

Mental Health Issues for Asian Americans

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One of fastest-growing population groups in recent decades, Asian Americans represent a vastly diversified and rich mixture of cultures, languages, beliefs, and practices, many of which differ widely from those of European Americans. As immigrants, Asian Americans have experienced and continue to experience various emotional and behavioral problems. However, they tend to underuse existing services except those that are culturally appropriate and linguistically compatible. Misdiagnosis frequently occurs, and the existence of culture-bound syndromes points to a lack of precise correspondence between indigenous labels and established diagnostic categories. Due to Asian traditions of viewing the body and mind as unitary rather than dualistic, patients tend to focus more on physical discomforts than emotional symptoms, leading to an overrepresentation of somatic complaints. Traditional practices and healing methods are frequently used to alleviate distress both before and after patients and their family members approach the conventional mental health care system. Help seeking typically is a family venture. Asian patients respond well to highly structured therapeutic interventions such as those used in behavioral, cognitive, and interpersonal models. When applying pharmacotherapy, clinicians should pay attention to Asians' unique responses to psychotropics, especially in regard to dosage requirements and side effects. Research in this area as well as on other important issues is in the early stage of development. (*Psychiatric Services* 50:774-780, 1999)

The growth of the Asian-American population in recent years has been phenomenal. Since 1960 it has increased by more than 100 percent every decade and has expanded from less than 1 million to more than 8.5 million in three decades, representing 3.3 percent of the total U.S. population (1). In all likelihood, this trend will continue into the next century. Thus clinicians can ill afford to remain unfamiliar with issues that are of particular importance in providing care to this population.

Furthermore, as the technology of communication continues to advance,

various aspects of mental health practices will likely become increasingly global and cross-cultural. As Asians represent more than 50 percent of the earth's population, their perspectives on mental health care warrant more careful attention (2). Understanding the mental health issues that confront Asian Americans takes on a special significance, because they tend to retain the cultural traits from their ancestral land. Furthermore, many of the issues facing Asian Americans may also be relevant for Asians outside of North America.

Like terms used for other major

population groups, such as Hispanic, Native American, African American, and Caucasian, the terms Asian and Asian American may convey a false sense of homogeneity. In reality, when examined closely, each of these commonly used labels refers to a group that encompasses tremendous heterogeneity. Asian Americans, for example, represent more than 28 Asian groups (3), each with its distinct culture, language, religious traditions, dietary practices, and immigration history. Furthermore, each cultural group—such as Chinese, Japanese or Khmer—includes wide variations in educational levels, family income, residential preference, exposure to war trauma, and levels of acculturation. Such intragroup diversity calls into question the validity and utility of any attempt at generalization and points to the danger of stereotyping.

However, at the same time, most of these cultural traditions, though distinct, have been in constant interaction and exchange for several millennia and reflect repeated large-scale migrations and intermixture of populations (4). Major traditions and belief systems, such as Buddhism and Confucianism, permeated a large part of the Asian continent and continue to exert profound influences on the general populace (5,6). They helped shape world views and value systems that often are different from and at times clearly at odds with those found in European-American traditions.

Partly because of such influences, Asians and "Westerners" diverge significantly in conceptualizations of the self, the relationship between the self and social groups, and the relationship between the body and the mind (7-9). Such differences are likely to have profound and pervasive influences on the

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recognition and reporting of psychiatric symptoms, the process of help seeking, the use of mental health care systems, and the response to various contemporary mental health treatment modalities. In addition, emerging data indicate that, for both genetic and environmental reasons, Asians who are treated with psychotropic medications may differ from Caucasians in their dosage requirements and side effect profiles (10).

This paper reviews mental health issues for Asian Americans in the areas of utilization of mental health services, psychiatric diagnosis, cultural patterns of illness presentation, the role of indigenous treatments, the role of the family in treatment, and use of psychosocial and pharmacotherapeutic interventions.

Utilization of mental health services

Extremely low admission rates to state hospitals have been consistently documented for Asians in the past (11). In recent years, these findings have been augmented by equally substantive reports of their low utilization of outpatient mental health services (12-14).

Earlier researchers suggested that the low utilization rates might reflect low rates of psychopathology among Asians. This line of reasoning considered Asians a "model minority group," who, despite discrimination and the adversities generally associated with being immigrants, remained resilient and immune from emotional breakdown and behavioral problems. However, when Asian patients were more closely examined, their conditions were significantly more severe and chronic than those of patients of other cultural backgrounds and consequently required more intensive treatment and longer hospitalization or outpatient care.

