MENTAL DISORDERS AND SYNDROMES FOUND AMONG ASIANS RESIDING IN THE UNITED STATES

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Abstract:
The Asian population in the United States is the fastest growing minority; consequently it behooves psychiatric nurses and other mental health professionals to be aware of symptom presentation of emotional problems that may differ from those of other population groups. Specific syndromes, psychiatric disorders, and symptoms that commonly present as physical disorders are discussed. Recommended adaptations of psychiatric interventions, including medications and other therapies, are offered to enable mental health professionals to provide culturally sensitive care. Mental health care that is culturally competent may improve access to care for Asians residing in the United States.

Article:
Ethnicity, race, beliefs, values, religion, and customs, as well as socioeconomic status, influence the symptoms or the presentation of emotional disorders related to mental health and illness (Campinha-Bacote, 1997). Symptoms associated with specific disorders may vary from culture to culture, or some syndromes may be more prevalent in one culture than in another (Campinha-Bacote, 1988; Leveck, 1991). In Asian cultures, somatic symptoms are less stigmatizing than in the Caucasian American culture (M. T. Kim, 1995). It is the custom that one does not discuss feelings, especially bad feelings, so that somatization of illnesses such as depression is more acceptable. Expression of emotional distress is considered unacceptable, because to openly discuss negative emotions is a disgrace to the client and his or her family (C. L. Kuo & Kavanagh, 1994). The psychiatric nurse or mental health provider (MHP) may find a depressed patient complaining of pain, such as headaches or stomachaches, rather than presenting with sad affect and tearfulness (M. T. Kim, 1995; Stewart, 1995). A review of the literature on mental health and illness among Asians provides psychiatric nurses and MHPs the opportunityto examine potential mental health problems that might otherwise be overlooked because of lack of knowledge about cultural variations.

Asians believe that mental health can be achieved by avoiding bad thoughts (Stewart, 1995). They will usually turn to their families for support and, if willpower and family support do not help, they then turn to the local indigenous healer rather than seeking help from an American psychiatrist or an MHP at a community mental health facility (M. T. Kim, 1995). Many Asians prefer to first deal with symptoms using traditional Eastern remedies such as acupuncture or meditation. Often Asians will delay treatment and consequently will come into a mental health

facility with more severe symptoms because they have been reluctant to seek mental health care (Marsella & Higginbotham, 1984). During the course of psychiatric treatment they tend to drop out early because they do not trust the mental health system, they experience a conflict of Eastern and Western values, or they are uncomfortable with Western psychiatric methods, especially the use of medications with side effects that may make them feel bad (Cheung & Snowden, 1990; Jung, 1998; Marsella & Higginbotham, 1984; Stewart, 1995; D. W. Sue & Sue, 1990; S. Sue & McKinney, 1975, 1980).

Misdiagnosis of mental illness in an Asian is common, for the following reasons: (a) the presenting symptoms are different from the symptoms displayed by other groups; (b) there is a lack of knowledge about Asian cultures on the part of many psychiatric nurses and other MHPs; and (c) many professionals lack self-awareness about their own cultural sensitivity, and language barriers lead to misunderstandings between professional and patient (Campinha-Bacote,1997; Cheung & Snowden, 1990; Hutchinson, 1992; Jung, 1998; Lin, Inui, Kleinman, & Womack, 1982; Louie, 1996; Nah, 1993; Spector, 1996; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue & Sue, 1990; S. Sue & McKinney, 1975, 1980). Understanding culturally based presentations of mental illness will enable the psychiatric nurse to recognize mental illness when the patient does seek help. Early case finding and treatment may prevent future long-standing disabilities. Modifying traditional psychiatric approaches may enhance compliance for Asians who are in need of mental health care (D. W. Sue & Sue, 1990).

By the year 2050, Asians will have experienced the greatest percentage increase of any other minority group in the United States: from 3% of the population in 1990 to 10.7% in 2050 (Aponte, Rivers, & Whol, 1995). Asians are the most diverse of the minority populations in the United States; they speak more than 20 different languages; come from many different countries and cultures, for different reasons; and arrive on the U.S. shores at different points in history. There are also wide educational and socioeconomic differences among Asians (Herrick & Brown, 1998). There is a myth among Americans in general, including MHPs, that people in higher socioeconomic groups and those who are well educated have fewer mental health problems. A large percentage of Asian Americans are well educated and earn good salaries, which may contribute to a lack of attention to their social and psychological problems, according to Morrissey (1997).

