Mental Health of Asian Indians:
Relevant Issues and Community Implications

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The current body of research on Asian–American mental health issues has
not sufficiently addressed the needs of Asian Indians. Demographically and
historically this group is distinct from other Asian immigrant groups. This
article examines how the unique aspects of Asian Indian culture may
differentially impinge on mental health issues such as acculturation, rates
of psychopathology, and manifestation of psychiatric symptoms. The
ramifications of these factors for the construction of community mental
health models for these groups are also addressed. Recommendations and
hypotheses for future research in this area are suggested.

Asian Indians represent the fourth largest Asian group in the United States. The
1990 census indicates that there are over 815,000 Asian Indians residing in this country.
Asian Indians also represent one of the fastest growing immigrant groups, with a 125%
growth in the last decade (U.S. Department of Commerce, Department of the Census,
1991). Most Asian Indian immigrants entered the United States in the last 30 years with
the passage of the Immigration Act of 1965, which allowed increasing numbers of Asian
Indians to enter the United States.

Despite their growing numbers, Asian Indians are underrepresented in the American
mental health literature. For example, in a review of more than 100 studies on the
utilization of mental health resources by Asian groups, Leong (1986) notes that most
of the studies pertain to Chinese and Japanese Americans. He observed that Koreans,
Filipinos, and Pacific Islanders were underrepresented in the literature. The omission
of Asian Indians, one of the largest Asian groups, was not addressed.

Several explanations for this neglect may be considered. First, a cycle may be set
up where scarcity of empirical research discourages further research. Second, there are
very few mental health professionals and researchers whose focus is Asian Indian mental
health. Thus few students are being mentored and trained to develop expertise in this
area, again setting up a negative cycle where a core group of researchers in the area
is lacking. Third, as the literature on other Asians grows there may be a tendency to
group all Asian subgroups together and overlook the unique aspects of individual
subgroups. The growing numbers of Asian Indians in the United States make it a
demographic imperative that we begin to study this immigrant group in its own right.

This article will deal with issues that impinge on the understanding of mental health
issues facing Asian Indian groups in the United States. Many of the issues discussed

here pertain to the "content" issues of therapy. We believe that the "process" aspects of conducting therapy with Asian Indians may be similar to those practiced with Asian Americans. The integral differences in intervention and therapeutic issues between Asian Indians and other Asian ethnic groups are believed to be based in the substantive, content-based issues. Content and process dimensions will be expanded on throughout this paper.

Where important issues have not been addressed in the literature, the authors will attempt to generate hypotheses by drawing from their own background and experience. We will explore issues of self-identification and labeling, the structure and dynamics of the Asian Indian family, and manifestation of psychiatric illness and symptomatology. These issues and how they relate to the role of community psychology for the Asian Indian communities will be addressed. Recommendations for future research with these groups will also be discussed.

Self-Identification and Labeling of Asian Indians

Review of the literature revealed a lack of consistency in the labeling of Asian Indians. Overall the term "Asian Indian" was used in the North American literature, whereas in the British literature the terms "Indian" or "Asian" were used to refer to Indians in Britain. This discrepancy may be explained by the need for Americans to distinguish Asian Indians from Native Americans, traditionally referred to as "Indians" in the American literature. Additionally, researchers in Britain have tended to group together people from such diverse countries as Pakistan, Bangladesh, and Sri Lanka under the umbrella term "Asian."

Most Asian Indians agree that they are distinct from all other Asian immigrant groups. Asian Indians have never considered themselves to be "Oriental," the Western term traditionally used to identify persons originating from Far Eastern countries such as China, Japan, and Korea. This may indicate why Asian Indians do not identify with the current Western term "Asian," which has replaced the term "Oriental."

Sodowsky and Carey (1988) addressed the issue of self-identification of Asian Indians in the United States and found that in their sample, most Indians viewed themselves as "More Asian Indian than American" or bicultural ("Indo-American"; p. 120). However, the use of a fixed response format may have resulted in artificial categories of identification that were not personally relevant to the respondents. Personal inquiry regarding ethnic identification of Asian Indians in the United States revealed that these individuals do not have an automatic response to the question of ethnic identity.

