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Mental Health

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For decades, a popular belief among the general U.S. public has been that Asian Pacific Americans are extremely well adjusted, as reflected in their low rates of social deviance (e.g., juvenile delinquency and criminality) and divorce as well as high socioeconomic mobility (e.g., educational and occupational attainments) (Sue & Morishima, 1982). Although there is increasing recognition that the popular conception of well-adjusted Asian Pacific Americans is actually a stereotype, little knowledge exists on the mental health problems experienced by members of this community or on strategies to increase the availability and effectiveness of services for this population. The intent of this chapter is to review the available data and literature on mental disorders and intervention programs or services for Asian Pacific Americans.

Prevalence of Mental Disorders

Unlike other ethnic groups, such as African and Hispanic Americans, Asian Pacific Americans have had to confront stereotypes of extraordinary well-being and mental health. In psychological research on Asian Pacific Americans, the critical question is not whether mental health problems exist, because all groups encounter these problems. The meaningful questions involve the extent of mental disorders, the nature of psychopathology, and the particular Asian

Pacific American groups at risk for disorders. I will address these questions in this section by discussing some prevalence, personality, and needs assessment studies.

Prevalence Studies

Prevalence studies attempt to specify the new and ongoing cases of disorders in a particular population over a specified period of time. This is usually accomplished by surveying a population or a representative sample of the population, using a valid measure of psychological disturbance. For example, in the Epidemiologic Catchment Area Study, one of the largest and most rigorous prevalence investigations ever undertaken in the United States, Myers et al. (1984) used the Diagnostic Interview Schedule to ascertain the mental health status of thousands of Americans in different cities across the United States. The investigators found that over a 6-month period, nearly 20% of Americans had experienced or were currently experiencing a mental disorder. The most frequent disorders involved were anxiety and depression.

Unfortunately, in the case of Asian Pacific Americans, no large-scale prevalence studies have been conducted. Thus it is difficult to specify what the rates of mental disorders are within this population, or to compare the various Asian Pacific American groups with each other and with non-Asian Pacific American groups. Because the population of Asian Pacific Americans is relatively small (less than 3% of the U.S. population) and is composed of many different groups, researchers have had difficulty finding adequate and representative samples with which to conduct studies. Furthermore, lack of funding for research on Asian Pacific Americans and problems in finding cross-culturally valid measures of psychopathology have also hindered attempts to study the prevalence of psychiatric disorders among this population. The few available investigations of Asian Pacific Americans have been small-scale studies, often based on selected groups or on selected disorders, and some have not been true prevalence studies. The data that are available, however, provide evidence that suggests the rates of psychopathology among Asian Pacific Americans have been underestimated. Examples of studies with selected groups include the work of Westermeyer, Vang, and Neider (1984), who studied a small group of Laotian Hmong refugees in Minnesota. Using various measures of psychopathology (e.g., the Self-Rating Depression Scale and the Symptom

Checklist-90), these researchers found that the refugees had very high rates of psychiatric disorders. Other studies have also revealed that Southeast Asian refugees are at risk for mental disorders (Berry & Blondel, 1982; Lin, 1986). Investigations by Kuo (1984; Kuo & Tsai, 1986) have examined community samples of four different Asian American groups: Chinese, Japanese, Filipino, and Korean. Using the Center for Epidemiological Studies-Depression Scale, Kuo found that Asian Americans had higher average scores on the measure than did whites. About 19% of the Asian Americans studied were identified as potential cases of depression on the measure.

Finally, in an epidemiological study, Hurh and Kim (1990) examined the correlates of mental health in more than 600 Korean Americans. For male immigrants, being married and being employed in a high-status occupation were related to better subjective mental health. In the case of female immigrants these variables were also important, but less so than in the case of males. The investigators interpreted the findings in terms of Korean gender role ideology.

Personality Surveys

In addition to prevalence studies, personality investigations have provided insight into the mental health problems of Asian Pacific Americans, because they often assess levels of adjustment. Using the Omnibus Personality Inventory (OPI), Sue and his colleagues compared Japanese and Chinese American college students with non-Asian students at the University of California, Berkeley (D. Sue, 1973; Sue & Frank, 1973; Sue & Kirk, 1973). No differences between Chinese and Japanese American students reached significance. However, when race-by-sex comparisons were conducted, significant differences were found. In terms of anxiety level, Chinese American males and females expressed significantly more discomfort than did their control counterparts. On the Personal Integration Scale, Chinese American males and females and Japanese American males expressed more feelings of isolation and loneliness than did their control counterparts. On the Social Extroversion Scale, these three groups also had greater tendency to withdraw from social contacts. Japanese American females did not differ from the control females on any of these scales. Finally, in their responses to the Impulse Expression Scale, Chinese American males and females and Japanese American females were more likely to inhibit the expression of impulses than were control males and females. These results

suggest that Chinese American males and females and Japanese American males show more feelings of anxiety, discomfort, loneliness, and isolation than their control counterparts. In addition, they are less socially extroverted and less likely to express impulses than other students. The results are less clear for Japanese American females.