In examining statistics related to specific psychiatric disorders, we found a paucity of data, because prevalence rates in the United States among Asians were not specifically identified for this population group. Asians are often identified as "other." Kessler et al. (1994) conducted a survey in the United States of psychiatric disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (third ed., rev. [DSM—III—R]; American Psychiatric Association, 1987) and comorbidity rates. Categories in this study were "White, Black, Hispanic and Other" (p. 11). Hoyert and Kung (1992) studied mortality rates of Asian Americans and reported that suicide was the leading cause of death for Asian Indians aged 15±24 years. However, in the data they published about the top five leading causes of death in Asian American groups, suicide was ranked fifth for Koreans and Hawaiians but was not in the top five causes of deaths for other Asian groups.

Weissman et al. (1996) studied population patterns for major depression and bipolar disorders in 10 countries, including 2 Asian countries: Taiwan and Korea. They found striking similarities across cultures. Weissman et al. suggested that "cultural differences" in prevalence rates had to do with "different risk factors that may affect the expression of the disorder" (p. 293). In every country, rates of depression were higher in women than in men; however, rates of bipolar disorder were equal in men and women. Across cultures, people with major depression frequently were at higher risk for substance abuse and anxiety disorders. Symptoms of depression included insomnia and loss of energy for most people, irrespective of culture. On average, the age of onset was earlier for bipolar disorder than for depression, across cultures. Weissman et al. speculated that "social stigma and cultural reluctance to endorse mental symptoms" (p. 298) may have accounted for some of the differences in prevalence rates for depression in Taiwan and Korea, compared with other countries.

In spite of differences among the subgroups of Asians, there are some common values and beliefs that may affect their mental health care. Beliefs and values that are common to Asian cultures include a family structure that is patriarchal and hierarchical and the importance of the extended family (del Carmen, 1990; S. C. Kim, 1985; Kitano & Kikumura,1980; D. W. Sue & Sue, 1990). Leveck (1991) identified the phenomenon of "filial piety" to include respect for male dominance, the extended family, and ancestors. The family is highly valued, and family secrets, including symptoms of mental illness, are kept within the family and are not shared with outsiders.

Illnesses, both mental and physical, are considered an imbalance among spiritual, social, and physical domains (D. W. Sue & Sue, 1990). Other factors that should be considered by MHPs are that (a) many Asians have experienced discrimination in American society, which affects their mental health, and (b) others, namely the Cambodians and Vietnamese, have been victims of atrocities that have had lasting psychological effects on their mental health (Carlson & Rosser-Hogan, 1991; Kessler & Neighbors, 1986; Kinzie & Fleck, 1987; Spector, 1996). The influences of Asians' pre- and postimmigration experiences, as well as the kind of support they received on arrival, will affect their mental health and should be considered (W. H. Kuo & Tsai, 1986; Nicholson, 1997).

A review of the literature revealed some syndromes that are uniquely Asian. The presentation of symptoms of mental disorders may differ from those of other populations (Carlson & Rosser-Hogan, 1991; Cohen & Singer, 1995; D'Avanzo, Frye, & Froman, 1994; Leveck, 1991) and therefore go unrecognized as needing psychiatric care. Underutilization of mental health services by Asians is a concern among MHPs (Crystal, 1989; Herrick & Brown, 1998; Jung, 1998; Sue & Morishma, 1982; D. W. Sue & Sue, 1990). In this article we discuss common mental disorders and syndromes that are uniquely Asian and suggest modifications of usual psychiatric interventions. Culturally competent care may increase the utilization of mental health services by Asians.

CULTURALLY BASED SYNDROMES

Kelly (1998) claimed that culture defines normal and abnormal physical and mental health. According to DSM±IV (American Psychiatric Association, 1994), culture-bound syndromes are "locality-specific patterns of aberrant behavior" (p. 844).

Campinha-Bacote (1988) distinguished a syndrome from a disease, indicating that a syndrome is a "perception, evaluation, explanation and labeling of symptoms" (p. 246) rather than a disease with biological and psychological malfunctioning. Culture-bound syndromes are usually limited to a specific culture and are rarely equivalent to a DSM diagnosis. The following are brief descriptions of syndromes found in the psychiatric nursing and mental health literature.

