Practicing Multiculturalism

Affirming Diversity in Counseling and Psychology

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Counseling and Psychotherapy with Asian American Clients

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This chapter addresses the mental health issues involved in the clinical treatment of Asian American clients. The guidelines and resulting recommendations are based on the most current research in the field and on well-documented clinical and professional experiences in working with this clientele.

In working with Asian American populations, it is important to appreciate and account for the social and psychological diversity that exists among members of this ethnic minority group. Generalizing about any group is perilous, particularly when considering peoples with roots in Asia, which comprises 30 percent of the Earth's total land mass and is home to over three-fifths of this planet's population, with the inhabitants ranging from preliterate hunter-gatherers to cosmopolitan multilingual urbanites (Columbia Encyclopedia, 2001). It is therefore best to consider the specific background of an Asian American client and to be cautious in the tendency to generalize information across distinct ethnic groups.

Moreover, to make counseling or treatment recommendations for such a diverse group becomes even more challenging in view of the limited amount of empirically based information available on cultural influences in treatment. The bulk of the research reviewed in this chapter involves primarily group or population-focused studies in which research has examined ethnic or cultural group influences on therapy process and out-

comes. Although this parameter-based research has provided important information about the mental health treatment experiences of ethnic minorities, the focus on group differences often has obscured important variations among members of a particular minority group. More significantly, the descriptive nature of this research has precluded exact determination of how culture affects the treatment experience and eventual outcomes. Recently, greater emphasis has been placed on variable-focused studies that examine how specific psychological elements associated with ethnic or cultural group differences affect treatment or moderate treatment effectiveness. This shift to study culturally based variables such as cultural value orientation, cultural identity, control orientation, shame and stigma, etc., allows us to better explain and understand the specific effects of cultural influences.

Given these limitations, we proceed as judiciously as we can, outlining the demographics and sociopolitical history of Asian American subgroups, reviewing key cultural tendencies, issues, and conflicts likely to be encountered in counseling and psychotherapy, drawing out some implications for working with this population and offering several illustrative case studies. We recognize that culture is only one relevant factor in establishing an explanatory model for mental illness, and that, depending on the circumstances, other aspects may be more influential. The literature reviewed represents trends that have been observed and should be considered as general guidelines for working with Asian American clients. However, when possible (as addressed by the research), we will also discuss individual differences in psychological dimensions, as well as inter-ethnic and intra-ethnic group differences.

Demographics and Sociopolitical History

Asians began immigrating to North America in the 1840s, up to six generations ago. More recently, new waves of immigrants have once again substantially augmented the Asian population. The 2000 United States Census showed Asian Americans increasing from 7.27 million in 1990 to 10.24 million in 2000, a 46 percent growth rate (U.S. Census Bureau, 1990; U.S. Census Bureau, 2000). They are presently the fastest growing ethnic group in North America. The percent of foreign-born people in this country is higher than it has been in more than half a century, and more of these foreign-born individuals (28 percent) come from Asia than any other continent. The largest subgroups among the overall Asian American community are Chinese Americans (2.4 million), Filipino Americans (1.9 million), Asian Indians (1.7 million), Vietnamese Americans (1.1 million), Korean Americans (1.1 million), and Japanese Americans (0.8 million). Smaller subgroups together represent 1.3 million additional Asian Americans.

Asian Americans are a very heterogeneous group, not only because of clearly distinct countries of origin but also because of unique sociopolitical histories concerning their arrival in North America. The first Asian immigrants were men from southern China, who began arriving in 1848 for the Gold Rush in California and western states. Soon after, Americans' fears of losing jobs to Chinese workers led to the 1882 Chinese Exclusion Act, banning further immigration. This ban was repealed in 1943 when the United States recognized China as an ally in World War II and relaxed its immigration laws somewhat. With the 1882 ban on Chinese immigration, Japanese immigrants began to arrive to work Hawaii's sugar plantations, but anti-Japanese sentiments grew there as well. A 1907 Executive

Order prohibited Japanese migration to the U.S. mainland from Hawaii and Mexico, the 1908 Gentlemen's Agreement restricted immigration from Japan to wives of Japanese already in the United States, and the 1924 Immigration Bill ended further immigration from Japan altogether. Relations with Japan deteriorated just prior to World War II, a conflict characterized by markedly anti-Japanese sentiments. In 1942, Executive Order 9066 permitted forcible removal of Japanese Americans from the west coast to internment camps. This political history is unique to Japanese Americans, but other aspects of anti-Asian discrimination and racism have targeted all of the Asian American groups.

Laborers from Korea began arriving in Hawaii to work the sugar plantations in 1903. The 1907 Executive Order banned them, along with the Japanese, from migrating to the mainland United States, and the 1924 Oriental Exclusion act prevented almost all Korean migration to this country. Korean migration resumed after World War II ended, with the arrival of the Korean wives and children of United States military servicemen. U.S. support during and after the Korean War was influential in later waves of immigration.

When Spain ceded the Philippines to the United States in 1892, Filipinos became United States nationals, and unrestricted immigration was permitted so that they could work the cane fields and pineapple plantations of Hawaii, orchards of California, and fisheries and canneries of Washington, Oregon, and Alaska. More Filipino immigrants arrived in response to the 1946–1965 recruitment drives of the U.S. Armed Forces during the Cold War of the 1950s. Immigration was severely reduced when the Philippines later achieved commonwealth status. However, the Immigration Act of 1965 resulted in substantial increases in Asian immigration when the national origins system was replaced with the fixed quota system of 20,000 people from each foreign country.

Large numbers of Vietnamese war refugees came to the United States in the 1970s after the fall of Saigon. The United States resettlement policy often distributed refugees across diverse areas of the United States to sponsoring individuals and groups responsible for helping them find employment, education, and other services (Tran, 1991). Recently, diplomatic ties between the United States and Vietnam have been reestablished, prompting a second wave of Vietnamese immigrants (Banerjee, 2001).

Profiles of other recent immigrants differ widely. Many Southeast Asians, Laotians, Hmong, Cambodians, and Vietnamese were refugees who fled retaliatory persecution for supporting United States. Many of these refugees have often experienced economic and psychosocial adjustment challenges upon their arrival in the United States. By contrast, the Asian Indian population tends to have a higher mean income and level of education than all other Asian American groups, and it has grown the fastest in the last decade (106 percent), growth which is attributed in part to the creation of H-1B visas that encourage high-tech industry immigrants from Asia (KTVU/Fox 2, 2001).

As a whole, Asian Americans reside predominantly in urban settings (96 percent live in metropolitan areas). About half of all Asian Americans live in the western United States, with 20 percent in the Northeast, 19 percent in the South, and 12 percent in the Midwest. Their rate of growth from 1990 to 2000 was significant across many states: e.g., 10 percent in Arkansas, 110 percent in South Dakota, 94 percent in New Jersey, 83 percent in Pennsylvania (Armas, 2001), 78 percent in Florida (Word, 2001), 71 percent in Michigan (Warikoo, 2001), 61 percent in California (KTVU/Fox 2, 2001).