A more recent study using the OPI found similar results between Chinese American students at UCLA and those from the UC Berkeley study that was conducted more than 10 years earlier (Sue & Zane, 1985). Most important, the study revealed that anxiety levels of students were directly related to acculturation: Recent immigrants were more likely to experience anxiety than were immigrants who had been in the United States longer. Interestingly, the academic achievement levels (i.e., academic grades) of the Chinese students exceeded those of the general student body. Thus the fact that Asian Americans perform well in terms of academic achievement should not be used as an indicator of emotional well-being or adjustment.

Needs Surveys

Needs surveys are intended to provide information on the needs that particular groups have. The needs investigated may include economic, housing, legal, employment, and service requirements. These surveys frequently assess mental health needs and provide an understanding of the extent and nature of emotional/adjustment problems of a given community. Two early needs surveys among Asian Pacific Americans are quite revealing. B. L. C. Kim (1978) studied Chinese, Japanese, Korean, and Filipino Americans (immigrants and citizens) in the Chicago area. Kim assessed social, economic, educational, and mental health needs as well as attitudes and beliefs about social service organizations and cultural resources. He found important differences within and between Asian American groups, but one of the more general problems he found was that of language. Not surprisingly, Asian Americans tended to be concerned about English proficiency. The lack of English facility seemed to exacerbate virtually every problem faced by the Asian Americans in Kim's study. Other common problems included cultural differences, insufficient income, employment problems, and experiencing discrimination.

The second revealing needs survey, conducted in Hawaii, provides insight into the public awareness and perception of mental

health services (Prizzia & Villanueva-King, 1977). A significant proportion of respondents in this survey were unaware of the availability of local mental health services, although the vast majority considered such services important. About a third of the respondents reported that they would feel some degree of discomfort in using services, particularly Samoan and Filipino Americans; there was less discomfort among whites and Japanese Americans.

These early needs surveys helped to document the kinds of problems faced by Asian Pacific Americans and their attitudes toward services. In view of the rapid increase in Asian and Pacific Islander immigrants and refugees in recent years, a more current appraisal of needs was undertaken by Zane, Fujino, Nakasaki, and Yasuda (1988) in Los Angeles. These researchers held meetings with community leaders and residents and conducted key informant interviews to assess the needs of various Asian Pacific American groups, such as Cambodians, Chinese, Japanese, Koreans, Laotians, Filipinos, Samoans, Thais, Tongans, and South Vietnamese. In general, employment, legal, and English-language needs were of top priority, especially for recent immigrants and refugees. Mental health needs were also considered important, although they were secondary to employment and language needs.

The findings from the available research on prevalence, personality, and needs strongly imply that major mental health problems exist among Asian Pacific Americans. The few prevalence and personality studies demonstrate some of the emotional problems (i.e., anxiety and depression) that are common. Although the validity of measures for ethnic minority groups can always be questioned in the absence of validation studies, the evidence is quite convergent. The needs assessment research reveals that mental health needs are judged to be secondary to language, employment, and legal concerns. However, emotional well-being and adjustment are likely to be strongly related to these concerns. Although it is difficult to specify the prevalence of disorders, the available research findings are contrary to the widespread belief that Asian Pacific Americans are extraordinarily well-adjusted.

Disorders and High-Risk Groups

Given the fact that little is known about the nature and distribution of mental disorders among Asian Pacific Americans, one can only speculate as to the kinds of emotional problems individuals in

this population experience. Many Asian Pacific Americans report conflicts involving the family, such as in parent-child interactions. Children often feel that parents maintain traditional role relationships that hinder the children's attempts to be independent. For example, a first-generation father may perceive a second-generation son as being disobedient and no good; in turn, the son may view the father as authoritarian, distant, and old-fashioned. Another common problem among Asian Pacific Americans is extreme shyness and the identity conflicts that can result. Although shyness is not intrinsically negative, many Asian Pacific Americans find this personality pattern disturbing and want to be less shy, especially in a society that values assertiveness and where ethnic minority group individuals encounter stereotypes and discrimination. How these problems are reflected in rates of actual mental disorders is unclear.

