Mental Health Services Research, Vol. 3, No. 4, December 2001 (© 2001)

Barriers to Providing Effective Mental Health Services to Asian Americans[1]

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Using the research framework recommended by L. Rogler, R. Malgady, and D. Rodriguez (1989), the current paper examines the barriers to providing effective mental health services to Asian Americans. Beginning with the recognition that Asian Americans consists of numerous heterogeneous subgroups, the issue of the stereotype of Asian Americans as the "model minority" was also discussed. The primary focus of the paper is on Stages 2, 3, and 4 within the Rogler et al. (1989) model and the identification and discussion of cultural factors that hinder the delivery of mental health services to Asian Americans. The paper is therefore organized into these three sections: (a) help-seeking or mental health service utilization, (b) evaluation of mental health problems, and (c) psychotherapeutic services. In each of the sections, not only are the barriers to delivery of effective mental health services discussed but so are the research and methodological problems as well as some directions for future research. This critical review of the literature has been prepared with the goal of serving as a "blueprint" for us to pursue rigorous but relevant research to identify and reduce these cultural barriers to providing effective mental health services to Asian Americans.

KEY WORDS: Asian Americans; mental health services; psychotherapy; underutilization of services.

With the stereotype of being a "model minority," Asian Americans are often perceived to experience few if any social and psychological problems in their adjustment in the United States (Sue & Morishima, 1982). Yet, research over the last three decades have shown (e.g., Sue & Morishima, 1982; Uba, 1994) and continue to show that Asian Americans do suffer from a range of mental health problems that are worthy of further investigation. In addition, two common patterns have emerged in the literature on the mental health of Asian Americans, namely that they, like other ethnic minority groups, tend to underutilize mental health services and when treatment is sought, they premature terminate at a much higher rate than nonminority clients. The purpose of this paper is to review the literature on the utilization of mental health services by Asian Americans and to identify the barriers to service utilization that can be changed in order to improved access and promote better mental health among Asian Americans.

To prevent stereotyping and overgeneralizations, we should first begin with the caveat that Asian Americans as an ethnic minority group is quite heterogeneous with over 20 subgroups (e.g., Chinese, Japanese, Filipino, Korean, Vietnamese, Laotian, Cambodian, etc.) each made unique by linguistic, cultural, and sociodemographic backgrounds, and immigration histories in the United States (Sue & Morishima, 1982). This diversity between ethnic groups has been found to be associated with a variety of differences in mental health service need, utilization, and outcome.

Many findings of intergroup heterogeneity in mental health services demonstrate poorer functioning in Southeast Asian groups and compared to other East Asian groups. These differences are linked to their refugee and involuntary minority status,

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1522-3434/01/1200-0201/0 © 2001 Plenum Publishing Corporation

exposure to war time trauma, and socioeconomic disadvantage. For example, Southeast Asians have been found to have lower levels of functioning than Chinese Americans (Uehara, Takeuchi, & Smukler, 1994) and are overrepresented in public outpatient mental health services relative to their population in the community (Ying & Hu, 1994). Findings of utilization rates among Southeast Asians have been mixed, with one study finding lower utilization and more premature termination among Vietnamese (Zane, Hatanaka, Park, & Akutsu, 1994) and another study finding higher rates of use for Southeast Asian groups (Ying & Hu, 1994). Perhaps most discouraging are findings indicating that Southeast Asian groups show less improvement in services than do other Asian groups (Ying & Hu, 1994; Zane, Lau, & Gock, 2000).

Other reports suggest that Koreans may have high levels of need similar to Southeast Asians, with similar patterns in psychiatric diagnoses (Kim & Chun, 1993). Compared to other East Asian groups Koreans have been found to have greater depressive symptoms (Kuo, 1984), more clinically elevated MMPI scores (Koh, Ceca, Koh, & Liu, 1986), more psychotic symptoms, and poorer treatment outcomes (Zane et al., n.d.). Investigators have attributed these findings to the relative newness of Korean Americans as immigrants with accompanying problems of social and cultural adjustment, and fewer social and economic resources (Koh et al., 1986; Kuo, 1984).

With these ethnic differences in mind, it becomes clear that it is of great importance to study this heterogeneity and have this research impact service delivery systems. The findings of Uehara et al. (1994) lucidly demonstrate how erroneous conclusions can be drawn when investigators treat Asian Americans as a single category. However, it is not often feasible to conduct community and mental health services research with sufficient sampling to disaggregate the ethnic groups that constitute the Asian American category. In this paper, we attempt to review the literature as it pertains to the large, heterogeneous group of Asian Americans, while specifying where possible the specific ethnic groups that have been the subject of study. Although Pacific Islanders (e.g., Hawaiians, Guamanians, Samoans, etc.) have often been lumped together with the other Asian American groups by the federal government for convenience in statistical accounting, there are major differences between the "East Asia" Asian Americans and the Pacific Islanders. Therefore, this paper should not be used as a basis for understanding the mental health delivery issues for Hawaiians and Pacific Islanders.