The population of India itself is not homogeneous, and within the group of Asian Indians are several subgroups which retain their own cultural and religious practices. For example, many Asian Indian immigrants in the United States believe that they have little in common with other Asian Indians who immigrated from different parts of India. For example, Asian Indians who follow the Hindu religion believe themselves to be quite different from Sikhs from the state of Punjab.[1] Thus researchers studying Asian Indians need to remain aware of the religio-ethnic and regional origins of their subjects. Conclusions drawn from a subset of Asian Indians may not apply to the larger group

[1]In India, ethnicity is closely tied to religion. Hindus constitute more than 80% of the population of India (Pothen, 1989), and form the majority of Asian Indian immigrants in the United States. It is beyond the scope of this paper to deal with the different religio-ethnic groups in India such as Sikhs, Buddhists, and Muslims. The interested reader is referred to other sources for further information (Roland, 1988; Wenzel, 1968). In this paper specific references to Hindu Asian Indians will be made when relevant.

of Asian Indian immigrants. Overall, the issue of labeling the Asian Indian group is a complex one. At present, we believe the term "Asian Indian" may provide the best classification for this group.

The Asian Indian Family

The structure of Asian Indian families is inherently different from Western European and Caucasian American families. Asian Indian culture and religion often focus on the family rather than the individual as the unit of analysis (Shon & Ja, 1982), a characteristic common to most Asian groups. Asians and Asian Indians are group-focused or allocentric and value the sacrifice of individuals for the benefit of the group or family (Segal, 1991). Family roles are clearly defined, with males being categorized as wage earners and primary decision makers.

The primary role of children in Asian and Asian Indian families is to bring honor to their families through their achievements. Qualities such as generational interdependence, obedience, conformity, obligation, and shame are valued by both Asian and Asian Indian families (Segal, 1991; Stopes-Roe & Cochrane, 1990). These values may be in conflict with American and Western European values of individualism, independence, and self-sufficiency.

Children in Asian Indian families are often viewed as a culmination of the parents' life work. In Hindu families, one of the three aims of marriage is *praja* or children/progeny (Pothen, 1989). The goal of parenting is not to provide the children with sufficient skills to leave the family but to instill a sense of obligation and duty through which they may achieve higher spirituality. Clearly, such philosophies are in contradiction to American and Western European goals and ideals for child-rearing. Given such contradictions, children of Asian Indian immigrants may experience dissonance between the collectivist demands of their family and the call for independence and individualism issued by their environment. This may also act to polarize children and their parents, and make effective communication more difficult (Segal, 1991).

Although values such as familial obiligation are shared by many Asians and Asian Indians, their impact may be different for the two groups. For Asian Indians, problems around marriage and dating are numerous and affect the ease with which parents and children adapt to American culture. The hope of many Asian parents is that their children marry within the culture. However, in Asian Indian families this tradition takes on much greater significance, made evident by the accompanying structures surrounding marriage.

These structures may create potential points of contention between children and parents. For example, the concept of arranged marriage in Asian Indian culture dictates that a young man or woman marry a person chosen by his or her parents. Partners are chosen on the basis of social and cultural compatibility, which is usually determined by examining a potential partner's caste. A caste is a social group into which a person is born, based on the caste of his or her parents (Roland, 1988). The caste system, which is increasingly coming under scrutiny as obsolete and prejudicial, is still considered important by many Asian Indians. Caste appears to be an especially important variable for an arranged marriage, as it is considered a heuristic for gauging social and cultural compatibility of potential partners. V. Ouseph, an Asian Indian psychiatrist working with this population, explained that Asian Indians believe that compatibility on these dimensions will assist in building and maintaining a successful marriage (personal communication, July 15, 1993).