Latah and Ainu

Campinha-Bacote (1988) described two syndromes that are found among Asians. Latah is a syndrome that occurs in southeastern Asian women, and ainu is found among Japanese women. The symptoms are triggered by a startle and include "imitative behavior, automatic responses to commands and utterances of obscenities" (p. 246). These symptoms are usually seen in postmenopausal women and may be part of a postmenopausal depression. Speculation is that these behaviors allow women to express their aggression in a male-dominated society.

Hsieh-Ping, Koro, and Amok

Campinha-Bacote (1988) described two syndromes found primarily in men. Hsieh -ping is a trancelike state in which Chinese males believe they are possessed by their dead relatives. Koro is a panic state experienced by southeastern Asian males. In both syndromes the male fears losing his penis, which he thinks will retract into his abdomen, causing death. This illness may be interpreted as castration anxiety that is due to guilt regarding real or imagined sexual encounters. Leveck (1991) described a condition known as amok. The afflicted person, who is from Indonesia, "runs amok" through a village, after a depression, wielding a weapon and threatening murderÐperhaps the expression of the anger component of depression. Koro and amok are described in the Appendix of culture-bound syndromes in the DSM±IV (American Psychiatric Association, 1994).

Busy-Busy Syndrome and Anomic Syndrome

Aylesworth, Ossorio, and Osaki (1980) described two syndromes found among Vietnamese that they attributed to an underlying depression. A person with busy-busy syndrome presents with hypomanic behaviors that may give way to an acute depression. The person is preoccupied with trivial tasks. Another syndrome is known as anomic syndrome, described as an amotivational syndrome that has the added component of acting out bizarre behaviors. Anomic syndrome is usually found in young males who have few family ties, many of whom are servicemen.

Hwa-Byung

M. T. Kim (1995)described hwa-byung syndrome as a Korean folk illness that has symptoms that overlap with symptoms listed by DSM—III—R for major depression, including dysphoria, anxiety, irritability, and difficulty concentrating. The syndrome primarily looks like a physical illness rather than a major depression. Physical symptoms include feelings of constriction in the chest, palpitations, heat sensations and headaches. Kim stated that hwa-byung is typical of the way that emotional problems are expressed as a physical illness among Korean patients and that the syndrome should be treated as a depression. Hwa-byung is attributed to anger suppression and literally means “anger syndrome,” according to DSM±IV (American Psychiatric Association, 1994, p. 846).

Shenjing and Shenkui

Both Shenjing and Shenkui are Chinese syndromes described in DSM—IV (American Psychiatric Association, 1994). The first is identified as a neurasthenia with physical and mental fatigue, dizziness, headaches and other pains, and difficulty sleeping as well as concentrating, including memory loss. Other symptoms are gastrointestinal and sexual dysfunction. Psychological symptoms include irritability and excitability. This diagnosis is included in the Chinese Classification of Mental Disorders (2nd ed., [CCMD-2], DSM—IV, 1994, p. 848). The disorder is attributed to anxiety. Shenkui is similar to an anxiety or panic disorder with somatic symptoms of dizziness, backache, fatigue, weakness, insomnia, and excessive dreaming, accompanied by sexual problems. It is thought to be caused by the excessive loss of semen through nocturnal emissions or masturbation.

Specific treatments for these syndromes were not discussed in the literature. An assumption could be made that most of the syndromes mask anxiety or depression and, therefore, treatment for the underlying anxiety or depression might decrease the symptoms associated with the syndrome.

MENTAL DISORDERS

Information about mental disorders diagnosed in Asians living in the United States is scant and often contradictory. According to Carlson and Rosser-Hogan (1992), depression and posttraumatic stress disorder (PTSD), especially among Cambodian refugees, are the most prevalent mental disorders discussed in the literature. According to M. T. Kim (1995), depression has been found to be higher among Asian Americans than among Caucasian Americans (p. 13). Jung (1998, p. 218) reported the following percentages of mental disorders among Asians seeking community mental health services in California: schizophrenia and mood disorders were 40% each, anxiety disorders were 10%, and other diagnoses composed 10%. Leveck (1991) stated that the rates of mental illness among Asians are similar to other cultures, although Asian clients are less likely to seek psychiatric treatment, and therefore the actual incidence of mental disorders may not be accurately reflected in mental health statistics. According to Fugita (1990), "there has been no comprehensive epidemiologic survey of Asian/Pacific Americans" (p. 69).