Consistent with the guidelines set forth by the Guest Editor of this special issue, our paper will be organized using the theoretical framework of Rogler, Malgady, and Rodriguez (1989), which is comprehensive, integrated, and sensitive to cultural context. According to Rogler et al., in order to understand the mental health of ethnic minority groups in this country, it is important to have a sequential model that accounts for the cultural context in which mental health services are provided. They proposed a five-stage integrated sequential model to guide minority mental health research. According to the model, cultural factors influence not only what happens within each stage but also the transition from one stage to another. We will discuss the culture-related barriers to providing effective mental health services to Asian Americans, using this model. Within this model, Stage 1 is concerned with epidemiology and the emergence of mental health problems in the specific ethnic minority community. Given that this journal is devoted to mental health services, we will focus on Stages 2, 3, and 4 within the model, namely (a) help-seeking or mental health service utilization, (b) diagnosis and evaluation of mental health problems, and (c) psychotherapeutic services.

STAGE 2: HELP-SEEKING BEHAVIOR

The problem of underutilization of mental health services by Asian Americans can be understood in terms of barriers of two types: (1) barriers to initiation of mental health services and (2) barriers to persistence in treatment once it is sought. Indeed, Asian Americans have been found to be more resistant to interface with formal mental health services, and those Asian Americans who do make contact with the system tend to drop out of treatment earlier than do European Americans. Hence, adequate treatment of this topic involves examination of barriers at each stage of the help-seeking process. In this section, barriers to initial help-seeking will be reviewed and barriers to treatment persistence will be addressed in the section on psychotherapeutic services.

One major influence on Asian Americans' attitudes toward help-seeking is acculturation. Studies have typically found that more highly acculturated Asian Americans express more positive attitudes toward seeking psychological services (Atkinson & Gim, 1989; Tata & Leong, 1994; Ying & Miller, 1992) and show higher levels of actual help-seeking behaviors (Ying & Miller, 1992). Leong, Wagner, and Kim

(1995) further note that it is the integrationist mode of acculturation that is most promoting of positive attitudes toward seeking mental health counseling. That is, individuals who simultaneously retain their native cultural identity and also move to join with the dominant society (Berry, 1990) tend to have more favorable attitudes toward help-seeking. These findings suggest that the barriers to help-seeking discussed ahead may be more salient for individuals at lower levels of acculturation, and for individuals with a separationist or marginalist mode of acculturation. Indeed, studies assaying attitudes toward mental illness and help-seeking among highly acculturated Asian American groups find less pronounced differences from European American groups (e.g., Narikiyo & Kameoka, 1992).

Barriers to Help-Seeking

Cognitive Barriers

One class of barriers to seeking mental health services involves culturally informed conceptions of mental illness shared by Asian American groups. These cognitions encompass traditional Asian notions of the nature, causes, and cures of mental illness and of well-being. A necessary precursor of any help-seeking behavior is the illness labeling process. Angel and Thoits (1987) argue that while the clinical characteristics of an illness may be invariant, culture influences the phenomenological experience and identification of illness. For example, South East Asians come from cultural context in which people do not associate mental disorder with negative feelings and emotional difficulties (Tung, 1985). Instead some Asian Americans consider behaviors as signs of mental illness only if they are upsetting to the social group and thus will generally only seek professional help only for psychotic, dangerous, or disruptive behaviors (Moon & Tashima, 1982), but not for typical personal problems or general emotional distress (Tracey, Leong, & Glidden, 1985).

Often, indigenous notions of etiology lead to proscriptions for sources of help-seeking. Research indicates that the nature of the attributed cause for a problem is related to the intended solution for the problem and the sources of help seen as appropriate (Cheung, Lee, & Chan, 1983). For many Asian American groups, one cognitive barrier to seeking psychological interventions stems from the widely help concept of mind–body holism. Within this framework there is no clear distinction between psychological and physical ailments. Asian Americans are more likely than European Americans to believe that mental disorder is brought on by organic factors (Sue, Wagner, Davis, Margullis, & Lew, 1976). Although European Americans consult a physician for physical health problems and a mental health practitioner for emotional problems, many Asian Americans will seek help from medical professionals for psychological problems. The tendency of some Asian Americans to somaticize psychological distress is also related to their reliance the medical sector instead of mental health professionals (Brown, Stein, Huang, & Harris, 1983; Sue & Morishima, 1982). When causal attributions are physical or metaphysical, Asian Americans may rely on alternative healers, such as herbalists or acupuncturists for relief from emotional difficulties in addition to Western oriented medicine (Lin, Inui, Kleinman, & Womack, 1982).

In terms of culturally informed conceptions of cure, many Asian Americans think that it is detrimental to dwell on and analyze gloomy or disturbing thoughts (Sue et al., 1976). Studies indicate that have found that Chinese Americans tend to view mental illness as a problem remediated by willpower and the avoidance of morbid thoughts (Arkoff, Thaver, & Elkind, 1966; Lum, 1982; Root, 1985; Sue et al., 1976). Since Western models of psychotherapy often call for intense exploration of highly emotional content, this intervention would seem highly incongruous to many Asian Americans' beliefs about problem solution. The construct of credibility is closely related to cultural conceptions of cure. Sue and Zane (1987) proposed that the ingredient most promixal to promoting treatment utilization among ethnic minority clients involves minimizing problems with perceived credibility of the treatment or treatment provider. Support for this model has been found by Akutsu, Lin, and Zane (1990) who demonstrated that perceptions of the counselor's credibility were indeed the most powerful predictor of utilization intent among Chinese students.

