

Health Issues of
Asian Pacific American Adolescents

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Asian Pacific American (APA) groups are the fastest-growing ethnic-minority populations in the United States, but little is known about the health status and service needs of the youth (i.e., those ages 10 to 18). This chapter examines the health status and needs of different APA groups; cultural influences on risk and protective factors for health; cultural factors that affect utilization and effectiveness of health and related services; and program and policy changes that may better meet the needs of APA youth and their families.

Population Characteristics of APAs

In 1980, APA population exceeded 3.7 million, easily doubling the 1.5 million figure in 1970 (U.S. Bureau of the Census, 1989). Similarly, from 1980 to 1990 the population almost doubled to 7.3 million, counting for 2.9% of the U.S. population (*Asian Week*, 1991). These increases can be attributed largely to immigration and, secondarily, to births. More than 50 APA groups have been identified by the U.S. Bureau of the Census, with the largest groups being Chinese, Filipino, and Japanese. Table 5.1 shows the 1990 distributions of the largest APA groups.

The diverse nature of APAs is also revealed by the proportion of the population born in other countries. The vast majority of Vietnamese, Koreans, Asian Indians, Filipinos, and Chinese in the United States were born overseas. However, Samoans, Japanese, Guamanians, and Hawaiians were largely born in the United States (U.S. Bureau of the Census, 1989). About 70% of APAs live in just five states—namely, California, Hawaii, New York, Illinois, and Texas.

Asian Pacific Americans tend to be young, although their age range

Table 5.1 Distribution of Asians in the United States, 1990

Group	Number	Percentage
Chinese	1,645,472	22.6
Filipino	1,406,770	19.3
Japanese	847,562	11.7
Asian Indian	815,447	11.2
Korean	798,849	11.0
Vietnamese	614,547	8.4
Hawaiian	211,014	2.9
Lao	149,014	2.0
Cambodian	147,411	2.0
Thai	91,275	1.3
Hmong	90,082	1.2
Samoan	62,964	0.9
Guamanian	49,345	0.7
Tongan	17,606	0.2
Total APA population	7,273,662	95.4

Source: U.S. Census, 1990.

varies among the different groups. A slightly higher proportion of APAs, 30.2%, are under the age of 18, compared with 28.2% for the entire nation. The percentage of APAs under age 18 living with their parents exceeds that of the national average, 85% to 77%, respectively.

The bimodal demographic characteristics revealed by the U.S. Bureau of the Census (1989) are important to note. Substantial differences exist on characteristics, such as percentage of high school graduates ages 25 years and older (75% to 66%) and college graduates (33% to 16%), but a greater percentage of APAs (5.3% to 2.4%) have fewer than six years of schooling. Median family income is \$22,700 (compared with \$19,900), although poverty levels were similar (13% to 12%). The dropout rates for Filipinos are substantially higher than those for other Asian groups and White Americans. Thus, the extent of specific health risk factors such as dropout rate may also be quite different depending on the Asian group studied.

Several implications can be drawn from these statistics. First, APAs differ from the general population in many demographic characteristics. Findings concerning health needs and services based on the general U.S. population may not be generally applicable to this population. Second, APAs constitute an extremely diverse population. For example, some groups, such as Japanese Americans, are likely to be highly acculturated relative to recent arrivals to the United States, such as the Vietnamese, over 90%

of whom were foreign born. Third, most groups exhibit a great deal of within-group variability. For example, the majority of Chinese are foreign born, but a substantial proportion of them (37%) are American born. Moreover, foreign-born Chinese come from different parts of the world (e.g., mainland China, Taiwan, Hong Kong) and speak different dialects of Chinese.

Any discussion of the cultural tendencies among APAs must consider important individual differences that exist within this population (e.g., acculturation level, education level). Cultural factors should be interpreted as a set of contextual variables for understanding the health behaviors and practices of APAs, rather than as stereotypic statements about how APAs live and function.

Scope of Analysis

Previous investigators have pointed to several problems in examining the health issues of the APA population (Kitano & Daniels, 1988; Leong, 1986; Sue & Morishima, 1982). First, relatively few empirical investigations in this area have been devoted to APAs. For example, in an analysis of grants and contracts funded by the National Institute of Drug Abuse, the Alcohol, Drug Abuse, and Mental Health Administration found that not a single award had been made to study substance abuse among APAs over a ten-year period (Alcohol, Drug, and Mental Health Administration, 1984). An examination of annual reports on health and vital statistics published by the U.S. Department of Health and Human Services and the National Center for Health Statistics reveals little information on APAs, except in a few special reports. If ethnic or racial statistics are presented, they typically include White, Black, and "other" Americans. Second, many of the studies that have been conducted lack adequate sample sizes or focus on unrepresentative samples. Third, most investigations have included different groups within the rubric of "Asian Pacific Americans" so that differences among the groups are masked, or researchers may study one particular group and be unable to draw conclusions concerning other APA groups. Fourth, the great growth rate of the APA population is largely the result of immigration. Few studies have been conducted to determine the needs of newly arrived groups such as the Southeast Asian refugees. Even fewer investigations have been conducted on APA adolescents. One must rely on inferences drawn from the available evidence, which may be quite indirect because the data constitute primarily adult samples.

