Chapter 2
Identification and Approach to Treatment of Mental Health Disorders in Asian American Populations

Shirin Ali

Introduction

This chapter will describe an approach to mental health assessment and treatment in Asian Americans, a diverse and rapidly growing group within the US population. The chapter places an emphasis on understanding concepts related to how Asian Americans may understand mental health conditions and how mental health professionals can approach this population in a culturally sensitive and curious manner. I hope this chapter will help mental health clinicians, educators, and researchers develop a thoughtful and flexible approach to evaluating and working with Asian American patients. To develop a complete understanding of the patient, the mental health professional will have to weave together the patient’s unique health beliefs, culture, language, family, religion, narrative, genetics, pharmacological history, and relevant life experience. Asian Americans cannot be treated as a monolithic group and in the following pages, topics and themes will be raised that lead the professional away from viewing the patient’s difficulties through only one lens. After reading this chapter, the reader will hopefully gain more knowledge about Asian American health beliefs and culture and integrate this into his or her unique style in mental health practice, education, and research to effectively help Asian American patients. This chapter concludes with three blended cases based upon my work and cases of colleagues shared with me from years of experience in working with Asian Americans. These cases will help the reader to synthesize the different topics and themes discussed in the chapter in realistic clinical scenarios. These cases will clearly demonstrate the complexity and diversity of Asian American patients and help to model an integrated approach to working with Asian Americans in a culturally sensitive manner in clinical, research, and educational settings.

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Who are Asian Americans?

Based on US Census information from 2011, there were an estimated 18.2 million persons of Asian descent living in the United States and currently Asian Americans comprise approximately 5.8 % of the total population [1, 2]. Of the 50 states in the United States, California, and New York had the largest numbers of Asian Americans in 2010 [1]. Asian Americans were the fastest growing racial group with the largest proportional population increase between the 2000 and 2010 census, even compared to Hispanics and Latinos, which had the largest increase in population [1, 3]. Currently among people who identify with one country of origin, the largest subgroup among Asian Americans is of Chinese descent, followed by Filipino Americans, Indian Americans, Vietnamese Americans, Korean Americans, and then by Japanese Americans [1]. Not surprisingly, after English and Spanish, Chinese is the third most widely spoken language in homes in the United States. While Asian Americans have made tremendous strides in acculturation since the first Chinese and Japanese immigrants came to the United States in the mid 1800’s, Asian Americans are still largely a population made up of immigrants, with 74 % of Asian American adults having been born in another country [2].

Among Asian Americans, 28 % live in a multigenerational family, defined by having at least two adult generations in the same household, which is higher than Whites, Blacks, and Hispanic Americans [2]. On the whole, Asian Americans have a relatively high educational status, with approximately 85 % of adults over age 25 having attained a high school diploma. 49 % of Asian American adults over age 25 are college graduates, compared to 28 % of the general population. However, there is a disparity in the percentage of college graduates in different Asian American ethnic groups. For example, only 26 % of Vietnamese Americans over age 25 are college graduates, which is lower than the general population. Approximately half of Korean, Chinese, Japanese, and Filipino Americans over age 25 are college graduates. Indian Americans have a much higher percentage of college graduates over age 25, 70 %. These interethnic differences may reflect different immigration patterns from the countries of origin. While the median income of an Asian American household is $66,000, and higher than the national median, 12.5 % of Asian Americans lived in poverty in 2009 and 17.2 % were without health insurance [1]. Additionally, Asian American households are often larger than those of other ethnic groups. While these facts and figures do not reflect the diversity of the Asian American population, they help to provide a broad characterization of the group.

A Brief Immigration History

The first Asian immigrants to the United States arrived from Japan in 1843 and were soon followed by Chinese men who came in 1850s and 1860s to work on the transcontinental railroad, gold mines, and in agriculture [1, 4]. The Chinese Exclusion Act of 1882, which put an end to all new immigration from China, was a reflection
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of the opposition to Asians immigrating to the United States and becoming permanent residents. The Asian exclusion Act of 1924 was a continued response to concerns about Asian immigration, which limited the new immigrants per year from East Asia, Southeast Asia, and South Asia [2]. Asian immigrants were thought to be unable to assimilate into the US population due to phenotypic differences in appearance, unlike European immigrants. A Supreme Court case in 1923 of US vs. Bhagat Singh Thind denied an Indian immigrant the ability to apply for citizenship citing this concern in the official decision [4]. The doubt about the allegiance of those of Asian origin to the United States lasted well into the middle of the twentieth century. During World War II, over 80,000 US-born citizens of Japanese origin were held in internment camps by the government [4].

Immigration from Asia radically changed over the course of the twentieth century with different ethnic subgroups greatly increasing as a response to the loosening of governmental restrictions and quotas. For example, in the middle of the century, naturalization and immigration of the war brides of US soldiers from Japan, Korea, and Vietnam became permissible [4–6]. In 1965, the Immigration and Nationality Act ended quotas with regard to Asian immigration and lead to huge increases in the numbers of immigrants from Asia. This act also changed the ethnic landscape of Asian immigrants, who until that time had largely been from Japan, China, and the Philippines. In the 1970s, there was an influx of refugees from war-torn Laos and Cambodia [7]. Currently, Asian immigrants are most likely to come to the United States with work visas, but also come through student visas, temporary visas, and unauthorized status [2].

Today, as a result of the varied historical waves of immigration, there is tremendous diversity among the immigration and acculturation experiences in Asian Americans. The term Asian American captures the breadth of experience of an elderly Japanese American man whose family has been in the United States for many generations and the 18-year-old female refugee from Myanmar who recently arrived to the United States. Despite their age gap, the Japanese American man whose grandparents immigrated in one of the early waves immigration will likely be more acculturated than the 18-year-old who arrives to resettle in a very foreign culture. As the chapter’s focus turns toward mental health in Asian Americans, it will be important to continue to consider each patient or family’s immigration history as it informs aspects of who they are and what issues may arise when they may present themselves to mental health professionals.

Prevalence of Mental Health Disorders in Asian Americans and Utilization of Mental Health Services

According to the Surgeon General’s Report on Mental Health in 2001, now well over 10 years old, there was little adequate data about the prevalence of mental health disorders in Asian Americans. One of the larger studies mentioned in this report, the CAPES study, demonstrated that Chinese Americans in the Los Angeles
area had a moderate rate of depression, with 7% of study participants endorsing having experienced depression in their lifetime and 3% in the prior year [8]. Studies in the 1980s and early 1990s that assessed symptoms of depression rather than the diagnosis of depression in Asian American populations found higher rates of depressive symptoms in Japanese American, Korean Americans, Filipino Americans, and Chinese Americans in various major cities in the United States [8]. One of the concerns underscored in the Surgeon General’s report is the lack of adequate data about DSM diagnoses in Asian Americans and the report questioned whether or not Asian Americans truly have lower rates of psychiatric disorders compared to other populations. Due to potential cultural bias in the reporting of and asking about symptoms, it was unclear whether or not accurate data about mental health conditions in Asian American was captured by numerous studies. Culturally informed ways of expressing symptoms, prevalence of somatization, and culture-bound syndromes were all raised as possible confounding factors. The report clearly states that there were inadequate data about the prevalence of disorders in Asian Americans who did not report mental health concerns and did not see mental health professionals. Rather than demonstrating that Asian Americans were a resilient “model minority” group, the report showed that the scope of mental health problems of Asian Americans was not adequately detected. Without perceiving a realistic mental health need, treatment could not occur, except for high-acuity populations, like Southeast Asian refugees with post traumatic stress disorder, whose need was more evident [8].