Family Dynamics and Issues

Although substantial inter-group heterogeneity exists among Asian Americans, these groups share certain commonalities of family structure and functioning. A number of factors mitigate these tendencies, the most notable being the effects of acculturation on Asian American families and their members (cf. Lee, 1989). However, certain family tendencies in child rearing practices, communication patterns, role relations and expectations, as well as potential sources of interpersonal conflict persist among Asian Americans despite societal pressures to acculturate in social, political, financial, and educational domains (Ching, McDermott, Fukunaga, Yanagida, Mann, & Waldron, 1995).

Child Rearing Practices

Confucius laid the general template for Asian families centuries ago—a vertical structure with father at its head, mother deferential and supportive of him, and children obedient to and respectful toward both authority figures. To reinforce core family values such as work ethic and academic achievement, parents may use shame, guilt, or an appeal to duty and responsibility to help children understand that they must not embarrass, shame, or dishonor their families (Isomura, Fine, & Lin, 1987). Even across many generations residing in North America, Asian Americans continue to see families as responsible for their individual members' behavior (Lin, Miller, Poland, Nuccio, & Yamaguchi, 1991). Asian Americans value family lineage, considering that the behavior of any individual reflects upon and impacts both preceding and future generations of the family. Thus, it is vital that counselors and therapists understand an individual's identity and place within the family context whenever conducting therapy with Asian Americans (Sodowsky, 1991). Traditional Asian emphases on paternal hierarchy, authoritative parenting, filial piety, interdependence, conformity, and saving face can contrast with the Western preference for more child independence and egalitarian parenting, an approach in which children are taught about individuality, the need for autonomous functioning, self-reliance, and the uniqueness of their personal qualities.

There are, of course, variations in how Asian groups socialize these traditional Asian values (Uba, 1994). For example, Chinese Americans tend to closely supervise children, emphasize achievement, and view childrearing as a mother's responsibility. Filipino Americans tend to lull, carry, and play with their infants, but Korean Americans may view playing with children as undermining the children's respect for adults. Southeast Asian parents tend to become more restrictive as children grow older, gradually increasing their emphasis on such things as disobedience, failure to fulfill responsibilities, and aggression toward siblings. Taken as a whole, however, many Asian American parents still differ appreciably from mainstream American parents. For example, in contrast to Asian parents, White American parents tend to see play with children as an integral part of the learning process, and they often treat their children as equals or at least as participants in the decision making process. Asian American mothers often anticipate the needs of their children, while White American mothers are inclined to want their children to verbalize their needs. Attachment and interaction patterns between mother and child reflect cultural values, and

differences in these practices across cultures often result in unique socioemotional, identity development, and individuation processes (cf. Takahashi, 1986).

Communication Patterns and Norms

Traditional Asian families emphasize collectivist values of interdependence, conformity, and harmony; communication is indirect, implicit, nonverbal, and intuitive. Direct confrontations are avoided (Hsu, 1983). Japanese consider emotional expression to be "bad form," and Japanese language has restrictive words for affect expression (McDermott, Char, Robillard, Hsu, Tseng, & Ashton, 1983; Takeuchi, Imahori, & Matsumoto, 2001). Filipino women demonstrate the use of *delicadeza* for nonconfrontational communication (Araneta, 1993), and Koreans use *noonchi*, a "measuring with eyes," or intuitive perception of others (Kim, 1993). Love and affection are not expressed verbally as much as shown through the mutual fulfillment of obligations and consideration of tending to physical needs. A language of emotions is characteristic of Western cultures, and traditional Asian cultures tend to view emotions as a sign of weakness and disgrace. For example, as Chinese Americans report becoming more "American," their reports of affective behavior show increased variation (Tsai & Levenson, 1997), reflecting the Westernized tendency for more open and verbal affective expression.

Because so much of communication in Asian cultures is through indirect means, intra-familial conflict and misunderstandings often occur. Older generation parents who have grown accustomed to certain styles of interacting may not be able to fully express themselves directly, but their more Americanized children may not be fully able to "read" these meaningful cues. The more acculturated children may also be more vocal, and this further upsets the family hierarchy, as the younger generation family members may unwittingly overstep certain cultural norms and expectations such as the appropriate display of deference and respect to elders.

Attitudes toward Marriage and Relationships

With the more traditional, less acculturated families, marriage is not seen as an individual decision based upon love but as a union between families, emphasizing the appropriate match in economic and social status of the families rather than the romantic inclinations of the spousal relationship. Whereas Westerners raise children to become autonomous individuals who are able to lead their own lives separate from their parents, Asians raise their children with a respect for the familial role in their present and future lives. Asian Americans who are raised by parents holding one worldview of family and marriage, yet grow up in a society where love and affective emotion are bases for relationships, may find themselves in conflict when they choose to marry an individual for love. The difficulties that individuals may encounter when marrying someone from another culture must also be kept in mind. Some Asians look down on Asian women who marry non-Asians; they see these women as "business girls" whose only goal is economic advancement (Ratliff, Moon, & Bonacci, 1978). And the strong in-group and out-group inclinations of Asian American groups (Tanaka, Ebrero, Linn, & Morera, 1998) may cause interracial marriage to be considered a betrayal of the family heritage. Factors that increase the rates

of out-group marriage include acculturation and assimilation to North American society (Kitano, Fujino, & Sato, 1998) and dissatisfaction among Asian women with the gender hierarchy of traditional Asian cultures (Kitano et al., 1998).

Worldviews Relative to the Family and Extended Relationships

The collectivistic values characteristic of many Asian Americans also have a large impact on identity and sense of the self, which differ markedly from typical Western self-perceptions (Landrine, 1992; Markus & Kitayama, 1991). The Western view of "self" assumes that people are completely independent and separate from others, whereas the Asian view of "self" emphasizes social influences, with each person defined in relation to others. Sense of self, particularly in first generation immigrants, is strongly tied to family and ethnic groups (Sodowsky, Kwan, & Pannu, 1995). With so much of psychotherapy predicated on the Western perspective of self, it is not surprising that therapy dropout rates are so high for Asian American clients. Enmeshment, codependence, lack of individuation, social anxiety, and other psychopathological labels are frequently given erroneously to this group by practitioners who impose the Western conceptualization of self onto the behavior of Asian Americans.

