<td>Global Impairment Scale</td>
<td>Asian (n=132)</td>
<td>23.87</td>
<td>7.59</td>
<td>19.76</td>
</tr>
<tr>
<td></td>
<td>Pacific Islander (n=51)</td>
<td>21.82</td>
<td>7.49</td>
<td>22.54</td>
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<tr>
<td></td>
<td>White (n=133)</td>
<td>20.80</td>
<td>6.26</td>
<td>19.43</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>22.16</td>
<td>7.11</td>
<td>20.58</td>
</tr>
<tr>
<td>Global Symptoms Scale</td>
<td>Asian (n=132)</td>
<td>51.41</td>
<td>18.31</td>
<td>47.37</td>
</tr>
<tr>
<td></td>
<td>Pacific Islander (n=51)</td>
<td>52.22</td>
<td>22.40</td>
<td>57.33</td>
</tr>
<tr>
<td></td>
<td>White (n=133)</td>
<td>49.11</td>
<td>13.78</td>
<td>48.02</td>
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<tr>
<td></td>
<td>Mean</td>
<td>50.91</td>
<td>18.16</td>
<td>50.91</td>
</tr>
</tbody>
</table>

*(SD) = standard deviation
*Note: For all measures, higher means indicate more behavior problems
Table 2. Pearson Correlation Coefficients Between HDI-S Scales by Method of Reporting

<table>
<thead>
<tr>
<th>Measure</th>
<th>Written Method (n = 162)</th>
<th>Interview Method (n = 154)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morale (Distress) Scale</td>
<td>Global Impairment Scale</td>
</tr>
<tr>
<td>Morale (Distress) Scale</td>
<td>1.00</td>
<td>0.60</td>
</tr>
<tr>
<td>Global Impairment Scale</td>
<td>0.67*</td>
<td>1.00</td>
</tr>
<tr>
<td>Global Symptoms Scale</td>
<td>0.75*</td>
<td>0.75*</td>
</tr>
</tbody>
</table>

* p < .0001

Because this study involved three dependent variables that are significantly correlated with each other, MANOVA was utilized as a first stage in the analyses. An initial MANOVA examined group by method interaction using Wilks' Lambda statistic, which was significant \[F(6, 616) = 2.14, p = .048\]. Therefore, as a next step, MANOVA was run with group as a factor for each method. For the written method, the effect of group was significant \[F(6, 314) = 2.62, p = .017\]; however, for the oral method, group was not significant \[F(6, 298) = 1.76, p = .107\]. Furthermore, three follow-up MANOVAs were run to identify which group(s) were different on the three scales when the written method was used. Significant group differences were only found between females patients of Asian and White groups \[F(3, 131) = 3.36, p = .021\].
Another MANOVA was run with method as a factor for each group. The effect of method was significant for female patients of Asian descent, \(F(3, 128) = 5.01, p = .003\) and for female patients of Pacific Islander descent \(F(3, 47) = 2.87, p = .046\). However, for females patients of White descent, the effect of method was not significant \(F(3, 129) = .76, p = .51\).

Main and interaction effects for each of the three dependent variables were then examined with a 3 (group) x 2 (method) ANOVA and are presented in Table 3.

Table 3.
Main and Interaction Effects for HDI-S Scales

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morale (Distress) Scale</strong></td>
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</tr>
<tr>
<td>Group</td>
<td>2</td>
<td>17.30</td>
<td>8.65</td>
<td>1.06</td>
<td>0.35</td>
</tr>
<tr>
<td>Method</td>
<td>1</td>
<td>7.57</td>
<td>7.57</td>
<td>0.93</td>
<td>0.34</td>
</tr>
<tr>
<td>Group*Method</td>
<td>2</td>
<td>65.80</td>
<td>32.90</td>
<td>4.03</td>
<td>0.02</td>
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<tr>
<td><strong>Global Impairment Scale</strong></td>
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<td></td>
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<tr>
<td>Group</td>
<td>2</td>
<td>253.75</td>
<td>126.88</td>
<td>2.99</td>
<td>0.05</td>
</tr>
<tr>
<td>Method</td>
<td>1</td>
<td>162.22</td>
<td>162.22</td>
<td>3.83</td>
<td>0.05</td>
</tr>
<tr>
<td>Group*Method</td>
<td>2</td>
<td>251.53</td>
<td>125.77</td>
<td>2.97</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>Global Symptoms Scale</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2</td>
<td>1482.72</td>
<td>741.36</td>
<td>2.86</td>
<td>0.06</td>
</tr>
<tr>
<td>Method</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Group*Method</td>
<td>2</td>
<td>771.02</td>
<td>385.51</td>
<td>1.49</td>
<td>0.23</td>
</tr>
</tbody>
</table>
**Results for Morale Scale.** The $3 \times 2$ ANOVA for the Morale Scale, reported in Table 3, indicated nonsignificant main effects for group and method but a significant group x method interaction. As indicated in Table 1, the means on the Morale Scale were higher in the written than the interview method for the females of Asian and White descent groups and lower for the females of Pacific Islander descent group. Post-hoc analyses using the Tukey-Kramer post hoc criterion for significance on the Morale Scale scores between written and interview methods for each group revealed no significant differences within each group.