Problems arise when children of Asian Indian immigrants who have acculturated to American culture do not consider caste to be a valid heuristic for compatibility, nor an assurance of success in marriage. Thus the very structure which Asian Indian parents believe to be valuable in ensuring their children's welfare may be that which causes the most friction between themselves and their children. For parents, stress caused by concern for their children's welfare is compounded by anger and hurt at their children's rejection of tradition (and, by extension, themselves). For the children, stress caused by frustration with the "traditional" way (often synonymous with obsolescence) is compounded by guilt felt for making choices not approved of by their parents.

Although there are no survey data addressing the issue of caste, our experience indicates that the more traditional Asian Indians in the United States have retained some aspects of the caste system in their lives, particularly with regard to marriage. The importance of the caste system for individual Asian Indians will vary depending upon such factors as whether or not they were born and raised in India, personal experience with the caste system, and acculturation into American egalitarianism. In working with Asian Indians in individual or family therapy, it is important that the researcher or clinician elicit information on this issue.

Related to the caste system as it impinges upon marriage is the institution of dowry. A dowry is a payment made by the family of the bride to the groom's family (see Saini, 1983; Khan & Ray, 1984; Billig, 1992). Unfortunately, the dowry system is often abused in India. In extreme cases, women who enter a marriage with a poor dowry are so abused by their husbands and/or in-laws that they commit suicide. In other cases, such wives are sometimes killed by abusive in-laws. The negative images associated with the dowry have caused many women in India to reject it, causing friction between children and their parents (who wish to carry on the traditions of their culture). In the United States there are no known reports of homicide or suicide relating to the dowry. It appears that dowry may be practiced in a more subtle manner in America. For example, the bride's family may pay transportation and lodging expenses for the family of the groom during the wedding.

Language is another potential problem in choosing marriage partners. Parents usually require that the potential partner for their child speak the same language. This may seem an easy requirement to meet, but in fact there are 16 distinct languages (and numerous dialects of each) spoken in India (Ramakrishna & Weiss, 1992). Additionally, potential mates are often from families that are acquainted with each other. This ensures that marriage partners will be accountable to the families involved. In a Hindu family, marriage may be conceptualized as occurring between two families, rather than between two individuals. Parents are thus invested in the choice of a marriage partner for their child. Segal's (1991) work illustrated that Asian Indian parents greatly feared that their children would not marry Asian Indians, and thus lose their cultural values and traditions. Segal also found that the children involved were afraid of having a marriage arranged for them.

It should be noted that the practice of arranged marriage is not always understood by these children, nor by many people in Western culture. It is often believed that an arranged marriage requires that the bride and groom not meet until the wedding day. In fact, Asian Indian men and women are allowed to meet and talk with prospective mates, and "reject" any that they feel are not appropriate. Nevertheless such visits are often chaperoned, and do not approximate "dating" in the United States. Rarely is there physical or sexual contact between Asian Indian men and women in an arranged marriage prior to the wedding.

Children of Asian Indian immigrant parents who become acculturated to American views on dating and marriage may find themselves in a difficult situation. As these children become socialized into American social networks, they observe the dating practices of their peers. However, the firm message at home is that dating is not an option, and that decisions about marriage are made collectively by the family. This situation has led to much conflict between Asian Indian immigrant parents and their children. Parents even refer their children for counseling, reporting that the latter are "crazy" or "rebellious" because they will not comply with their parents' wishes about marriage (V. Ouseph, personal communication, April 13, 1993). These issues surrounding marriage (arranged marriages, the caste system, dowry, and prohibitions against dating) could affect all members of an Asian Indian household. It would be important to identify and discuss such issues when counseling this group.

The Manifestation and Meaning of Psychiatric Disorder

Rates of psychiatric disturbance in Asian Indians in the United States have not been addressed in a systematic manner. Some researchers have examined rates of psychiatric disorder among Asian Indians and Pakistanis in Britain (see London, 1986). Reports of inpatient admissions from these studies have been mixed. Among Asian Indian and Pakistani inpatients, schizophrenia was the most common diagnosis, and occurred at a frequency which was higher than expected. Epidemiologic reports on inpatients in India indicate a similar pattern (Nandi et al., 1983). Affective disorders were generally found to occur at a rate comparable to the British population, and suicide occurred at a lower rate.