Holistic cognitive orientations, which emphasize interrelationships and interconnectedness, also clearly influence the perceptions of many Asian Americans. Compared to other groups, Asians are highly context-sensitive, attending to the whole environment rather than to its focal features (Ji, Peng, & Nisbett, 2000; Tsai, 1999). Additionally, they are more inclined towards dialectical thinking, the "cognitive tendency towards acceptance of contradiction" (Peng & Nisbett, 2000, p. 742). They are able to deal with contradictions by compromising and finding truth in two contradictory ideas, rather than insisting upon only one correct premise. For example, Morris and Peng (1994) found that Chinese individuals process behavior using situational factors, preserving contextual information in their mental representations and simulating counterfactual situations in addressing problem situations, which results emphasize to the salience of context, audience, and dialectic thinking. The Asian worldview, whereby attention is directed towards the environment rather than inward to the self, has important implications for cognitively oriented practitioners, in that highly context-specific problem formulations and dialectic thinking that encourage compromises in conflict resolution can be used by the therapist in treatment.

Similarly, the holistic thinking of Asian philosophies is counter to the mind-body dualism of Western thinking. Asian languages typically blend descriptors of psychological experiences with physical body sensations. Moreover, excessive emotions are believed to endanger both relationships with others and one's own physical well-being (Hsu, 1983). Asians may therefore voice mental illness in somatic terms, and their children may monitor physical symptoms and communicate with somatic representations, which poses problems for Western practitioners, who are unaccustomed to working with somatic complaints as indicators of mental distress. This tendency also creates difficulty in Asian American families, where older generations call for help indirectly or somatically, but their more Westernized children require more verbal and explicit descriptions of mental health problems than elders are able to provide.

In sum, East-West cultural differences involve collectivism/interdependence versus individualism/autonomy, hierarchical versus egalitarian structures, indirectness versus emotional expressiveness, holistic integration versus separation of mind, body, and spirit, an interconnected versus separated sense of self, and a sense of belonging to a small nuclear family versus an extended clan, including a web of past ancestors and yet-to-be-born progeny. For Asian Americans, these cultural conflicts and tensions take place as much in the family as they do within the individual, and they continue to present in various forms across generations as acculturative forces that vary in their effects on different family members.

Age and Cohort Issues

Adolescents and Young Adults

Asian American adolescents and young adults face cultural challenges in the developmental issues of establishing their identity, establishing a career of some kind, and choosing a partner. In identity development, they must navigate the powerful cross pressures to adhere to more traditional family and cultural traditions and to become "more American." The question "Who am I?" is often quite a different issue to Asian American youth than it was for their parents. Table 10.1 shows the dominant frameworks for conceptualizing the development of Asian American ethnic identity. All three frameworks listed assume that an identity acknowledging and integrating both ethnic and majority cultures results in optimal psychological well-being and functioning (Phinney, Cantu, & Kurtz, 1997). In some ways, the ambivalence and, at times, hostility often observed among Asian American youth toward their ethnicity and culture may be considered "rational" and normal in view of the bicultural pressures and demands usually experienced by these youth. It is important that mental health professionals help them work through filial piety/individuation and other differential acculturation-accelerated conflicts (e.g., overt expression of emotions and caring vs. emotional self-restraint, asserting one's opinion and needs vs. deference and respect for elders, promoting oneself vs. modesty and self-effacement), enabling them to leave treatment with a better integrated answer to their "Who am I?" question, irrespective of the presenting problem.

Another stressor commonly experienced by Asian American youth is the enormous pressure they feel to excel academically. The Chinese, like many other Asian groups, have a long tradition of academic aspirations for their children, dating back to the centuries-old Mandarin system (Lam, Chan, & Leff, 1995). This parental emphasis on work ethic and academic achievement is reinforced by the reality that many Asian American youth are excluded or discouraged from pursuing other avenues of achievement (Sue & Okazaki, 1990). In addition, the "American Model Minority" myth can often marginalize this group as docile, hard working, and upwardly mobile—respected but disliked (Lin & Fiske, unpublished manuscript). Given these circumstances, many Asian American youth feel that they have little choice but to excel in academics, and they see scholastic failure as unacceptable personally and as a major disappointment to the family.

TABLE 10.1 ***Models of Ethnic Identity and/or Ethnic Identity Development***

Racial/Cultural Identity Development Model (R/CID) (Sue & Sue, 1990)	
Stage 1	Conformity—individual rejects ethnic identity in favor of host culture
Stage 2	Dissonance—individual begins to question their initial rejection of their ethnic group
Stage 3	Resistance & Immersion—individual completely identifies with Asian American culture, actively rejecting the host culture
Stage 4	Introspection—individual questions their complete immersion in their ethnic culture, and begins search for self-identity
Stage 5	Integrative Awareness—individual is secure in ethnic identity and appreciates other racial/ethnic groups
Tse's (1999) Stage Model of Ethnic Identity Development	
Stage 1	Ethnic unawareness—individual is unaware of minority status
Stage 2	Ethnic ambivalence/evasion—individual actively distances self from ethnic group; adopts the host group culture
Stage 3	Ethnic emergence—individual realizes that joining the ethnic group is not possible, and begins to seek other affiliations
Stage 4	Ethnic identity incorporation—individual joins their ethnic minority group
Phinney's (1989) Model of Ethnic Identity Development	
Stage 1	Diffusion/Foreclosure—individual does little exploration of ethnic identity
Stage 2	Moratorium—individual engages in active ethnic identity search, increased awareness about the importance of ethnicity
Stage 3	Identity achieved—individual has come to terms with their ethnic identity and emerges identified with their ethnic group

Elderly

Elderly Asian Americans face very different problems from the youth. They experience developmentally related losses of their parental, work, marital, and other roles (Merton, 1957). Moreover, aging in a culturally incongruent society exacerbates these losses. Traditionally the elderly are revered and respected in Asian countries; traditions of filial piety dictate that elderly parents' children fulfill their needs, care for them, treat them with reverence, and obey their wishes and plans (Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1992). If Americanized adult children do not fulfill these obligations and expectations, the personal and cultural incongruencies that elderly Asian Americans feel can lead to increasing tension, conflict and dysphoria (Kim, Hurh, & Kim, 1993). Among

people age 75 and older in San Francisco during 1987–1996, 20% of suicides were committed by Asian Americans, a rate disproportionately higher than that of other ethnic groups (Shiang, 1998).

Refugees and Recent Immigrants

There is a clear contrast in the circumstances of refugees vs. immigrants (Matsuoka, 1990). While immigrants voluntarily left their native lands to pursue better opportunities or reunite with loved ones in North America, refugees were forced to abandon their homes and seek safety elsewhere. Asian refugees, particularly those from Southeast Asia, have typically experienced significant and protracted trauma involving persecution or genocidal campaigns, torture or containment as prisoners of war, abrupt severance from ancestral homelands, rupture of extended kinship networks, loss of family members often through traumatic events, and protracted family separation or long stays in crowded refugee camps en route to this country (Matsuoka, 1990; Nicholson & Kay, 1999). As a group, refugees are typically burdened with more mental health problems and have fewer resources than other Asian immigrants for coping with the continuing stresses of adjusting to their new environment.

