# UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY ASIAN- AMERICANS RESIDING IN THE UNITED STATES

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## Abstract:

Asian-Americans are the fastest-growing minority in the United States, and they are a culturally diverse group. Knowledge about this growing minority population is important for the purposes of planning appropriate mental health care. Asian-Americans living in the United States rarely use mental health services. The reasons for this, along with suggestions for developing more culturally sensitive mental health services, are presented. A model for cultural competence can provide a framework for psychiatric nurses and other mental health professionals (MHPs) to become more aware of Asian-American values and beliefs and provide more culturally sensitive care. Awareness tools are included to guide MHPs in determining whether culturally competent care is available locally to meet the needs of this underserved population.

## Article:

Culture molds people's values, attitudes, and beliefs; influences their perceptions of self and others; and determines the way they experience their environment. Ethnicity, race, dietary habits, alcohol and drug use, health beliefs and values, religion, customs, and socioeconomic status all determine the expression of stress and the symptomatology of emotional disorders. Although basic symptoms of specific disorders may be similar, symptoms of specific disorders may differ from culture to culture. For example, "auditory hallucinations are observed more frequently in Western Countries, whereas in non-Western Countries, people tend to exhibit more visual, olfactory and tactile hallucinations" (Louie, 1996, p. 571). Similarly, in Oriental cultures, "depression is almost exclusively manifested by somatic/vegetative symptoms" (Townsend, 1993, p. 432). In Asian-American cultures, somatic symptoms are less stigmatizing, and nonverbal expression of feelings is more culturally acceptable. Therefore, Asian-American people do not talk about feeling depressed or seek mental health services. A study conducted by Kuo (1984) supported Asian- Americans' "underutilization of mental health facilities" (p. 456). M. T. Kim (1995) reported that "depression has been found to be higher among Asian-Americans than has been reported for Caucasian Americans" (p. 13).

Many Asians believe that mental health can be achieved through willpower and by avoiding bad thoughts (Stewart, 1995). An Asian- American college professor stated recently, "We have no concept of mental health or mental illness. If someone was jumping up and down and having a

fit, we would say he was having a fit, not having mental health problem" (C. Kim, personal communication, April 18, 1997).

Asian-Americans, including Chinese, Filipinos, Japanese, Koreans, Indians, Vietnamese, Cambodians, Laotians, Thai, and others, are the fastest growing minority group in the United States. The mental health of all immigrants, including Asian-Americans, reflects an interplay between their migration experience and the experience of assimilation (Americanization); individual hardiness; their attachment to their original cultural group, including the extent of their social support from family and friends; and their experience of acceptance in this country (Hurh & Kim, 1990; Kessler & Neighbors, 1986; M. T. Kim, 1995; Kuo & Tsai, 1986). Franks and Faux (1990) found that perceived stress and mastery were predictors of depression among immigrant women. Furthermore, the values and beliefs held by various subcultures have a great influence on their perceived stress and distress and, subsequently, their motivation to access mental health services. According to Cheung and Snowden (1990), "indigenous beliefs have been neglected in the study of symptomology and treatment" (p. 285). Understanding these factors is crucial to developing care that serves the mental health needs of this population. Like all minorities in the United States, Asian-Americans have experienced discrimination because of racism and stereotyping. Stereotypes include the view that Asian- Americans do not experience mental illness, and thus they do not participate in the services offered by the mental health system as much as whites, blacks, and Hispanics. Asian-Americans are considered the "model minority" because they are the most educated minority, and they have higher paying jobs than other minority groups in the United States. (P. S. Kim, 1994; D. W. Sue & Sue, 1990). In 1980, S. Sue and McKinney found that (a) "rates of psychopathology among Asian-Americans have been underestimated, and (b) available resources for handling their mental health (MH) problems are inadequate" (p. 223). Ten years later, Cheung and Snowden (1990) stated that "Asian-American/Pacific Islanders use community mental health services less [than any other minority group ... and] disruptions in services continue to plague minority clients" (p. 277).

Furthermore, Asian-Americans often delay treatment until they are extremely ill. Consequently, they come into a mental health facility sicker than other patients and then tend to drop out early in the course of their therapeutic regime. There seem to be many reasons for this. Asian-Americans believe that emotional and behavioral problems reflect youth and life circumstances, that these problems must remain within the family, and that it is a sign of weakness to ask for help. It is a sin or "bad blood" to have emotional problems within one's family (P. S. Kim, 1994). If the family members decide they need to seek help outside the family for a member with a problem, they will seek village elders, a priest, a shaman, or a fortune teller (P. S. Kim, 1994). Only if these cultural healers fail to cure the problem and encourage the person to seek Western health services does the Asian-American seek mental health services. That is why Asian-Americans are often very ill before they seek mental health services.

Asian-Americans' patterns of use±nonuse of mental health services reflect their cultural beliefs, their lack of trust in the mental health system, and their lack of comfort with Western psychiatric methods (Cheung & Snowden, 1990; Stewart, 1995; S. Sue & McKinney, 1975, 1980). It is clear from a review of the current literature that the current American mental health care system does not meet the needs of many Asian Americans. Knowledge about this growing minority population is important for planning appropriate mental health care that is culturally competent.