S. Sue and Morishima (1982) indicate that mental illness is shameful and stigmatizing to Asian Americans. The concept of stigma in mental illness in India is complex. Fabrega (1991) notes that in ancient India, psychiatric illness was not treated differently from other chronic medical conditions. However, other ancient codes of India indicate that psychiatrically ill individuals did not qualify for certain social privileges. Despite these mixed findings on the historical meanings of psychiatric illness in India, current research suggests that stigma about mental illness is clearly present in contemporary India (Bhatia, Khan, Mediratta, & Sharma, 1987; Malhotra, Inam, & Chopra, 1981). Because most Asian Indian immigrants entered the United States in the last 30 years, it is likely that they have retained some traditional Indian beliefs about mental illness. Thus it may be assumed that mental illness is likely to carry stigma and shame for Asian Indian immigrants in the United States.

Literature on psychological disorder and symptom levels among Asian Indians in Britain indicates that compared to Whites, Asian Indian immigrants endorse fewer items relating to psychological symptoms, as measured by self-reports (Cochrane & Stopes-Roe, 1981a). Earlier examinations of symptom levels in Asian Indians and Pakistanis revealed similar patterns of lower symptomatology (Cochrane & Stopes-Roe, 1977; Cochrane & Stopes-Roe, 1981b). These findings were contrary to the authors' hypothesis that the stresses associated with immigration and membership in a minority group would precipitate greater levels of psychological disturbance.

Such findings indicate a distinct difference between Asian Indians and Asian Americans. Research on the endorsement patterns of Asian Americans indicates that Asian Americans report higher levels of symptomatology compared to Caucasian Americans (D. Sue & S. Sue, 1987; S. Sue & D. W. Sue, 1974). The British literature suggests that Asian Indians in Britain report a lower level of symptomatology. These

findings have not been replicated in the United States, but they point to potential differences between Asian Americans and Asian Indians that may have implications for differential provision of mental health resources for these two groups.

This difference in self-reported levels of psychiatric symptoms may be related to demographic differences. Compared to Asian Americans, the Asian Indian immigrant population in the United States forms a group that is less socioeconomically diverse. An earlier wave of Sikh immigrants from India entered Canada and the United States from 1906–1947 largely as farm laborers (Ramakrishna & Weiss, 1992; Wenzel, 1968), but in general, Asian Indians are more visible in the professional and business communities (Ramakrishna & Weiss, 1992). Currently, the Asian Indians in the United States are a highly select group (Segal, 1991). Many of them have graduate degrees and most speak fluent English. Most Asian Indians immigrate for educational and professional opportunities. Thus the Asian Indian immigrants may have more resources (economic, educational, and perhaps psychological) with which to combat the stressors of immigration.

However until epidemiological studies are conducted, it is not known whether these "selection" characteristics will produce a different distribution of mental illness than is observed in Asian Americans and other immigrant groups. Researchers and clinicians must be cautious not to draw false conclusions about the mental health of this group. Asian Indians may appear to have more resources than other recent immigrant groups, but this does not render them immune to psychiatric illness.

Beliefs regarding the mind and body may also account for lower reports of psychiatric symptoms among Asian Indians. Theories of Ayurvedic medicine often underlie the experience and manifestation of psychiatric symptoms in Asian Indians. Ayurvedic medicine is rooted in a humoral theory of health, where a balance of the bodily humors indicates health. Ayurvedic theories provide a holistic approach to understanding health (Ramakrishna & Weiss, 1992; Weiss et al., 1988). The mind, body, and soul are viewed as being a system, and disruption in any of these systems causes illness. In this systemic approach, mental and physical health are conceptualized as being interrelated and not separate entities (Ramakrishna & Weiss, 1992). Many Asian Indians may not be familiar with Ayurvedic texts, and yet subscribe to a humoral theory of physical and mental illness, a factor of which Western practitioners need to be aware.

