

ASIAN AMERICANS IN PSYCHIATRIC SYSTEMS

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Prior to the 1960's, very little interest had been shown in researching patterns of American utilization of mental health facilities. The notion of culturally different patterns of psychological "normalcy" for Asian Americans as a distinct population had not been adequately explored. Although a few case studies of Asian-American patients did appear in the literature from time to time, no extensive or systematic research into the demographic and psychological characteristics of Asian-American patient populations had been presented.

Since 1960, a limited number of reports and papers have been written describing the local psychosocial milieu and its affect upon Asian Americans. Reports documenting the conditions of community mental health centers repeatedly state the need for bicultural, bilingual professional and paraprofessional staff (1, 2, 3, 7, 8, 17). Clinical reports on Asian-American psychiatric patients point out subtle differences between Asian-American and Caucasian patients as well as variations within the Asian-American population based upon generation and ethnicity (2, 4, 5, 6, 9, 10, 18).

Two areas of concern most frequently cited as requiring immediate attention are: (1) the recent immigration of foreign-born Asians (1, 3, 8, 17), and (2) the "underutilization" of mental health facilities by Asian Americans in general (7, 14, 16). Foreign-born Asians, as a high risk group, are a very pressing concern. The influx of more than 150,000 Southeast Asians into the United States in 1975, and the prospect of another 15,000 persons entering the United States in the near future, will require the development of appropriate, culturally specific programs staffed by sensitive professionals. Until the requisite programs are implemented, sensitivity and care will be needed to reach across the cultural gap that separates many Asian-American patients from those who are able to lend some assistance.

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According to Segal and Lourie:

Although the number of [Southeast Asian refugee] psychiatric casualties has been insignificant this cannot be viewed as a barometer of overall psychological distress among the refugee population. Furthermore, it is likely that the problems will increase over time as the ambiguities of new life and the shock of family separation increases. . . . Staff must be sensitized to handle the many and often subtle human issues, thus an intensive staff training program should be developed and utilized. (15)

While the authors stress the need for staff training and sensitivity to specific refugee problems and issues, why should this sensitivity stop with recent immigrants from Southeast Asia? All Asian and Pacific Island people are faced with the problems of adjustment and disorientation that are encountered upon entering American society. The Chinatown Family Outreach Center in Oakland, California, has found that 87.6 percent of its clients seeking help are foreign born (3). Tom and his research group from the Northeast Mental Health Team have also stressed the difficulties that foreign-born Asian Americans experience in an American cultural setting (17). The Asian Community Mental Health Service (1) in Oakland, California, has found that a large number of their clients are foreign-born Asians. Brown et al. (2) have identified newcomers in the Chinese population of Los Angeles' Chinatown as a high risk group.

The Asian Community Mental Health Service (1) and Kim (11,12, 13) have identified a high risk group within the generalized foreign-born Asian-American population. These are Asian-born women married to United States military personnel. The specialized problems and concerns of this particular group of Asian Americans have been documented by Bok-Lim Kim (11,12,13).

Mental health service and outreach programs directly involved in the Asian-American community have repeatedly noted Asian-American underutilization of mental health facilities. These sources have also identified recent Asian immigrants/foreign-born Asians as a very high risk group.

Clinical work and inpatient studies concerning Asian-American psychiatric patients have emphasized the difference in cultural orientation and the necessity for sensitivity and awareness on the part of the hospital staff. Enright and Jaeckle (5) question the appropriateness of the Krapelinian diagnostic system for individuals with a non-western cultural background, especially in the case of Asian-American patients. Tseng et al. (18) have pointed out differences among Chinese Americans, Japanese Americans, Korean Americans, and Pilipino Americans in Hawaii. Katz and Senborn (10) point out differences between Japanese-American psychiatric patients who are:

. . . more schizoid, withdrawn and retarded, and caucasians [who] are more emotional. Pilipino patients are more excited, hyperactive and have [more] manic qualities compared to Japanese patients. (10)

Ikedda et al. (9) notes a difference between Japanese Americans who trace their ancestry to the main islands of Japan and Japanese Americans of Okinawan descent in relative incidence and diagnostic proportions of mental illness in the Hawaiian Asian-American population. Draguns et al. (4) have found a "difference in spheres, but not in individual symptoms or roles between Christian and Buddhist Japanese American psychiatric patients in Hawaii." Finney (6) and Kitano (14) have also noted "differences in the kinds of psychological sickness to which [Asian Americans] are prone" (6).