Affective Barriers

Even after a problem is cognitively defined as psychological, culturally based affective responses may act as barriers in seeking help among Asian Americans. Despite the acknowledgment of distress, willingness to report problems and express them publicly may be low because of feelings of shame

and stigma associated with psychological difficulties (Root, 1985). Although there is a pervasive social stigma around mental illness among Americans, Asian and Asian American communities are thought to feel even more stigmatized by such problems (Kleinman & Lin, 1981; Uba, 1994). Research suggests that the concern of stigmatization impedes the help-seeking behaviors of Asian Americans. Tabora and Flaskerud (1997) found that the cultural value placed on the avoidance of shame acts as a barrier to utilization of mental health services among Chinese American female immigrants. In their early study, Lin, Tardiff, Donetz, and Goretsky (1978) documented poignant examples of this delay in the help-seeking process. They described Chinese Canadian families who resisted seeking psychiatric assistance for their schizophrenic sons. They attempted to try to confine their family member in the home for as long as possible until their behavior became unmanageable and/or violent. At this point, the patient was usually turned over to the psychiatric facility and the families tended to disengage. The European Canadian families, on the other hand, sought psychiatric help early and stayed involved in the patient's care. These authors hypothesized that among Chinese immigrants, social stigma was the primary reason for deferring professional consultation. Because the family name and "face" are so important to Asian Americans, they tend to look first to their families for help to avoid having their name viewed poorly by others (Webster & Fretz, 1978) and to be more reticent in publicly admitting problems and seeking help. As a result, compared to other ethnic groups, Asian Americans show more extended and intense family involvement in help-seeking, and also show the longest delays in seeking professional mental health care (Lin et al., 1982).

Value Orientation Barriers

Another type of barrier to psychological help-seeking involves cultural value orientations that govern norms for emotional management and communication that are highly relevant to mental health treatment. Atkinson and Gim (1989) cogently argue that the conflict between cultural values of Asian Americans and the values inherent in the Western mental health system may be the cause of lack of initial contact with the system, whereas the inappropriateness of services may account for the high dropout rate among Asian Americans who do enter the system. In this section, we will explore some of the inherent value conflicts that may interfere with initial entry into the mental health system.

It has been argued that collectivistic values that are traditionally held by Asian Americans (Triandis, 1988), oppose the values associated with Western psychotherapy (Leong, Wagner, & Tata, 1995). Many traditional psychotherapy orientations place high value on open verbal communication, exploration of intrapsychic conflicts, and a focus on the individual. Sue and Sue (1977) maintain that these processes encourage the client to put their own individual goals before those of the collective. This priority runs in direct conflict with allocentric values held by traditional Asian Americans, which involve the subordination of individual goals to the goals of the collective.

Another potential area of dissonance for Asian Americans with collectivistic values deals with the issue of open and intimate communication and the willingness to verbalize intense emotions in psychotherapy. In general, the collective for Asian Americans is circumscribed by familial and kinship lines. For example, the sphere of privacy for Chinese Americans extends from the individual to the immediate family and then to the extended family, which may include relatives by marriage, or close friends of parents (Lin & Lin, 1978). Individuals with roots in Asian cultures typically prefer to keep information about family problems kept in confidence within this kinship domain. Members of societies that stress collectivism often perceive disclosure of personal problems as bringing shame to family members and the community (Ho, 1984). In collectivist communities, there is less interaction with out-group members and thus more difficulty in being open and with a therapist who is a stranger (Leong et al., 1995). Indeed, research indicates that, unlike European Americans, Asian Americans do not indicate a preference to seek counselors as a source of help (e.g., Pilner & Brown, 1985; Webster & Fretz, 1978).

These differences in value orientation can present barriers to acceptance of mental health services as a legitimate source of assistance for Asian Americans. Research indicates, however, that the relationship between individualism–collectivism and help-seeking attitudes is complex. Tata and Leong (1994) found that holding more individualistic values was related to negative attitudes toward seeking professional psychological help among Asian Americans. This finding appeared to be due to the emphasis on self-sufficiency within the individualistic framework. These results highlight the multifaceted nature of individualism–collectivism and the complexity

of the influence of these value dimensions on help-seeking.

Physical Barriers

There are also other factors that may not be related to culture as much as to social class—the client's lack of awareness about available services and their inability to access services due to economic and geographic realities (e.g., having to work two jobs, unable to get time off to seek services, lack of child care, unmanageable distance to facility, lack of transportation, etc.). Research has documented ethnic differences in perception of structural barriers. One study noted that Asian Americans (Japanese and Filipino) in Hawaii cited lack of awareness of services as a perceived barrier to help-seeking for alcohol and emotional problems more often than did Caucasian Americans (Takeuchi, Leaf, & Kuo, 1988). Similarly, Loo, Tong, and True (1989) found that lack of knowledge of existing services appeared to be a major reason for low utilization of mental health services among residents of San Francisco's Chinatown.