Health Status and Health Needs

Little in the way of empirical research can be found on the incidence and prevalence of the health problems of various APA groups; data on adolescents are virtually nonexistent. The extent of morbidity and mortality for adolescents can only be inferred from data on adults. Available statistics on mortality rates for 1980 reveal some interesting findings (see Yu, 1987). The age-adjusted mortality rates per 1,000 population in the United States is 3.5 for Chinese, 2.9 for Japanese, 5.6 for Whites, 5.8 for American Indians and Alaska Natives, and 8.3 for Blacks. Thus, two APA groups show relatively low mortality rates. Death rates are high for ages 0-5 years and drop to a minimum for ages 5-14; after age 14, the rates increase with age for the entire population. In every age group, the largest APA groups have lower rates than those for Whites.

Yu (1987) also examined the leading causes of death. Heart disease, cancer, cerebrovascular disease, and accidents were the first four leading causes for Chinese, Japanese, Filipinos, and Whites. The fifth cause of death was pneumonia and influenza (Chinese, Japanese, and Filipinos) and chronic obstructive pulmonary disease (Whites). While previous studies of the general population reveal that social class and mortality are negatively related, no analysis of this relation has been performed for APAs. Yu did find that the mortality rate for foreign-born APAs was much higher than for native-born APAs in all age ranges. It is not clear why nativity is related to mortality, although factors such as the premigration health of immigrants or differences between foreign- and native-born APAs in socioeconomic levels, stressful life experiences, adjustment, available resources, cultural practices, and diets are likely to be involved.

For the past three decades, APAs have suffered from a pervasive stereotype concerning their extraordinary physical and mental health and social adjustment. Statistics on low divorce, crime, and juvenile delinquency rates coupled with high educational attainments and family incomes have obscured the within-group differences among Asians and their health problems. Some of the statistics are clearly misleading (Sue & Morishima, 1982). For example, many medical practitioners are often unaware of the health-risk status of Southeast Asian refugees. Compared with the general population, refugees are at higher risk for developing tuberculosis (14-70 times) and have a greater proportion of chronic carriers of hepatitis B, a major risk factor for primary hepatoma and cirrhosis (Lin-Fu, 1988; Ng,

1989). This population also has a higher prevalence of certain disorders seldom seen in the United States, including alpha and beta thalassemia, hemoglobin E disorders, nocturnal sudden death syndrome, cholera, malaria, and leprosy (Hoang & Erickson, 1985). Refugee infants and children are known to have a high incidence and prevalence of baby-bottle tooth decay and dental caries.

Mental-health problems of APAs have also been underestimated, as APAs tend to underutilize Western mental-health services. Once in treatment, they show high levels of disturbance and terminate therapy prematurely (Brown et al., 1973; Kitano, 1969; Los Angeles County Department of Mental Health, 1984; Shu, 1976; Sue & McKinney, 1975; Sue & Sue, 1971, 1974). The few available surveys reveal that APAs have high mental-health needs (Gong-Guy, 1987; Kim, 1978; Peralta & Horikawa, 1978; Prizzia & Villanueva-King, 1977). Moreover, studies of college students have also suggested that many experience major adjustment problems (Leong, 1986; Sata, 1983). Certain groups such as Southeast Asian refugees and immigrants have extremely high levels of depression and other disorders (Liu & Cheung, 1985; Owan, 1985).

Health Needs of Specific Asian Groups

One major study (Zane et al., 1987) on the health needs of various APA groups was conducted in Los Angeles. The investigation used key informant interviews and community forums with leaders and service agency personnel from the Cambodian, Chinese, Japanese, Korean, Lao, Filipino, Thai, Tongan, and Vietnamese communities. This research provided some insights into important Asian group similarities and differences with respect to their health-care needs and service-delivery issues. For instance, there was a great need for mental-health services among the Southeast Asian populations. A recent study on the Southeast Asians in California found that Cambodians, Lao, and Vietnamese were $3\frac{1}{2}$, $3\frac{1}{2}$, and 2 times, respectively, more likely than the general population to need inpatient or outpatient mental-health care (Gong-Guy, 1987). Many Southeast Asians had suffered great physical and psychological trauma experienced during their migration that placed them at greater risk for developing physical and mental-health problems. A significant number of Vietnamese (16.5%) and Lao (13.4%) had suffered the death of a close family member,

whereas close to two thirds of the Cambodians had experienced this type of loss. However, there were important differences among the Southeast Asian groups with respect to other human-service needs. Cambodians were concerned about overcrowded and poor sanitary living conditions that fostered illness and disease, whereas the Vietnamese placed great priority on the need for low-cost health-care clinics and health education programs.