As illustrated in Table 1, the Pacific Islander group, but not the Asian and White groups, scored higher on the interview method than on the written method. Post-hoc analyses using the Tukey-Kramer test on the Morale Scale scores between groups on the interview method revealed no significant differences.

**Results for Global Impairment Scale.** The $3 \times 2$ ANOVA for the Global Impairment Scale, reported in Table 3, indicated significant main effects for group and method and group x method interaction at the level of significance. As illustrated in Table 1, the means on the Global Impairment Scale were higher in the written compared to the interview method for the females of Asian and White descent groups and lower for the females of Pacific Islander descent group. Post-hoc analyses using the Tukey-Kramer post hoc criterion for significance on the Global Impairment Scale scores between written and interview methods for each group revealed a significant difference only for the females of Asian descent group ($t = .0046, p = .05, d = .00$).

Table 1 also shows that for this scale, the females of Asian descent group in the written method had the highest mean ($M = 23.87, SD = 7.59$) and the females of White
Of the three scales, significant differences among scores were found in the Global Impairment Scale, an indicator of impairment in fulfilling major life roles. Scores for the
written method of reporting for female patients of Asian descent were significantly higher than the face-to-face oral interview method of reporting behavior problems. These results are consistent with Okazaki’s (2000) findings of differential patterns of reporting in which she found persons of Asian descent reporting more depressive and social anxiety symptoms in the questionnaire condition than in the interview condition.

The significantly higher scores in the written method than the interview method of reporting behavior problems among female patients of Asian descent in this study suggests support of Gross and John’s (1998) study that this population may have less confidence in their expressive skills and make more attempts at masking their feelings. It may also support Lai and Linden’s (1993) findings that persons of Asian descent were less emotionally expressive than persons of White descent.

There was also a significant difference in the reporting of behavior problems between two of the three groups in the Global Impairment Scale. Females of Asian descent were found to report significantly more behavior problems in the written format of reporting compared to females of White descent in the interview format. The results that indicate significant primary role (occupational, social relationships, self-care) impairment by female patients of Asian descent suggest higher levels of difficulty in functioning in these roles compared to female patients of White descent. These roles may include initiating and concentrating on tasks, problems meeting demands of and being interested in one’s occupation or education, difficulty in relationships with important others, meeting family obligations, sexual functioning, ability to maintain good health habits, enjoyment of leisure activities, use of friends for support, or ability to do things to promote positive self-regard (Saunders & Wojcik, 2004). This suggests that
females of Asian descent may require but do not receive or seek resources—such as family, job, or personal counseling—to address behavior problems with primary life roles.

The relatively small sample size of female patients of Pacific Islander descent ($n = 51$ compared to females patients of Asian and White descent, $n = 132$ and $n = 133$, respectively) was a limitation in this study. Female patients of Pacific Islander descent reported more behavior problems than female patients of White descent, and a larger sample size of female patients of Pacific Islander descent could result in significant differences in scores between these two groups. For example, as indicated in Table 1, mean scores for female patients of Pacific Islander descent were higher, although not significantly, than scores for female patients of White descent on almost all scales. A larger sample size may have supported Gregersen, et al.’s (2004) study which showed college students of Pacific Islander descent with significantly higher total scores than the normative sample of persons of White descent, indicating greater emotional and behavioral distress. Additionally, total mean scores of female patients of Pacific Islander descent were the highest on all three scales among all racial groups. Future studies should explore this question with a larger sample size of female patients of Pacific Islander descent.

Further study with a larger sample size of female patients of Pacific Islander descent may also show significant findings that this population discloses more behavior problems when questioned face-to-face than by written questionnaire. Female patients of Pacific Islander descent consistently scored highest in the interview method of reporting
behavior problems on all three scales compared to female patients of Asian and White descent.