Recent large-scale studies have yielded more useful data about the prevalence of mental health diagnoses in Asian Americans and utilization of mental health services. However, diagnosis-specific studies have focused only on ethnic subgroups of Asian Americans and there are not reliable data on the prevalence of psychiatric diagnoses in Asian Americans as a whole. One of the large-scale studies is the National Latino and Asian American Study (NLAAS) that reflects the prevalence of psychiatric diagnoses to be 0.8%. This study was designed to assess the 12-month prevalence of mental health disorders from 2002 to 2003 among Asian Americans and Latinos, to assess the psychosocial context of the emergence of the disorders, and to determine how often mental health services were sought, in comparison with White, Hispanic and Black populations [9]. In one analysis by Dr. Jennifer Abe-Kim of the NLAAS data, 8.6% of the population surveyed sought mental health treatment compared to 17.9% of the general population when assessed in other large-scale studies [10]. In the general population, 41.1% of persons with a probable DSM IV diagnosis sought psychiatric treatment compared to 34.1% of Asian Americans. Additionally, the propensity to use mental health services was inversely correlated to generation of immigration. Second generation immigrants were more likely to use mental health services than immigrants; third generation immigrants were more likely to use mental health services than second generation immigrants at a rate more similar to the general population [10].

In the NLAAS study, the prevalence of lifetime suicidal ideation in Asian American populations was found to be 8.8% and the prevalence of suicide attempts was found to be 2.5%. Factors that were positively correlated with suicidal ideation and attempts include being female, conflict with family, a history of depression or
anxiety, and perception of discrimination. Stronger identification and sense of belonging with one’s ethnic group was negatively correlated with suicidal ideation and attempts [11]. The 2010 National Drug Use Survey on Health by SAMHSA, a large-scale survey on mental health and alcohol, tobacco and drug use patterns among over 60,000 responders over 12 years old showed that the rate of illicit drug use was 3.5% in the month prior, lower than Whites, Native Americans, Blacks, or Hispanics. Among the 38.4% of Asian Americans who endorsed alcohol use in the month prior, 8.8% were binge drinkers and 2.4% were heavy drinkers of alcohol [12]. Rates of substance abuse or dependence were lower among Asian Americans at 4.1% compared to other ethnic groups, which is consistent with what others studies have found [12] (Table 2.1).

Table 2.1 Findings from large-scale studies of mental health in Asian Americans

<table>
<thead>
<tr>
<th>Study</th>
<th>Mission</th>
<th>Major findings</th>
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| National Latino and Asian American Study (NLAAS) | Assess the prevalence of mental health diagnoses in Latinos and Asian Americans from 2002 to 2003 | • 0.8% prevalence of mental health diagnosis
• 8.6% of Asian Americans sought treatment compared to 17.9% of general population
• More recent immigrants less likely to use mental health services
• 8.8% lifetime prevalence of suicidal ideation |
| 2010 National Drug Use Survey on Health    | Assess tobacco, drug, and alcohol use in adolescents and adults          | • Rate of illicit drug use 3.5% per month, lower than other ethnic groups
• Among alcohol users, 8.8% reported binge drinking in the last month
• Rates of substance abuse or dependence 4.1%, lower than other ethnic groups |

Sources: [9–12]

Smaller scale studies in specific ethnic populations of Asian Americans have identified prevalence rates in these subgroups, but conclusions from these studies do not necessarily generalize to the heterogeneous group of Asian Americans. For example, Yeung et al. in 2004 found the prevalence of major depressive disorder among Chinese Americans in a primary care setting in Boston to be 19.6%, much higher than the estimate from the CAPES study in Los Angeles described earlier [13]. Another study from 2000 found that the prevalence of panic disorder in Cambodian refugees being treated at a psychiatric clinic was approximately 60% [14]. Another study examined the prevalence of eating disorders in Asian Americans based on data from NLAAS study and found overall low prevalence of eating disorders in Asian Americans, less than 1% for anorexia and bulimia. Women had a higher lifetime prevalence of binge eating disorder than men, 2.67% compared to 1.35% [15]. The author believes that it is difficult to draw conclusions about a particular individual based on these heterogeneous data. One interpretation of these data is that mental health professionals should expect that refugees from Asia will
likely exhibit symptoms of anxiety disorders. However, with less high-acuity populations, the mental health professional should be more vigilant for mental health symptoms, which may be underreported or may manifest in different ways, as will be reviewed later on in this chapter.

The Surgeon General’s Report in 2001, in addition to emphasizing the need for better epidemiological data on mental health conditions, also highlighted the low utilization of mental health services by Asian Americans compared to other minority groups, which has continued to be true in the ensuing decade when compared to Whites, Blacks, and Hispanics [8, 16]. Since that time, many studies have examined this question with differing results. Barriers for the individual Asian American patient may include any of the following: cultural bias in how the patient describes his symptoms, bias in how the clinician or researcher assesses the symptoms, decreased perception of need for treatment, stigma, foreign-born status, wishing to save face, initial use of family support and traditional healing methods, focus on somatic symptoms, length of time in the United States, lack of culturally appropriate services, lack of language appropriate services, and lack of health insurance [8, 10, 16–18]. For every 100,000 Asian American and Pacific Islanders, there are 70 Asian American and Pacific Islander mental health care providers, which is less than half of the number of providers for Whites. Also, Asian Americans may have difficulty accessing the US health care system in general, as suggested by the fact that Asian Americans who are Medicaid eligible are much less likely to have Medicaid than their White counterparts [17]. While it is not possible to review all of the nuances of the methodological difficulties in assessing the prevalence of mental health disorders in Asian Americans and the disparity in their treatment, excellent reviews are provided elsewhere [16, 17].

**Idioms of Distress Among Asian Americans**

It has been well established that certain ethnic groups, like Asian Americans, are more likely to express social or emotional distress through bodily symptoms and medical help seeking, particularly in cultures where the expression of emotional distress may be discouraged [19]. Somatization has referred to physical symptoms in psychiatric disorders as well as physical symptoms without an organic cause. Historically, researchers have also noted a higher prevalence of somatization in populations who are making either cultural or geographic transitions, particularly refugee populations [19]. Asian Americans are likely to somatize as a result of tacit cultural prohibitions against verbalizing psychological distress. Somatization also may result in more help for the patient from religious figures, family, and traditional healers than expressing distress in psychological terms [20]. In a Japanese psychosomatic clinic, Nakao et al. found amplification of somatosensory symptoms occurred in patients who had difficulty identifying and expressing their feelings [20]. Another study found that among Chinese Americans, individuals who somatized were most likely to seek professional help and that individuals with anxiety or depression were less likely to seek help than those with somatoform disorders [21]. An earlier study
of somatizers among Chinese American and White patients in Boston who did not express psychological distress, found that Chinese Americans were more likely that Whites to be “true somatizers” and in both populations, somatization was associated with the presence of a mood disorder or an anxiety disorder [22].