Taken together, these data suggested that Asians rarely utilized services because they often did not reach the service systems until very late in their help-seeking process (15), when their condition was extremely severe and all other resources had been exhausted (16). This hypothesis was indeed supported in other well-designed studies (17). The data showed that Asian patients with schizophrenia typically

Editor's Note: This paper is the second in an occasional series on the mental health needs of nonwhite populations in the United States. The aim of the series is to improve awareness of the variety of psychiatric needs in the increasingly diverse population of the U.S. The first paper in the series—on African Americans—was published in March. Future papers will address the psychiatric needs of Native Americans and Latinos. Carl C. Bell, M.D., chief executive officer of the Community Mental Health Council, Inc., in Chicago, is the editor of the series.

were contained within the family and the community and generally did not reach the mental health system until three years after the initial onset of their psychotic symptoms. This delay was significantly longer than for their counterparts in Caucasian and African-American groups, who entered the mental health system an average of one and one and a half years, respectively, after onset of symptoms.

Based on these findings, specialized mental health programs for Asian Americans have been successfully established in many parts of the country (18,19), including Boston, Los Angeles, New York, Portland, San Francisco, and Seattle. Staffed with bilingual and bicultural professionals and paraprofessionals who together cover a wide range of Asian languages and cultures, these clinics strive to provide culturally appropriate services in locations close to major Asian communities. They have been strikingly successful, at least in terms of increasing utilization and shortening the delay between onset of symptoms and contact with the mental health system.

Almost invariably, these clinics were started amid intense political struggles, with funding agencies frequently expressing doubts about their ability to survive, because of the pervasive belief

that the need and demand for them did not exist. However, once situated in the community, they were filled to capacity within a short time. Many of these clinics expanded into full-fledged community mental health centers within a relatively short period.

Although these specialized programs have made a visible impact on the mental health care of Asian Americans, service barriers to the overall mental health system and low utilization of services continue to be major issues, both in the public and the private sectors (20,21).

Psychiatric diagnosis

Besides the availability and accessibility of services, another major issue that deserves closer scrutiny is the degree of fit between current psychiatric diagnostic systems and assessment practices on the one hand and Asian-American subcultures on the other. Current psychiatric theories about etiology and nosology largely derived from generations of clinicians' work with European and North American patients (22-24). Most research testing the coherence and relevance of these theories has also been conducted with Caucasian subjects. Consequently, it is unclear to what extent such a nosologic system might be useful for patients with other cultural and ethnic backgrounds.

What is clear, however, is that misdiagnosis often occurs in cross-cultural situations (25-27) and that assessment tools developed in one cultural setting may be found invalid when translated (28). We recently examined the relationship between ethnicity and psychiatric diagnosis among patients treated in a major urban mental health system and found that atypical diagnoses were significantly overrepresented in all ethnic minority groups, including Asian Americans. (Yeh M, Chung R, Lin K, unpublished data, 1997). These results further support the hypothesis that there is greater ambiguity and difficulty when applying the DSM diagnostic system with non-Caucasian patients.

Cultural patterns of illness

Somatization

One of the ongoing debates about the relationship between culture and psychopathology has to do with the long-

reported tendency of Asians to present primarily with somatic symptoms when in distress (29,30). The tendency of Asian psychiatric patients to focus on physical discomfort while ignoring or suppressing the reporting of emotional symptoms has been a challenge for clinicians who work with this population.

Various theories have been proposed for such a phenomenon, including speculations about Asians' relative lack of psychological mindedness and a putative deficiency of psychological descriptive terms in Asian languages. Both have since been refuted as unfounded. A newer generation of researchers, represented by Kleinman (31) and his colleagues, showed that for the majority of the Asian patients, somatic symptoms are used as culturally sanctioned "idioms of distress," whose mechanism may thus be quite distinct from the process of somatization as commonly understood.

A series of studies conducted by Cheung (32,33) in Hong Kong further supported this explanation. She found that although patients typically focused on their somatic complaints when visiting a physician, they were often fully aware of their emotional problems as well as stresses derived from social relationships that might be related to their emotional as well as somatic symptoms. Based on these findings, she suggested that most patients selectively presented their symptoms according to what they perceived as appropriate and tended to focus only on somatic suffering while in health care settings.