Suicide

Suicides among rural Chinese females residing in China have been epidemic, with the overall rate being 60% higher than for women aged 20-24 in the United States (Bueber, 1993). Suicide rates in a population of Asians in San Francisco were also higher for both males and females than the national average in the United States (Fugita, 1990). In San Francisco, the peak age for suicide of Asians was reported to be 55-65 years. Rates were higher among foreign-born Asians living in San Francisco who were over 55 years of age and were unmarried, unemployed, or retired (Fugita, 1990). This picture of social isolation is often associated with suicide in other U.S. cultures. The only source of rates of suicide among American Asians was Hoyert and Kung’s Monthly Vital Statistics Report (1997). The lack of data may be due to the frequent categorization of Asians as "other" in epidemiological studies; see, for example, the Kessler et al. (1994) study.

Alcoholism

Alcoholism is rarely mentioned in the literature as a mental health problem of concern to Asians, and alcohol use varies among the ethnic subgroups (D'Avanzo, 1994; Fugita, 1990; Maddahian, Newcomb, & Bentler, 1985). Generally, Asians do not consume as much alcohol as Americans, probably because they do not metabolize it as well and experience uncomfortable symptoms, including flushing and heart palpitations (Fugita, 1990). However, some authors have expressed concern that the patterns of use have been changing among adolescents and that alcohol use is on the increase (Leung & Sakata, 1990). The misuse of tobacco and drugs among young people may be the result of the process of acculturation into U.S. society and may also be the result of peer pressure. Yee and Thu (1987) found that alcohol, drug, and tobacco use among Indochinese refugees was becoming an increasing concern. Bueber (1993) noted an absence of patients with dual diagnoses, substance abuse disorders, or personality disorders in China. Therefore, one could speculate that abuse of alcohol and other substances may be associated with the trauma of migration; it might be a way of coping with symptoms of anxiety and depression. D'Avanzo (1994) associated alcohol and drug abuse with anxiety and depression among Cambodians who were suffering from PTSD. In these clients, treating the PTSD and the depression must proceed concomitantly with treating the addiction.

When Asians encounter problems with alcohol or drugs, they may not be responsive to services available to treat addictions (Fugita,1990). Alcoholics Anonymous's (AA) methods of using group support and confrontation are alien to Asians. Group interventions are unacceptable to Asians because they consider the revelation of unacceptable behavior and unacceptable thoughts and feelings in a public forum to be taboo. Assigning a sponsor to work with the client individually or with an indigenous healer would be a more culturally appropriate intervention than AA. Education in the schools and school-based mental health programs could provide early identification and interventions with adolescents (Jung, 1998).

Depression

C. L. Kuo and Kavanagh (1994) examined Asians' somatization of depression. Self-control, the desire to save face and protect one's family, and the stigma of mental illness demand that symptom presentation be somatic rather than psychological. Denial of depression occurs frequently, because depression is viewed as a reflection of poor family relationships or thinking bad thoughts. Preservation of self-image and the family's image prevents the free expression of depressive feelings (C. L. Kuo & Kavanagh, 1994; W. H. Kuo, 1984). M. T. Kim (1995) identified the most frequent symptoms of depression as headaches, back pain, indigestion, stomach pains, dizziness, insomnia, loss of vital energy, anhedonia (loss of jae-mi), muscle pain, and irritability. However, clients' descriptions of the experience were dysphoric, as shown in this example: `Everything that surrounds me is dark and black, my chest feels heavy as if a rock were sitting on it, nothing in the world makes me feel joy, and I am not able to laugh" (M. T. Kim, 1995, p. 15).

Tabora and Flaskerud (1994) reviewed the literature on depression among Chinese Americans. Several studies found that rates of depression were influenced by socioeconomic status; gender (higher rates were found among females); amount of education (the higher the educational level, the lower the rate of depression); degree of assimilation, including the ability to speak English; and the amount of stress encountered during the acculturation experience (Franks & Faux, 1990;

Hurh & Kim, 1990; Kessler & Neighbors, 1986; M. T. Kim, 1995; W. H. Kuo,1984; Woods, Lentz, Mitchell, & Oakley, 1994). W. H. Kuo (1984) suggested other variables frequently associated with depression, namely unemployment, social isolation, and recent immigration. Hurh and Kim (1990) concluded that "mental health is certainly subjected to an interplay between assimilation ... and ethnic attachment" (p. 710). All of these related factors should be addressed at the time of the mental health assessment.