Most Asian groups considered low-cost health services staffed by bilingual, bicultural care providers to be a high priority health need, but these services were emphasized by the Chinese, Koreans, Thai, Tongans, and Vietnamese. Concerning specific services for youth, the Japanese, Filipino, Korean, and Thai communities tended to emphasize the need for substance-abuse interventions and family-focused mental-health programs addressing intergenerational and identity issues. Even within this domain, important intergroup differences were found. For example, the Korean community members indicated that family counseling services would be especially beneficial for one youth subgroup, adopted Korean children. It is no surprise that the Zane et al. (1987) findings indicate that, while there may be some overlap in the health needs among different Asian American groups, there also exists important inter-Asian differences that must be considered in delivering appropriate health care to these communities.

Risk Factors

DIETARY HABITS

Particularly for immigrants and refugees, dietary habits are significantly affected by social and economic factors. For example, Fishman, Evans, and Jenks (1988) noted that the average immigrant household typically lacks the presence of extended family members. Thus, dietary decisions are often made by young Asian parents with relatively little knowledge of nutritional value and no elder guidance to maintain traditional diets. Mainstream nutritional educational campaigns have minimal effect because most of these prevention efforts are conducted in English by nonbilingual health educators using nontraditional foods as models.

Studies of the dietary patterns among APA groups have found diets that are very high in sodium (Caplan, Whitmore, & Dui, 1984; Chew, 1983). Popular foods include bean sauces, dried shrimp and salted fish, pickled

vegetables, and monosodium glutamate (Chew, 1983). Sodium restriction, of obvious importance in moderating hypertension risk, may be difficult to accomplish within the framework of traditional Asian food practices (Asian/Pacific Task Force on High Blood Pressure Education and Control, 1984; Chew, 1983).

Dairy products are also used to a much lesser extent among Asian and Pacific Islander groups than among the general U.S. population (Suttor & Crowley, 1984). Asian families often live in communities where the traditional sources of dietary calcium in Asian diets (tofu, green leafy vegetables, fish) are not available or are supplanted by conveniently or economically available foods that are low in calcium, which compounds the problem (Kim, Kohrs, & Twork, 1984). Given the need for dietary calcium in the formative years, this pattern points to high risk for immigrant and refugee youth. Nutrition information on the content of foods commonly used in the United States is important because immigrant adolescents are typically the most likely to adopt a Western diet.

Some data suggest a greater prevalence of linear growth stunting among APA children in comparison with either national standards or to the prevalence of growth stunting among White children (Centers for Disease Control, 1983). These comparisons were made from a population of low-income children who had received publicly funded services. For APA children less than 2 years old, the prevalence of low height for age was 17%–20% in 1979–1981, compared with the expected 5% prevalence of growth stunting for the national sample and the 9% prevalence among White children for the five-year period 1977–1981. For APA children 2–5 years old, even greater differences in growth stunting rates were found—33%–37% during 1978–1981 compared with the expected 5% normative prevalence and 9% prevalence for White children. No discernible patterns of risk were evident, however, based on the hemoglobin or hematocrit data. On the other hand, one study that controlled for the height and weight of the parents noted no stunting in the Asian children (Yip, Stanlon, & Trowbridge, 1992).

Griego (1989) found that Asian and Latino children have health problems similar to those previously found among White and Black children. Many were overweight and had low cardiovascular endurance and high cholesterol levels. In this Los Angeles sample, 38% of the Asian and Latino children had above-normal cholesterol levels for children, and 13% had

cholesterol levels above normal for adults. By current health standards, 40% of the boys and 45% of the girls were moderately to severely obese. Investigators predicted that these poor health trends will continue until better health education and physical education programs are developed for children and parents.

SMOKING

Most studies have found that the smoking prevalence for APA males is similar to or greater than the rate of the general male population, but APA females tend to have lower rates than those found in the general female population. For example, a National Health Interview Survey of the Vietnamese population in California found that 35% of the males and 1% of the females were current smokers, compared with the general U.S. population rates of 22% and 19%, respectively (Centers for Disease Control, 1992). No prevalence studies have examined smoking among APA youth. However, for the most part, smoking patterns follow patterns observed in the Asian country of origin (Frerichs, Chapman, & Maes, 1984), and studies in East Asia have consistently found that Asian men begin smoking at an early age.

One study examined smoking among Chinese adolescents in Beijing and found that, by the early age of 10–11, 8.2% of the boys were smoking (Ye & Lin, 1982). This rate increased to 34% by the ages of 18–19. Given this trend, smoking may become an increasing health problem for recent immigrant youth. For example, Yee and Thu (1987) found that 45% of the Vietnamese in their sample reported trouble with drinking alcohol and/or smoking tobacco, although other drugs were not seen as problematic. Moreover, a significant number of those respondents viewed alcohol and smoking as acceptable ways to cope with stressful situations and to alleviate problems associated with stress.