Recent or new immigrants from Asia vary widely in education, income, and country of origin, but all experience some degree of acculturative stress as they struggle to adjust to their new environment, find employment, enter schools, and learn English. Western education, employment, urbanization, and settlement patterns, along with changes in socialization practices and pressures to conform to the Western culture are just a few of the many new stressors that may be encountered when adapting to American culture (Sodowsky, Lai, & Plake, 1991). Settling in a densely Asian community can provide supports for traditional structures and values but can correspondingly diminish the speed of adaptive acculturation. In any case, new immigrant families often must work long hours, isolating themselves from local culture and practices (Lam et al., 1995). The immigrant wife who works outside the home may help relieve financial stress on the family but augment other difficulties by inadvertently undermining the patriarchal family structure. Commonly, immigrant children become English-fluent faster than their parents, thereby becoming the primary interpreters and culture brokers, further destabilizing the traditional family system.

Experience as an Ethnic Minority

Asian Americans are oftentimes the targets of racism in its various forms. This country's long history of anti-Asian legislation (exclusionary acts, the internment of the Japanese Americans during World War II, anti-miscegenation laws, etc.) reflects the fact that Asian Americans have not been seen as Americans, but as foreigners. Ying, Lee, and Tsai (2000) found that racial discrimination decreases subjective competence ratings for both foreign-born and U.S.-born Chinese Americans, with this effect being stronger for the latter. These researchers hypothesize that immigrants, retaining psychological attachment to their native culture, may be more able to distance or buffer themselves from discrimination than are persons of Asian descent who are born in the United States. American-born Asian Americans, though in their home country, must repeatedly confront the question *"Where are you from?"*

which implies foreign status. For Asian Americans, being accepted as American is considered "achieved and provisional, rather than a taken-for-granted and stable" (Kibria, 2000). Research indicates that racial discrimination produces the same psychological and physical stress effects that other psychosocial stressors do (Williams, Spencer, & Jackson, 1999), and mental health practitioners should anticipate the additional issues that Asian clients may bring to therapy concerning their place in this society that often involve their experiences of marginalization, alienation, and discrimination.

Gender Issues

Traditionally, Asian societies have well-defined social roles, especially in the context of family (Marsella, 1993; Uba, 1994; Sue, 1999). Social roles across genders are no exception. Although there is a trend towards increasing gender equality, Asian cultures tend to encourage men and women to hold different responsibilities and to abide by rules of conduct that emphasize social stability over individual rights. For East Asian societies such as those found in China, Korea and Japan, Confucian teachings have strictly differentiated proper behavior for each sex (Hong et al., 1993).

"The most beautiful and gifted girl is not so desirable as a deformed boy" (Hong, Yamamoto, Chang, & Lee, 1993) reflects the traditional pre-eminence and perceived desirability of boys, who are needed to carry on the family name and perform necessary family rituals. With a legacy of male favoritism, it is not surprising that even today implicit expectations for boys and girls can be very unequal. Among Asian Americans, eldest sons (as well as individuals with no siblings) may feel special pressure to carry on the family line (L. Nguyen & Peterson, 1992; N. A. Nguyen & Williams, 1989), succeed economically (Espiritu, 1999), and become caretakers of aging parents (Sue, 2001). This dutiful familial role is at odds with the freewheeling, independent, "own-man" image of American masculinity and career success (Sue, 1999). Therefore, Asian American men may present with conflicts over family responsibility and obligations versus the emphasis on autonomy, overt masculinity, and self-reliance that characterizes male behavior in American society. Historically, Asian daughters have been devalued, expected to be obedient and modest, and perceived as belonging to their future husband's household (Morrow, 1989; Lee & Cynn, 1991). Strict adherence to these values is now rare among modern Asian American households, but the tendency to be more liberal with sons than with daughters often persists. Less acculturated parents typically grant less social freedom to daughters than they would to sons. If women marry, they are usually expected to subordinate their personal agendas and careers to those of their spouses and to share the husband's family responsibilities, including taking care of the parents-in-law in their old age. If husbands spend most of their time away from home, care of elderly in-laws can become solely the daughter-in-law's responsibility. Many Asian American women feel caught in competing cross-pressures to defer to their husbands and take care of in-laws, while being assertive and independent achievers in the context of American society.

Homosexual and transgender Asians and Asian Americans may experience emotional distress compounded by a cultural heritage emphasizing family (Baytan, 2000). Research aimed at describing the experiences of these individuals is needed. Because many Asian

cultures are family-based and do not have acceptable models for different lifestyles, lesbian and gay individuals may understandably feel the need to hide their sexuality from their families in order to avoid both personal rejection and family shame. In addition, most Asian cultures do not openly discuss issues of sexuality. Therefore, the idea of "coming out" is not likely to be a familiar concept. Consequently, there may be few social supports for individuals experiencing the double jeopardy of being both an ethnic and sexual minority.

Spiritual Beliefs, Values, and Practices

Hundreds, if not thousands, of religions are practiced in Asia (Central Intelligence Agency, 2001). For more than 2000 years, the elements of Confucianism, Buddhism, Taoism, Hinduism, animism, and shamanism have blended to yield some main principles as well as a host of alternative belief systems and attendant alternative therapies. Even though some Asian immigrants bring a tradition of Christianity with them from their country of origin or convert to Christianity after arriving in North America, the underlying beliefs, values, and philosophies of their earlier religious traditions continue to exert powerful and inchoate influences on them (Tan & Dong, 2000).

Unlike the Confucian doctrine of righteous action and moral codes of conduct, Buddhism prescribes a program of passive acceptance, detachment from desire, and meditation. A Buddhist believes that only by extinguishing one's personal desires and attachments can suffering be overcome and the spiritual self liberated and fully awakened. The Buddhist practice of meditation to elicit "evenly hovering attention" is compatible with the here-and-now "mindfulness" of some humanistic treatments, such as gestalt approaches, and with certain cognitive-behavioral approaches (Finn & Rubin, 2000).

Taoism emphasizes the inseparability of the body, psyche, and spirit, as well as a connection with nature through quiet reflection, balanced diet, breathing techniques, and disciplined living to promote health and longevity. It is the basis of traditional Chinese medicine, which provides a variety of cures to ailments attributed to an imbalance of the social or physical world (Unschuld, 1985). *Feng shui*, a form of geomancy addressing physical environmental factors, and *tai chi chuan*, a martial art form combining physical exercise and mental discipline, are two of the derivatives. The worldviews of many Asian Americans incorporate the complementary forces of *yin* and *yang*, and of *chi*, one's life energy. Many Taoist concepts are making their way into a variety of new Asian-influenced alternative approaches to restoring and maintaining well-being which are beginning to coalesce in North America.