A number of studies have shown that depression was frequently overlooked by health care providers (Carlson & Rosser-Hogan, 1991; Cohen & Singer, 1995; Morrissey, 1997). Culturally sensitive mental healthcare for the Asian client requires that mental health nurses educate primary care providers, as well as their own colleagues, to be acutely aware of the potential for misdiagnosis and the resulting lack of attention to the underlying depression that is often masked by physical symptoms. When symptoms are primarily somatic, a careful examination of the individual's history may identify a trauma or loss that preceded the onset of the symptoms. The physical symptoms may also be accompanied by symptoms commonly found in a major depression, such as anhedonia. A trial of antidepressant medication along with supportive individual or family counseling may provide symptom relief, supporting the diagnosis of depression while treating the symptoms. Outcome studies are needed to ascertain the most effective culturally sensitive interventions.

PTSD

Several researchers have addressed the severe trauma experienced by Cambodians during the communist government of the Khmer Rouge, which controlled Cambodia from the mid-1970s until 1979 (Boehnlein, Kinzie, Ben, & Fleck, 1985; Carlson & Rosser-Hogan, 1991, 1992; D'Avanzo et al., 1994; Ganesan, Fine, & Yi Lin, 1989; Kinzie, 1981; Kinzie & Fleck, 1987; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984; Mollica et al., 1993; Mollica, Wyshak, Lavelle, Truong, Tor, & Yong 1990; Nicholson, 1997). The symptoms listed for women were similar to those for men and other populations who have experienced traumatic events; however, more women experienced psychogenic blindness (Mattson, 1993; Rozee & Van Boemel, 1989). Many complained of a significant loss of energy (D'Avanzo & Frye, 1992). Treatment for these patients resulted in the improvement of some symptoms but not others. Intrusive thoughts, sleep disorders, startle responses, and hypervigilance showed consistent improvement after 1 year of treatment. However, avoidance behavior, shame, social isolation, and the inability to care for others remained untouched by treatment. Treatment consisted of different antidepressant medications and weekly counseling. Although the Cambodian clients improved, they remained vulnerable to stress and were unable to function in the world of work and school. They were still considered impaired after 1 year of treatment and were also considered a "highly traumatized group" (Mollica, Wyshak, & Lavelle, 1987,p. 1567). The Cambodians had difficulty putting their experiences into words, not only because of their culture, which discourages the expression of feelings and insists on avoidance of bad thoughts, but also because talking about the traumas evoked unbearable memories of past experiences involving major emotional and physical traumas. Kinzie and Fleck (1987) recommended providing a long-term supportive relationship and medications for symptom relief while supporting the clients' traditional values.

Schizophrenia and Other Disorders

There is very little literature on disorders other than depression and PTSD among Asians residing in the United States. In a personal communication with an MHP at a local southeastern mental health center, the MHP noted that there were few Asians among the current patient population diagnosed with schizophrenia or bipolar disorder. Those who did attend the mental health center because of these disorders were extremely ill, generally noncompliant, isolated from family and community, and monitored by a local social service agency, which periodically brought them to the mental health center for medication (V. Traung, personal communication, April 1997). Bueber (1993) found that in mainland China there were supernatural explanations for bizarre behaviors. Mental illness is considered by the Chinese to be a result of angry ancestors possessing the spirit. Symptoms include auditory and visual hallucinations of being raped or tormented by ghosts.

Anders et al. (1997)examined the characteristics of long-term psychiatric patients hospitalized in Tokyo, Japan. "In a population of 12million, there are approximately 120,000patients with a diagnosis of schizophrenia" in Tokyo (p. 139). It may be that the client who exhibits bizarre behaviors is sheltered by his or her family and therefore is not brought to the attention of MHPs. According to Leveck (1991), many psychotic patients are hidden away from public awareness by their families to save face and avoid stigma and shame. Lack of awareness of psychotic disorders among Asians in the U.S. mental health system may also be due to the presentation of symptoms, which are so different from those of other U. S. populations that a psychiatric disorder is misdiagnosed. Louie (1996) claimed that people from non-Western countries exhibit more visual, olfactory, and tactile hallucinations than auditory hallucinations. Thought disorders among Asians are not frequently addressed in the current mental health and psychiatric nursing literature, even though there are claims that the incidence of schizophrenia is similar across cultures.