Another limitation is the population generalizability of the findings from this study. The majority of participants was college students (285 of 316) and may not be representative of female primary care outpatients in general. Studies using sample populations from primary care providers outside of a college setting are warranted to address this issue. Limitations on generalizability are also associated with the race of the interviewer (in this study, interviewers of Asian descent), which may have contributed to differences in responses. Controlling for response bias was attempted with two interviewers of the same race and similar age, although demand characteristics are still possible.

As previously mentioned as a footnote in the description of the HDI-S, the HDI-S was altered for purposes of the study. This included the rewording of a question in the Morale Scale from “How distressed have you been in the past two weeks because of the problem for which you are seeking treatment?” to “How much distress have mental or emotional problems caused you in the last two weeks.” It should be noted that the developers of the HDI-S, Saunders and Wojcik (2004), had also similarly reworded this question as part of their normative data collection to evaluate the psychometric properties and construct validity of this questionnaire (i.e., from “‘How distressed have you been in the past two weeks because of the problem for which you are seeking treatment?’” to “How distressed have you been in the past two weeks?”). Also, two questions in the Morale Scale were omitted because they implied the existence of behavior problems (“How confident are you that you will be able to learn to deal with the problem(s)?”) and
“How important is it for you to be in treatment at this time?”). Lastly, items in the Global Symptom Scale addressing substance abuse (i.e., rates of cravings, feeling guilty because of drug or alcohol use, using alcohol or drugs excessively, and lying about or hiding drinking or drug use) were omitted as a requirement by the outpatient primary care clinic study site, University Health Services Mānoa.

Additionally, as discussed by the developers of the HDI-S (Saunders & Wojcik, 2004), a limitation is that it is not known whether the HDI-S can identify patients with behavior problems in a primary care setting, nor can it be relied upon to diagnose specific behavior problems. However, it can be useful as a screening tool for detection of possible behavior problems in primary care settings to determine whether treatment should be sought or provided.

This study suggests that the level of reporting behavior problems may depend on the context in which the information is collected and the primary racial category with which female primary care patients most closely identify. Because “race” is often difficult to identify in heterogeneous populations such as those found in Hawai‘i and different racial groups may report more behavior problems depending on the method of inquiry, it may be prudent for primary care providers to utilize both methods of reporting behavior problems.

Cross-cultural assessment implications of behavior problems are also suggested. Evidence of higher rates of behavior problems and lower utilization of services for these problems among persons of Asian and Pacific Islander descent compared to persons of White descent raises concerns of mental health services that may be required for these populations. Primary care providers can play an important role in the detection,
treatment, or referral of behavior problems for female patients of Asian and Pacific Islander descent.
APPENDIX A

PERSONAL INFORMATION FORM

Today’s Date: ________________

Gender: Female ___
       Male ___

Age: _______ years

Status: Student: ___Freshman ___Sophomore ___Junior ___Senior ___Graduate
        Faculty ___
        Staff ___
        Other ___

Primary Racial Descent (check the category with which you most closely identify):

       ____Asian
       ____Native Hawaiian/Other Pacific Islander
       ____White
       ____Black
       ____Native American/Alaskan Native
       ____Hispanic/Latino
       ____Two or More Races

Marital Status: ___Single  ___Married  ___Separated  ___Divorced  ___Widowed
APPENDIX B

Health Dynamics Inventory—Self-Report Form

This is not a test; there are no right or wrong answers. The questions are about how you are doing. Please answer the questions as openly and honestly as possible. The answers you give to these questions will be kept strictly confidential.

1. How would you rate your current mental or emotional health?
   [ ] Very poor  [ ] Poor  [ ] Fair  [ ] Good  [ ] Very good

2. How much distress have mental or emotional problems caused you in the last two weeks?
   [ ] Extremely  [ ] Very  [ ] Moderately  [ ] Slightly  [ ] Not at all

3. In the past four weeks, how much of the time have you felt content or satisfied with your life?
   [ ] None of the time  [ ] A little  [ ] Some  [ ] Most  [ ] All of the time

4. In the past four weeks, how much of the time have you been a happy or cheerful person?
   [ ] None of the time  [ ] A little  [ ] Some  [ ] Most  [ ] All of the time

Rate how much difficulty emotional or behavioral problems cause in your ability to do the following (check "NA" if the item does not apply to you).