We also know that certain groups are at greater risk than others for mental health problems. Recent immigrants, for example, encounter numerous problems involving English-language skills, minority group status, cultural conflicts, and employment that are basic to survival and well-being. The Sue and Zane (1985) study mentioned above demonstrated that recent Chinese immigrants are more likely to report anxiety than are later immigrants or American-born Chinese. Other studies have revealed that Southeast Asian refugees are at particular risk for depression and post-traumatic stress disorder, because of premigration traumas and the postmigration stressors of adapting to and living in a new culture (Gong-Guy, 1987; Westermeyer et al., 1984).

Aside from interest in the distribution of disorders and high-risk groups, researchers have focused attention on somatization among various Asian Pacific American groups. Investigators have argued that certain groups, such as the Chinese, exhibit somatic complaints in their psychiatric symptomatology. For example, researchers have found that many Asians who are treated for mental health problems complain of headaches, back and chest pains, and the like (Kleinman, 1982; Sue & Morishima, 1982). In a study of cultural differences in symptom expression, Kitano (1969) found that Japanese schizophrenics, compared with Caucasian schizophrenics, were more likely to be withdrawn and to exhibit fewer acting-out behaviors. He attributes the differences to cultural factors, such as the tendency for many Japanese to react to stress by becoming more inward (*ga-man*)—somatizing and suffering without showing overt signs

of agitation. Among many Asians there is a belief in unity between the mind and the body, so emotional disturbances are often reflected in somatic symptoms. For example, in a study of the symptoms exhibited by whites, blacks, and Chinese, Chang (1985) found ethnic differences in the patterns of depressive symptomatology. Cognitive concerns characterized the white group, a mixture of affective and somatic complaints was found among blacks, and Chinese were the most likely to exhibit somatic complaints in depressive symptomatology. Similarly, Tung (1985) asserts that in the case of many Southeast Asians, somatic symptoms such as headaches, insomnia, fatigue, loss of memory, and poor appetite are quite common. These complaints may represent more culturally legitimate means of expressing distress, as physical affective symptoms are less stigmatizing than are emotional or psychiatric problems.

The meanings of findings pertaining to somatization have been debated. One view is that somatization actually represents a depressive disorder (Kleinman, 1982). Somatization may be a socially acceptable means of suppressing direct depressive affect while allowing the individual to receive secondary gain—for example, the attention and dependency that comes with the sick role. Another view is that somatization is a function of the lack of available social supports rather than of the suppression of emotions. The lack of social support leads to feelings of hopelessness, which may cause somatization, especially in cultures where the conceptualization and labeling of mental illness is different from Western cultures, where direct “psychologizing” of problems exists (W. H. Kuo, personal communication, 1989). Others have argued that somatization is often under the control of display rules that dictate when, where, and what symptoms are shown (Cheung, 1982). In this view, it is not so much that Chinese suppress or repress affective symptoms as that the context of the situation influences what is presented. Chinese may display somatic symptoms to mental health workers but show depressive symptoms to others. Although these explanations are similar in some respects and are culture based, they differ in emphasis, on whether somatization is viewed as being under the control of intrapsychic or environmental demands. The issues surrounding somatization are important for assessment and treatment. If somatization represents an underlying depressive condition, then the validity of assessment instruments that do not take into account cultural expressions of symptoms may be called into question. If

somatization operates under certain display rules, then it is important for a practitioner to understand the rules before rendering a diagnosis. In terms of treatment, confusion over the meaning of somatic symptoms hinders the determination of appropriate forms of treatment and the problems that should be addressed.

Mental Health Services

In the past, utilization of mental health services was used as an indicator of psychopathology in particular populations. The assumption was that if one group had a high prevalence of mental disorders, that group would tend to utilize services more often than would a group with a lower prevalence rate: The *demand* for services was considered to be a reflection of the *need* for services. It is now widely recognized that demand does not indicate need, especially for some groups. Nevertheless, utilization of services must be examined, because it reveals possible cultural differences in defining and approaching mental health problems, provides information about the kinds of problems clients have, indicates the responsiveness of the mental health care system, and yields some insight into how we may better treat or prevent problems. In this section I will examine studies of utilization and then discuss factors that influence help seeking in the service system.

Utilization

Table 9.1 lists a number of studies that have examined utilization among various Asian Pacific American groups. Almost all past studies have demonstrated low rates of utilization among Asian Pacific Americans. Kitano (1969) presented findings on the admission of patients to California state mental hospitals; admission rates for mental disturbance were many times lower for Japanese and Chinese Americans than for Caucasian Americans during each of the years from 1960 to 1965. Data from the state of Hawaii also revealed low Asian and Pacific Islander rates of admission to state hospitals for mental disorders. Chinese, Hawaiian, Japanese, and Filipino Americans all exhibited lower rates of admissions than expected from their proportions in the population.