In summary, the barriers to initial help-seeking stem from cultural influences in the areas of cognitive processing of information regarding mental health and illness, affective responding to emotional problems, and cultural values governing communication norms. In addition, Asian Americans may be deterred from help-seeking due to socioeconomic realities and institutional barriers. These and other factors have likely contributed to the pervasive problem of underutilization of mental health services among Asian Americans. In a review, Sue (1994) found that in 11 studies of Asian Americans utilization of mental health services, 10 provided evidence of underutilization. Education about the utility of mental health service is much needed in the Asian American community, especially among less acculturated individuals (Ying & Miller, 1992).

Barriers for Asian American Subpopulations

Asian American Women. Investigators suggest that Asian American women may be more vulnerable than Asian American men to psychological distress, as manifest by occurrence of affective disorders (Homma-True, 1990) and completed suicide (Yu, 1986). Asian American women are often confronted with difficulties associated with dual oppression, being conferred inferior status in terms of both race and gender. Bradshaw (1994) observes that Asian women in America are subjected to multiple and conflicting gender stereotypes portraying them sometimes as erotic, shy, submissive, and eager to please, other times as wily, manipulative, and untrustworthy, and still at other times as the unattractive, impersonal and efficient worker. Many Asian cultures themselves impose devaluing sanctions and role obligations stemming from Confucian social philosophies. In some traditional Asian societies, the cultural expectations to embody deference, acceptance of suffering and personal sacrifice may be magnified for Asian women. If Asian women are subject to heightened role expectations favoring sacrifice and stoicism, this may be associated with a gender ethnicity interaction that more strongly prohibits help-seeking. However, in studies of treated populations there appear to be equal (Homma-True, 1990) if not greater proportions (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995; Ying & Hu, 1994) of Asian American females receiving outpatient mental health services. These findings support the idea that Asian females may be a more vulnerable population, but they do not confirm greater reluctance for help-seeking among Asian females. In studies assessing help-seeking attitudes, most studies report no significant gender effect (Akutsu et al., 1990; Atkinson & Gim, 1989; Leong et al., 1995) whereas one study found that Asian American females reported greater willingness to seek counseling (Gim, Atkinson, & Whiteley, 1990). Further study of the intersection mental health needs and specific barriers to help-seeking among Asian American women are indicated.

Asian American Elderly. Asian American elderly comprise a particularly vulnerable group owing to an array socioeconomic risk factors. A substantial proportion of Asian elderly falls into the extreme low-income group. Asian elderly have a significantly lower median income, greater proportion of individuals with no formal education, higher rate of unemployment than White elderly men. Furthermore, many Asian American elderly have worked in low-paying jobs with no Social Security or other pension benefits, such as garment work, self-employed small business, domestic work, and farming (Kang & Kang, 1995). These factors may present both elevated risk of mental health problems and barriers to mental health services.

Studies have identified several risk factors associated with poorer mental health status among Asian

elderly. For example, the living arrangements of Indochinese elderly are associated with maladjustment, such that elderly who did not live with their family and those who reside in more crowded residences had lower social adjustment scores (Tran, 1991). Feelings of alienation and greater vulnerability to depression have been found in Korean elderly who are isolated in communities without a large coethnic enclave (Moon & Pearl, 1991). Furthermore, Asian elderly are at greater risk for psychopathology when they are more recently immigrated (Moon & Pearl, 1991), and have less education and lower English proficiency (Yee & Thu, 1987). Unfortunately, this is also the profile associated with more barriers to utilization of mental health services. This older, more traditional, less acculturated group of Asian elderly are may hold stronger to the cultural beliefs, values, and attitudes toward mental health treatment outlined earlier that discourage help-seeking. More research and outreach are warranted to target this vulnerable group.

STAGE 3: EVALUATION OF MENTAL HEALTH

Once the threshold has been passed and an individual either alone or with the support and/or pressure of the family, seeks professional help for psychological problems, the next stage is the evaluation problem by mental health professionals. Just as the threshold of distress required to spur help-seeking is influenced by cultural factors, so too is the evaluation process affected by culture. In this section, we will address "cultural factors influencing clinical diagnosis and assessment."

Threats to Cultural Validity

Leong and Chou (1997) have proposed a model for examining problems in clinical diagnosis and assessment with Asian Americans using the concept of "threats to cultural validity." According to these authors, there are several major factors that may contribute to the lack of cultural validity in clinical diagnosis. These threats to cultural validity in diagnosis are due largely to a failure to recognize or a tendency to minimize cultural factors in clinical diagnosis. The literature suggest that there are several factors that may serve as the sources of threats to cultural validity. These factors include (a) therapist bias in clinical judgment, (b) inappropriate use of diagnostic and personality tests, (c) cultural factors influencing symptom expression, (d) language capability of the client, and (e) pathoplasticity of psychological disorders.