Recent studies have questioned the assumption about the relationship of somatization and perceived need of mental health treatment in Asian Americans. Based on data analyzed from the NLAAS study, physical symptoms in Asian Americans were associated with a greater sense of need for mental health treatment [23]. In another study by the same authors, also based on data from NLAAS study, Asians were actually less likely to report three or more physical symptoms than Whites and Latinos [24]. Somewhat surprisingly, more acculturated individuals were likely to report more physical symptoms than less acculturated people, even with adjustments for psychological distress, medical conditions, and disability, which may reflect in part the better health of recent immigrants. Taken together, these findings suggest that somatization, while an expression of distress, can lead to greater perceived need for mental health services in Asian Americans. However, somatization alone cannot account for the lower utilization of mental health services by Asian Americans [23, 24]. It is also very important to be aware of the possibility of somatization in the primary care setting. While some Asian Americans with somatization may seek mental health care, others may seek help in the primary care or medical specialty setting. Practitioners in these areas should consider the possibility of somatization as well as mental health diagnoses when evaluating a patient’s physical symptoms. The meaning and social use of somatization may also have shifted over time as the population of Asian Americans has continued to diversify in ethnic origin and acculturative status.

**Culture-Bound Syndromes**

Culture-bound syndromes are repeated clusters of symptoms and behaviors specific to a geographic region which can cause both physical and mental distress in an individual and may result in impairment of functioning and help seeking behavior. The symptoms may include somatic symptoms as well as symptoms that may or may not overlap with a psychiatric disorder classified in the DSM [25]. Various culture-bound syndromes are associated with particular Asian and Asian American populations and are a continued area of study as psychiatric researchers and clinicians alike determine how best to approach their diagnosis and treatment (Table 2.2).

Identification and management of culture-bound syndromes is a continued controversial area of inquiry. A recent review on amok challenged the notion of this being only a culture-bound syndrome given the more frequent episodes of violence and aggressive behavior in Western countries as well as Asian countries, by people of Asian descent and non-Asian descent [26]. The author of the review recommended screening for amok in all patients in order to have amok as part of a differential diagnosis and expanding the assessment of a patient’s risk for violence. The author of the review suggested treating people at risk for amok as psychiatrists would any patient at risk for violence, assessing for mood, psychosis, substance
abuse, and personality disorders and recommending treatment to minimize harm for the individual and society in a person at risk [26]. Choy et al. examined two features of the offensive subtype of taijin kyofushu in patients diagnosed with social anxiety disorder in the United States and Korea and found an association between the culture-specific symptoms and severity of social anxiety, suggesting more overlap in DSM diagnoses and taijin kyofushu than previously thought. This conclusion raises the possibility of incorporation of other symptoms thought to be culture bound into DSM criteria for psychiatric disorders. The expansion of culture-bound syndromes has also been raised by other studies that show that dhat or semen loss anxiety occurs also in China and Western Europe and that latah may occur in White and Black populations [27, 30]. The prevalence of culture-bound syndromes may also continue to shift. In their study, reviewing the history and prevalence of neurasthenia in China, Lee and Kleinman postulate that the worldwide impact of the DSM has made it less likely that Chinese psychiatrists use the diagnosis of neurasthenia in China [31]. Culture-bound syndromes continue to evolve over time, particularly as technology and communication continue to impact cross-cultural exchange of information and ways of understanding illness.

There are methodological barriers to further characterizing culture-bound syndromes. One study described the development of a validated scale to assess symptoms of Hwa-Byung in Korean college students, but raised the question of whether or not the scale would necessarily be valid in Korean Americans [28]. Additionally, as with depression and other disorders in the DSM, clinicians and researchers are continuing to work to better refine the criteria of culture-bound syndromes. For example, clinical cases of Taijin kyofushu describing phobia of one’s own glance, lead to this subtype being put forth for inclusion in the DSM. This subtype is present in the Japanese diagnostic and classification system, but has been omitted in the

<table>
<thead>
<tr>
<th>Name</th>
<th>Asian Country where seen</th>
<th>Features</th>
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<tbody>
<tr>
<td>Amok</td>
<td>Southeast Asia</td>
<td>Violent and aggressive episodic behavior without clear cause, mostly in males</td>
</tr>
<tr>
<td>Dhat</td>
<td>South Asia</td>
<td>Anxiety about discolored or lost semen</td>
</tr>
<tr>
<td>Hwa-byung</td>
<td>Korea</td>
<td>Related to suppression of anger; insomnia, fatigue, panic, pain, GI distress, fear of death</td>
</tr>
<tr>
<td>Koro</td>
<td>Southeast Asia, South Asia, China</td>
<td>Sudden fear of genital retraction into the body and death from anxiety or paranoia</td>
</tr>
<tr>
<td>Latah</td>
<td>Southeast Asia, particularly Malaysia, Thailand, Japan, and Philippines</td>
<td>Extreme sensitivity to fright with dissociative or trance like behavior</td>
</tr>
<tr>
<td>Qi-gong induced psychosis</td>
<td>China</td>
<td>Episodic psychotic or dissociative reaction after improper practice of Qi-Gong</td>
</tr>
<tr>
<td>Neurasthenia</td>
<td>China</td>
<td>Physical, mental fatigue and dizziness, headaches, sleep problems, problems with memory, GI distress</td>
</tr>
<tr>
<td>Taijin kyofusho</td>
<td>Japan, Korea</td>
<td>Intense fear that one’s physical features, smell or behavior is displeasing or offensive to others</td>
</tr>
</tbody>
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Sources: [25–32]
DSMIV [33]. Efforts are also being made to recognize new culture-bound syndromes, such as hikkomori, a syndrome of social withdrawal in Japanese adolescents and young adults who may avoid school or work for years and do not meet criteria for another psychiatric disorder [34]. Culture-bound syndromes will continue to be a challenging area for clinicians treating Asian Americans as there is a strong need for additional research and consensus on how these disorders are conceptualized and managed.

Religion, Philosophy, and Health Beliefs

Many values and beliefs common among Asian American populations have underpinnings in Asian religions and philosophy. These value systems are comprehensive, describing the integration of the body and the mind as well and an approach to managing both one’s internal and external world. Asian Americans are an extremely diverse group, and while all Asian Americans will not uphold these beliefs, it is useful to briefly review them here as they inform the conceptualization of mental health and illness as well as general cultural values in many Asian cultures.

Much of Eastern philosophy is based on principles in Confucianism, Taoism, Hinduism, and Buddhism. Confucian thought brought order to Chinese civilization by emphasizing concepts such as interpersonal harmony, acceptance of a person’s place in society, hierarchy within the family with older adults and males in higher positions, unconditional obligation toward the family, and orientation toward the group rather than the individual [35, 36]. Taoism emphasizes the importance of maintaining balance and harmony both internally and with the larger world, respecting nature, and maintaining personal qualities of humility and receptivity [36, 37].

In Buddhism, the individual cultivates compassion for the suffering of others, acceptance of one’s fate, or karma as a result of acts in a past life, and an acceptance of the ephemeral nature of life, as well as emphasis on non-attachment to aspects of the self [38, 39]. Elements of animism, belief in the existence of spirits, gods, and ghosts and the belief in a larger spirit world infused in natural inanimate and animate objects, has informed elements of Asian philosophy from Taoism, Confucianism, and Buddhism that include respect or worship for ancestors as a virtue [39]. Hinduism and Islam are the most common religions in South Asian nations. Aspects of Hindu belief have overlap with Buddhism such as the values of knowledge of life, emotional regulation, control over desire, the value of humility, and the importance of societal duty [40]. Muslims also have a strong belief in destiny or fate, similar to karma, in that events occur because of the will of God, and similar ideas of sin to Judeo Christian religions. Many Muslims also believe in the spirit world of the jinn and some may have supernatural beliefs about the evil eye [41].