These and more recent studies consistently demonstrate that Asian Americans tend to be underrepresented in psychiatric clinics and

Table 9.1 Studies Examining Mental Health Service Utilization Among Asian Pacific Americans

Study	Population	Measures	Findings
Sue and Sue (1974)	students	MMPI, critical items	underutilization, more disturbed, high dropout
Kitano (1969)	general population/ inpatients	—	underutilization
Hawaii State Department of Health (1970)	general population	—	underutilization
Brown et al. (1973)	general population/ inpatients	ratings	underutilization, more disturbed
S. Sue (1977)	general population	diagnosis	underutilization, more disturbed, high dropout
L. A. County Department of Mental Health (1984)	general population	—	underutilization
Cheung (1989)	general population	—	underutilization
O'Sullivan et al. (1989)	general population	GAS	no underutilization, no greater disturbance, low dropout
Snowden and Cheung (1990)	general population/ inpatient	diagnosis	underutilization, longer stay
Sue et al. (1991)	general population	diagnosis	underutilization, greater disturbance
Matsuoka (1990)	general population	—	underutilization

hospitals compared with their proportions in the larger population (Brown, Huang, Harris, & Stein, 1973; Cheung, 1989; Los Angeles County Department of Mental Health, 1984; Snowden & Cheung, 1990; S. Sue, 1977; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). The underrepresentation occurs whether student or nonstudent populations, inpatients or outpatients, or different Asian Pacific American

groups are considered. In one of the most comprehensive analyses conducted to date, Matsuoka (1990) examined Asian Pacific Americans' use of services at state and county mental hospitals, private psychiatric hospitals, Veterans Administration psychiatric services, residential treatment centers for emotionally disturbed children, nonfederal psychiatric services in general hospitals, outpatient psychiatric clinics, multiservice mental health programs, psychiatric day/night services, and other residential programs in the United States. In general, Matsuoka found that utilization of services by Asian Pacific American populations was low, regardless of their population density in various U.S. states. The only exception to findings of underutilization is found in a study by O'Sullivan, Peterson, Cox, and Kirkeby (1989). Analyzing the community mental health service utilization rates for ethnic groups in the Seattle area, the investigators found that Asian Americans were not underrepresented as users. It is unclear why the results of this study are at variance with all of the others. One potential explanation is that the utilization figures for 1983 were compared with Seattle population data from the 1980 census. If the Asian Pacific American population had marked growth from 1980 to 1983 in Seattle (as it did elsewhere—Asian Pacific Americans represent the fastest-growing ethnic minority in the United States), then this group may indeed be underrepresented as clients. Perhaps the findings are unique to Seattle. In any event, underutilization appears to be the rule rather than the exception.

Severity of Disturbance

The term *underutilization* implies that Asian Pacific Americans are not using services when they need to. Is it possible that this population is relatively better adjusted than other populations, so that greater utilization of services is unnecessary? Every population underutilizes in the sense that not all individuals with psychological disturbance seek help from the mental health system. For example, in the Epidemiologic Catchment Area Study, which compared the prevalence rate of mental disorders with the rate of utilization of mental health care services, the vast majority of afflicted individuals did not seek services (Shapiro et al., 1984). The real issue is whether Asian Pacific Americans with psychiatric disorders have a greater propensity to avoid using services than do other populations. Although this issue cannot be fully addressed in the absence

of information on prevalence rates, considerable indirect evidence exists that Asian Pacific Americans are more likely than the general population to underutilize services. As mentioned earlier, the available small-scale prevalence, personality, and needs assessment studies of Asian Pacific Americans suggest that considerable mental health problems exist, and yet utilization is dramatically low. Other lines of evidence, such as severity of disturbance, also point to underutilization.

A study in which I took part in the 1970s analyzed the Asian American (primarily Chinese, Japanese, and Korean) students who utilized the student psychiatric clinic at the University of California, Los Angeles (Sue & Sue, 1974). We obtained information on the number of Asian American student clients, MMPI test scores, and therapists' impressions of these clients. Our findings indicated that Asian American students, who represented 8% of the campus population, constituted only 4% of the clients at the psychiatric clinic—an underrepresentation factor of one half. When we examined the MMPI records, we found that Asian American students exhibited more severe disturbances than other students. Therapists' clinical notes also confirmed that the Asian American students had more serious symptoms than did non-Asian students. The findings revealed that Asian Americans underutilized mental health services and exhibited greater disturbance among the client population. Our inference was that moderately disturbed Asian Americans, unlike Caucasian Americans, are more likely to avoid using services (unless one takes the unusual and unsupported position that Asian Americans have low rates of overall disturbance but high rates of severe mental disorders).