Given that Asian Indians subscribe to a holistic theory of health and the interrelatedness of mind, body, and soul, those Asian Indians presenting with mental illness are likely to manifest both psychiatric and physical symptomatology. This is supported by literature which indicates that somatization of psychiatric symptoms occurs frequently in Asian Indian patients (London, 1986; Ramakrishna & Weiss, 1992; Steiner & Bansil, 1989). Skultans (1991) noted that somatization was observed frequently in Asian Indian women. It is unclear in these studies whether somatization of symptoms occurs because it is less stigmatizing, or whether the holistic belief system leads to the manifestation of psychological problems through physical symptoms. Theories of somatization in Asian Americans indicate that physical manifestation of symptoms is acceptable among this group (Kuo, 1984; T. Y. Lin, 1982). The somatization of symptoms in Asian Indians may represent a confluence of factors including acceptability of somatic symptoms and belief in holistic theories of mental illness such as Ayurveda.

Intervention and Treatment

In some Western models of psychotherapy a primary goal is to achieve self actualization as indicated by Maslow's (1968) hierarchy. This goal would be quite foreig

to Asian Indians, because Hindu philosophies minimize the importance of the self as an individual entity and focus on the self as part of the "cosmic absolute" (Sodowsky & Carey, 1987). The Western model of self-actualization contrasts with traditional Asian Indian perspectives of the ideal person. Therapy with Asian Indians should be geared toward achieving a balance between the individualistic demands of Western culture and the interdependence of the Asian Indian family.

The framework of process and content dimensions in therapy will be helpful in examining intervention with Asian Indians. The process dimension of therapy with Asian Indians closely parallels that seen in Asian Americans in general. For example, S. Sue and Zane (1987) have suggested that the outcome of therapy is enhanced by such characteristics as credibility and giving. Such characteristics are also likely to be successful with Asian Indian clients. Thus suggestions from the literature regarding treatment of Asian Americans may provide some insight on how to treat Asian Indian individuals and families.

Regarding the content dimension of therapy, however, there are issues pertinent to Asian Indians that differentiate them from other Asian groups. For example, the issue of arranged marriage is specific to, and important for Asian Indians. This issue can be expected to arise frequently in therapy, particularly with young adults and their parents. Client–therapist match may also be considered a content issue, although regarding Asian Indians there is insufficient research in this area. Thus it is a moot point to conjecture whether Asian Indians would prefer an ethnically similar therapist, or whether they would feel uncomfortable discussing their problems with an ethnically similar therapist. The work of S. Sue, Fujino, Hu, Takeuchi, and Zane (1991) indicates that Asian–American clients have better treatment outcome when they are seen by Asian–American therapists. Further research in this area could include Asian Indians to observe the trend in this group.

American and Western European therapists working with Asian Indians must also be alert to value conflicts that may arise in the course of psychotherapy. The strong value placed on interdependence in the Asian Indian family may be misconstrued as enmeshment and pathological dependency by mental health professionals using an individualistic model. Mental health professionals could assist the client to negotiate the boundaries between the demands of the family and social expectations of the new culture that the client has internalized. Often, clients may feel "trapped" in the conflict, not knowing their own needs. Yet, in the midst of this discomfort the family is still considered to be the prime unit of identity.

Steiner and Bansil (1989) argue that to divorce the client from the family is counterproductive to therapeutic goals. They caution that "changing" one member of a family unit may not be accepted by other family members, and may lead to greater discord for the individual and the family. This formulation may be consonant with the family systems model of psychotherapy, but even within an individual psychology model, psychologists should consider using a systemic approach and consider the close family ties of the Asian Indian client.

Segal (1991) suggests that an educational model be used in the early stages of therapy with Asian Indians. This would be especially useful with clients who are less acculturated. Such a model would provide the client with information on the goals, process, and content of therapy. It may also be helpful to differentiate psychological therapy from medical treatment, and indicate that the time frame and client involvement will be of a different nature. With older clients and parents who are immigrants, the educational model could be used to disseminate information about such issues as generational differences, dating and marriage in America, and general issues pertaining to acculturation. With younger

and more acculturated clients, education could be used to ameliorate the communication gap between the generations, and to help achieve a sense of pride in the clients' multicultural background. Because third-party mediation in conflict is valued in Asian culture (Augsburger, 1992), the therapist could utilize this role to reconcile tensions.