CULTURALLY APPROPRIATE INTERVENTIONS

Available, accessible, affordable, acceptable, appropriate, and adoptable mental health care is needed for Asians as well as for other populations (Campinha-Bacote, 1997, p. 87). There is a need to develop programs that do a better job of reaching out to Asians who are suffering from mental health problems. Because of the stigma associated with mental health problems, which inhibits people from attending mental health centers, a couple of other suggestions have been examined, including school-based mental health clinics and training and using guidance counselors as mental health counselors (Morrissey, 1997). Another culturally sensitive program that might increase access to care is the in corporation of mental health services into primary care settings, because the chief complaints during depression are physical symptoms (Hong, 1987). Further research is needed to determine appropriate culturally sensitive program development.

Three modes of treatment are primarily found in the literature on psychiatric interventions for Asians seeking mental health care: medication, family therapy, and individual counseling and psychotherapy. The preferred choice for many Asians is medication, because it is considered a more direct way of dealing with a "psychological" problem that they view as a "physical" problem. Counseling and psychotherapy may be viewed as unacceptable. Self-disclosure is in direct contrast to Asian values and beliefs about health and healing for the following reasons: (a) Asians do not distinguish between physical and mental health; (b) they attribute mental illness to a lack of willpower or the imbalance of cosmic forces; (c) they do not express feelings directly,

because restraint is valued; (d) interdependence is more important than independence and autonomy; (e) avoiding confrontation is necessary to be polite; and (f) silence is valued over the revelation of family secrets.

Family, group, and individual psychotherapies are talking therapies, which may prove to be uncomfortable for many Asians. Therefore, MHPs may see high attrition rates among Asians and high rates of noncompliance. Group work is not as useful with Asians as individual and family therapies are, because they consider public discussion of private or personal issues to be socially unacceptable (Kinzie & Fleck, 1987; Lin et al., 1982; Root, 1989; D. W. Sue & Sue, 1990; Tsui, 1985). Individual and family therapies, coupled with medication, should be tried with the consent of the client or family (Chin, Liem, Domokos-Cheng Ham, & Hong, 1993; del Carmen, 1990; S. C. Kim, 1985; Kinzie & Fleck, 1987; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue & Sue, 1990). Whether the initial focus should be on the individual or the family should remain a negotiated decision between client and therapist.

Establishing rapport is an essential ingredient to the success of any psychiatric intervention involves three concepts: joining, transference, and empathy. Joining is a therapeutic concept defined by the family therapy theorists Minuchin and Fishman (1981), who said that joining was more than establishing rapport. Joining involves "experiencing reality as the family members experience it and becoming involved in the repeated interactions that form the family structure and shape the way people think and behave" (p. 2). According to Root (1989), joining with the client and family is central to developing trust. Acquiring the confidence of clients who may be skeptical of Western therapies must be the initial goal. By conveying care and concern while trying to understand the client's values and beliefs, the MHP can become a trusted adviser.

The Asian culture idolizes superiors and respects authority. It is a patriarchal culture as well as a hierarchical one; therefore, clients will expect the MHP to be authoritative and directive (Ganesan, Fine, & Yi Lin, 1989). Once rapport has been established, the psychiatric nurse or MHP will be viewed by the Asian client as the "all knowing, advice giver, or as a wise and caring authority figure whose recommendations are to be followed" (Chin et al., 1993, p. 21). Therefore, the MHP should not hesitate to assume an authoritarian role once rapport has been established.

According to Johnson (1997), a competent therapist must be able to convey genuineness, acceptance, and empathy. Being honest with clients and accepting them in the context of their culture, and understanding the importance of their values and beliefs, is necessary for establishing rapport. "Empathy becomes a bridge connecting us with our clients" (Chin, et al., 1993, p. 51). Cultural empathy is the ability to step into another culture to personally get in touch with the client's feelings within his or her cultural context. The MHP/psychiatric nurse/therapist can achieve cultural empathy by experiencing cultural encounters, developing sensitivity through self-awareness, and seeing clients within the context of their own family and community, outside of the mental health facility. Home visits are highly recommended. As soon as rapport is established, the MHP is ready to conduct the assessment, diagnose the problem, and design a plan of care (S. Sue & D. Sue, 1987).