Other studies demonstrate that the phenomena of low utilization and greater severity among Asian Pacific American clients are not confined to students. Brown and his colleagues (1973) investigated Chinese American patients at Resthaven Community Mental Health Center in the Chinatown area of Los Angeles. They examined records of 23 Chinese and 23 Caucasian American patients who were matched on variables such as sex, age, financial status, and legal status (voluntary or involuntary admission). The researchers obtained data from patients' backgrounds, treatment records, and behavioral rating measures. Ratings of patients on the Twelve Psychotic Syndromes Scale revealed that Chinese Americans scored significantly higher than Caucasian Americans on psychomotor retardation, seclusiveness, help needed, and psychotic disorganization.

Brown et al. also found that Chinese Americans underutilized the community mental health center by about half the rate expected on the basis of their proportion of the population in downtown Los Angeles.

In the Seattle Project, I collected records of clients from different Asian American groups, such as Chinese, Japanese, Korean, and Filipino Americans, as well as non-Asian groups, from 17 community mental health centers for a 3-year period (S. Sue, 1977). My intent was to investigate utilization rates, severity of disorders, and demographic characteristics of clients. Relatively few Asian Americans used services: Although they represented about 2.4% of the population served by the centers, only about 100 (or less than 1%) of the 13,000 patients were Asian Americans. To determine whether they were more severely disturbed than whites, I compared Asians with whites in the proportion of functional psychotic diagnoses. A significantly higher percentage of Asian American patients (22%) were diagnosed as psychotic, compared with the 13% figure for white patients. The difference persisted even after I controlled for demographic differences between the two groups in age and educational attainments.

Finally, the National Research Center on Asian American Mental Health at UCLA acquired a large data set on thousands of clients seen in the Los Angeles County mental health system from 1983 to 1988. Preliminary analysis of the data set revealed that Asian Pacific Americans were underrepresented in the outpatient mental health system. They represented 8.7% of the county population, but they constituted only 3.1% of the clients. Latinos were also underrepresented. On the other hand, blacks used services in proportions greater than expected given their relative proportion in the population. When the proportions of clients having psychotic diagnoses were tabulated by ethnic group, Asian Pacific Americans were more likely than whites, blacks, and Latinos to have individuals with psychotic diagnoses in inpatient and outpatient services.

The evidence is quite convergent that few Asian Pacific Americans use the mental health service system. This underutilization is found among all Asian Pacific Americans groups studied, among inpatient and outpatient facilities, and among students and adults. Furthermore, the studies consistently show that on a variety of measures Asian Pacific Americans have greater disturbance levels than do non-Asian clients. The alternative explanation that low utilization of services is caused by the low rate of mental distur-

bance is weakened by findings that Asian Pacific Americans who seek treatment are more severely disturbed than are Caucasian Americans who do so. These findings suggest that more moderately disturbed Asian Pacific Americans may simply not be using professional mental health services. Lin, Inui, Kleinman, and Womack (1982) found that Asian Americans were more likely than whites to have delays in the recognition of mental health symptoms and in actual participation in a treatment program.

Reasons for Underutilization of Services

A number of factors affect utilization and effectiveness of mental health services, including accessibility (e.g., ease of using services, financial cost of services, location of services), availability (e.g., existence of services), cultural and linguistic appropriateness of services, knowledge of available services, willingness to use services, and existence of alternative and competing services. Further, the nature of an individual's problems also influences utilization. In this section I will focus on culture-based factors such as shame and stigma, conceptions of mental health, and alternative services as factors that affect utilization and appropriateness of mainstream services (i.e., services that are available to the general U.S. population).

For many Asian Pacific American groups, cultural attitudes and beliefs must be considered in the analysis of service utilization. Particularly important is the concept of *shame* or *face*. *Haji* among the Japanese, *hiya* among the Filipinos, *mentz* among the Chinese, and *chaemyun* among the Koreans are terms that reveal concerns over the process of shame or the loss of face (B. L. C. Kim, 1978). The existence of certain problems in the family—such as juvenile delinquency and acting-out behaviors, mental disorders, AIDS, poverty—is considered shameful and likely to bring disgrace on the entire family (Sue & Morishima, 1982). Consequently, many Asian Pacific Americans tend to avoid the juvenile justice or legal system, mental health agencies, health services, and welfare agencies, because the utilization of services for certain problems is a tacit admission of the existence of these problems and may result in public knowledge of familial difficulties. For example, Asian Pacific Americans have been found to differ from white Americans in help-seeking behaviors for emotional difficulties. They are less likely to request outside help for these difficulties, turning first to

their families for help and to outside agencies or mainstream services only as a last resort (Tracey, Leong, & Glidden, 1986). Although most Americans are likely to turn to their families as the first resource, and to feel shame or stigma over certain problems, the avoidance of mainstream services is more pronounced among Asian Pacific Americans. That is, there is a differential effect caused by the strong concern over loss of face among Asian Pacific Americans.