These different religions and philosophies are very tied to beliefs about health and the mind and body in Asian cultures and patients use their beliefs as a way to understand their difficulties. What Western trained psychiatrists may consider a psychiatric problem, an Asian American individual may conceptualize as a psychiatric problem, culture-bound syndrome, physical problem, spiritual problem, or some
combination of all of these. For example, a Hindu Indian American man experiencing dhat may believe his symptoms of semen loss and physical and mental weakness are the result of excessive attachment to sexual desire and decide to pursue yoga therapy to help him detach from his sexual desire and restrict masturbation. He may have pursued traditional treatments after a dissatisfying experience with a psychiatrist who recommended that the patient start an antidepressant to reduce the patient’s excessive worry about semen and reassured him that semen loss was not dangerous [42]. A patient may also ascribe to a more pluralistic health belief system and pursue allopathic and traditional treatments simultaneously. For example, a Chinese American patient may believe that his low energy and mood are the result of an imbalance of yin and yang and may wish to take traditional herbs from a root doctor along with the antidepressant recommended by his psychiatrist [42]. Understanding traditional beliefs may also help mental health clinicians, researchers, and educators gain insight into a family’s approach to managing a particular condition in a family member and the challenges that may arise. When a social worker recommends that an elderly Vietnamese woman with dementia go to a nursing home to alleviate stress in the family, her primary caregiving daughter may acknowledge the difficulties of care giving, but believe that it is her duty to care for her mother, that it may give her good karma, and that it is necessary for her to demonstrate compassion to those who are suffering. The breadth of religions and philosophies upheld by Asian Americans was briefly reviewed here, but the mental health clinician can improve their understanding of the individual Asian American patient’s approach to his mental health by learning more about his or her particular belief systems.

Asian American Family Culture

Based on the deeply ingrained idea of filial piety in the vast majority of Asian cultures, the family is the unit on which society is based. Filial piety is a core value based on Confucian principles. It emphasizes the importance of family throughout the life cycle of the individual. Children are expected to demonstrate respect, support, and sacrifice for their parents and ancestors, to care for their parents and as they age, and behave in a way that brings honor to the family name. While Western cultures are more individualistic and autonomy oriented, Asian cultures are more group oriented [35]. Some families may be hierarchical with the elderly and males holding positions imbued with greater authority or respect, though mothers may be more responsible for the emotional harmony of the family and have more covert influence [35]. Asian Americans are more likely to live in multigenerational families than other ethnic groups and are more likely to live in larger families than other ethnic groups [2]. However, within the joint family, Asian American children, even adult children, are often expected to act in accord with their parents’ wishes and family cohesion is viewed as valuable [35]. For example, a South Asian couple living with the husband’s parents in Chicago might discuss vacation plans with the husband’s parents before making arrangements for a flight to ensure that they approve.
The interdependence of family members among Asian Americans manifests itself in various ways, one of which is when Asian Americans contemplate making major life decisions. In surveys of Asian American adults with children over age 18, 68% felt that parents should have some influence in determining what career their child pursues. In the same group, approximately 66% felt that parents should have at least some influence in their child’s choice of spouse. Another way in which the interdependence of Asian families reveals itself is in how families react to the actions of one member of the family. Often behavior of one family member is considered to be representative of the family as a whole to the rest of society. Families may value academic and occupational achievement of their children as bringing honor to the family in part for this reason. On the other hand, behavior against the family or cultural values, such as a delinquent behavior, a suicide attempt, being gay or lesbian, or taking a partner from a different religion or ethnic background may be viewed as bringing shame to the family or causing the family to “lose face” and lead to conflict within the family.

Cultural values of displaying more tempered emotions, and family harmony may lead to more indirect or restrained communication between family members than in non-Asian American families. Additionally the emphasis placed on respect and obedience to parental authority can also decrease the likelihood of open communication between different generations, particularly when there is conflict. Acculturation differences between generations as detailed in the next section in Asian American immigrant families may also be a cause of problems in family

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**Clinical Example**

As the intake social worker at an urban psychiatric clinic in New York City, you receive a phone call from a Korean man working temporarily in the United States. He asks that you evaluate his wife who has been very upset about failed infertility treatments. Her infertility specialist recommended that the wife have a mental health evaluation after her last treatment did not work. You arrange an initial meeting with the couple. During the first visit with the couple, the husband describes much of the wife’s history and the couple’s immigration history. The wife occasionally disagrees with the husband, but mostly remains silent. The couple expresses how sad they are about being unable to conceive another child. Because they have been afraid of disappointing their extended family, neither wife nor husband has discussed their trouble conceiving with any family members, who continue to ask them why they have not had a second child. Their extended family expects them to have other children by the time they return to Korea. Both husband and wife are worried about returning to live with the husband’s parents and the shame they will face for not having another child. The husband agrees that the wife will come to meet with you for the second visit alone.
communication. Acculturation and enculturation are related concepts. Both reflect aspects of the process of change an individual undergoes when he moves to a new culture. In acculturation, this change reflects affiliation with the new dominant culture; in enculturation, this change reflects affiliation to the individual’s old culture. Dissonant acculturation, which will be reviewed below, reflects how the process of acculturation may cause tension within a family.

**Acculturation and Families**

Connections among family members undergo transition as immigrants move to a new culture and attempt to adapt to the culture. In a process known as acculturation, the individual adapts with regard to identity, beliefs, and values in relation to the new dominant culture [44]. Enculturation, a related concept, functions in the opposite manner and is a process in which a person strengthens their ties to social norms and values of their culture of origin [44]. Hwang has referred to the term acculturation family distancing (AFD) to encapsulate the difference between the parent and child generation in immigrant households who may acculturate at different rates, leading to a difference in values and also difficulties in communication [35, 45]. Other researchers have referred to this phenomenon as “dissonant acculturation” and believe this is particularly relevant in conflict between parents who may struggle to maintain ties to the old culture and children who because of their age and desire to connect with peers may have greater exposure to the new culture [44]. For example, while the parents in a family may struggle to learn a new language and understand new cultural values, the children in a family may more rapidly acculturate to the new culture due to increased exposure to the dominant culture at school. An immigrant child in middle school may learn English more quickly than his or her parents because of ESL (English as a Second Language) classes. The child may learn styles of dress and about current popular music from her peers. The child may also see how her non-Asian peers interact with their parents and try to adopt that style of communication or rebel against values that she had previously accepted in her family. Areas in which different values may cause greater conflict include how different generations communicate or make choices about appearance, sexuality, education, careers, home ownership, and marriage.

This acculturation gap can also occur between elderly relatives that are coming from the country of origin to live in the United States with their children. Grandparents may be brought to the United States with the idea that they can benefit from better health care or provide childcare for the family. Immigration is often alienating for older immigrants, who likely face greater functional limitations and language limitations than younger generations [35, 46]. It is also more challenging for the elderly to establish a peer group and a grandparent new to the United States may experience an acculturation gap with their children and an even greater one with their grandchildren.
Acculturation is part of the process of making a cultural and geographic transition and can lead to significant intergenerational conflict in Asian American families. As will be discussed in the treatment section, this type of conflict can be quite distressing in families that value loyalty and harmony and may lead to Asian Americans presenting to mental health treatment.

Engaging Asian Americans in Treatment

As with any initial encounter with a patient, it is important for the clinician to understand the nature of the Asian American patient’s problem and to start to formulate an approach to help the patient with his or her difficulty. Given the importance of family, a mental health clinician or researcher should be prepared to have multiple family members present for any or all of an initial appointment or assessment [47]. Additionally, the clinician may at first primarily communicate with the family member in the position of authority, even before the appointment and during the appointment itself. In addition to the usual information gathered in an intake the clinician may also consider asking about the patient’s cultural background, religious beliefs, family’s immigration history, patient and family’s acculturation experiences, the patient and his family’s belief about the etiology of his problem and about what other forms of treatment or help the patient and his family sought or are seeking.