STRESS

The unique needs of recently arrived Asians, who have been uprooted from their home culture and perhaps endured life in refugee camps with little or no preparation for the lifestyle facing them, have often been overlooked (Sue and Morishima, 1982). Numerous physical and mental-health problems have been linked to trauma from the migration and the resettlement camp experiences. Adolescent refugees often suffer from a delayed onset of chronic posttraumatic stress disorder syndrome and depressive

disorders. Frequently, these problems are first manifested in the form of physical and medical complaints (Kinzie, 1985).

ALCOHOL AND SUBSTANCE USE AND ABUSE

In their review of the substance use research on Asian populations, Zane and Sasao (1992) concluded the following: alcohol use has apparently been underestimated, particularly for certain Asian groups such as Japanese and Filipino males; some evidence suggests that the use of barbiturates may be a major substance-abuse problem for older Asian groups; cultural factors appear to play an important role in either limiting or enhancing substance use among certain Asian groups; and past research has not indicated which Asian groups are being studied. More important, Zane and Sasao note that the Asian groups that appear at greatest risk for developing substance-abuse problems have seldom been studied. Present estimates are likely to grossly underrepresent actual substance use and abuse among APAs because many of the groups with the highest social risk factors (i.e., Southeast Asian refugees, Koreans, and Filipinos) are also the fastest-growing groups in the Asian population. Whereas Japanese and Chinese Americans constituted the largest groups in 1970, by the year 2000, the Filipinos will be the largest group, followed by the Chinese, Vietnamese, Korean, Indian, and Japanese. These population shifts will undoubtedly be associated with significant changes in patterns of substance use and abuse.

Protective Factors

FAMILY SUPPORT

The most recently arrived Asian immigrants and their families must adapt to the effects of urbanization, role changes in the family, cultural conflicts, and acculturation pressures (Hoang & Erickson, 1985). Strong kinship and family ties are not only culturally consonant; they also provide the economic and social support needed for adjustment to a new culture. Males tend to serve as the heads of the household within family contexts in which age, experience, and seniority are respected and shape the hierarchy of role relationships (Shon & Ja, 1982). Therefore, those physical and mental health programs that have promoted family decision making have tended to be more successful. Similarly, health education campaigns that have emphasized the network of supportive family relationships appear to have been especially effective for immigrant groups (Zane et al., 1987).

COMMUNITY NETWORKS

Community networks also have a powerful influence on health information and associated behavior change (Weaver, 1976). Subgroup communities or ethnic enclaves are frequently self-contained (e.g., Chinatowns and Koreatowns) with residents being predominantly immigrants and the elderly (Gould-Martin & Ngien, 1981). These ethnic communities tend to be quite cohesive and provide individuals with familiar, stable, and supportive environments. Residents generally do not travel beyond community boundaries for services and often encounter cultural and language barriers when they do. This support network can work against individuals seeking health services, especially when the person must seek help for a highly stigmatized disorder (e.g., AIDS, mental-health problems).

Cultural Factors Affecting Utilization and Effectiveness of Health Services

A number of factors affect the utilization and the effectiveness of health and related services. These factors involve accessibility (e.g., the ease of use, costs, location), availability, cultural and linguistic appropriateness, knowledge of available services, willingness to use services, the existence of alternative and competing services, and the nature of the health problems.

For APAs only one major study has examined the relationship between the use of services and social and health problems. Kim (1978) conducted a survey of problems and needs of Chinese, Japanese, Filipino, and Korean Americans (foreign and native born) in the Chicago area. Although the study was confined to respondents over the age of 18, the findings showed language and legal assistance services appeared to dominate as the highest-priority need for most Asian communities over such needs as mental-health service, employment service, vocational training, public aid, and bilingual referral service.

This study contributes to our understanding of APA adolescent health needs even though it was conducted with adults, for parents determine the kinds of services that their children use and socialize their children to the cultural attitudes and beliefs concerning health problems.

SHAME AND STIGMA

Most Asian cultures are "face" oriented, which means an individual's public actions and consequent sense of social integrity and status are tied to and

directly reflect on one's family and other important kinship groups. Japanese *haji*, Filipino *hiya*, Chinese *menz*, and Korean *chaemyun* are terms for the processes of loss of face or shame (Kim, 1978). The existence of certain problems in the family—such as juvenile delinquency and acting-out behaviors, mental-health disorders, AIDS, and poverty—is considered shameful and likely to bring loss of face or disgrace on the entire family (Sue & Morishima, 1982). Consequently, many APAs may avoid the juvenile-justice or legal system, mental-health agencies, health services, and welfare agencies.