Because of shame and stigma, several consequences can be hypothesized. First, those behaviors that create shame and stigma are the ones that are most likely to be denied. For example, the behaviors of children and adolescents are considered a reflection of family upbringing. Therefore, parents may delay using services for their children if such services are needed for problems that would bring shame upon the family. It should be noted that the shame associated with having health and mental health problems may be experienced more acutely by Asian Pacific Americans who reside in immigrant communities. In such communities there are great expectations for doing well in America for the sake of family members both in the United States and back in the country of origin. The personal networks in these communities are often extensive, and information about others is easily shared and disseminated. Within this context, the development of a mental health problem that may compromise a person's productivity or status can generate significant loss of face. Moreover, the need to seek outside help for such a problem only exacerbates the shame. Thus available services tend to be underutilized. Second, as mentioned earlier, the need for services is not equivalent to the demand for services. Asian Pacific Americans may have needs for certain services that are not reflected in their utilization patterns. Third, if services are avoided and used as a last resort, problems may be exacerbated by the delay in finding assistance. Fourth, because Asian Pacific Americans pay taxes for services that they avoid using, they do not receive their fair share of services.

The nature of mental health is strongly influenced by culture. As noted earlier, cultural influences help to shape the symptoms an individual exhibits when emotionally disturbed. Cultural factors also affect interpretations of the causes of disorders and interventions deemed appropriate to overcome health and mental health problems (Leong, 1986). In traditional Chinese culture, for example, many diseases or physical afflictions are attributed to an imbalance of cosmic forces—yin and yang. The task is to restore

balance through proper diet, exercise, and psychosocial relationships with others. Essentially, this is a holistic approach to health. Kinzie (1985) notes that many Southeast Asians have a folk tradition in which illness is believed to be caused by physiological factors or supernatural forces (e.g., as the consequence of offending a deity or spirit). Thus they may be unwilling or unable to differentiate among psychological, physiological, and supernatural causes of illness.

Because of the cultural factors that influence symptom expression and conceptions of illness, it is apparent that Asian Pacific Americans are likely to differ from mainstream Americans in the types of interventions used to prevent or treat emotional disturbances and illnesses. The interventions may involve restoration of balance and holistic approaches that are consistent with their cultural beliefs: use of herbal medicine, consultations with folk healers or fortune tellers, acupuncture, certain forms of exercise, and so on. The extent of utilization of these alternatives among different Asian Pacific American groups is unknown, although it is assumed to be highest among recent immigrants or those who are relatively less acculturated to American society. In a study of the utilization of medical care systems among Chinese Americans in Boston, Hessler, Nolan, Ogbu, and New (1975) divided utilization patterns into Chinese medical care only, Western medical care only, predominantly Chinese care, and predominantly Western care. Demographic variables, as well as identification with being Chinese, predicted the type of health care sought. Not surprisingly, Chinese medicine was favored by those subjects less acculturated to American society. Other Asian Pacific American groups also make use of alternative forms of treatment.

The notion that underutilization is, in part, caused by the use of alternative resources is supported by studies of Asians in other countries. For example, Lin, Tardiff, Donetz, and Goresky (1978) found that Chinese resorted to family for support before seeking assistance from medical professionals. Only after a long period of delay did they enter the mental health care system. Although most Americans tend to rely on family and friends before turning to mental health workers (Gourash, 1978; Gurin, Veroff, & Feld, 1960; Lieberman & Glidewell, 1978), there is a marked tendency for Asian Pacific Americans to avoid mental health providers.

These studies suggest that Asian and Caucasian Americans do have different conceptions of mental health and disturbance. Asian

Pacific Americans tend to perceive more organic or somatic involvement in emotional disturbance. They also believe that the exercise of willpower, the avoidance of morbid thoughts, and a focus on pleasant cognitions are means to enhance psychological well-being (Sue & Morishima, 1982). Because professional mental health treatment often stresses insight-oriented approaches that require self-disclosure of morbid (that is, disturbing and embarrassing) thoughts, Asian Americans may avoid Western forms of mental health treatment and seek medical treatment for emotional problems.

Enhancement of Services

Counseling and psychotherapy in the United States generally represent a particular (white, middle-class, Western) worldview. The characteristics of American therapy may conflict with values, styles, and expectations commonly found among Asian Pacific Americans (S. C. Kim, 1985). Thus services may not be culturally consistent with the backgrounds and experiences of Asian Pacific Americans. How can services be organized to respond better to the needs of Asian Pacific Americans? Three directions are discussed below: changes in mental health programs, awareness of interpersonal processes in treatment, and community education.