The hierarchy in the family may be clear to the clinician in the first contact with the patient’s family, whether on the phone or in person, and is important to respect in creating an alliance with the patient. A clinician may have to pay extra attention in a meeting with a family and observe who sits down first and who speaks first and whose opinion most family members defer to. For example, the husband in a Bangladeshi couple may first contact the clinician to set up an appointment for his wife and join the clinician and his wife for the initial intake appointment. When treatment options are given, the patient may look at her husband for guidance before expressing an opinion. In another family, the most elderly member of a family may be a mother and her adult children may defer to her for decision-making.

Many Asian Americans may view the clinician as an expert or an authority and feel that it is impolite to express disagreement or ask too many questions of the clinician. Patients may overtly exhibit deference to authority in a variety of ways: calling all clinicians “doctor,” avoiding direct eye contact, profusely thanking the clinician or bowing [47]. Patients may feel more comfortable with the physician or mental health clinician being authoritative rather than joining with the patient and their family in a more collaborative manner. It is possible that Asian patients may expect the clinician to act more as the model of the paternalistic healer [47]. Patients may covertly express disagreement or dissatisfaction with the recommendations of the clinician by remaining silent and not contradicting the physician’s advice, or accepting a prescription but not filling the prescription or taking medications. While silence in Western Culture may be viewed as tacit assent, with Asian American patients,
silence can mean dissent [47]. For clinicians, it is important to not assume that lack of direct eye contact is indicative of paranoia, disengagement or social anxiety and also that silence means that the patient completely agrees with treatment recommendations and will follow them. Patients or family members may ask personal questions of the clinician to humanize the physician and relate to him as a trusted elder or family member, to assess his cultural knowledge, to ensure that the clinician does not know others in the patient’s community due to worries about confidentiality, or to find out if the mental health practitioner will judge the patient for their difficulties. Like with all patients, some Asian American patients, as described later in the stigma section, may be fearful about seeing a mental health practitioner for fear that this may mean that they are insane or that others will find out that they have seen a psychiatrist and this will bring on shame for his or her family.

Some Asian Americans may have limited English language proficiency, which can pose a challenge for the patient, their family, and the mental health professional. There is very limited data on the use of professional interpreters and nonprofessional (family or friends) interpreters or cultural brokers in Asian American patients, both in medical and mental health settings. One study of over 2,000 Chinese and Vietnamese immigrant adults at community health centers in the United States found that patients who used interpreters compared to those who had a clinician who spoke the same language were less likely to ask questions about mental health [48]. In this study, patients who rated their interpreters as high quality were also more likely to rate their overall health care as being of high quality [48]. The data from this study suggests that Asian American patients may feel more comfortable with a clinician who speaks the same language rather than using an interpreter, particularly for asking about mental health problems. However, it is very difficult to make generalizations about the use of interpreters, cultural brokers, or language concordant professionals with the heterogeneous group of Asian Americans based on only one study.

I have included some basic guidelines for the initial encounter summarized in Table 2.3 from my experience and the collective experiences of colleagues working with Asian American patients over the last 8 years in urban settings in the emergency room, inpatient unit, research setting, and private practice. As described earlier in this chapter, it is important to not make assumptions about the patient and their personal narrative based on the general principles in this chapter but rather to use these principles as framework for understanding the patient and how their present situation came to pass.

**Psychopharmacology**

Studies have shown that Asian Americans may benefit from initial lower dosages of medications than White populations and may require lower doses for therapeutic effect. These ethnic differences have been attributed to pharmacogenetic differences in the cytochrome p450 system, a system of enzymes responsible for metabolizing psychiatric and other medications. Other factors, such as smoking, diet, age, gender, and use of other medications may also impact effective plasma levels of
psychiatric medications. Henderson et al. provide a very thorough review of ethno-
psychopharmacology in different minority populations [49]. While there is limited
data on ethnopsychopharmacology in persons of Asian descent, it is worthwhile to
examine the relevant findings and consider how these findings may impact mental
health research and treatment of Asian American populations.

With regard to the cytochrome p450 system, the metabolic activity of particular
isozymes in this system has been shown to be lower in Koreans, Chinese, and
Japanese compared to Whites [18]. In particular, a third of Asians are homozygous
for a particular mutation, CYP 2D6*10. This mutation leads to slower activity of the
CYP2D6 enzyme that metabolizes traditional antipsychotics and tricyclic antide-
pressants [18]. This indicates that an Asian American patient with this mutation
may need a lower dose of an antipsychotic or tricyclic antidepressant to achieve the
same therapeutic blood level of a medication when compared to a patient of another
ethnic backgrounds. Additionally, approximately 20 % of persons of Asian descent
may have a mutation of CYP2C19 called m2. This mutation causes 20 % of Asians
to be poor metabolizers of the benzodiazepine diazepam compared to 3 % of White
persons [18]. Another study by Lin showed that both foreign-born and US-born
Asian Americans responded to lower doses of alprazolam than Whites [50]. In this
study, there was no difference in the response to the medication between foreign-
born and US-born Asians, which suggests that the difference between Whites and
persons of Asian descent was pharmacogenetic [50].

Nongenetic factors also impact the activity of various isozymes of the cyto-
chrome p450 system. For example, the activity of isozyme CYP1A2, involved in the
metabolism of typical antipsychotics, olanzapine, clozapine, amitryptiline, clomip-
ramine, nortryptiline, mirtazapine, and fluvoxamine, can be induced by the con-
sumption of char broiled beef and a high protein diet, which may be consumed by
particular East Asian populations [18]. The activity of another isozyme CYP3A4 is
notably inhibited by consumption of citrus fruits and corn [18].

### Table 2.3 Ten tips for the initial encounter with an Asian American patient

1. Expect and welcome family participation in the initial evaluation, possibly from several
generations
2. Ask detailed questions about the patient and family’s health beliefs
3. Ask about what treatments they have tried, both Western medical and traditional treatments, and what they are currently doing to improve their condition.
4. Obtain the patient and family’s immigration history
5. Plan for the initial appointment to be mostly structured by you and somewhat formal. It will likely help the patient feel more comfortable with your authority
6. Do not be put off by a patient’s limited eye contact or deferential manner if this occurs
7. Be sensitive to family conflicts and intergenerational conflicts as a possible reason for the patient’s seeking treatment
8. Remain mindful of the mind body connection as you ask questions and recommend treatment for the patient
9. Remain open to the integration of the patient’s traditional healing methods and what you recommend
10. Do not assume that a patient upholds to a particular religious or cultural belief, make sure to ask about it!
There may be other differences that account for differing response to psychiatric medications in Asians. For example, treatment with Lithium in East Asian populations yields a therapeutic effect at levels less than 0.8 meq/mL [18]. The author of the review, Lin, suggests that this could be due to pharmacodynamic factors, factors related to the effect of a specific medication on the target organ. Another study from 1988 examines the differences in serum haloperidol and serum prolactin concentrations in White, American-born Asian, and foreign-born Asian American volunteers. This study found significant differences between patients of Asian descent and White patients in both serum haloperidol levels and prolactin levels, suggesting both pharmacokinetic differences as well as a possible difference in dopamine-receptor-mediated response to the medications [51].