METHODOLOGY

Most of the literature available on Asian-American patterns of utilization of mental health facilities has been restricted to comparisons between a particular Asian-American ethnic group and Caucasians in general, or among selected Asian-American ethnic groups. Consequently, only the major Asian-American population groups, such as the Japanese American, Chinese American, and, to some extent, the Pilipino American, appear in the literature. In addition, many of the cited reports cover a specific region, such as Hawaii, the San Francisco Bay area Asian-American communities, or the Los Angeles Chinatown community. Again, these studies focus on very specific Asian-American groups and fail to present data on smaller populations of Asian Americans.

In order to explore and possibly clarify some of the issues surrounding utilization patterns of mental health facilities by Asian Americans, a pilot study was undertaken in San Diego, California. San Diego is characterized by the absence of distinct geographical boundaries within which Asian Americans reside. In this respect, it differs from cities such as San Francisco and Los Angeles where large numbers of Asian Americans are concentrated within specific areas.

Three inpatient psychiatric facilities were selected as a source of patient information. A community mental health hospital, a private psychiatric hospital, and a university teaching psychiatric facility were selected.

A twenty-nine item questionnaire was developed to serve as a method of standardizing the reporting of case material for each Asian-American patient identified by a chart survey as having utilized any of the various facilities. Three basic areas are covered by the questionnaire. The first section provided an organizational framework for all the available demographic data on each patient. The second section focused on the psychiatric

background of the patient and the patient's family. The last section consisted of a symptom review of the treatment period. The preliminary analysis presented below will focus on the first section of the questionnaire.

A ten-year period, from 1965 to 1975, was selected as the framework for data collection. In each institution, all of the charts were manually searched in order to identify as many Asian-American patients as possible. Although a very careful and methodical search procedure was established and constant cross-checking through the data gathering phase was utilized, it is quite possible that all Asian-American patients were not located. Between 1965 and 1975, 209 charts were located that could be positively identified as being Asian American. Once a chart was located, the relevant information was completed in the questionnaire, and each completed questionnaire was compared with other completed forms to insure that no duplicate records were constructed for any patient. The responses were then coded and processed for evaluation.

Determination of ethnic identity or consistency in reporting ethnic identity did not seem to be a major concern of the hospital staff. In some cases, no ethnic identity would appear in a patient's chart. In other cases, obscure references to the patient's ethnic identity were all that could be located. This confusion covered not only the patient's ethnicity, but extended to diagnosis, medical history, and family history of illness. For the purposes of this study, only those patients who could be positively identified as Asian American were included. As one of the research staff stated, "Ethnicity, biographies, the number of outpatient and inpatient visits, treatments, diagnoses, and prognoses were inconsistently recorded. In some cases, no information was recorded at all, or, if information was recorded, it might have no resemblance to that information that allegedly justified the final diagnosis."

Given these limitations and the biases that may be introduced through the questionnaire itself, the research staff, and the institutions selected, the following results have been obtained.

FINDINGS

According to Table 1, twelve different Asian or Pacific Island ethnic groups are represented in the psychiatric patient population. During the ten years covered by the study, almost 80 percent of the patients were of Japanese, Chinese, or Pilipino ancestry. Although there are nine other ethnic groups represented during the study period, it is impossible to make any generalizations that could be considered representative of the entire population. However, these smaller Asian-American populations do

indicate that there is no single group at risk and that consideration must be given to even the smallest Asian-American ethnic group, although it should be noted that the full impact of the most recent Southeast Asian immigration has yet to be felt. These smaller populations of Asian-American ethnic groups also indicate the multitude of cultures that are covered by the term "Asian American." Programs and staff must have access to information regarding each ethnic group in order to provide adequate and appropriate care and treatment modalities for an Asian-American patient. A second factor raised by this first table is the extremely high proportion of Asian-American women in the sample population. Of all Asian-American patients identified, 73 percent were women.

TABLE 1

ETHNICITY AND SEX

Asian-American Psychiatric Patients, 1965-1975,
Selected Psychiatric Facilities, San Diego, California

| Ethnicity | Sex | | |
|------------|------|--------|-------|
| | Male | Female | Total |
| Chinese | 19 | 20 | 39 |
| Guamanian | 1 | 4 | 5 |
| Hawaiian | 4 | 4 | 8 |
| Japanese | 12 | 75 | 87 |
| Korean | 1 | 5 | 6 |
| Malaysian | 1 | 1 | 2 |
| Okinawan | 0 | 3 | 3 |
| Pilipino | 13 | 28 | 41 |
| Samoan | 3 | 3 | 6 |
| Tahitian | 0 | 1 | 1 |
| Thai | 1 | 2 | 3 |
| Vietnamese | 0 | 3 | 3 |
| Happa* | 1 | 4 | 5 |
| Total | 56 | 153 | 209 |

*Happa is the Japanese term for children of mixed marriages.