Similarly, in a longitudinal follow-up study of Vietnamese refugees (34), most of those who were interviewed initially reported only physical symptoms (35). However, their response to the Cornell Medical Index showed extremely high mean psychological as well as somatic scores, indicating that when they were asked specifically, they did not have difficulty reporting psychological symptoms (36). Other studies using a variety of self-report instruments have also supported the thesis that Asians have no difficulties in identifying and reporting psychological symptoms (27,32).

One fundamental issue that might be at the crux of the matter is the rela-

tionship between the body and the mind. The Western view that emphasizes the separateness of the two has roots in the Greek philosophies and has been firmly established since the time of Descartes. This dichotomous model not only has provided the foundation of modern medicine, but also has exerted profound influences on practically every aspect of modern Western life, including how distress is expressed (37-39).

In diametric opposition to this perspective, Asian traditions have always regarded body and mind as one (40). Despite Western influences, most contemporary Asians continue to adhere to such a unitary model, which consciously or unconsciously permeates all aspects of their lives, including language and help-seeking preferences. Therefore, Asians, who are less inclined to dichotomize body and mind, tend to report distress accordingly. This tendency, added to a natural tendency to be reticent about emotions that may be linked to a person's private life, may result in the exclusive reporting of somatic symptoms.

Although the meaning and nature of somatization among Asians are awaiting further clarification, what is clear is that a somatic presentation of symptoms often predominates during an Asian patient's first mental health contact (37). It is also clear that for the majority of these patients, psychological and behavioral symptoms will emerge if the clinician inquires specifically about these symptoms. In view of the belief in the unity of body and mind, it may also be crucial for clinicians not to focus predominantly on the psychological side of the patient's suffering, but to present a formulation compatible with the patient's cultural orientations.

Culture-bound syndromes

The discrepancy between Chinese and American psychiatrists in the use of "neurasthenia" ("shenjing shuairuo" in Mandarin Chinese) as a diagnostic term has been the subject of a major international debate for the last two decades. Neurasthenia was popular as a disease concept in North America and Europe during the late 19th and early 20th century, but it gradually lost its currency and is now an obsolete

concept among contemporary Western physicians. Paradoxically, after the concept was transplanted to China and other parts of Asia around the turn of the century, it quickly took root and flourished (41,42).

The ambiguity of its meaning in the past apparently has encouraged its inappropriate use, to the extent that some surveys showed up to a 10 percent prevalence rate in the general population in China (43). In addition, there is documented evidence in Japan and China that physicians collude with patients with schizophrenia and their families in using the term neurasthenia to minimize stigma (44).

Such reports led to serious doubts about the validity of the concept of neurasthenia as used in China. In 1982 Kleinman (45) reported that 87 percent of patients diagnosed by Chinese psychiatrists as having neurasthenia could be reclassified as having major depression according to *DSM-III* criteria. These findings triggered extensive debates and eventually led to operationalization of a more narrowly defined diagnosis of neurasthenia by Chinese psychiatrists.

Using such operationalized criteria sets as well as one subsequently developed by the World Health Organization's *International Classification of Diseases, Version 10 (ICD-10)* (46), recent studies demonstrated that the illnesses of a substantial number of patients, both in clinics and in community settings, fit best with a diagnosis of neurasthenia rather than with any of the *DSM* categories. For example, an epidemiological study of Chinese Americans in Los Angeles found that 6.7 percent of respondents experienced *ICD-10* neurasthenia, and less than 50 percent of them had a *DSM-III-R* diagnosis (47). Our clinical study involving 486 subjects from Los Angeles, China, Hong Kong, and Taiwan showed similar results (Lin KM, Weiss M, Zheng, UP, unpublished data, 1995).

Korean and Korean American patients suffering from similar mixtures of a wide variety of somatic and emotional symptoms often label themselves as suffering from "hwa-byung," which literally means both "fire disease" and "anger disease" (48). As these terms suggest, patients believe that their problems are caused by

chronic unresolved anger that led to the imbalance of the body by the excessive accumulation of the fire element, as conceptualized in Oriental medicine theories. A community survey in Los Angeles showed that 12 percent of Korean Americans residing in the city labeled themselves as suffering from hwa-byung and that these subjects had a significantly elevated risk for also suffering from *DSM-III-R* major depression (49). The findings were comparable to those of studies conducted in Korea, using similar research strategies (50).

Hwa-byung is another example of how Asians conceptualize the body-mind relationship. Although the concept denotes the existence of chronic social stress as well as emotional responses, most patients with hwa-byung believe that their problems are primarily physical. Some are even convinced that the anger and the chronic imbalance have resulted in the accumulation of harmful substances in the epigastric area in the form of a mass that could kill them if untreated.