Asian Americans, because of potential slower metabolism of medications, may be more sensitive to side effects of medications or have toxic reactions to medications prescribed at recommended doses [52]. A study of desipramine pharmacokinetics in White and Chinese volunteers found higher clearance of desipramine in White volunteers compared to Chinese volunteers when controlling for body weight. The authors suggest that treating Chinese patients with standard doses for desipramine would put these patients at greater risk for toxicity [52]. A general approach to prescribing psychotropics to Asian American patients may be to “start low and go slow” as with geriatric psychiatric patients who are often started at half the typical dose of medications and monitored closely for and educated about side effects. It may also be worthwhile to get blood levels of medications to assess whether or not a patient is a normal or slow metabolizer after an Asian American patient has been on a steady dose of medication for several weeks.

With regard to psychoeducation, as with all patients, it is helpful for Asian American patients to know that antidepressants and mood stabilizers take weeks to work and antipsychotics take days to work. Some Asian American patients may be more likely to believe that medications should be short term and work quickly, based on traditional beliefs [53]. For these patients, it is very important to understand the difference between medications that work quickly like benzodiazepines and stimulants and ones that they need to remain on for longer to achieve their effect. Patients may not be familiar with how psychotropics work and may need psychoeducation that involves reframing the purpose of the medications in a culturally sensitive manner. For example, in the treatment of a Southeast Asian refugee with severe PTSD and depressive symptoms, a clinician may explain that the patient’s symptoms are due to an excess amount of stress not due to a brain problem and that the medications may help the patient eat and sleep better [54].

**Psychotherapy**

An Asian American patient may expect a more pragmatic or directive approach in therapy initially due to viewing the clinician as a wise authority figure and may want advice or feel uncomfortable with an unstructured session. A cognitive behavioral
therapy approach could be helpful for this type of patient. CBT approaches to PTSD and group therapy approaches in Southeast refugees have been very successful, focusing on pragmatic strategies for managing life and also helping patients understand and manage their symptoms [54]. Additionally some clinicians have also developed psychotherapeutic treatments for culture-bound syndromes, such as a nursing treatment program designed for patients with Hwa-Byung that incorporated drama therapy, music therapy, and group therapy for to help patients express anger. This was more effective treatment for the patients than the control condition [55].

Some authors have suggested the use of traditional stories or parables in psychotherapy with less acculturated patients who may have less difficulty talking about conflicts or symptoms in displacement [47]. Other patients may be willing and suitable for engagement in a more insight oriented or exploratory treatment and may benefit tremendously from it [56]. Paying attention to the use of defenses like with all patients can help the therapist initially determine how to engage the patient, as well as sensitivity to family dynamics. There have been some excellent case studies describing the details of different Asian American patients in psychotherapy [56, 57]. Determining a psychotherapeutic approach is very individual specific and will be addressed further in the clinical cases section at the end of the chapter.

Integration of Traditional Medicine and Western Approaches

Some patients may wish to pursue traditional treatments in addition to or instead of their treatment with their mental health practitioner, whether it involves consulting with a shaman for exercising bad spirits, acupuncture, meditation, acupuncture, herbalist or root medicine, tai-chi or other traditional treatments. Before suggesting allopathic psychopharmacologic or psychotherapy, asking about what traditional treatments the patient has tried would be valuable. Furthermore, some knowledge or willingness to learn more about these treatments will aid the mental health professional in understanding the patient’s problem more deeply [58]. In an article about working with Asian Americans in a culturally sensitive way, Park et al. detail the example of a psychiatrist working with an Asian American psychotic patient who sought consultation from an herbalist about herbal treatments for psychosis to educate the family of the patient along with the treating psychiatrist [58]. For example, knowing that a patient with panic disorder incorporates meditation into her daily life may help a psychologist consider a wide variety of treatments for overwhelming anxiety and fear, including mindfulness-based cognitive behavioral therapy, relaxation exercises, dialectical behavioral therapy, as well as the more traditional route of cognitive behavioral therapy for panic disorder.

Mental health clinicians may have a skeptical reaction to non-evidence-based treatment or feelings of discomfort by the patient’s pursuit of alternative treatments. While Asian American patients may view the Western trained clinician as an expert or an authority, the clinician has little to lose in the eyes of the patient by being open and flexible about alternative methods of treatment and the unique way in which the
patient conceptualizes his or her difficulty. A dismissive reaction could be alienating to some Asian American patients; however, other Asian Americans may not be interested in pursuing traditional treatments at all or may have exhausted them already.

If a practitioner is prescribing medications to patient, it is important to check with the patient about whether or not they are taking any traditional medications, teas, or supplements and to ask about their diet to ensure that there is not any interaction between any of their treatments [58]. In the primary care setting, it is important to include questions about culturally traditional treatments and practices in initial appointment paperwork with questions about the patient’s other medications. This is important for a culturally sensitive approach but also to ensure the safe integration of traditional and allopathic treatments. Also, in the initial visit of an Asian American patient to any medical specialty, surgical clinic, or research assessment it is important that the nurse practitioner, social worker, or physician consider that a somatic symptoms may be a manifestation of a mental health problem or culture-bound syndrome.

Stigma, Shame, and Denial

As previously described, Asian American populations underutilize mental health services compared to other ethnic populations. In addition to other barriers to access of services, Asian Americans may delay seeking psychiatric services for themselves or a family member to the point that the patient’s condition may have become very serious [18]. Delays in seeking treatment may be related to the stigma of mental illness in Asian cultures and an effort to ward off shame for the patient and his or her family [59]. For example, a young South Asian American man with a psychotic illness at a city hospital told his treating physician that he had been off antipsychotics for months while living at home and was paranoid to the point that he was hoarding his urine and excrement at home with his physician parents. In this case, the patient’s parents may have believed that seeking treatment for their son in a small community would bring about shame to their family and the denial of his illness may have helped to preserve their good image of themselves or their son. A family may believe that the illness is because of karma and telling mental health professionals that a family member is ill may reveal that a family member may have acted poorly in a past life. Stigma may also be influenced by the age of the individual. One study found older Korean Americans were more likely than younger Korean Americans to view depression as character weakness bringing shame to the family [60].

For some communities, in which there is a tradition of arranged marriages or family brokered unions, like also in the Orthodox Jewish community in which mental illness is very stigmatized, the idea of revealing that a family member has a psychiatric problem may taint marriage prospects not only for the patient but also for their siblings or for generations to come [61]. For the individual’s community, the acknowledgement of psychiatric problems may represent a character defect or genetic defect in the person or in the family or person.
Along this same vein, it may be difficult in the treatment setting to obtain an accurate family history due to stigma. Family members may not tell the clinician about other relatives in the family with mental health diagnoses. Furthermore, the stigma can be so powerful in families that in some cases a patient may not have even shared with his or her spouse that there is mental illness on his or her side of the family and at times a patient may have no idea that he or she has a relative with a psychiatric problem.

This level of shame may lead to difficulty accessing treatment for the patient and family and even may result in a family colluding with the patient’s own resistance to getting desperately needed help [62]. For example, a mother may minimize her child’s hyperreligious manic behavior of disrobing publicly and giving away all of his money as a part of a religious ritual not understood by doctors from a different culture and insist that her child does not have an illness. The family might support the patient’s wish to be discharged from the emergency room, despite the patient’s extreme difficulties with functioning. A physician parent may take over prescribing antipsychotics for his or her own child and misdiagnose them with an anxiety disorder. Families may even send a mentally ill family member to relatives in a different country to live with them in the hopes of a geographic cure to maintain denial and escape questioning of others in their community.