Table 2 indicates the breakdown of utilization of the three psychiatric facilities: County Mental Health, a community mental health hospital; Mesa Vista, a private facility; and University Hospital, a university teaching psychiatric facility.

TABLE 2

ETHNICITY, SEX, AND PSYCHIATRIC FACILITY

Asian-American Psychiatric Patients, 1965-1975,
Selected Psychiatric Facilities, San Diego, California

| Ethnicity | County Mental Health | | Mesa Vista (Private) | | University Hospital | | Total |
|------------|-------------------------|--------|-------------------------|--------|------------------------|--------|-------|
| | Male | Female | Male | Female | Male | Female | |
| Chinese | 13 | 5 | 3 | 9 | 3 | 6 | 39 |
| Guamanian | 1 | 3 | 0 | 1 | 0 | 0 | 5 |
| Hawaiian | 3 | 3 | 0 | 1 | 1 | 0 | 8 |
| Japanese | 7 | 26 | 2 | 35 | 3 | 14 | 87 |
| Korean | 1 | 3 | 0 | 1 | 0 | 1 | 6 |
| Malaysian | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| Okinawan | 0 | 3 | 0 | 0 | 0 | 0 | 3 |
| Pilipino | 9 | 13 | 1 | 11 | 3 | 4 | 41 |
| Samoaan | 3 | 3 | 0 | 0 | 0 | 0 | 6 |
| Tahitian | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Thai | 0 | 1 | 1 | 0 | 0 | 1 | 3 |
| Vietnamese | 0 | 1 | 0 | 1 | 0 | 1 | 3 |
| Happa* | 0 | 2 | 1 | 2 | 0 | 0 | 5 |
| Total | 38 | 65 | 8 | 61 | 10 | 27 | 209 |

*Happa is the Japanese term for children of mixed marriages.

Table 3 presents the characteristics of the patient population by place of birth. A vast majority of the Asian-American patients are foreign-born Asians. Only 14.8 percent of all the Asian-American patients were American born. If Asian Americans born in Hawaii are included with the mainland-born population of Asian Americans, the proportion of American-born Asians rises to only 23.4 percent. In this population, the foreign-born/new-arrival Asian American is much more likely to utilize available mental health facilities than either the mainland-born or Hawaiian-born Asian American.

Why American-born Asians do not utilize mental health facilities as readily as foreign-born Asians has no simple answer. The available literature speculates upon such factors as the cultural stigma for American-born Asians, lack of awareness about mental health facilities by American-born Asians, and consequently a need for education about mental illness and mental health facilities for American-born Asians. However, the elevated utilization rates of foreign-born Asians would seem to indicate that other factors may be at work. This variation in utilization

patterns by American-born Asians and foreign-born Asians needs to be explored by integrating cultural differences between American-born Asians, foreign-born Asians, and Caucasians. The expectations, roles, and norms of the various groups as they relate to mental health may be a portion of the explanation.

TABLE 3

ETHNICITY AND PLACE OF BIRTH

Asian-American Psychiatric Patients, 1965-1975,
Selected Psychiatric Facilities, San Diego, California

| Ethnicity | Place of Birth | | | Total |
|------------|----------------|--------|--------------|-------|
| | Mainland | Hawaii | Foreign Born | |
| Chinese | 6 | 2 | 31 | 39 |
| Guamanian | 0 | 0 | 5 | 5 |
| Hawaiian | 0 | 8 | 0 | 8 |
| Japanese | 16 | 4 | 67 | 87 |
| Korean | 0 | 3 | 3 | 6 |
| Malaysian | 0 | 0 | 2 | 2 |
| Okinawan | 0 | 0 | 3 | 3 |
| Pilipino | 6 | 1 | 34 | 41 |
| Samoan | 0 | 0 | 6 | 6 |
| Tahitian | 0 | 0 | 1 | 1 |
| Thai | 0 | 0 | 3 | 3 |
| Vietnamese | 0 | 0 | 3 | 3 |
| Happa* | 3 | 0 | 2 | 5 |
| Total | 31 | 18 | 160 | 209 |

*Happa is the Japanese term for children of mixed marriages.