Asian Pacific Americans are less likely to request outside help for emotional difficulties, turning first to their families for help and to outside agencies or mainstream services as a last resort (Tracey, Leong, & Glidden, 1986). Several consequences of the effects of shame and stigma can be hypothesized and appear to be supported clinically. Those behaviors (e.g., mental-health problems) that are likely to create shame and stigma are the ones that are most likely to be denied and services treating them underutilized. Thus, the need for services is not equivalent to the demand for services, and needs for certain services are likely not reflected in utilization patterns. If services are avoided and used as a last resort, problems may be exacerbated by the delay. Finally, a significant factor affecting service use by APA youth is the fact that a child's behavior is considered a reflection of the family upbringing. Therefore, parents may delay using services for their children if such services are needed for stigmatized problems.

In APA communities, there are great expectations for doing well in America for the sake of the family in the United States and in their native country. The personal networks in immigrant communities are often extensive and information about others flows quickly and widely. The development of physical or mental-health problems that may compromise a person's status can generate significant loss of face, and the need to seek outside help for such problems only exacerbates the shame for the entire family.

CONCEPTIONS OF HEALTH

The cultural orientations of APA populations can affect how health risks and problems are defined and identified, how symptoms are manifested once one becomes ill, the causes attributed to these problems, and the preferred modes of coping and seeking help (Leong, 1986). For example, Kitano (1969) found that Japanese schizophrenics were more likely to be with-

drawn and to exhibit fewer acting-out behaviors than White schizophrenics. He attributed the differences in symptom patterns to cultural influences, such as the tendency for many Japanese to react to stress by becoming more stoic and to accept one's suffering (*ga-man*) without showing overt signs of agitation.

Many Asians perceive a unity between the mind and the body, and emotional disturbances may often be expressed in association with somatic symptoms. In a study of depression experienced by Whites, Blacks, and Chinese, Chang (1985) found ethnic differences in the patterns of symptomatology. Cognitive concerns characterized the White group; a mixture of affective and somatic complaints were found among Blacks; and Chinese were the most likely to exhibit somatic complaints. Similarly, Tung (1985) noted that somatic symptoms involving headaches, insomnia, fatigue, loss of memory, and poor appetite are quite common for many Southeast Asians with psychiatric problems. Some researchers (e.g., Kleinman, 1977; Marsella, Kinzie, & Gordon, 1973) have argued that this symptom pattern reflects a more culturally acceptable means of expressing emotional distress, since physical difficulties are less stigmatizing than having emotional or psychiatric problems.

Interpretations of the causes of disorders are also influenced by culture. In traditional Chinese culture, many physical afflictions are attributed to an imbalance of cosmic forces—yin and yang. The healing task restores balance through proper diet, exercise, and proper psychosocial relationships with others. Kinzie (1985) observed that many Southeast Asians believe illness to be caused by physiological factors or supernatural forces (e.g., the consequence of offending a deity or spirit). They may not differentiate between psychological, physiological, and supernatural causes of illness. The U.S. health-care system is predicated on the concept of discreet disease categories; consequently, many APAs may not consider mainstream services as the most credible or useful source of help.

Other Asian values affect health interventions. The desire for personal and familial self-sufficiency is especially strong, and a substantial fear or shame associated with dependency on outside help, particularly from non-family agents, exists (Shon & Ja, 1982). High value is also placed on personal, interpersonal, and environmental harmony. In traditional Asian households, children and youth are socialized to be in control of their feelings, needs, and impulses and not disrupt this harmony. Physical and emo-

tional health are inseparable, as is the relation of the individual to the social and physical environment (Tung, 1980).

This holistic orientation suggests that health prevention concepts stressing balance and the avoidance of excess behaviors may be quite effective in many Asian communities. Highly credible interventions may also involve traditional approaches designed for actual restoration of balance. Since parents are responsible for the care of their adolescent children, they are likely to refer their children to those services that are consistent with their cultural beliefs. Those interventions that emphasize the service (and dependency oriented) nature of the program or incur public "face" loss during the process of providing care may be less effective and underutilized.

Utilization Patterns of Health Care

PHYSICAL-HEALTH SERVICES

In a review of data collected by the National Center for Health Statistics on visits to physicians by APAs, Yu and Cypress (1987) noted that, for both APAs and Whites, more females (60%) than males visited physicians. Interestingly, age differences were also found. Among those APAs who saw physicians, 30% were children under 15 years of age, compared with only 18% for Whites. One might expect to see this result, as the APA population is somewhat younger than that of White Americans. Another possible reason is that APA parents may be more concerned about their children's health than their own. The 45-years-and-over age group of APAs constituted only 29% of those who saw physicians, compared with 41% for Whites. One explanation for this pattern may be the relative younger age of APAs compared to Whites.

Yu and Cypress (1987) also examined the types of providers and services sought. Asian Pacific Americans were more likely than Whites to use pediatricians and less likely to see surgeons or psychiatrists, but more physician visits were made for preventive care than for Whites. Asian Pacific Americans were less likely than Whites to have problems with accidents, poisoning, and violence. Again, most of the findings do not specifically provide insight into the use of physician services by adolescents. They do suggest that APA users of mainstream health services tend to be relatively young and that important cultural differences exist in utilization patterns.