Due to a lack of precise correspondence between these indigenous labels and *DSM* diagnostic categories, both hwa-byung and shengjing shuairuo (neurasthenia) were placed in appendix I of *DSM-IV* (51). "Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes," as examples of culture-bound syndromes. Although controversy about the wisdom of this decision and the meaning of culture-bound syndrome continues, such inclusions do highlight the importance of cultural factors in shaping symptom manifestation and clustering. Many of the so-called culture-bound syndromes appear to apply to cases with features of both mood disorders and somatoform disorders, suggesting that for non-Western populations the boundary for these two domains may not be as distinct as *DSM* proposes (52). Research on these syndromes may inform future development in psychiatric nosology.

Indigenous or alternative treatment

As shown in recent studies, alternative or unconventional treatments are widely available and are frequently

used by patients with all kinds of afflictions, including those with primarily psychiatric problems (53,54). Nationwide, the annual out-of-pocket expenditure on alternative care, including meditation, herbal medicine, and spiritual healing, has been estimated to surpass the total outpatient medical cost (55).

The literature strongly suggests that such treatment and healing methods may be even more widely used by patients with ethnic minority backgrounds (56). In practically all contemporary Asian societies, multiple indigenous care and healing traditions continue to exist and thrive side by side with the conventional Western health care system. Traditional practitioners, who include not only Oriental medicine doctors and acupuncturists but also various kinds of herbalists, bone setters, psychic healers, and spiritual mediums, also are widely available in Asian-American communities (57).

Asian-American psychiatric patients often consult these practitioners before contacting the mental health system and continue to utilize their services even after entering psychiatric care. Because patients understandably do not volunteer the information that they are using alternative treatments, mental health clinicians generally are unaware of the extent of these contacts, their effects on patients' conditions, and their possible contributions to premature termination of therapy. Also remaining largely unclarified is the extent to which these traditional practices might interact with modern mental health care. Emerging data now strongly suggest that some of the commonly used herbs might interact with psychotropic medications through pharmacokinetic or pharmacodynamic mechanisms (58).

Aside from whether and to what extent any of these traditional practices and healing methods might be efficacious in ameliorating psychiatric symptoms or what their potential for toxic effect might be, it is essential that clinicians working with Asian Americans be familiar with the alternative practices that are widely available and frequently used by them, as well as the health beliefs behind these practices.

Such understanding and efforts at accommodation would enhance trust and therapeutic alliance and thereby provide clinicians with the opportunity to intervene when necessary (58).

The role of the family

Reflecting the deeply ingrained individualistic orientation in Western cultures, contemporary American mental health practice focuses its attention primarily on the patient as an individual and to a large extent neglects the fact that a person is always a member of a social group. The involvement of family members with the patients and their treatment is often regarded by mental health professionals as intrusive and pathological (59). Concerns about confidentiality often further limit clinicians' contacts with the family. Despite the emergence in recent years of research findings showing the importance of involving family members in the care of psychiatric patients and despite the concerted efforts of family groups such as the Alliance for the Mentally Ill in promoting collaboration between family members and professionals, this individualistic emphasis remains strong.

The exclusion of the family poses an even larger problem for Asian patients. In contrast to the Western emphasis on the individual, Asian traditions in general regard the family as the basic unit of the society. A family member's illness is considered a threat to the homeostasis of the family, which often leads to the mobilization of the family's resources. Help seeking typically is a joint family venture rather than a personal decision.

An Asian patient's first mental health visit often is initiated by a family member and not infrequently is preceded by phone calls from one or more family members. In a cross-cultural study comparing treatment responses of Asian and Caucasian patients with schizophrenia, the majority of the Asian patients were accompanied by one or more family members (60). Unless specifically instructed, family members typically assume that it is their responsibility to be with the patient when the patient talks to the clinician. Clinicians unfamiliar with the cultural underpinning of such behavior might regard it as a

manifestation of the patient's pathological dependency or the family's overinvolvement. Attempts at confronting such "inappropriate" behavior may lead to confusion and a sense of humiliation and may result in premature termination.

Psychosocial interventions and psychotherapy

Contrary to earlier impressions, Asian patients are often receptive of and are likely to benefit from psychotherapeutic interventions (61-63). Important ingredients of successful therapy, such as the instillation of hope, the fostering of trust, the identification or construction of "explanatory models" that make sense to the patient, and the mobilization of forces toward recovery (64), likely apply to patients irrespective of cultural backgrounds.