Establishing rapport may be difficult with clients who have suffered cruelty by others in the form of atrocities or for those who have suffered from discrimination. To overcome mistrust, the MHP may involve the indigenous healer, provide opportunities for other community members to participate in the treatment planning and interventions to provide the client and family emotional support, or both. To overcome language barriers, involving an interpreter on the treatment team is important (Benhamida, 1988). Meeting with the interpreter before and after each therapeutic session is essential to understand and validate the meaning of what occurred during the session. Initially, the MHP should use a formal approach, conveying respect to the client and family. Consultation with the interpreter about appropriate protocol is important. Introductions should be made, along with a description of the roles of both the therapist and interpreter. Other guidelines for psychiatric nurses and MHPs for establishing rapport and planning therapeutic interventions are listed in Table 1.

GUIDELINES FOR THE THERAPIST

An interdisciplinary team approach to include the family, the indigenous healer, an interpreter, and community members, as well as the psychiatric nurse and other MHPs, is recommended in planning care for the client. The care will most likely involve medication and individual or family therapies. Often mental health services are not family oriented or culturally competent and do not meet the needs of Asians living in the United States; therefore, family-centered, culturally appropriate care should integrate Western and Eastern strategies and involve significant members of the client's social network (Herrick, 1997; Marsella & Higginbotham, 1984). If an Asian professional is available, that person should be assigned either as the therapist or case coordinator. A multi- system approach that may cut across agencies, as well as disciplines, may be a more appropriate method of delivering mental health services rather than the traditional manner of focusing on the individual and his or her symptoms with the delivery of care in one mental health agency (Herrick, 1997).

TABLE 1. Guidelines for the Mental Health Care Professional

- Initially concentrate on establishing rapport.
- Use silence and active listening.
- Use an indirect gaze, soft voice, and few words.
- Refrain from asking too many questions.
- Respect the client's reluctance to verbalize thoughts and feelings.
- Educate the client about counseling and psychotherapy.
- Reassure the client about confidentiality.
- Focus on the presenting problem.
- Pay attention to somatic symptoms—consider that they may be a reflection of psychological distress.
- Be active and directive.
- Avoid psychodynamic interpretations.
- Do not use psychiatric jargon.
- Be flexible.
- Negotiate with the client about when and who should participate in the therapeutic process.
- Include the interpreter, the indigenous healer, the family, or community members, as appropriate.
- Seek consultation from community leaders, spiritual leaders, or both.
- Consider intergenerational conflicts.
- Plan care within the context of the culture, community, and family.
- Assess strengths and build on them.
- Set short-term goals.
- Prescribe medications in low doses and monitor medications closely for side effects.
- Use storytelling to elicit the expression of feelings.
- Coordinate community support systems: vocational, educational and other community support systems.
- Teach problem-solving techniques.
- Conduct research to determine effective interventions to promote bicultural identity and enhance self-esteem.
- Conduct outcome studies of culturally sensitive interventions and programs.

Note. Sources: Kelly (1998); Leveck (1991); Louie (1996); Pederson (1984); D. W. Sue and Sue (1990); Serafica et al. (1990); Taylor, Malone, and Kavanaugh (1997); True (1987).

Medications

Physiological differences between Asians and other cultural groups must be considered when planning mental health care. Psychotropic medications, including neuroleptics, antidepressants, and lithium, should be given in lower doses because of the risk of side effects (Hutchinson, 1992; Kroll et al., 1990; Stewart,1995). According to Campinha-Bacote (1997), Asians are "slow metabolizers" (p. 83) and may experience more adverse side effects—such as extrapyramidal symptoms with the use of neuroleptics—than Caucasians. Mohr (1998) stated that Asians have a "lower concentration of a particular plasma protein known to bind several psychoactive agents" (p. 18). Therefore, close monitoring of the effects of the medication is vitally important. Kinzie (1981) described the effectiveness of a combination of antidepressant medications and "talking" therapy with Indochinese refugees suffering from PTSD: "The use of medicine actively suggests to the patient that something is being done; effective use of psychotropic drugs can provide appropriate symptomatic relief for long-standing difficulties" (p. 255). Kinzie prescribed imipramine for the Cambodians, 50 mg at bedtime— a lower dose than is usual for Caucasians. Encouraging the refugees to tell their horror stories by actively listening and assisting them in acknowledging emotional pain also proved helpful for some refugees. Consequently, counseling should be considered in conjunction with medication, if the client is willing to do both. Kinzie,

Leung, Boehnlein, and Fleck (1987) discussed Asians' lack of compliance with medicine, as well as the need for lower doses of tricyclic antidepressants. They suggested careful monitoring of clients by performing tricyclic antidepressant blood levels periodically to determine compliance and the effectiveness of dosages. In summary, psychotropic medications should be carefully monitored for side effects and for symptom relief because of the smaller therapeutic range for Asians compared to other patient populations.