The extent to which alternatives to Western forms of medical treatment are used by different APA groups is unknown. In a study of the use of West-

ern and Chinese medical-care systems among Chinese Americans, demographic variables, as well as identification with being Chinese, predicted the type of health care sought (Hessler et al., 1975). As expected, Chinese medicine was favored by those who were less acculturated to American society.

MENTAL-HEALTH SERVICES

Research on the utilization and treatment outcome of mental-health services reveals that few APAs use mental-health services. APA clients may avoid services until difficulties are severe and tend to be more disturbed than non-APA clients, and a high proportion of APA clients prematurely terminate treatment because they find the services to be ineffective or culturally incongruent (Sue & Morishima, 1982).

Zane and Sue (1991) reviewed the research and identified a number of factors that may contribute to these problems, including cultural differences in values (e.g., Lee, 1980), communication style (Chang, 1985), problem-solving preferences (Murase & Johnson, 1974), treatment expectations (Yuen & Tinsley, 1981), and mental-health beliefs (e.g., Sue et al., 1976). For example, differences between Asian and White cultures in the "language of emotion" (Chang, 1985) may adversely affect the working relationship between the client and the therapist. In Asian cultures, there is a tendency to convey affection through the use of gestures, often involving the exchange of material goods and services for the person's physical well-being. Also, metaphors are frequently used to communicate feelings; somatic terms often can be used to communicate affective states. Somatization tendencies among Asian clients may not reflect a denial of emotions or a lack of psychological sophistication but, instead, result from different display rules for problem expression (Cheung, 1982; Cheung & Lau, 1982; Cheung, Lau, & Waldmann, 1981; Kleinman, 1977; Marsella et al., 1973). In contrast, Western psychotherapy tends to rely on verbal expressiveness, open self-disclosure, and in-depth examination of emotional conflicts on the part of the client to resolve psychological problems. These aspects can conflict with the tendency by Asians to be less verbal and to refrain from the public expression of feelings (Kim, 1973).

BARRIERS TO SERVICE UTILIZATION

There is reason to believe that barriers exist in the delivery of services to APAs. Kim (1978) asked respondents to rate the most important characteris-

tics of different service agencies. The most important were the availability of bilingual staff and the helpfulness of staff. Because of the large proportion of immigrants in this population, many APAs have limited English proficiency, which creates problems in knowing the sources of assistance, the services that are available, and the procedures and practices required to obtain effective and efficient care (Kim, 1978). Furthermore, immigrants are accustomed to services provided in a personal and informal manner. Health-care providers in Asia often function as friends, advisers, and advocates for their clients. The formality and regulations associated with health services in the United States may be contrary to what many Asians expect from a health-care provider.

As mentioned throughout this review, the research on APA adolescents is sparse. It is assumed that the research findings based on adult samples are to some extent pertinent to adolescents. They may have similar experiences with respect to racism and discrimination, cultural conflicts and adjustment, and the support and pressures involved with close social networks. Parents also help to determine adolescents' nutritional intake, health habits, place of residence, social patterns, and type of care sought.

But there are important differences to consider. Asian Pacific American adolescents, particularly if they are second generation, are more acculturated than their parents, are exposed to non-Asian peers in school, will experience different psychological issues such as ethnic self-identity, and are likely to follow higher health standards and practices than those found in Asian countries. Moreover, intergenerational conflicts are often exacerbated by these acculturation differences. Important differences may also be expected to occur between APA youth and their immigrant parents in diet (e.g., consumption of "fast foods") and the use of medical services (e.g., opposing use of folk healing services advocated by parents).

Implications and Recommendations for Adolescent Health Services

TYPES OF SERVICES NEEDED

The highly variant health needs and service issues among the different APA ethnic groups must be integrated into policies and programs. These differences appear to be especially marked between the predominantly recent immigrant (e.g., Korean) or refugee communities (e.g., Cambodian) and the predominantly early immigrant (e.g., Chinese) or American-born (e.g., Japanese) communities.

Affordable health services continue to be a high priority for many APA communities. Research has consistently found that recent immigrants, particularly Southeast Asian refugees, are at high risk for the development of health and mental-health problems (Sutherland et al., 1983; Van Deusen, 1982). Many APA families and individuals would benefit greatly from health education programs that promote disease prevention (e.g., tuberculosis, AIDS) and better nutrition practices. Accessible, community-based health-care clinics staffed by bilingual personnel can promote culturally responsive, appropriate health care to provide systematic health screening services (e.g., blood pressure exams) to reinforce a more preventive orientation toward health care.