It is also possible because of shame and stigma that patients with trusted relatives or friends who are physicians or mental health care professionals may have been asked to treat the patient or advise on his or her care in an informal way. While this behavior could be seen as culturally acceptable or preferable, for the patient it may be difficult to be as open with a person in their social circle and may make it difficult for the patient to get an accurate assessment of their difficulty. It is also possible that in some communities, particular diagnoses, like bipolar disorder, schizophrenia, or substance abuse may be more stigmatizing than others. For example, compulsions related to hyperreligious obsessions related to cleanliness may be more acceptable in some communities than other psychiatric symptoms.

**Major Mental Illness**

As mentioned in the previous section, there are a variety of reasons that an Asian American family may not want to seek help for psychosis, mania, or a severe depression in their loved one. The family may be mistrustful about how their family member will be treated or may be mistrustful of treatments recommended by doctors trained in the United States. Since the DSM and ICD have not been validated in all populations, patients and families may be skeptical of whether psychiatric diagnoses exist and whether there is a more culturally appropriate explanation for their behavior, as in the case of the young manic man with hyperreligious behavior. Families may also be misinformed or have misconceptions about mental health treatment for these conditions based on inhumane conditions at treatment facilities
in their native culture and may perceive hospitalization as abandoning the patient [58]. Families from any cultural background may also feel it is their duty to care for a family member with mental illness, but the culture value of filial piety may lead to caregiving being more of a cultural obligation for Asian Americans [62]. As in all populations, Asians Americans will have the same worries about diagnosis and prognosis for the patient. Because many Asian American families are interdependent, it can be very helpful for the patient’s treatment to include multiple family members in family meetings in the hospital, to meet with the entire family in inpatient and outpatient settings for culturally appropriate psychoeducation, to have regular contact with the head of the family when needed and to consider the family as part of the patient as well. The clinician also has the responsibility of giving the patient and the family hope, a realistic prognosis, and reassurance that these illnesses are treatable.

**Intergenerational Conflict**

More traditional Asian American families may try to minimize conflict within the family or be ashamed about revealing the layers of family conflict to the treatment team or professional. In particular, a parent may be quite distraught about a child rebelling against them and may have difficulty admitting this without feeling ashamed. A parent may manifest their distress in indirect ways, such as somatization or other symptoms. Similarly, children with aging parents may be extremely uncomfortable or feel disrespectful if they question an elderly parent’s cognitive abilities or their behavior to make decisions. They may try to save their parents shame in front of the professional and either minimize difficulties or contact the professional later to be more honest with them. Family conflicts can take a great toll on Asian Americans. Greater intergenerational conflict and acculturation gap have been found to correlate with poorer mental health in Asian American college students [63]. Intergenerational conflict can also be very difficult for parents, as described in a study showing increased depressive symptoms in Korean America parents with young children. Conflicts around the child’s social life, expressions of love, disagreements about proper children’s behavior and the notion of saving face were most associated with parental depressive symptoms [64]. Asian American families are particularly at risk of a surge in intergenerational tension as the younger generation enters adolescence. While in Western culture, adolescence is associated with rebellion and individuation from parents, in most Asian cultures, adolescence is associated with increased responsibilities and continued obedience to parental authority with regard to important decisions. This gap in values in expectations can be a major source of conflict between Asian American parents and children and can lead to tension, depression, anxiety, and suicidal ideation in children and adolescents [43, 65].
Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) Asian Americans

While Asia has made more progress in the last 10–20 years of having more openly homosexual populations, individuals who are lesbian, gay, bisexual, or transgendered, or questioning (LGBTQ) are still often highly discriminated against, marginalized, and can be subject to violence in Asia. While in the United States, LGBTQ individuals have found increased acceptance in recent decades, Asian cultures lag far behind in this respect. Some areas that have a reputation for being LGBTQ friendly include Nepal, which hosted the first Asian Symposium on Gay and Lesbian Tourism in 2010, Bangkok, Shanghai, and Manila [66]. Because of values of the importance of Confucian, Hindu, and Islamic values about gender roles, marriage, and family lineage, homosexuality is still as unacceptable in many families of Asian origin [67]. Families may feel that having a homosexual child brings shame to the family and makes them subject to social judgments. Parents may accept their child’s sexuality within the family, but they may strongly pressure a child not to be open about their sexuality to extended family. Additionally, while they may accept that their child is gay or lesbian, they still may pressure the young adult to marry so that they can save face among the extended family and community. Furthermore, there may also be pressure on the individual to get married in order to have children to continue the family lineage. Sexual minority Asian Americans may struggle to feel accepted and may be forced to choose between gaining support of the LGBTQ community or their ethnic community, though there are increasingly more available resources for LGBTQ Asian Americans [67].

Abuse/Trauma

As a clinician, educator, or researcher working with Asian American populations, it is very important to be alert to histories of trauma. There are many subgroups within Asian American communities that have experienced traumatic incidents on wide level including the Vietnam war, serving as comfort women in Korea, Japanese internment in the United States; human trafficking for prostitute or domestic slavery; Cambodian Civil war, imprisonment, and torture under repressive governments [47, 54]. Patients may or may not initiate a discussion about these experiences due to shame, but may exhibit some symptoms of PTSD or maltreatment on exam. Trauma may also happen on an individual level and patients may feel ashamed about discussing these issues with the clinician for fear of bringing shame onto their families as well. Other traumas common in Asian American households include domestic violence, incest, rape, sexual abuse, physical abuse, and verbal abuse [47]. A patient may have difficulty even identifying abuse in the home as abnormal or traumatic. For example, an Indian American patient with depression, promiscuity, and emotional outbursts may not readily identify her mother’s physical abuse and emotional
abuse of her as a child as connected to her present difficulties. In these cases, it is up to the careful clinician to explore these issues sensitively and to decipher the meaning behind the patient’s description of their experiences.

To help the reader synthesize the information in this chapter, the complexities of what was just discussed is illustrated in these blended cases based on my own clinical work, consultations with experts, and the cases of colleagues in clinical, educational, and research settings.

Case Vignettes

Case 1

A 33-year-old Thai female, engaged and employed, with one prior psychiatric hospitalization for a suicidal overdose on Tylenol resulting in liver damage after a break up with a past boyfriend, is brought into the emergency room by her the aunt of her fiancé because of strange behavior while she was babysitting. The patient had previously been treated with low dose haloperidol (antipsychotic medication) for 2 years after her first hospitalization, but this had been tapered off after anxiety and auditory hallucinations had not returned. The patient agrees to hospitalization and is restarted on haloperidol and her psychotic symptoms improve over the course of 1 week. She is able to talk much more freely with the treatment team, who determines that the patient may have suffered a recurrence of her psychotic symptoms after moving in with her fiancé. The patient also tells the team that she came to the United States to be a domestic worker and her outpatient therapist confirms this. The patient wonders what her diagnosis is and wonders if she will be able to have children in the future and asks if she will need to stay on her antipsychotic medication permanently. She speaks to her mother on the phone while she is in the hospital and her mother tells her that she will get her to see a Thai doctor when she visits Thailand next and expresses concern about the patient taking haloperidol.