<table>
<thead>
<tr>
<th>Rate how much difficulty emotional or behavioral problems cause in your ability to do the following (check &quot;NA&quot; if the item does not apply to you).</th>
<th>No difficulty at all</th>
<th>A little bit of difficulty</th>
<th>Quite a bit of difficulty</th>
<th>A great deal of difficulty</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Begin or initiate tasks.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>6. Concentrate on tasks.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>7. Meet demands of work or school (promptness, finishing tasks, etc.).</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
<tr>
<td>8. Be interested in work or school.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>9. Have good or satisfying relationships with friends.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>10. Have a good or satisfying relationship with your spouse or partner.</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>11. Meet obligations to family members (children, parents or siblings).</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>12. Get satisfaction or enjoyment from sexual activity.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>13. Maintain good diet or health habits.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>14. Get satisfaction or enjoyment from leisure (hobbies, reading, etc.).</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>15. Use friends or family to help manage stress.</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>16. Do things that help you to feel good about yourself.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>How often have you been bothered by the following during the past two weeks?</td>
<td>Not at all</td>
<td>Rarely</td>
<td>Somewhat</td>
<td>Almost every day</td>
<td>Several times per day or more</td>
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<tr>
<td>1. Feeling sad, blue, or depressed</td>
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<tr>
<td>2. Lack of interest or loss of pleasure in activities usually enjoyed</td>
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<td>3. Low self-esteem, feelings of worthlessness, or shame</td>
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<td>4. Rapid or strong mood swings</td>
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<td>5. Appetite change, unintended weight loss or gain</td>
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<tr>
<td>6. Repeated thoughts about death or suicide</td>
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<td>7. Feeling fatigued, tired or weak; low energy</td>
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<tr>
<td>8. Difficulty expressing yourself or knowing what you are feeling</td>
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<td>9. Sleep difficulties (sleeping too little [ ] sleeping too much [ ] )</td>
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<tr>
<td>10. Feeling anxious, agitated, or unable to relax</td>
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<tr>
<td>11. Panic attacks; feeling fearful of going crazy or dying</td>
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<td>12. Excess or unrealistic worry that you can't control</td>
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<td>13. Pain or physical discomfort (headaches, stomach problems)</td>
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<tr>
<td>14. Nightmares, flashbacks, or painful memories</td>
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<tr>
<td>15. Repeated and intrusive thoughts, ideas, or impulses</td>
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<td>16. Trouble paying attention</td>
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<td>17. Feeling thoughts or too much energy</td>
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<tr>
<td>18. Beliefs that others don't understand</td>
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<td>19. Feeling that your thoughts or actions are being controlled against your will</td>
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<td>20. Hearing or seeing things that others don't hear or see</td>
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<td>21. Purging behaviors (vomiting; laxative or diuretic abuse)</td>
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<td>22. Fear of gaining weight or becoming fat</td>
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<td>23. Binge eating (eating large amounts of food)</td>
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<td>24. Being troubled by body shape or physical features</td>
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<td>25. Cravings</td>
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<td>26. Feeling guilty because of drug or alcohol use</td>
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<td>27. Using alcohol or drugs excessively</td>
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<tr>
<td>28. Lying about or hiding drinking or drug use</td>
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<td>29. Angry outbursts</td>
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<td>30. Problems with sexual interest, impulses, or behavior</td>
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<td>31. Using force (violence) when angry or upset</td>
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<td>32. Feeling out of control of your anger, or feeling ashamed of your anger</td>
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</tbody>
</table>
Dear Participant:

You are being invited to participate in a brief research study about reporting methods while you wait for your meeting with the medical provider today. If you have NOT already participated in the study and are 18 years of age or older, you are eligible to participate. If you are interested, please read the attached research description and consent form; and if you agree to participate, you can go ahead and fill out the two questionnaires.

If you are not eligible or not interested in participating in this study, please return these forms to the researcher now.

Mahalo!

Disclaimer: Please note that this study is for a graduate research project. University Health Services has given us consent to ask clinic clients for their participation but otherwise is not involved in the study and will not see the forms you complete.
APPENDIX D

Reporting Method Disparities Study
Project Description

Dear Participant:

You are being invited to participate in a brief research study about reporting methods while you wait for your meeting with the medical provider today. If you have NOT already participated in the study and are 18 years of age or older, you are eligible to participate. If you are interested, please read the attached research description and consent form; and if you agree to participate, please notify the researcher you are ready to answer the study’s questionnaires.

If you are not eligible or not interested in participating in this study, please return these forms to the researcher now.

Mahalo!

Disclaimer: Please note that this study is for a graduate research project. University Health Services has given us consent to ask clinic clients for their participation but otherwise is not involved in the study and will not see the forms you complete.
APPENDIX E

Research Description and Consent Form

Title of Study: Reporting Method Disparities

Investigators: Dawn T. Yoshioka, B.A., University of Hawai'i, Department of Psychology
Stephen N. Haynes, Ph.D., University of Hawai'i, Department of Psychology

Description: The purpose of this study is to investigate reporting of potential emotional and behavioral problems. Information from this investigation will be used to help primary care providers to screen patients and promote patient mental health and well-being.