Community Psychology and Asian Indians

The construction of parallel mental health centers or community mental health centers usually implies the existence of a geographically defined community of ethnically similar individuals. This model is helpful with certain Asian–American groups, because of the existence of such residential communities. However, Asian Indians tend not to reside in defined communities with other Asian Indians (Segal, 1991). The largest groups of Asian Indians live in Southern California, and in and around New York City. The two groups are considered to be comparable in terms of demographic characteristics. In both areas there are commercial districts which serve Asian Indians and have businesses that sell Indian spices, clothing, and jewelry. These districts rarely serve as residential areas for Asian Indians, and most of them travel to these areas to conduct their business. The geographic spread of Asian Indians in the United States limits the extent to which centralized community services would be necessary or utilized.

As mentioned above, Asian Indians are usually not as economically disadvantaged as other recent immigrant groups (Kahl, 1983). Asian Indian immigrants often enter the United States with some wealth and college or professional education. Hence, low-cost community mental health services may not be a necessary first line of service for this group. This does not eliminate the need for ethnic-specific services for this community. The existence of parallel services for other Asian–American groups may not serve the specific needs of the Asian Indian population. As noted above, many Asian Indians do not self-identify as "Asian" and may not be inclined to use services targeted specifically for Asian Americans and Pacific Islanders.

However, because of the similarities between Asian Indians and other Asian groups, information obtained on the former may shed some light on issues about the latter group. For example, in the absence of data, the rate and pattern of utilitization of mental health resources by Asian Indians relative to their numbers in the population is unknown. Several sources have indicated that Asian Americans in general underutilize mental health services (S. Sue et al. 1991; S. Sue & Morishima, 1982). If stigma about mental illness is retained among Asian Indian immigrants, then Asian Indians may also underutilize mental health services.

In general, Asians tend to prefer medical or other traditional health care (such as acupuncture or herbalists) as a first line of help for psychiatric symptoms (K. Lin, Inui, Kleinman, & Womack, 1982; T. Y. Lin, Tardiff, Donetz, & Goresky, 1978). Weiss et al. (1986), found that in India, many people used folk healers before turning to hospitals and other "medically" based treatments. However, when folks healers are scarce (as they are in America), Asian Indians who retain humoral or naturalistic explanations for mental illness are more likely to turn to medical professionals for what would be considered in the West to be mental health problems. Some Asian Indians may also turn to Hindu priests to confer about "emotional" problems such as depressed mood. It appears that Western mental health resources are rarely considered an option for Asian Indians.

Literature on utilization of mental health services by Asian Americans also indicates that Asian Americans prefer to utilize family support and traditional health care channels (such as physicians) over the use of mental health facilities (Shon & Ja, 1982; S. Sue & Morishima, 1982). For Asian Indians, the family may be conceptualized as the "com-

munity," because Asian Indians do not reside in well-defined communities. Kallarackal and Herbert (cited in London, 1986) suggest that family support may mitigate pathology such as conduct disorder among Asian Indian children in Britain.

Structural barriers such as ignorance about services, location of facilities, and scarcity of ethnically similar therapists may be formidable impediments to help seeking for Asian Americans in general (Takeuchi, Leaf, & Kuo, 1988). Because Asian Indians are a recent immigrant group, these structural barriers may be particularly salient for them. Indeed, London (1986) observes that Asian Indians delay utilizing medical and mental health services. Thus, although Asian Indians were utilizing mental health services at the same rate as Whites, they reported a longer duration of symptoms prior to entering treatment.