Hinduism, originating in the Indian subcontinent, posits numerous gods and goddesses, is reflected in numerous rituals, prescribes yoga as a spiritual path, and explains the development of a soul through karma and reincarnation. Karma is inherently a belief in one's personal responsibility—"as a man sows, so shall he reap," if not in this lifetime then in the next—and in the essential fairness of life (Sharma, 2000).

Animism, the oldest spiritual tradition worldwide, deifies Nature in spirit forms that can then be worshipped and interacted with symbolically. Illnesses can result from malevolent or displeased spirits, sometimes sent by other people casting a curse or spell (Unschuld, 1985). Rituals to appease or distract the spirits are prescribed, often involving the

actual or symbolic sacrifice of an animal or object in exchange for the nature spirit's release of the sick person's spirit. Shamanism is closely related to animism. The human and spirit worlds are held to be linked, such that disturbance in one creates disturbance in the other, and problem solving in one brings peace in the other (Vitebsky, 1995). Shamans, chosen by the spirits (Howard, 1998), may manifest their spiritual calling through hearing voices, speaking in tongues, having a physical or mental anomaly or possessing an unusual ability to communicate with animals or read the signs of nature. They are both celebrated and marginalized in their own society. Shamanism is widespread in Asia, particularly among people marginalized from the official power structure: individuals from rural areas, women, and ethnic minorities (K. Howard, personal communication, March 18, 1999).

Together, the strains of Confucianism, Buddhism, Taoism, Hinduism, animism, and shamanism have woven an almost countless number of specific cults across the vast continent of Asia, most of which identify afflictions along with their etiologies and remedies. Asian spiritual beliefs emphasize the centrality of family and clan, the place of individuals in a larger cosmos, the spiritual connection with deceased ancestors as a link to the spirit world, and a holistic view of body, mind, and spirit. Beyond this, the therapist must tactfully probe for spiritual and culture-specific explanations of the manifest symptoms and attendant culture-prescribed remedies.

Culture-bound syndromes, symptom clusters that are identified and mediated in particular cultural contexts, may sometimes be observed in Asian clients, particularly if they are immigrants from rural areas. Table 10.2 shows some of the better-documented Asian culture-bound syndromes, although there are many others not yet commonly seen in the West. These syndromes can only be understood by viewing their etiologies and symptom manifestations from a spiritual and culturally relativistic perspective.

View of Mental Health Professions

By tradition, Asian Americans see mental health problems as shameful—reflecting moral weakness in the individual and family, disgracing ancestors and future generations, and resulting from the past sins by family members. Families often shield mentally ill members from the public to save face and to avoid shame and stigma. Many only seek outside help as a last resort in acute stages (Zane & Sue, 1996). Moreover, many Asian Americans conceptualize mental illness very differently from views of mental health professionals. Many Western forms of psychotherapy require (a) a separation of mental from physical problems in symptoms, causes, and cures, which can be at odds with Asian holistic approaches; (b) a level of self-disclosure that offends notions of privacy and propriety in a face-conscious culture; (c) a focus on interpersonal conflict and direct confrontation, which is difficult for harmony-oriented individuals; (d) a language of emotion not always consonant with cultural cognitive and communication forms; and (e) an emphasis on individuation and pursuit of personal wants and needs in contrast to collectivistic norms and obligations emphasized by the Asian cultures. In view of these cultural incongruities between psychological treatment and Asian values and worldviews, it is not surprising that Asian Americans are relatively skeptical about the Western mental health profession, relatively unlikely to present for treatment, and relatively likely to drop out prematurely (from the therapist's

TABLE 10.2 *Asian Culture-Bound Syndromes*

Name in English	*Asian Names*	*Endemic Area*	*Cultural Explanation*	*Symptoms*
Divine Illness	*Shin-byung*	Korea	Invasion by angry ancestral spirits onto a descendant with weak constitutions, caused by improper observance of ritual.	Sense of double-facedness (*ijung inkyukja*), persistent and sometimes acute physical pain, sleeplessness, fatigue, anxiety, sudden outbursts of anger and distress.
Penis Retraction Syndrome	*Koro* *Suo yang, Siok iong, or Shuk yang Rok-joo* *Jinjinia bemar*	Malaysia China, Hong Kong & Taiwan Thailand Assam	Spirit invasion, excessive masturbation.	Sudden intense fear and sensation of the penis retracting into the abdomen resulting in death; a female correlate, in which the vulva and nipples recede into the body, also exists.
Qi-gong Psychotic Reaction or Cultivation Insanity	*Zho hwo ru mwo*	China	Practicing *qi gong* with an unrighteous mind, resulting in spirit or animal possession and has various mentalities such as pursuing a *qi gong* state to show off.	Time-limited psychotic episode of dissociative, paranoid, or other psychotic and non-psychotic symptoms after participating in qi-gong (a folk health-enhancing body movement/meditative exercise).
Neurasthenia	*Shenjing shuairuo* *Shinkei shitsu*	China Japan	Imbalance of the body, environmental stress, weak bodily constitution.	Physical and mental fatigue, dizziness, headaches and other pains, difficulty concentrating, memory loss, sleep disturbance.
Spirit Possession	*Hsieh-ping* *Shin-byung*	Taiwan Korea	Possession by an ancestral spirit who is trying to communicate with family members.	Tremor, delirium, visual or auditory hallucinations, disorientation; trancelike state.
Fear of Wind/Fear of Cold	*Pa-feng/Pa-leng*	China	Fear of excessive *yin* energy from wind and cold.	Phobic fear of wind and cold, respectively; bundling up in warm clothes, eating "hot" foods.