Therapist Bias in Clinical Judgment

Another major barrier to providing effective mental health services to Asian Americans is the potential for clinical misdiagnosis or inaccurate evaluation of the mental health problems among Asian American patients. There is a considerable body of literature that has examined the impact of cultural differences on the diagnostic and evaluation process. To the extent that diagnosis guides treatment assignment and treatment planning, then any misdiagnosis due to cultural biases in our psychiatric nosology or to training biases among our mental health professionals, will lead to inappropriate treatment that in turn probably contributes heavily to the premature termination problem among Asian Americans who seek help. Furthermore, cultural problems in our diagnostic system opens the question of the reliability and validity of our estimates of incidence and prevalence of mental disorders in the Asian American community.

Diagnostic assessment can be complicated when a clinician from one ethnic or cultural group uses the Western nosological system to evaluate an individual from a different ethnic or cultural group. Ethnic minorities and Euro-Americans with similar underlying problems frequently define and express their problems differently because of cultural behavior patterns and communication styles. Misdiagnoses can occur when the diagnostician has a narrow and rigid way of defining what disorders exist and how they are manifested. Lopez (1989) describes two types of errors that can be made in clinical assessments: overpathologizing and underpathologizing. Overpathologizing occurs when a clinician who is unfamiliar with the nuances of an individuals' cultural frame of reference may incorrectly judge as psychopathology those normal variations in belief, behavior, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g., hearing or seeing deceased relative during bereavement) may be misdiagnosed as hallucinations or manifestations of Psychotic Disorder. Underpathologizing can occur when a clinician indiscriminantly applies a cultural explanation to explain a patient's presentation . For example, attributing an extremely reserved interpersonal style and flat affect to a cultural communication norm rather than to depressive

symptoms of withdrawal and anhedonia. Clinicians must avoid overdiagnosing (misinterpreting culturally sanctioned behavior as pathological) and underdiagnosing (attributing psychiatric symptoms to cultural differences).

Cultural influences on therapist judgments of psychopathology were well illustrated in Li-Repac's early investigation (Li-Repac, 1980). In this experiment, five Chinese American and five White viewed videotaped interviews of Chinese and White clients, and rated the clients on a number of personality and symptom dimensions. Findings indicated that the White therapists tended to view the Chinese clients as more depressed and inhibited, with more interpersonal skill deficits than did the Chinese American therapists. Chinese American therapists, in turn, judged the White clients as demonstrating more severe pathology than did the White therapists. These differences suggested that the therapists' assessments were influenced by their own world view and notions of social norms, which seemed to differ across cultural lines.

Cautions in the Use of Diagnostic and Personality Tests

Besides clinical diagnosis, the use of psychological instruments to evaluate mental health problems and its treatment and outcome is another area of concern. Instruments that are used with culturally different populations need to be examined with respect to their cross-cultural equivalence in multiple domains: (a) conceptual, (b) linguistic, and (c) metric or scale equivalence. With the expansion of cross-national and cross-cultural investigations of mental health, many psychodiagnostic tools have been translated into Asian languages. Many times, the job of such translation is complicated by issues of conceptual and semantic equivalence (e.g., Kuo, 1984). In their study using questionnaire data to compare the mental health status of Hmong refugees to a general community sample, Dunnigan, McNall, and Mortimer (1993) discussed the difficulties of translating between investigator and subject lexicons and, consequently, of equating the conceptual systems they signify. They concluded that whether or not psychosocial variables standardized within a general population can be used to study the adjustment of linguistically unassimilated ethnic minorities depended on the nature of the semantic discontinuities that existed between the source and target languages.

Once they are appropriately translated, the interpretation of widely used assessment tools is then complicated by findings that the original factor structure of self-report scales often does not generalize to Asian American samples (e.g., Takeuchi, Kuo, Kim, & Leaf, 1989) and psychiatric scales may not afford discriminant validity even when reliability indices are satisfactory (e.g., Chang, Chun, Takeuchi, & Shen, 2000). Two other considerations are the use of culturally appropriate norm groups for interpreting test results and the potentially distorting effects of culturally mediated response sets. The former is a contentious issue because it is quite expensive and impractical for test developers to actually develop separate norms for Asian Americans (remember our earlier discussion of sampling rare events) and even more difficult to obtain subgroup norms (e.g., Vietnamese vs. Filipino Americans). However, in the absence of such normative data, we have no way of knowing the extent and types of misdiagnoses of Asian Americans that may be occurring in clinical practice. As for the impact of culturally mediated response sets on our evaluation instruments, we simply need more research. Most studies to date have focused on evaluating cross-national and interethnic differences in responding to specific psychodiagnostic instruments (e.g., Butcher & Han, 1996; Nishimoto, 1988). Future research on culturally competent assessment of Asian Americans must examine issues such as cultural response sets to different modalities of assessment (e.g., self-report paper and pencil instruments vs. interview based instruments) with an eye toward the changing sociopolitical context (Okazaki, 1998). Without further information on cultural response sets and cultural equivalence of our measurement instruments, we are at risk of overpathologizing and underpathologizing Asian Americans when we rely on our current psychodiagnostic measures.