Organization of Services

In another context I have offered three suggestions for more effectively meeting the mental health needs of Asian Pacific Americans (Uba & Sue, in press). First, in mainstream mental health facilities where there are few Asian Pacific American personnel, service providers can receive training for working with Asian Pacific American clients. Such training would cover assessment, psychotherapy, and case management and would include issues such as cultural values and behaviors and pre- and postmigration experiences. The intent of the training would be to enhance skills and knowledge about Asian Pacific Americans. Special Asian Pacific American consultants should be available to the service providers. Second, mainstream mental health programs should employ more Asian Pacific American personnel who are bilingual and bicultural. Such personnel can be of immense benefit in the effective provision of

services. In recent work my colleagues and I have found that when Asian Pacific American clients are matched with therapists who are of the same ethnicity and who speak the clients' language, they stay in treatment longer, tend not to terminate services prematurely, and have better treatment outcomes (Sue et al., 1991). Third, parallel or nonmainstream services should be created. Parallel services are those that may be similar to mainstream ones (e.g., a clinic or hospital) but are specifically designed to serve an ethnic population. For example, a specific ward was created to serve Asian Pacific Americans at San Francisco General Hospital, and in Los Angeles, the Asian Pacific Counseling and Treatment Center was established. Such services typically employ bilingual and bicultural personnel, post notices in English and Asian languages, serve "Asian" foods or drinks, and so on—all in an attempt to respond to the cultural needs of Asian Pacific Americans. Existing parallel services should be strengthened, and new parallel programs should be designed.

Interpersonal Processes

In addition to organizational changes in the service delivery system, therapists must develop skills for working with Asian Pacific Americans. How can clinicians become more effective in working with Asian and Pacific Islander clients? Traditionally, researchers and practitioners have advocated two strategies—one concerning the importance of knowing the culture and background of clients and the other concerning specific techniques to use with ethnic minority clients. Neither strategy has been very effective. Acquiring cultural knowledge is important, but such knowledge has not led directly to an increased understanding of how to conduct psychotherapy. For example, if a practitioner knows that South Vietnamese are family oriented, how should he or she apply this knowledge in therapy? Several other questions can be raised. How much cultural knowledge is necessary? Isn't it impossible to know enough about all the cultures of all the diverse groups in the United States? Does studying the cultural background of a client lead to the danger of stereotyping the client?

The difficulties in addressing these questions have led some investigators to question whether cultural knowledge is a sufficient condition for conducting effective psychotherapy and to offer more concrete suggestions on how to conduct therapy. Some clinicians

have attempted to devise what are considered culturally consistent forms of intervention. For example, Asian Pacific Americans tend to prefer psychotherapists who provide structure, guidance, and direction rather than nondirectiveness in interactions (S. C. Kim, 1985), and therapists have been advised to be directive with Asian Pacific Americans. Similar suggestions have been made for other minority group clients. However, these recommendations also raise questions. Is it possible for therapists to change their therapeutic orientations in working with ethnic clients? For instance, a psychoanalytic therapist might find it very difficult to become more directive when working with an Asian client. By using a specific approach—one presumably based on the culture of the client—how does one deal with intragroup variability, given that ethnic minority clients may show many individual differences? Is there a single, culturally consistent form of treatment for each ethnic group? Given the problems in fully answering these questions, Nolan Zane and I have recommended the investigation of therapeutic processes rather than simply argued for cultural knowledge or culture-specific forms of treatment (Sue & Zane, 1987). The two processes we believe to be critical, at least in initial treatment sessions, are credibility and gift giving (i.e., seeing that the client receives a benefit early in the treatment process).

Credibility. Two factors are important in the area of credibility: ascribed status and achieved status. *Ascribed* status is an individual's position or role as it is assigned by others or by cultural norms. For example, in some cultures the young are subordinate to elders, women defer to men, and those who are naive submit to those in authority. Credibility can also be established through *achieved* status. In a clinical context, achieved credibility comes about through the skills and actions of the therapist in treatment, as when the therapist does something that is perceived by the client as being helpful. Ascribed and achieved credibility undoubtedly are related, but they tend to have distinct and different implications for ethnic clients in terms of the psychotherapeutic process. Lack of ascribed credibility seems to relate to clients' willingness to use services, whereas lack of achieved credibility may better explain premature termination and problems related to poor rapport.