(continued)

TABLE 10.2 *Continued*

Name in English	*Asian Names*	*Endemic Area*	*Cultural Explanation*	*Symptoms*
No translation found	*Taijin kyofusho*	Japan	Over-nurturance by maternal figure.	Intense fear of offending or embarrassing others with one's body, body parts, or bodily functions; hypersensitivity of one's appearance, odor, facial expressions, and movements.
Soul Loss	*Imu Latah* *Amurakh, Irkunii, Ikota, Olan, Myriachit, and Menkeiti* *Bah-tschi, Bah-tsi ,& Baah-ji Mali-mali & Silok*	Japan (Ainu, & Sakhalin), Malaysia, Siberia, Thailand, Philippines	Soul loss or detachment due to a sudden shocking event.	Hypersensitivity to sudden fright, dissociative or trancelike behavior, command obedience, echolalia, or echopraxia.
Anger Syndrome	*Hwa-byung or wool-hwa-byung*	Korea	Suppression of deep anger.	Insomnia, fatigue, panic, fear of impending death, dysphoric affect, indigestion, anorexia, dyspnea, palpitations, generalized aches and pains, and a feeling of a mass in the epigastrium.
** No translation found **	*Amok*	Malaysia Philippines	Being irreparably wronged.	Brooding, followed by sudden violent frenzy, ending with amnesia.
Semen-loss Syndrome	*Dhat & Jiryan* *Sukra prameha* *Shen kui & Shen k'ui*	India Sri Lanka China	Loss of life energy from too much sexual intercourse, nighttime emission or masturbation; yang energy deficiency.	Dizziness, backache, headaches, mental and physical fatigue, insomnia, frequent dreams, complaints of sexual dysfunction (i.e., impotence, premature ejaculation)

point of view). Liu, Pope-Davis, Nevitt, and Toporek (1999) therefore strongly suggest that therapists consider clients' acculturation level and perceptions of mental health. Atkinson and Gim (1989) found that attitudes toward professional psychological help are directly related to acculturation, suggesting that psychological services need to be modified if immigrants are to view such help as legitimate and credible.

In addition to this wariness or skepticism, many Asian American individuals and families simply lack awareness about mental health services and their usefulness. Providers wishing to better serve Asian Americans, particularly the newer immigrants and refugees, may want to focus on alternative means of outreach—innovative arrangements with ESL programs, employers, churches, schools, medical clinics, and civic associations salient to this group, as well as outreach efforts to community elders and indigenous healers. These approaches can help establish culture-consonant and community-endorsed approaches to prevention, early detection and treatment, and community empowerment. Language-appropriate written materials, translators, and support groups are often needed.

Strategies for Counseling and Psychotherapy

The preceding discussion has addressed some of the major East-West differences the mental health practitioner should be aware of in preparing to work with Asian Americans, and it pointed to the enormous heterogeneity in this group. Next we list a number of suggestions for approaching an Asian American client or family. These strategies are tendered in the spirit of working hypotheses that can guide counseling and treatment but should not be considered as specific prescriptive courses of action. Rather, it is suggested the practitioner amend and adapt these strategies as an accurate reading of the clients and their issues may suggest alternative or even opposing approaches.

Establish Credibility and Initial Formality

Most Asian Americans have traditions of scholarship and respect for authority. The practitioner can establish initial credibility by comfortably accepting the "doctor" or "*sensei*" (esteemed teacher for Japanese) expert authority role. Demonstrating capacity for cross-cultural effectiveness and inspiring confidence in one's ability to help are of paramount importance in the critical first encounter. Use of formal names (e.g., Mrs. Huong, Dr. Lee) with correct pronunciations is suggested. It is also advisable to show distinct respect to elders and to acknowledge traditional structures by addressing husband before wife and adults before children initially. If the client bows slightly at the time of handshake or other salutation, it is courteous to reciprocate the gesture. If a business card is offered, it should be treated with the same respect that would be shown the person. If a modest gift is given, the counselor or therapist should accept it humbly to the degree possible (Yang, 1994). Particularly in the first session, decorum, dignity, and respect will be valued. Honoring the client is never inappropriate, regardless of ethnic background, but it becomes exceedingly important with face-conscious Asian American clients. It is easier to become less formal, but much harder to become more so after the initial meeting.

Permit Indirect Contextual Communication and Low Emotional Expressiveness

If clients present with a nonlinear contextual interactional style, the practitioner is advised to respect this form of communication, permit it, and indeed join in it, at least initially. This may appear as initial conversational "small talk" or even "beating around the bush" as both parties search for cues to contextualize the other (e.g., their background, acquaintances in common, familiarity with the client's culture, capacity to help). The counselor or therapist should listen for information and store it for later use, in turn using this style of communication to subtly inform the client of his or her knowledge, experience, and capacity to provide meaningful help. In this initial interaction, one should avoid unnecessarily intrusive questions and demands for high emotional expressiveness and confrontations until it appears appropriate to venture in those directions; it is good to permit silences in conversational turn taking, however difficult this may be. This is all part of high context communication. Contrary to the inscrutable stereotypes, Asian American clients typically communicate a rich amount through metaphors, subtle nonverbal language, choice of words said and not said, and the use of silence, so the counselor's challenge is to slow down, watch for issues of face and dialectic, and for holistic modes of thinking, and learn the codes of communication. This indirect, high context communication and low emotional expressiveness is most likely to be seen with more traditional and less acculturated Asian Americans, at the beginning of sessions and when focusing on particularly difficult issues.

Assess Acculturation and Ethnic Identity

Accurate assessment of acculturation level on different dimensions and of ethnic identity requires that a counselor generate hypotheses from intake information, this should be a dominant activity in the first session. Moreover, this assessment may continue on refined points and issues throughout a treatment episode. Incorrect assessment can lead to grievous albeit unwitting offenses to the client and to inappropriate, ineffective diagnosis, treatment plans, and intervention modalities. The less acculturated the Asian American client, the more salient the following guidelines will be. The more "Americanized" the client, the more the counseling can resemble that of mainstream clients, although cultural issues are still paramount even for very acculturated individuals. Lethal *faux pas* can occur if a practitioner treats an Asian American as less acculturated than the client feels he or she is (invoking "foreign-ness" challenges) or as more acculturated (e.g., requiring intimate disclosures, display of intense emotions, use of confrontational strategies or lapses into informality too early). The practitioner should remember, in assessing acculturation, that (a) it is uneven, and a client may be very American in some areas of functioning and very Asian in others; (b) it continues for at least several generations, and family members may be at different acculturative levels and issues; and (c) people cannot always report accurately on their level of acculturation, so responses to direct queries may not always be accurate and/or may reflect socially desirable biases.

In contrast to acculturation, ethnic identity refers to how individuals think of and present themselves. Referencing oneself as Chinese American, or Asian American, or Chinese, or just

American indicates which group the client identifies with and may inform the therapist about the sociopolitical aspects of the client's worldview. In assessing ethnic identity, the provider will want to assess degree of "Chineseness," "Hmongness," and so on, as well as degree of "Americanness." Many highly acculturated individuals view themselves as strongly bi-cultural, with high proficiency in both cultures. Careful assessment of acculturation and ethnic identity is even more important when clients are racially and ethnoculturally blended individuals and families. The practitioner who is successful in these assessments will be rewarded with clients exploring with them, in time, the dilemmas and conflicts around acculturative or identity issues with which they may be involved.