Table 4 indicates a high incidence of schizophrenia for the patient population. Of all Asian-American psychiatric patients, 44.5 percent were diagnosed as schizophrenic. The other factor that is presented by this table is the large number of patients in the "other" category. Of the thirty-two patients in this category, sixteen were diagnosed as adult situational reaction, while five were diagnosed adolescent adjustment difficulties. The elevated incidence of schizophrenia agrees with research reports concerning Japanese in Hawaii (14). However, the number of patients diagnosed as having a life adjustment difficulty would seem to warrant closer examination. A more complete examination of the patient's past history and the cultural context are extremely important indicators that need to be explored.

TABLE 4

ETHNICITY AND DIAGNOSIS

Asian American Psychiatric Patients, 1965-1975,
Selected Psychiatric Facilities, San Diego, California

| Ethnicity | Diagnosis | | | | | | | | | Total |
|------------|-----------|-------------------|--------|----------|-------|------|-----|-------|-------|-------|
| | No Info | Primary Affective | Schizo | Neurosis | Drugs | EtOH | OBS | Combo | Other | |
| Chinese | 0 | 7 | 16 | 4 | 0 | 0 | 2 | 0 | 10 | 39 |
| Guamanian | 1 | 1 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 5 |
| Hawaiian | 1 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 3 | 8 |
| Japanese | 1 | 22 | 38 | 8 | 4 | 0 | 1 | 2 | 11 | 87 |
| Korean | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 6 |
| Malaysian | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Okinawan | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Pilipino | 0 | 5 | 22 | 5 | 0 | 0 | 2 | 1 | 6 | 41 |
| Samoan | 0 | 0 | 3 | 1 | 0 | 2 | 0 | 0 | 0 | 6 |
| Tahitian | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Thai | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 3 |
| Vietnamese | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 3 |
| Happa* | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 1 | 5 |
| Total | 4 | 39 | 93 | 23 | 4 | 4 | 5 | 5 | 32 | 209 |

*Happa is the Japanese term for children of mixed marriages.

To summarize, the Asian-American psychiatric patient population in this pilot survey had an extremely high number of women and foreign-born Asians with diagnosis of schizophrenia or life adjustment difficulties. These factors indicate that, at least in San Diego, a very different patient profile represents the Asian-American population that does utilize available mental health facilities.

DISCUSSION

Prior research on the nature of the Asian-American psychiatric population has focused on two types of services. The community mental health system and outreach programs have identified foreign-born Asians and Asian women married to United States military personnel as very high risk groups. Psychiatric inpatient reports have stressed differences between various Asian-American groups and the Caucasian population and differences among Asian-American groups. Although the present study is based upon a very small sample, some clear statements about the Asian Americans utilizing mental health facilities in San Diego can be made:

1. These findings add further substantiation to the assertion that foreign-born Asians are a very high risk group within the Asian-American population. Within the foreign-born category, women, especially Japanese women, are an extremely high risk group. Foreign-born Asians, especially women, may be isolated the most from social support systems and existing ethnic community networks. Their different cultural background adds further complications to utilization of support systems if there are no bicultural or bilingual staff to offer assurance and assistance.
2. The large number of schizophrenic and situational adjustment reaction patients might suggest a difficulty caused by cultural discontinuity or an inability to articulate needs or problems in an unfamiliar culture and language. Perhaps the appropriateness of these diagnoses should be reconsidered in light of the variances in symptomology found by other researchers.

The data gathering and data analysis of the material highlighted two concerns that apply to general hospital patients. The inconsistency and incompleteness of many files regarding diagnosis, ethnicity, date of birth, place of birth, length of residence in the United States, and familiarity with the English language become critically important factors when the patient is not familiar with this cultural system, especially the culturally approved notions about health, mental health, and healing. If this material is not available or given consideration by the staff during admission, treatment, and posthospital care, inappropriate diagnosis, treatment, and prognosis may occur. Secondly, a more consistent reporting format is necessary. It is almost impossible

to compare admission statistics or diagnostic statistics between ethnic groups without a more standardized reporting system. As long as the system is caring for and designed for only one ethnic group, it may function without too many difficulties. Because there is an indication that Asian-American psychiatric patients do vary from the majority population in a number of areas, appropriate consideration must be given or inappropriate treatment may result.

A number of concerns have been expressed by various interest groups concerning the nature of Asian Americans who utilize mental health facilities. Unless consistent and complete reporting procedures are developed and followed, the Asian-American psychiatric population will remain invisible, and indeed differences in utilization patterns and symptom expression will remain isolated bits of annoying information that are largely ignored. The real loss will be to the individuals and families that could benefit from such information if consistently and accurately recorded. Without careful and thorough background research in this area, the appropriateness of diagnosis and treatment for Asian Americans will remain a vague notion without foundation, validation, or consistency of results.

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