With the increasing conflict between APA parents and youth over such issues as interracial marriage, drug use, discipline, truancy, and familial obligations, family counseling services are needed to help families negotiate these intergenerational tensions. Counseling would be especially beneficial for intercultural couples attempting to cope with problems arising from differences in communication style, cultural values, and role relationships. All APA communities would benefit from more mental-health outreach programs to reduce the shame and stigma of using mental-health and other related services (e.g., substance-abuse treatment). Kim (1985) has noted that family intervention can be an effective intervention tool with APAs, provided that the intervention is culturally matched to the clients.

Professionally staffed mental-health programs are needed to handle severe psychological problems and family crises with culturally congruent skills. A significant number of APA patients require careful monitoring of their psychotropic medications. Mounting evidence indicates that therapeutic levels of psychotropic drugs are achieved at significantly lower doses for Asians than for Whites (Lin & Funder, 1983). Toxic side effects may occur for Asians if they are given higher doses, resulting in patients discontinuing medication or being harmed if they do not discontinue using them (Lin, Poland, & Lesser, 1986).

ORGANIZATION OF SERVICES

A number of promising strategies for serving APA communities have been identified with respect to how services are organized, the population focus of such services, the type of prevention and outreach used, the links with other important service systems, the use of support services, and the development of culturally competent service providers. A multipurpose, multi-

service center that provides both physical and mental health care has proved to be the most effective and culturally acceptable means of delivering these services to APA communities. Shame and loss are minimized if the center has multiple health and social services. These centers succeed because of convenience (several families can obtain services at one site), congruence with Asian values (the connection between physical and emotional health is treated holistically), and minimization of the stigma attached to seeking mental-health services (Sue & Morishima, 1982).

The recognition of the cohesive family unit as an important resource and support for Asians often generates recommendations to use family-based services and treatment approaches; however, for Asian adolescents at risk, a major problem may involve estranged family relations. The inclusion of family members must be considered carefully; Asian adolescents may be more willing to use health-care services without the involvement of family members.

ETHNIC-SPECIFIC PROGRAMS

Ethnic-specific programs frequently capitalize on culturally acceptable attitudes or practices to engage and treat clients. For example, the South Cove Community Health Center provides health services to low-income Asian immigrants and refugees in Boston, using bilingual and bicultural staff. The content works with natural support systems and establishes strong community interagency links.

The South Cove program also has incorporated several features that appear to be especially culturally responsive to APAs. Physical and mental health services are provided together with a coordinated, holistic orientation that minimizes shame and stigma, and special efforts are made to gain and maintain family involvement to the point that the family serves as the primary system of support and intervention. These efforts support the Asian cultural values of filial piety and family obligations. Health-care staff often deliver services in community-based settings not primarily concerned with health care (e.g., restaurants, schools) or in the home to engage more effectively the youth's parents and other family members. Interventions are planned and implemented in ways that do not undermine the youth's identity with parents and cultural norms. Physical and mental health problems are reframed and explained to make them compatible or at least less in conflict with folk medical beliefs and other cultural attitudes. The fact that many Asian families use Western medicine and indigenous

healing systems concurrently is acknowledged and accommodated at South Cove. Services also take into consideration the parents' work schedules. Outreach and health care tend to be more proactive and aggressive than those found in mainstream health clinics. For example, health education sessions are often held in restaurants and scheduled around work hours because many fathers work in the restaurant industry.

In San Francisco, the Chinatown Child Development Center (CCDC) has designed mental-health services to be more acceptable to Chinese immigrant families (Chan-Sew, 1980). Traditionally, Chinese culture places a high value on the child's education and, particularly in the United States, education is considered to have great utility for survival and upward mobility. The CCDC programs capitalize on these attitudes by offering mental health services in the context of educational experiences. The various types of mental-health services ranging from prevention to treatment are presented to Chinese immigrant families as a progression from general to more intensive education.

In addition to the usual outreach efforts, CCDC operates minimal-fee child-care services to initiate contacts with parents. Many parents are motivated to work with the program because of the chronic shortage of appropriate child-care facilities. The program then screens each child for the existence of mental-health problems and associated risks. An on-site mental-health education program enhances the continuity of service by offering parents classes and activities that address not only mental-health concerns, but also basic economic, language, and legal problems faced by immigrant families. Group counseling programs are offered to facilitate the development of support networks among the parents. Interaction between staff and parents is ongoing and more extensive than at most mental health clinics, resulting in cooperative, trusting relationships between parents and health-care providers. Such relationships appear to have reduced the resistance to subsequent referrals of the children for diagnostic evaluations and outpatient mental-health treatment.

AGGRESSIVE PREVENTION AND OUTREACH PROGRAMS

Aggressive prevention efforts are required especially in the area of mental health because such services are devalued and those who seek help are stigmatized (Kim, 1978). Because physical-health services are more acceptable and familiar to APA clients, they can be used as an outreach tool for the dis-

semination of mental-health information. For example, mental-health education can be presented at health fairs as people are completing blood pressure and other health screening exams. Videotapes of health education programs could be made in different Asian languages and shown to various community groups. Public educational messages can focus on specific health problems or psychological disorders such as depression and demonstrate the effect of these problems on daily functioning (e.g., they impair performance at work or school). Part of this prevention effort would involve consultation by center staff with other human-service agency personnel for professional education on the mental-health issues and needs of APAs. More accurate assessments can result in successful mental-health referrals and can address the issues of loss of face and stigma.