Use of Interpreters

When the client cannot speak English with sufficient proficiency and an interpreter is needed, trust issues and miscommunication problems can arise. Bilingual interpreters and service providers should have training in working with service providers and vice versa. The interpreter typically sits next to the client (and sometimes just slightly behind), so the client and provider can face one another and address each other directly. This underscores the primary relationship between therapist and client, maximizes nonverbal communication between them, and minimizes the diffusion and distortion in communication and relationship-building inherent in adding a third party. When speaking, the counselor or therapist should address the client: "When did these problems begin, Mr. Lee?" is preferable to "Ask him when these problems began." Interpreters should translate literally, resisting the temptation to impose lay or personal understandings onto the material they translate, thereby introducing an unknown personal bias into the discussion. For example, "I drank lemon grass tea and tried Chi Gung again for a while, but the pains kept getting worse and my son insisted I come here" is more informative than "He hasn't had any psychological treatment before." Accurate interpretation can at least double the time for assessment or a treatment session. Although it is clearly resource intensive, utilizing a professional interpreter is preferred to using a bilingual family member, because of the likely distortions and other dynamics related to family shame and face saving.

Honor Face and Face Saving

Maintenance of face and avoiding loss of face can be an important dynamic in effective relationships between Asian American clients and their practitioners. Face issues are implicated in many different aspects of treatment for Asian Americans. For example, studies have shown that loss of face is negatively related to self-disclosure in treatment situations, especially when the client discloses about his or her most intimate relationships. Moreover, differences in a person's preference for different treatment approaches (i.e., directive vs. nondirective approach) can be better explained by loss of face than by a competing model based on differential treatment expectations between Asians and Whites (Zane & Mak, 2003). Dignifying the client, normalizing rather than pathologizing, positively framing and reframing, emphasizing strengths and skill building rather than deficits, etc., are all useful with face-conscious clients. In addition, in keeping with the social sense of self of many Asian Americans, face presentation and maintenance concerns are common in issues brought to therapy.

How can the newly unemployed immigrant father save face in his community when he is now financially dependent on his daughter? How can the family accept the unorthodox career or marriage choice or sexual orientation of their firstborn son without losing face in their church or neighborhood? In the contextual Asian worldview, actions are judged within a specific situation and as seen from the perspective of salient others. For example, if a couple with marital difficulties presents with a list of the ways in which they cope, this list can be elaborated and commended, using positive frames, postponing the direct focus on undisclosed dysfunctions until the couple becomes more trusting and familiar with the therapist. Perceived denial, minimization, internal inconsistencies, poor role performances, and conflicts within the family can indeed be addressed, but the practitioner is advised to use tact and diplomacy, capitalizing on Asian capacities with metaphors, dialectical thinking, and high context communication where possible, to ensure that face remains honored.

Emphasize Structured, Directive, and Goal-Directed Problem-Solving

Many Asian Americans may respond well to directive, structured, problem-focused approaches, especially at the beginning of treatment (Root, 1985; Tan & Dong, 2000). Worldviews and styles of communication, thinking, and perceiving that are potentially disparate, along with face-related concerns, create an unfamiliar situation for the client who is in therapy in which the stimulus field is potentially too open, with too much room for misunderstanding and miscommunication regarding what is expected and what is acceptable. Firm, goal-directed structure and leadership from the practitioner can reduce the ambiguity and face threat in this situation. For example, Kim (1993) advocates a directive approach emphasizing the practitioner's authority, expertise, and knowledge when working with Korean clients. In addition, for the many Asian American clients who often present with major somatic discomfort (e.g., chest pain, headache, breathing difficulty) rather than more psychological symptoms, framing the therapeutic interaction in a formal medical model and treating somatic complaints directly before addressing the associated situational, emotional, and social problems is recommended (Kinzie & Leung, 1993). While certainly some relatively Westernized Asian Americans will seek out reflective, nondirective, open-ended process-oriented therapies, this will not be the preferred mode of intervention for most of this clientele. Indeed, if psychoanalysis is attempted in a language in which the client is not fully proficient, the analyst should expect significant transference associated with whether the immigrant is idealizing or retreating from the new country, its language, and its providers (Litjmaer, 1999). Practitioners are advised to be explicit, by the end of the first session where possible, in describing the treatment plan—the specific goal and time frame, along with what will be required of the client, what procedures will be like, and what research supports those procedures. Structure, directiveness, and problem-focused approaches enhance the practitioner's credibility and the client's hope and comfort, increasing the chances of return visits.

Emphasize the Family Context

Family treatment should be very carefully implemented when working with Asian American clients. In family-based treatment, it is important to acknowledge traditional authority

lines in ways that are sensitive to participating members. When an intergenerational conflict between individualist and collectivist values presents, it is advisable to couch it first from the collectivist stance as a way of recognizing the family as a whole. The more "Westernized" younger clients will likely recognize and respond positively to approaches that assume caring, wisdom, and authority from the older cohort. Reassured elders will then be more comfortable supporting their children's pursuits.

The power of Asian American families when they mobilize to support changes in individual or family functioning cannot be overstated. The practitioner should cast a wide net in determining the family system, since some recently immigrated families have key members still back in the home country, whose presence is still felt in a very immediate sense. Other families may keep a shrine in the home for deceased family members, on which they regularly place offerings—again reflecting the very real referred presence of another's influence on the current family dynamics. Even when the family therapy modality is not used, familial relationships and issues of collective face are still likely to surface in the counseling or treatment transactions.

Employ Spiritual Resources

Cultural consonance and efforts to work within the client's spiritual worldview enhance the credibility, attractiveness, and effectiveness of the treatment plan. For example, a colleague who uses biofeedback successfully for Asian Americans with anxiety disorders sometimes engages them first in a discussion of "*chi*" enhancement and alignment. Christian Asian American clients prefer Christian practitioners (Misumi, 1993; Tan & Dong, 2000), and will likely respond favorably to referencing Christian values and beliefs. American-born contemplative Buddhists may find cognitive behavioral and humanistic approaches which focus on "mindfulness" quite attractive and consonant with their meditation practices; they may actually be disproportionately involved in these forms of therapy (Finn & Rubin, 2000).

Exploration of the religious and spiritual aspects of the Asian American client often yields important material for therapy. Is the Japanese American's "it can't be helped" ("*shi kata ga nai*") attitude using the passive acceptance of Buddhist teachings in a positive or negative way? Is the Asian Indian American using the concept of karma to accept or to avoid personal accountability and responsibility? Does the Chinese American's Taoist perspective suggest treatment goals that are couched in terms of balance, or seem compatible with incorporation of meditation or use of a *tai chi* or *chi gung* group as an adjunct to treatment? Are the behaviors of the recent immigrant from a rural outer island in the Philippines in fact a culture-bound syndrome, not psychiatric but spiritual in etiology and remedy? Many American-born contemplative Buddhists are articulate about their beliefs and choice of spiritual leader (Finn & Rubin, 2000), and it is appropriate to explore these significant resources for growth or problem resolution efforts.