Giving. Asian Pacific American clients often wonder how self-disclosure of personal problems to psychotherapists can result in

the alleviation of emotional and behavioral distress. Generally, clients need to feel a direct benefit from treatment. I refer to this benefit as a "gift." This gift is essentially a gesture of caring on the part of the therapist. The therapist cannot simply raise the expectations of Asian Pacific American clients about outcomes; he or she must give direct benefits that can be experienced by these clients early in treatment. In this way the therapist can achieve status and, thereby, impart credibility to the therapy. Further, immediate treatment benefits address skepticism about Western forms of treatment on the part of many Asian Pacific Americans.

What kinds of gifts can be offered? Much depends on the particular client and situation, but several gifts can be considered. For example, clients who are depressed or anxious will perceive gains in therapy if they experience an alleviation or reduction of these negative emotional states. The therapist can frequently help clients who are in a state of crisis and confusion to develop cognitive clarity or a means of understanding the chaotic experiences they encounter. Such a technique is often used in crisis intervention. Also, therapists can lead clients through the process of normalization, through which the clients come to realize that their thoughts, feelings, or experiences are common to others as well. This may be a gift to those who do not talk to others and mistakenly believe that others do not have similar problems. Gift giving is intended to provide some type of meaningful gain early in therapy. The process of giving, of course, can be conceptualized as a special case of building rapport or establishing a therapeutic relationship. The main point is that therapists need to focus on gift giving and attempt to offer benefits from treatment as soon as possible for Asian Pacific American clients. Therapists should think of the gifts that they can offer, even in the first session.

Community Education

One of the most valuable strategies to use in addressing the mental health needs of Asian Pacific Americans is community education. Many Asian Pacific Americans are unfamiliar with Western mental health concepts and available services. They may consider mental health problems to be shameful or private and may lack understanding about how services can help. In such situations, education is needed to modify attitudes and to indicate methods by which problems can be addressed. Such educational efforts can be made

through schools, mass media (radio, television, ethnic newspapers), community forums, and other institutions, coordinated with mental health agencies.

Several points are important to make in the educational messages aimed at Asian Pacific Americans:

1. *Personal and interpersonal problems are common.* These problems can involve generational conflicts in the family, difficulties in adjusting to American society, anxieties, and depression. Unless the problems are addressed, individuals will continue to feel upset, to have interpersonal problems, and to fail to achieve more. (Examples of common problems should be given.) There is no need to be ashamed of having problems; shame simply hinders one's willingness to find means of overcoming them.
2. *Much can be done to prevent or overcome problems.* Learning how to anticipate or manage problems by oneself and talking with others are often very helpful approaches. (The early identification of potential emotional problems, stress management techniques, and communication skills should be emphasized.)
3. *Individuals should seek services for mental health problems if they find their problems too difficult to manage by themselves.* Although traditional, ethnic folk healing may be helpful, mental health services can be effective and should be considered a viable resource. Clients' problems are kept confidential (in accordance with laws) and therapists are available who can speak the ethnic language of clients. (A description of where services are available and the kinds of services available would be very helpful.)

In other words, educational programs should be designed that will describe accurately the nature of mental health problems and services, will provide some ideas of the means of handling problems, and will make services more accessible and acceptable.

Summary

In this chapter I have discussed the mental health problems among Asian Pacific Americans and some services and strategies for increasing the effectiveness of services to those in that population. The major themes can be readily summarized. First, although there has been little research on this population, Asian Pacific Americans have been shown to experience considerable mental

health and adjustment problems. Second, particular groups, such as refugees, are especially at risk for psychopathology. Third, adequate resources for Asian Pacific Americans are lacking, and evidence suggests that individuals in this population underutilize mental health services. Finally, much can be done to improve the delivery of services, such as reorganizing services and hiring appropriate ethnic personnel, training effective psychotherapists, and establishing educational programs.

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Tuberculosis

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Tuberculosis is a disease that antedates recorded history. There is evidence of spinal tuberculosis in neolithic and pre-Columbian skeletons. Tuberculosis was well known to ancient Greek physicians such as Aristotle and Hippocrates, who used the term *phthisis*, which later translated into "consumption." However, tuberculosis did not become a major problem until the crowded living conditions of the early Industrial Revolution provided a favorable environment for its spread.

Prevalence

It is estimated that in the eighteenth and nineteenth centuries, tuberculosis accounted for one fourth of adult deaths in Europe (Dubos & Dubos, 1952). At the beginning of the twentieth century, tuberculosis was the leading cause of death in the United States; since then, there has been a steady decline in the mortality rate, from 202/100,000 population in 1900 to approximately 3.3/100,000 or 6,500 deaths in 1968.

With the advent of modern treatment there is no longer a high mortality rate for tuberculosis. Thus the new case rate became a more accurate measure of clinical problems. The new case rate has also been steadily declining in recent years. However, with the influx of new immigrants from highly endemic regions of the world,