Further Issues in Language of Assessment

We have briefly addressed the challenges in translation of standardized instruments above, here we address the issue of the language of the clinical interview. The obvious preference would be to always interview a client in their native language. Of course, this is not always possible given the resources available in the community. Here, we would like to briefly discuss possible implications of conducting a diagnostic interview in a client's second language. Again we encounter the duel possibilities of overpathologizing

and underpathologizing. It is conceivable that the Asian American client for whom English is a second language may present as more disorganized, withdrawn, or disturbed when unable to communicate freely in his or her native language. On the other hand, Del Castillo (1970) observed the opposite pattern in assessing formal thought disorder among Hispanic Americans. He described several cases in which clients showed psychotic symptoms in interviews held in their native languages but not in those conducted in their second language. His hypothesis was that the intellectual effort of expressing oneself in a foreign language also exerts a type of vigilance that is relaxed when communicating in one's native language. Speaking in a second language, he argues, can act as a stimulus that makes one think, and puts one in better contact with reality. The interface between linguistics and psychiatric assessment merits further study within the Asian American population.

Cultural Factors Influencing Symptom Expression

According to Leong and Chou (1997), one major threat to cultural validity in clinical diagnosis is that the cultural background of clients may influence their symptom expression. Without reliable data on cultural variations in symptom expression, clinicians may be prone to making diagnoses that overpathologize or underpathologize culturally distinct groups. Do cultural factors also influence the diagnosis of Asian Americans? There are some studies that suggest that this may be the case. As an example of how ethnic origin may influence symptom expression, Enright and Jaeckle (1963) examined the behavioral patterns of Japanese and Filipino schizophrenic patients at the Hawaii State Hospital and found that Japanese patients expressed more depression, withdrawal, and disturbance in thinking. Filipino patients, on the other hand, exhibited more overt disturbance of behavior and had more delusions of persecution.

The tendency toward somatization is probably the strongest example of expression of symptoms among Asian Americans. Marsella, Kinzie, and Gordon (1973) identified Chinese, Japanese, and White students who had scored high on the Zung Self-Rating Depression Scale and administered a symptom checklist to them. They found that the Chinese American students were most likely to exhibit somatic symptoms in depression. Factor analysis of the checklist revealed that both the Chinese and Japanese groups had more gastrointestinal complaints, such as poor appetite, indigestion, and gas, whereas the Whites felt a need to continue to eat even when they were not hungry. In another study of symptomatology, Sue and Sue (1974) found that Chinese and Japanese American students using a psychiatric clinic were more likely to endorse MMPI items indicating somatic complaints. Studies with other Asian groups have also found this tendency to somaticize among the Filipinos (Duff & Arthur, 1967) and the Vietnamese (Rahe, Looney, Ward, Tund, & Liu, 1978).

Pang's study on Hwabyung provides an interesting example of the tendency to somaticize psychological symptoms among Asian Americans (Pang, 1990). Because of Korean culture's esteem of restraint, suppression of verbal aggression, and avoidance of confrontation, Hwabyung is a uniquely Korean culture-bound syndrome in which suppressed emotions reflecting anger, disappointment, sadness, misery, hostility, grudges, and unfulfilled dreams or expectations manifest themselves physically. Symptoms include chronic indigestion, poor appetite, constipation, heart palpitations, pains in knees or legs, cold hands or feet, vomiting blood, altered sensory perception, nightmares, decreased urine output, and hypothyroidism. Because of the inappropriateness (stigma) attached to expressing psychological symptoms, Hwabyung allows Koreans to deal with life problems by linking together emotional and bodily distresses in a model congruent to their cultural context.

Although the tendency toward somatization seems to operate among several Asian groups, the case of the Chinese may be elaborated further to serve as an illustration of the cultural factors underlying this tendency. Kleinman and Sung (1979), in reviewing the literature on Chinese throughout the world, have found that they tend to present somatic complaints in place of psychological ones. This is confirmed by Lin (1985), who points out that somatization plays an important role in influencing the diagnosis of depression:

> The application of Western diagnostic criteria of depression which consists mainly of psychological dysphoric symptoms, would leave out a large portion of Chinese depressives whose prevalent symptoms are predominantly somatic and vegetative. . . . An indirect but potentially important, supportive evidence of somatization can be found from linguistic studies. It has been pointed out that the Chinese words expressing the emotional state of dysphoric mood or depression are surprisingly limited when compared to the richness of somatic expressions which denote certain emotions. (Tseng, 1975, p. 8, cited by Gaw, 1982)

Tseng also found this tendency to somaticize among the Chinese and offered several reasons to account

for it. First, traditional Chinese medicine emphasized an organ-oriented concept of pathology, viewing the human body as a microcosm of the universe. Body organs and human emotions were believed to correspond to various phases in nature. Such cultural concepts of diseases readily argued that psychic distresses were expressed through bodily organ symbols. Second, expression of physical complaints is much more socially acceptable than of emotional complaints in Chinese culture because of their medical belief system. Third, the Chinese are reluctant to express emotion (particularly sexual or negative feelings) openly to others, preferring more subtle forms of communication. Fourth, there is social reinforcement for concerns about bodily symptoms, but not for psychological problems, because of the shame associated with the view that they are signs of personal weakness.

Sue and Morishima (1982) offer a similar set of reasons for this somatization tendency among Asian Americans: mental disturbance is highly stigmatized, there is a tendency to control expression of strong affect such as dysphoria, and a tendency to see unity between physical and psychological status. Earlier we discussed how issues of stigmatization and mind–body holism affect the help-seeking process for Asian Americans, the literature also makes it clear that these issues also have important consequences for symptom expression. It is vital to take these cultural values and beliefs into consideration when diagnosing Asian Americans, because their cultural background does seem to influence the expression of symptoms.