Therapists working with Asian American clients will want to be able to identify and access as needed the rich assortment of monks, priests, ministers, shamans, healers, and spiritual teachers their clients look to—sometimes as consultants, sometimes as referral sources or referrals, sometimes for adjunctive roles in treatment. Therapists will also want to remain alert to the potentially beneficial practices of their Asian American client's spiritual systems

(e.g., meditation, yoga, martial arts, and other mental-physical practices) and be able to work alongside these practices synergistically, from a holistic perspective where possible.

Enhance Own Cultural Understandings and Cultural Connections

There is a large and growing body of knowledge available about the many facets of Asian American subpopulations and their experiences and worldviews. Mental health practitioners can increase their understanding of these various sub-groups by mastering not only the professional literature but also the growing body of autobiographies, nonfiction accounts, and fictional novels and stories by Asian American authors or about Asian American subjects. Films, plays, and other lively arts also can enhance cultural understandings for the interested learner. Participating in activities of the local Asian American community and joining community groups that attract Asian Americans are other useful and productive ways of gaining greater insights into (and comfort with) cultural practices, forms of communication, and worldviews. This kind of learning by cultural immersion appears to enhance cultural understandings in qualitatively different ways. Bicultural individuals in a mainstream setting behave in accord with the mainstream norms, but behave quite differently in settings where they are the majority, so immersion in those ethnic community settings usually affords rich new perspectives and enhanced multicultural competencies. Community connections also provide the treatment adjuncts, referral sources, cultural materials, and cultural consultants so important for those who serve the culturally diverse.

Enhance Both Asian and American Connections of Client

Asian Americans experience the mixed blessing of biculturalism, each in his or her own way at any given time. Rarely do they seek treatment for bicultural or ethnic identity issues per se, but rather for managing their problems at work, their relationships and health, and the other problems of living. However, because issues of biculturalism, acculturative dynamics, and ethnic identity evolution seem forever part of the substrate, the practitioner might consider setting ancillary goals regarding improved identity alignment and enhanced empowerment in connections with both the mainstream American culture and organizations and the ethnic Asian ones. Outcomes may be measured as improved self-efficacy, greater comfort in declaring one's identity, greater ease in navigating across cultures, stronger connections with both mainstream and ethnic community organizations and values, or comfort in taking more leadership as a bridge person of sorts. It is our experience that when counseling or psychotherapy with Asian Americans is successful, this is an unsought but nonetheless significant benefit. The following case examples illustrate some of the strategies that have been discussed.

Case Examples

Roles, Obligations, Face, and Grief

David Uyemoto is the hospital liaison to the four grown children of Mrs. Watanabe, a 95-year-old Japanese American who came to the United States as a

picture bride, was long ago widowed, and has recently declined rapidly from Alzheimer's disease. Uyemoto's job is to help the children attend their mother's last days and make necessary decisions. These children are well-educated professionals with a 30-year age spread, acculturated in varying degrees. Only the two eldest speak Japanese; the women have out-married; and the youngest has divorced. Now they are arriving from all corners of the country.

At the family's request, Uyemoto holds several family counseling sessions around issues of who will pay for what expense, when to stop applying unusual life saving means, and what kind of funeral "*Okasan*" would want. In these sessions, the traditional duty of the eldest son clashes with pragmatics—some younger daughters are better informed and more skilled in performing the executive and case managerial duties that are his by tradition. Power issues surface: Should sons, particularly the eldest one, have greater decision-making power, or should the family function as a simple democracy? Japanese family dynamics of guilt and obligation become apparent. The siblings quarrel softly and obtusely about issues of filial piety: Who has done what to support *Okasan* and be there for her, along the way and at the end? The discussion about the funeral centers on what "a good Japanese" funeral would be like, but disagreements of what "Japaneseness" means reflect the acculturative heterogeneity within the sibling group. Mrs. Watanabe was Buddhist for most of her life, but had begun attending services and social events at the nearby Japanese Methodist church, where Japanese was spoken.

Dr. Uyemoto presides over the Watanabe children's decision-making sessions, staying task-focused and directing the group's discussion, while probing the different perspectives of the children. The reunited siblings interact intensely outside of their sessions with Uyemoto, grateful for the privacy to work through, outside of his presence, the intimate family matters of mourning, filial piety, and sibling rivalry, and to define what being "Japanese" and "American" mean to them as they confront the loss of *Okasan*, the most Japanese of them.

For the third anniversary of Mrs. Watanabe's death, the time of ascent to Buddhist heaven, the siblings contract Dr. Uyemoto to preside over their reunion, although none of them is a practicing Buddhist. Here the discussion covers their evolved sense of what being Japanese American means, their mourning and recovery, and their appreciation to Uyemoto for managing their journey together in such a fruitful and healing way.

Cultural Adaptations in Crisis and Mourning

The local Refugee Resettlement program calls Ann Lorenzo to attend a crisis. An eight-year-old Hmong boy has hung himself. Lorenzo drives to the public housing project where the family lives and sits on the floor of the cramped living room with a translator, the parents, and some younger children. The conversation does not much resemble a typical psychotherapy session with mainstream clients. Family members seem transfixed with fear, unable to keep

from glancing to the corner where the boy has hung himself with an electric cord. They talk about "ghosts" (per the translator), and want more than anything to change dwellings, to switch to a different unit in the project. The young translator is clearly embarrassed, calls them superstitious, and notes what his supervisor has told him—that this is not possible, given the housing rules.

In this difficult situation, Lorenzo develops the family's trust in three ways. She attends the boy's funeral in the town's Paupers Field. She successfully intervenes with the public housing authority to have the family moved to a different unit. She finds shamans in the local Hmong community and elicits the family's agreement that they be put in touch with each other. Later she learns that several sessions of shamanistic rituals have occurred to banish destructive spirits, and the family is at peace that their young child is safely home in their ancestral spirit world.

Lorenzo later meets with the family three more times. In these sessions, working with the same translator, she helps connect the father with a maintenance job, compliments the younger children for their growing grasp of English and exhorts them to help and obey their parents, and focuses extensively on the mother, who is deteriorating, complaining of incapacitating headaches, refusing to learn English, and remaining very disconnected from the extant Hmong community. Lorenzo recruits a kind and solicitous Hmong woman in the ESL program to serve as a volunteer sponsor, and this volunteer befriends the disconsolate mother, bringing her herbal headache remedies and inducting her to the ESL program. The client becomes a regular member of the Hmong ESL program, developing friendship supports in the community while learning English. Over time her headaches cease.

The typical issues of mourning the boy's death were never part of the therapy directly presided upon by Lorenzo, but instead were addressed by Lorenzo's attendance at the funeral, the introduction of the community shamans, and the recruitment of the outreach volunteers from the Hmong community. This resulted in strengthening the family and enhancing its adaptation to this new country, and it improved relations between the Hmong community and the mental health establishment.

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