However, because the format and the context of therapeutic and healing systems are drastically different from culture to culture, it is important that an orientation phase, during which the purpose and ground rules of therapy are specifically discussed, be offered before the inception of psychotherapy. The therapist should make a conscientious effort to identify with roles familiar to the patient, such as a medical professional or a teacher. Teachers in traditional Asian societies not only are regarded as instructors of technical knowledge but also are idealized as moral exemplars and counselors. Strict neutrality, as promoted by orthodox psychoanalysis, may be perceived as an indication of the therapist's indifference or rejection (65). To demonstrate efficacy and gain credibility, therapists may have to take a more active therapeutic stance, such as by providing structure, giving advice, and acting as advocate when necessary and appropriate (66).

Although empirical data about the relative efficacy and utility of various forms of psychotherapy with Asian patients are limited, there are reasons to believe that the newer, highly structured therapeutic models, such as behavioral, cognitive, and interpersonal therapies, may work particularly well. Rationales behind behavioral interventions, such as progressive relaxation, systematic desensitization, and behavioral modification, are specific

and relatively easy to grasp. Their results are demonstrable and measurable. Principles behind cognitive therapy often have echoes in traditional Asian beliefs. The emphasis of interpersonal therapy on roles and social relations also resonates well with Asian traditions. However, the effectiveness and utility of these specific methods with Asian American patients should be systematically tested.

Recent studies have shown the importance of psychosocial rehabilitation in the care of patients with chronic mental illness (67). However, how these models would fit well in Asian-American cultural settings remains to be determined. Researchers need to involve Asian patients in their studies in this area.

Pharmacotherapy

Although many mental health practitioners were unaware of the findings until recently, a large number of reports—starting in the late 1950s, when psychotropics were first introduced—strongly suggest that Asian Americans may have a unique response pattern to these potent medications, especially in dosage requirement and side effect profiles (10). Data that have emerged in the last two decades have identified pharmacogenetic, pharmacokinetic, and pharmacodynamic mechanisms that are responsible for the differences in clinical responses that were reported earlier (68).

The literature indicates that for various reasons, Asian patients often respond to substantially lower doses of psychotropics than those recommended in standard textbooks and publications based on studies typically involving Caucasian subjects. Among the factors that might be responsible for this phenomenon, the most extensively studied are related to pharmacogenetics, especially findings on the structure and function of a group of drug-metabolizing enzymes called cytochrome P-450 isozymes. They play a crucial role in the metabolism of most psychotropic medications as well as other medications.

The activity of a number of these isozymes has been demonstrated to be significantly slower among Asians, including Chinese, Japanese, and Ko-

reans, than among Caucasians. Some of these effects appear to be caused by specific mutations, such as the activity of CYP2D6 and CYP2C19, while the others appear to be due to environmental influences such as diet, notably the activity of CYP3A4 and CYP1A2. For example, approximately one-third of Asians are homozygote for a mutation called CYP2D6j (recently renamed CYP2D6*10) that significantly slows down the activity of the enzyme CYP2D6, which plays a crucial role in the metabolism of most traditional neuroleptics and tricyclic antidepressants (69). Asians also possess a specific mutation of CYP2C19 (m3) that is rarely seen in other ethnic groups. This mutation makes 20 percent of Asians poor metabolizers of drugs such as diazepam, compared with 3 percent of Caucasians.

Research data also suggest that the activity of other P-450 isozymes is slower in Asians even though no active mutations have been observed. Since these enzymes are highly responsive to environmental influences, cross-cultural differences in lifestyles, including dietary practices, are most likely responsible for such lower enzyme activity. For example, CYP1A2 is inducible by char-broiled beef, cruciferous vegetables, and a high-protein diet, and CYP3A4 is inhibited by certain citrus fruits such as grapefruit and plant products such as corn. Because these enzymes are involved in the metabolism of some of the newer neuroleptics and antidepressants, it is reasonable to expect that Asians and Asian Americans would also be more sensitive to these medications as well.

Besides ethnic differences in drug metabolism, evidence also suggests that ethnic differences in pharmacodynamics—the pharmacological effects on the target organs—also exist. In psychiatry the most prominent example is the difference between Asians and Caucasians in the range of serum lithium concentrations regarded as therapeutic (68). In various parts of Asia, including Japan, China, Hong Kong, and Taiwan, optimal treatment with lithium was achieved with serum lithium concentrations below 8 mEq/mL, in contrast to the range of 8 to 1.2 mEq/mL generally regarded as therapeutic in Western countries.

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