Discussion

Diagnostically, the clinician considered diagnoses of a psychotic disorder, major depression, as well as possible underlying emotional regulation difficulties, given the patient’s history of a past suicide attempt. In particular, due to the patient’s Asian background and presentation, the clinician sensitively and thoroughly asked the patient about any history of trauma in the past, specifically during the immigration and acculturation process. The treatment team met with both the patient and her fiancé for health education. The clinician used the culturally sensitive explanation of her illness, framing it as an imbalance in the balance of the body’s elements, rather than as a brain disorder. The clinician was sensitive to the fact that the patient may not believe in taking antipsychotic medication on daily basis after her symptoms had
dissipated, based on her beliefs about how medications work. Based on her Southeast Asian background, the clinician weighed the greater risk for extrapyramidal side effects with the use of haloperidol with the potential benefit of treating her with a low dose of this medication, which has fewer metabolic side effects than new antipsychotics. The clinician decided to continue the low dose haloperidol and checked a blood level before discharge to check that it was not in a toxic range for the patient.

The patient had been seeing a therapist for years through a nonprofit organization that provided services to recent immigrants and the treatment team spoke with the therapist. The patient had seen a psychiatrist after her first hospitalization, but did not feel very comfortable with him because of the difference in language and culture. The treatment team made an effort to find a Thai-speaking psychiatrist at discharge at one of the larger Asian mental health clinics in the city.

**Case 2**

A 24-year-old Chinese American female in law school is the only child of two parents living in a major Northeastern city. The patient became depressed prior to her exams during her second year of law school shortly after a trip home for Thanksgiving. The episode appeared to be precipitated by family tension surrounding the death of a grandparent in the family. The patient was unable to complete the necessary coursework to advance to the third year of law school and was required to take a medical leave to treat her depressive symptoms. While her parents work in the medical field, they are unable to fully grasp her difficulties and the patient often hides her problems from them. The patient has been also questioning her sexuality and feels pressure from her parents to get married after law school. Her father has been, prescribing her Valium (a sedative) that he also takes for sleep, and has recommended that she see a traditional Chinese doctor in Chinatown and consider acupuncture. When she was struggling during the semester, her parents insisted on coming to visit her every weekend, staying with her, monitoring her closely and cooking her food so that she could study. The patient approached her professor about her difficulties, who directed her to the student health and counseling center for an intake appointment with the social worker. She had met with a her internist previously when she was home over the summer about her sleep difficulties who recommended she go to the school counseling center for an appointment, but the patient did not follow up on the recommendations once she returned to school.

**Discussion**

The patient is facing a number of cultural stressors contributing to her presentation. She may have felt a cultural obligation to take time off school to spend time with her family to show respect for her deceased grandparent. She is also potentially facing intergenerational conflict with her traditional Chinese parents about her sexuality
and may be very distressed about how to approach dating. She may also have been confronting stigma in her family and in her larger cultural context, which has lead to a delay in her getting appropriate treatment for her condition, despite being aware of mental health services at school. Because of the shame in having mental health symptoms, her father has decided to prescribe her diazepam rather than suggesting she see a mental health practitioner. Her father does not seem completely skeptical of Western psychiatric medication, as he is prescribing her diazepam. The patient’s father and the patient may view Western psychiatric treatment as a last resort, to be explored only after meeting with a traditional Chinese healer and an acupuncturist. The social worker recommends an integration of traditional Chinese and Western approaches. The social worker recommends weekly acupuncture and psychotherapy for the patient as well as a family session by phone with her parents. The social worker hopes to show respect for the family hierarchy by discussing the treatment plan with the patient’s father. She hopes that this will decrease the shame and stigma in the family and also improve the patient’s adherence to treatment recommendations by gaining her father’s support of the recommendations. During the conversation with the father, the social worker verbalizes appreciation of the father’s commitment to helping his daughter improve her health. However, she also recommends that the patient consult with a psychiatrist to evaluate her for psychopharmacological treatments for mood and anxiety disorders and states that the patient could give the psychiatrist permission to speak with the father as well. The social worker also recommends a “coming out” group for young adults from ethnic minorities at the local LGBTQ center in the city for the patient. In this way, the patient may have another place to talk about her issues surrounding sexuality with others who can appreciate her difficulties in approaching her family about this.

**Case 3**

75-year-old married Japanese American male, living in the United States for 40 years, presents as an outpatient to his primary care physician’s office. He is a retired engineer, living with his wife at home, and has three adult children who live in different cities. He retired 2 years ago and since that time has become increasingly preoccupied with his physical health. He has had a difficult time staying busy since his retirement as most of his energy was thrown into his career throughout his life and he has been the major authority figure at home. He has become convinced that eating particular foods exacerbates his stomach pain and has restricted his eating to the point that he has lost 20 lbs in the past 6 months. His doctor has become concerned and has called his wife and recommended that the patient come into an appointment with his wife. This gentleman, who has not liked going to see his physician for most of his life, now goes to see his PCP every 2 weeks with long lists of questions. Of note, one of his children was married in the last year and she and her husband are expecting the patient’s first grandchild. The patient’s wife is very frustrated with the patient’s inability to get back to his old self and is very concerned about his weight loss and social isolation.
Discussion

The internist wonders if the patient is somatizing his psychological distress about the recent transitions in his life. The internist works to find a culturally sensitive way to discuss the patient’s underlying mental health issues with the patient. He frames the patient’s difficulties as the result of increased stress that can impact both the body and the mind, leading to his physical symptoms. The internist knows of the patient’s cultural background and feels that it is appropriate to involve the patient’s wife and his oldest son, who is available by phone. While the patient’s son lives in a different city, he adheres strongly to the value of filial piety, and has assumed the primary responsibility for caring for his parents as they age. The internist explains that patient has had many changes in his life and states that both his body and mind are still adjusting to the changes and states that the mirtazapine will help him with his appetite, weight loss, sleep, and will restore balance to his body. The doctor starts a very low dose because of the patient’s age as well as his ethnic background, which could potentially result in high blood levels in this patient. The patient asks about taking a traditional Japanese herbal combination (kampo) along with the mirtazapine. The doctor investigates the interaction of the kampo medication with the mirtazapine and decides that it is safe to combine these two treatments. The doctor also recommends that the patient become more physically active and suggests a tai-chi class, a meditation CD and a follow up appointment with both the patient and his wife for 2 weeks later.

Conclusions and Future Directions

The population of Asian Americans in the United States is rapidly growing and their mental health needs are mounting as well. These needs in Asian Americans will reach a crisis point if the mental health field does not grow in its understanding of this population. Asian Americans clearly underutilize mental health care services, though the reasons for this are still unclear, despite the best efforts of clinicians, researchers, and educators.

This chapter has highlighted that there is a lack of reliable data of the incidence and prevalence of mental health disorders in Asian Americans. This missing information makes the task of developing targeted interventions to decrease stigma and shame and increase awareness of mental conditions quite difficult. A realistic appraisal of the mental health diagnoses and impact of mental health disorders on Asian American populations is a critical future direction for researchers. Additionally, it is essential to assess the prevalence and incidence of different diagnoses in ethnic subgroups, as the population of Asian Americans expands and further diversifies.

Another significant area of further exploration is the utilization of interpreter services, family members as interpreters, and language concordant mental health services by Asian American populations. The current medical literature has a stunning lack of research in this area that would strongly impact the design of mental health services and interventions. Culture-bound syndromes continue to challenge
mental health clinicians and researchers with their potential overlap with DSM and ICD diagnoses. This is yet another area of further work that could dramatically change the use of mental health care by Asian Americans.

Asian Americans are clearly not a “model minority” when it comes to mental health and it is imperative that mental health clinicians, researchers, and educators work to further characterize and meet their needs.

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