A primary directive of community mental health services should be to remove these structural barriers by aggressive outreach using ethnic-similar and/or trusted professionals to communicate the availability of facilities. Because of the lack of a clearly defined geographic community such outreach could be conducted in areas where Asian Indians meet, such as the Hindu and Buddhist temples, and at community events (for example, Indian dance recitals or *Arangetrams*).
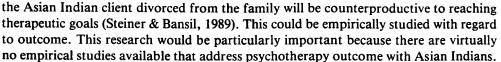
Research Recommendations

Clearly, a primary need is for more empirical research to be conducted on Asian Indians in the United States. Epidemiological studies on rates and manifestation of mental illness in these groups are necessary. Indian conceptions of mental health combined with exposure to Western concepts of mental illness may lead to patterns of presentation that are different from those seen among Asian Indians in India. Related to this is the need to examine the utilization of mental health services by Asian Indians. Professionals in the field have indicated that they are receiving increasing numbers of referrals from Asian Indians seeking psychological services. The reasons for referral ranged from alcohol-related problems to suicide (V. Ouseph, personal communication, April 13, 1993).

The acculturation of Asian Indians to American society is an important research issue, and has implications for the manifestation of mental illness and the process of psychotherapy. As noted, Asian Indians do not reside in homogeneous communities with other Asian Indians. They often maintain contact with each other by meeting at Hindu temples, Indian dance recitals, or visiting relatives (Anand, 1993). It would be interesting to examine whether this occasional contact is sufficient for Asian Indians to maintain their culture, or whether assimilation is accelerated by the lack of daily contact between them.

Were Asian Indians to be studied as a separate group in research, important information regarding differences in utilization rates and patterns may be obtained. And as increasing numbers of Asian Indians seek services, the need for research on treatment of Asian Indians becomes imperative, as many clinicians will need guidelines regarding the planning and implementation of treatment for this group.

The training of mental health practitioners and researchers is another area that should be addressed. The curricula in most departments of Clinical Psychology do not address the special needs of Asian families. Very few clinical supervisors are available who have an expertise with Asians or, in particular, Asian Indians. Such expertise is needed, because the literature indicates that the Asian Indian family is integrally different from that of Caucasian Americans (Shon & Ja, 1982). One recommendation is that clinical psychologists empirically examine the clinical implications of findings obtained in related fields such as social and cross-cultural psychology. For example, it was noted that treating

the Asian Indian client divorced from the family will be counterproductive to reaching therapeutic goals (Steiner & Bansil, 1989). This could be empirically studied with regard to outcome. This research would be particularly important because there are virtually no empirical studies available that address psychotherapy outcome with Asian Indians.

Preliminary findings (Akutsu, 1993) have indicated the increased attendance rate of Asian Americans at parallel mental health centers when compared to mainstream centers. Parallel centers are mental health centers accessible to the community, which provide ethnically responsive mental health services. These centers are often staffed by bilingual therapists who are of the same ethnicity as the clients. Currently there appear to be no parallel mental health centers for Asian Indian immigrants. Feasibility studies should be conducted to determine the need for these centers, and the type of community mental health centers that would be most useful for Asian Indians. For example, because Asian Indians do not live in defined geographic communities, referral sources for mental health services could be placed in settings where Asian Indians meet.

Asian Indian mental health theory represents an interface of medicine, psychology, and traditional theories of healing such as Ayurvedic medicine. This may necessitate a multidisciplinary approach to conceptualization and treatment of mental health problems in Asian Indians. It is not likely that Asian Indians will seek psychological help as a primary method of alleviating emotional distress. Rather, they may utilize other pathways such as family, medical help, or the help of religious advisors. Counselors could make themselves aware of alternatives used by Asian Indians, and introduce themselves as a referral for further treatment. Mental health practitioners seeking to reach Asian Indian clients should be aware that they may be one of the last sources of aid that Asian Indians consider.

Asian Indians have thus far been excluded from most mental health research in the United States. The growing body of research on other Asian groups may help elucidate some potential concerns of this group. Asian Indians also have unique institutions such as arranged marriages as well as other religious and demographic differences, which warrant separate research and exploration. Such research is particularly important as the number of Asian Indians continues to grow in the United States, and the need for community mental health services may increase. The authors hope that the issues raised here stimulate further ideas for research and provide some new avenues for practitioners to consider when dealing with this immigrant group.

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