STAGE 4: PSYCHOTHERAPEUTIC SERVICES

At the end of the evaluation process, two decisions are possible. The patient is either assigned to some form of mental health treatment or is determined to be not in need of treatment. If treatment is recommended, then the same cultural factors that operated in the evaluation process also enters into the psychotherapeutic process (see Leong, 1986; Sue & Morishima, 1982). For example, the tendency to ignore or minimize cultural factors in diagnosis may also operate in clinicians' conceptualization of Asian American clients and the nature of their mental health problems.

Earlier we focused on the dilemma of underutilization of mental health services in terms of factors deterring Asian Americans from initial contact with services. Presently, we turn to a discussion of factors leading to drop out and premature termination from services for Asian Americans who do make contact with the system. The question here is to determine what factors undermine the appropriateness of traditional mental health services delivered to Asian Americans. Unfortunately, and partly due to the difficulty of conducting such studies, there are very few empirical studies of psychotherapeutic services for Asian Americans (Leong, 1986; Sue, Zane, & Young, 1994). In their review of the literature, Sue, et al. (1994) found that the majority of the studies of the treatment process for Asian Americans consisted of preference studies, that is, analog studies with nonclinical samples asking them what type of therapies and therapists they prefer if they were to seek treatment. Ideally, we would conduct studies to determine what types of therapies work best with which group of Asian Americans for which problems and under what circumstances.

A few studies have emerged that attempt to address factors that ameliorate psychotherapy persistence and outcomes for Asian Americans. One barrier to treatment persistence that has garnered widespread attention is the lack of accessibility to culturally responsive services. Research by Stanley Sue and his colleagues has demonstrated that a lack of bicultural and bilingual staff may be an important factor in Asian Americans' underutilization of mental health services. In their study of 60,000 clients in the Los Angeles County mental health system, Sue et al. (1991) demonstrated that ethnic match between client and therapist was associated with increased utilization of services and decreased likelihood of premature termination among Asian Americans. Furthermore, among Asian American clients who did not speak English as their primary language, ethnic and language match were predictors both length and outcome of treatment. The authors conclude that the ethnic match afforded by bilingual and bicultural staff leads to the provision of more culturally responsive services. However, although this study revealed statistically significant differences between client–therapist ethnic matches and mismatches, the clinical significance of these differences is not clearly established (e.g., attending one or two more sessions). Moreover, Ying and Hu (1994) reported that therapist–client ethnic match did not predict increased service use for Southeast Asians. In the end, what is needed is a move away from proxy variables of cultural match to more direct tests of the culturally appropriate service hypothesis.

Another line of investigation has been conducted on evaluating the effectiveness of ethnic-specific

mental health services (ESS) for Asian Americans. Ethnic-specific services were established in recognition of the need to provide more culturally responsive mental health care for ethnic communities. The development of ESS occurred partly in response to research that highlighted problems of underutilization in the delivery of mental health services to ethnic minority communities (President's Commission on Mental Health, 1978). ESS agencies were set up address barriers to care for ethnic minorities. It was thought that traditional mental health services were inadequately serving ethnic clients by providing culturally inappropriate treatment that was leading to premature termination. Features of ESS agencies include the recruitment of bicultural, bilingual personnel, modifications in treatment practices that are presumably more culturally relevant, and fostering an atmosphere in which services are provided in a culturally familiar context. These agencies are located in communities with relatively large ethnic minority populations and serve predominantly ethnic minority clientele (Takeuchi et al., 1995).

Studies of the effectiveness of ESS compared with traditional or mainstream mental health services have provided reason to be optimistic about ESS. For example, Zane et al. (1994) evaluated patterns of utilization and outcome at an ethnic-specific community clinic in Los Angeles. Results indicate that the agency appeared to reduce service inequities (i.e., differential premature termination rates and treatment outcome) for Asian Americans, whereas not creating any such inequities for White clients.

A series of studies of the Los Angeles County mental health system have found significant effects of ESS on utilization and outcome in different subsets of clients. Takeuchi et al. (1995) found that ethnic adult clients who attended ethnic-specific programs had a higher return rates and stayed in treatment longer than ethnic clients using mainstream services. Similarly, Flaskerud and Hu (1994) found that depressed Asian American adults diagnosed with Major Depression had higher participation in treatment, as measured by number of sessions, in Asian-specific agencies than in mainstream agencies. Another investigation by Yeh, Takeuchi, and Sue (1994) found that Asian American children who received services at an ESS center were less likely to drop out after the first session, attended more sessions, and evidenced greater gains in level of functioning compared to those who attended mainstream centers, even when controlling for clinical and demographic variables such as social class and diagnosis. Finally, the results of a recent investigation indicate that ESS agencies may be more cost-effective for Asian American clients than mainstream services. Lau and Zane (2000) found that although the amount of individual therapy used by Asian Americans at ESS agencies was significantly related to improvements in level of functioning, this relationship between utilization and outcome did not hold in mainstream mental health agencies.