Care should be taken to tailor the outreach to specific APA communities and to accommodate important cultural differences among APA cultures. For example, outreach efforts by means of the television may be especially effective in the Chinese community but not in other APA communities. The use of community terminology is also important. For example, labeling services as psychological or mental health may be counterproductive because many APAs associate psychological terms with extreme, bizarre, and "crazy" behavior. Rather, mental-health problems should be defined in terms of their effects on daily functioning (e.g., problems in working with others, memory difficulties).

LINKS WITH SCHOOL SYSTEMS

Since school attendance is high for APA youth, integrating or linking services with the school system can greatly enhance the delivery of physical-health and mental-health services to them. Linkage with schools not only brings the services to the targeted population, but the efficiency of providing health services with educational ones may be especially appealing to Asian parents given the great value placed on education in Asian cultures.

SUPPORT SERVICES

Bilingual APA professional staff are often called on to interpret, translate, and perform case management functions for other service providers (Lee, 1980). As a result, their clinical services are not used efficiently, and they are at higher risk for burnout as they attempt to satisfy the multiple demands

for their time. It is important that health centers provide an adequate system of support services that includes bilingual personnel for interpretation and full-time case managers so that the bilingual Asian clinical staff can focus on their clinical work.

HUMAN RESOURCE DEVELOPMENT PROGRAMS

There is a constant shortage of bilingual, bicultural APA service providers (Asian American Subpanel to the President's Commission on Mental Health, 1978). Scholarships for training health-care providers, as well as increased funding for careers in service delivery, are needed to recruit individuals for these careers. Human resource programs for the development of bilingual APA professionals should be established to address this personnel shortage. In these programs, community organizers could coordinate and monitor the professional and paraprofessional manpower resources available in the various APA communities. The resource program could also function as an information network that community-based agencies would use to assist them in the development of grants and contracts to initiate, enhance, or expand health services. Service providers working in APA communities are often underpaid, and salary levels should be made competitive enough to attract qualified and talented personnel.

Summary and Research Recommendations

Asian Pacific Americans represent the fastest-growing ethnic minority population in the United States. The population comprises more than fifty distinct groups. There are marked within- and between-group differences in histories, residence experience (involving immigrant, refugee, or American-born origins), cultural practices, acculturation levels, English proficiency, socioeconomic status, health needs, and service utilization patterns—differences that are obscured by popular stereotypes and by the lack of ethnic-specific research on these groups. Even less research has been conducted on APA adolescents.

The available evidence suggests that this population has a number of health needs that have been inadequately addressed by the American health-care system. There also seems to be little question that many APAs have experienced great life stress because of cultural conflicts, English-language limitations, prejudice and discrimination, and trauma experienced

in their native countries and during immigration. These experiences may have especially adverse effects on adolescents, who must cope with such stressors during critical developmental periods. Intergenerational conflicts concerning independence versus obedience, achievement orientation, and ethnic identity between adolescents and parents or extended family members constitute additional sources of stress for APA youth.

Despite their needs for physical- and mental-health services, APA youth and their families have frequently avoided using mainstream health services because of both a lack of knowledge about how the U.S. health-care system functions and the unresponsiveness of the health-care system to their language, perceived needs from their worldview, and cultural traditions. Many Asian Pacific cultures are "face" oriented, and APAs may avoid using services for certain problems (e.g., substance abuse, mental health, and HIV/AIDS) associated with social stigma. Some APAs have different conceptions of health from the dominant Western paradigm and seek caregivers who provide services consistent with their conceptions, communication styles, coping styles, and role expectation.

In view of these problems, several recommendations should be considered. More ethnic-specific health research must be conducted, especially for adolescents, to discover the prevalence of health problems, the cultural values and behavioral patterns that affect health practices, and the intervention and prevention programs that could prove to be effective. The significant differences between and within APA groups must also be better understood. Additionally, gender and social-class differences in the incidence of disorders and response to treatment should be more thoroughly researched. In our review of the literature, very few studies considered the effect of either gender or social class on the health status of APAs; the impact of these important variables needs to be more fully explored.

Affordable and accessible health services must be provided, along with aggressive prevention and outreach programs. Such services should have bilingual and bicultural staff who can effectively communicate with different APA clients. The establishment of ethnic-specific multiservice centers involving a variety of physical- and mental-health and social services may improve utilization and the effectiveness of care. Finally, the recruitment and training of bilingual and bicultural personnel would greatly facilitate the delivery of effective health care to APA youth.

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