Individual and Family Counseling

The client may arrive with a member of the family, the entire family, a community healer or leader, or he or she may arrive alone. The initial referral may come from a family practitioner, the indigenous healer, or a community leader. Rarely will the family refer one of its own members, at least not until they have exhausted all other resources. Consequently, when they do bring a family member to a community mental health facility, the client is usually extremely ill (Root, 1989). If the client requests to be seen individually, the MHP must think in terms of a family systems framework because of the cultural value of filial piety (D. W. Sue & Sue, 1990). Change in one family member may produce stress on the family system, producing more family conflict rather than diminishing it (True, 1987). The MHP must be aware of the stigma and shame involved with mental illness and recognize that insistence on a family approach may be as inappropriate as a focus that is exclusively on the client. If the client does not wish his or her family to know that he or she has sought psychiatric help, then confidentiality is essential. The MHP should be open to either approach, depending on the needs of the client. Initially, the focus should be on whomever is present—the client, family, indigenous healer, or the community leader—and the chief complaint. S. C. Kim (1985) suggested a flexible approach, structuring the sessions with the individual, the whole family, subgroups within the family, community members and the client, or any combination of client and significant others at different stages in the therapeutic process, based on the MHP's best judgment, to be negotiated with the client.

Tsui (1985) suggested concrete, cognitive, or behavior-oriented approaches, such as Albert Ellis's rational–emotive therapy, which examines the person's self-perceptions and his or her view of the problem as well as the automatic thoughts associated with the perceptions of self and the problem. True (1987) suggested that Asian women were receptive to behavior therapies, especially assertiveness training and other "how-to" approaches. S. C. Kim (1985) recommended strategic and structural family therapy modalities, which are both oriented toward problem solving and use directive therapeutic approaches by the counselor or therapist. Using a metaphorical approach and telling stories may help the client express feelings while focusing on the problem (Kelly, 1998). Strategies to reinforce changing behaviors and to emphasize family participation in solving problems should be the therapeutic focus, rather than psychodynamic psychotherapy. The overall goal is to empower the client and family to solve their own problems and determine their own destinies.

RESEARCH

The lack of research on Asian American mental health care became readily apparent on review of the literature. Studies to determine prevalence rates that do not categorize Asians as "other" are needed to develop future programs to meet the growing needs of this diverse population. More data are needed regarding (a) the presentation of mental disorders that vary from other cultures commonly treated in mental health agencies, (b) culturally sensitive interventions, and

(c) development of culturally competent programs. Merchant and Dupuy (1996) suggested that researchers need competencies that are similar to those required of culturally competent MHPs, including self-awareness, understanding of the client's culture, and the use of culturally competent strategies for data collection.

SUMMARY

Recognition of the variety of symptoms experienced by Asians suffering from emotional disorders, and the ways in which they may differ from symptoms of other populations, is vitally important to plan culturally appropriate mental health care for the Asian client. Strategies to establish rapport and plan therapeutic interventions should be adapted to individual and family needs within the context of the client's culture. Although we have discussed generalizations about Asian responses to Western psychiatric modalities, it is important to remember that there are many different Asian cultural subgroups residing in the United States, requiring individualized care with a family-centered focus.

Asians are reluctant to use mental health services for a variety of reasons, including cultural taboos, misdiagnosis by professionals, and mental health services that are not culturally sensitive. Adaptation of treatment modalities to meet the needs of the individual and his or her family should include integration of Eastern therapeutic modalities, such as acupuncture or meditation, with Western modalities; use of lower doses of neuroleptic medication; recruitment of Asians as the primary therapists; and implementation of individual and family therapeutic modalities that are culturally sensitive and based on the client's needs. Therapeutic interventions should be cognitive or behavioral rather than psychodynamic. Goals should be short term and problem focused. Treatment plans that are individualized; family centered; flexible and culturally competent; and delivered within a coordinated multi-agency system of care, including school and neighborhood programs; may improve the access to mental health care for this underserved population (Jung, 1998).

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