Procedures: If you agree to participate, you will be given two questionnaires to complete while you are waiting to meet with your healthcare provider today. The questionnaires take about 5 to 10 minutes to complete. After you complete the questionnaires, please place them back into the envelope and return the envelope, clipboard, and pen to the researcher. You may keep this form for your records.

Anonymity: You will NOT be asked to give any identifying information, such as your name, student number, social security number, etc. The questionnaires you complete will be identified only by code number. Your packet of questionnaires will be retained by the researcher who will keep the results confidential. Thus, your name will never be associated with any information you provide.

Anticipated Risks and Benefits: In the unlikely event you feel distressed at any time, counselors at the Student Counseling and Development Center are available to talk to you. You can go there in person or call 956-7927. A potential benefit to you is knowing that you are contributing to a scholarly investigation designed to increase our ability to provide effective services to primary care patients and to increase our knowledge of the method of reporting emotional and behavioral problems.

Voluntary: Your participation in the study is strictly voluntary and will not affect the services you receive at the University Health Services Mānoa. You may either refuse to participate or withdraw from the study at any time without any penalty to you.

If you have any questions about the research or if you would like to a copy of the results when the study is completed, you can contact the Dawn Yoshioka or Stephen Haynes in the Department of Psychology, Garfield Hall, University of Hawai'i at Mānoa at 956-8414.

IF YOU FEEL FULLY INFORMED ABOUT THE STUDY AND ARE WILLING TO PARTICIPATE, PLEASE FILL OUT THE ATTACHED MATERIALS NOW. YOUR PARTICIPATION WILL BE GREATLY APPRECIATED. YOU MAY RETAIN THIS FORM FOR YOUR RECORDS.

(If you cannot obtain satisfactory answers to your questions or have comments or complaints about your treatment in this study, contact: Committee on Human Studies, University of Hawai'i, 2540 Maile Way, Honolulu, Hawai'i 96822. Phone: 808-956-5007.)
APPENDIX F

Research Description and Consent Form

Title of Study: Reporting Method Disparities
Investigators: Dawn T. Yoshioka, B.A., University of Hawai‘i, Department of Psychology
Stephen N. Haynes, Ph.D., University of Hawai‘i, Department of Psychology

Description: The purpose of this study is to investigate reporting of potential emotional and behavioral problems. Information from this investigation will be used to help primary care providers to screen patients and promote patient mental health and well-being.

Procedures: If you agree to participate, you will be given a personal information form to complete, and a researcher will ask you questions directly from a patient health questionnaire. This should take about 5 to 10 minutes to complete. After you complete the personal information form, please place it back into the envelope. The researcher will place the patient health questionnaire upon completion into the envelope as well. You may keep this form for your records.

Anonymity: You will NOT be asked to give any identifying information, such as your name, student number, social security number, etc. The questionnaires you complete will be identified only by code number. Your packet of questionnaires will be retained by the researcher who will keep the results confidential. Thus, your name will never be associated with any information you provide.

Anticipated Risks and Benefits: In the unlikely event you feel distressed at any time, counselors at the Student Counseling and Development Center are available to talk to you. You can go there in person or call 956-7927. A potential benefit to you is knowing that you are contributing to a scholarly investigation designed to increase our ability to provide effective services to primary care patients and to increase our knowledge of the method of reporting emotional and behavioral problems.

Voluntary: Your participation in the study is strictly voluntary and will not affect the services you receive at the University Health Services Mānoa. You may either refuse to participate or withdraw from the study at any time without any penalty to you.

If you have any questions about the research or if you would like to a copy of the results when the study is completed, you can contact the Dawn Yoshioka or Stephen Haynes in the Department of Psychology, Gartley Hall, University of Hawai‘i at Mānoa at 956-8414.

IF YOU FEEL FULLY INFORMED ABOUT THE STUDY AND ARE WILLING TO PARTICIPATE, PLEASE FILL OUT THE ATTACHED PERSONAL INFORMATION FORM NOW. YOUR PARTICIPATION WILL BE GREATLY APPRECIATED. YOU MAY RETAIN THIS FORM FOR YOUR RECORDS.

(If you cannot obtain satisfactory answers to your questions or have comments or complaints about your treatment in this study, contact: Committee on Human Studies, University of Hawai‘i, 2540 Maile Way, Honolulu, Hawai‘i 96822. Phone: 808-956-5007.)
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