However, the studies reporting positive ESS effects were all on the Los Angeles County mental health system. Further investigation with different Asian client populations and service agencies are needed to test the generalizability of these findings. One study examined ethnic differences in patterns of service utilization among 4,000 of the most seriously impaired clients (SMIs) across two county mental health services systems having differing histories of specialized minority-oriented programming (Snowden & Hu, 1997). In the county with a history of established ESS provision, Asian American clients made more use than Whites of outpatient and supportive/community services but used less inpatient care than Whites. The pattern was reversed in the county without a history of ESS care. These results imply that the system with ESS care managed to serve Asian American clients in the least restrictive and costly environment perhaps by being better organized to meet the sociocultural needs of severely mentally ill Asian American clients, thereby preventing hospitalization.

These findings of increased utilization, decreased drop out rates, and enhanced treatment outcomes imply that ESS may be providing an effective mechanism for delivering culturally responsive services to Asian Americans. However, there may be drawbacks to the establishment of parallel ESS systems, such as the inability to reach Asian Americans outside of major urban centers with large Asian populations, and the limiting of opportunities to promote culturally competent approaches among a wider range of mental health service providers (Uba, 1982). What is needed is research on therapy process at these ethnic-specific agencies to illuminate what elements of the services lead to enhanced outcomes when can then be implemented outside of ESS facilities. We presume that ESS involves the modification of traditional therapy approaches to be more culturally responsive. A shortcoming of the system level analyses reviewed is that they do not detail any such modifications and thus they do not offer any proscriptions for how to administer more culturally responsive treatments. Although there is a growing body of descriptive literature on

interventions purported to be reduce cultural barriers in psychotherapy Asian Americans (e.g., Chung & Okazaki, 1991; Ho, 1976; Hong, 1988; Kim, 1985; Lee, 1982; Lorenzo & Adler, 1984; Nishio & Blimes, 1978; Root, 1985; Shon & Ja, 1982; Sue & Morishima, 1982; Sue & Sue, 1991; Toupin, 1980; Zane & Sue, 1991), there is a dearth of empirical investigation on the effectiveness of these micro-level treatment modifications. Culturally minded authors have emphasized the importance of several treatment modifications for Asian American clients, including practicing psychotherapy within a medical model (e.g., Hong, 1988; Murase, 1982); the clinician adopting an authoritative stance (e.g., Lorenzo & Adler, 1984; Murase, 1982); the clinician establishing credibility in the eyes of the client (Kinzie, 1985; Zane & Sue, 1991); enlisting family support in treatment (e.g., Shon & Ja, 1982; Sue & Morishima, 1982); exercising patience in gathering information and exploring the client's more vulnerable feelings (e.g., Lorenzo & Adler, 1984; Nishio & Blimes, 1978); incorporating the client's interpretation and meaning of his or her symptoms into the assessment and treatment process (Tanaka-Matsumi, Sieden, & Lam, 1996); and using directive, concrete, problem-focused techniques (Kim, 1985; Lee, 1982). To the extent that the Asian American client's expectancies are violated by clinicians who are nondirective or use ambiguous psychodynamic approaches in the therapeutic process, then there should be some effect on the process and outcome. Studies are needed to empirically support the use of these intervention modifications with Asian American clients and families. For example, a study comparing several treatment approaches varying in the amount of therapist directiveness for Asian Americans who were randomly assigned would be quite useful.

With the lack of controlled clinical outcome studies on Asian Americans, any conclusions about the effectiveness of psychotherapy for Asian Americans is premature (Sue et al., 1994). There has been a great deal of attention focused on the need for empirically supported treatments in the field of clinical psychology in general. Chambless and Hollon (1998) propose a scheme for determining when a treatment may be considered to demonstrate efficacy for a delineated population. Efficacy is thought to be best demonstrated in randomized clinical trials, whereby clients are randomly assigned to the treatment of interest or one or more comparison conditions. These trials then need to be replicated by an independent investigatory team to avoid the possibility of drawing erroneous conclusions based on one aberrant finding. To date, we know of no treatment that can be said to be efficacious for Asian Americans based on these criteria. Future research should first strive toward demonstrating that psychotherapy works for Asian Americans, and next to determine what treatment modifications stand up to empirical tests as culturally competent (i.e., superior to treatments designed without reference to Asian American sociocultural needs).

In conclusion, the Chinese concept of "crisis" that combines the two characters representing "danger" and "opportunity" is the best way to characterize the state-of-the-art scientific literature on providing mental health services to Asian Americans. This crisis or "dangerous opportunity" reminds us that the danger lies in continued underutilization of mental health services among Asian Americans despite high levels of mental health problems. The added danger is that Asian Americans who do enter the mental health system may also be terminating prematurely due to culturally inappropriate or culturally insensitive diagnosis and treatments. The opportunity lies in the challenge for us to pursue rigorous but relevant research to identify and reduce these cultural barriers to providing effective mental health services to Asian Americans. The current paper is an attempt to provide a blueprint to guide that research effort. As psychologists have often pointed out, a developmental crisis is often an opportunity for growth and change if the appropriate supports are provided to meet the challenges encountered.

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