Understanding cultural factors that contribute to Asian-Americans' under-utilization of mental health services (Table 1) will assist mental health

**Table 1. Factors contributing to the underutilization of community mental health services by Asian-Americans**

**The underutilization of mental health services has been attributed to:**

1. Support and interventions of a tightly knit family system
2. Use of community-appointed spiritual leaders or indigenous healers
3. Stigma and shame that are associated with mental illness that reflects poorly on the family
4. Lack of access to culturally appropriate mental health services and the need for a more holistic Far-Eastern style of mental health care
5. The fact that Asian-Americans are often labeled with other minorities as "other" and are therefore not identified in demographic studies.

(Note: Adapted from Aylesworth, Ossorio, & Osaki, 1980; Campinha-Bacote, 1997; Keh-Ming, Inui, Kleinman, & Womack, 1982; Levek, 1991; Nah, 1993; S. Sue & McKinney, 1975, 1980).

professionals (MHPs) in planning appropriate and culturally competent mental health care.

DEMOGRAPHICS

Asian-Americans account for less than 3% (7,273,662 people) of the population of the United States, but they are the fastest growing, most diverse, and most affluent of all the minority groups (Bodoritz & Edmondson, 1991). Table 2 shows the predicted distribution changes of the U.S. population by race and origin through 2050. The white non-Hispanic group is predicted to decline from 75.7% in 1990 to 52.7% in 2050. The largest change will be in the percentage of Asian-Americans, from 3.0% in 1990 to 10.7% in 2050 (Aponte, Rivers, & Wohl, 1995).

During the last three decades immigration has accounted for three quarters of the growth among Asian-Americans. The birthrate for Asian- Americans is the lowest of all ethnic minority groups but higher than that of whites. Vietnamese, Laotians, and Cambodians have higher birthrates than other Asian groups (Aponte et al., 1995).

Asian-Americans are the most diverse of the ethnic groups in the United States. They have come to the United States at different times and from different countries; they speak different languages (more than 20), they have different reasons for coming, and they have arrived under different circumstances. They also come from different educational and socioeconomic levels. Aponte et al. (1995) reported that

The largest percentage of Asian Americans is Chinese (22%), Filipinos (21%), Japanese (19%), Koreans (10%), and Asian Indians (10%). These groups, as well as the more recent arrivals such as Vietnamese, Cambodians, and Laotians, vary in age, and have different cultural backgrounds,

**Table 2. Percentage distribution of the U.S. population by race and ethnic origin**

| Year | Non-Hispanic White | African-American | Hispanic | Asian and Pacific Islander | American Indian |
|---|---|---|---|---|---|
| 1990 | 75.7 | 12.3 | 9.0 | 3.0 | 0.8 |
| 2000 | 71.6 | 12.9 | 11.1 | 4.5 | 0.9 |
| 2010 | 67.6 | 13.6 | 13.2 | 5.9 | 0.9 |
| 2030 | 60.2 | 14.8 | 17.2 | 8.4 | 1.0 |
| 2050 | 52.7 | 16.2 | 21.1 | 10.7 | 1.2 |

*Note.* From Aponte, J.F., Rivers, R.Y., and Wohl, J. [1995] *Psychological Interventions and Cultural Diversity*, p. 3. Copyright © by Allyn & Bacon. Reprinted with permission.

languages, religions, and socioeconomic status.... Many of these Asians came to the USA seeking economic opportunities; others were fleeing oppression (p. 4).

Asian-Americans as a group earn salaries and have educational attainments higher than the other minority groups and the white population. However, within the Asian-American group approximately half the members have salaries higher than the average for whites, whereas the other half have the lowest salaries of the minority groups. This bifurcation of the Asian-American group encourages mainstream Americans to mislabel all Asian-Americans as earning high salaries and, consequently, to have racial prejudices toward them (Aponte et al., 1995). Racism has been cited as a key contributor to psychological problems in ethnic groups, including domestic violence among Asian-Americans (Ho, 1990).

Seventy percent of all Asian-American immigrants reside in three metropolitan areas: San Francisco, Los Angeles, and New York/Newark, NJ. Edmondson (1997) stated, "America's largest and wealthiest places are being transformed by Asian money.... As their numbers grow, Asians are leaving the coasts for greener pastures inland" (p. 1). Because many Asians are educated and speak English well, they are ready to assimilate. They move into businesses and mainstream American life very easily.

CULTURAL VALUES AND BELIEFS
Asians, like other groups who have immigrated to the United States, came primarily as young adults. Most of the old people stay in their homeland or come after the younger family members have settled and can assist them with the move. Some of the older Asians arrived here from war-torn countries where they were being persecuted; those who were able to flee did so, but many were tortured. Consequently, many of the older Asian-Americans suffer from mental health problems, especially post- traumatic stress disorders (Boehnlein, Kinzie, Ben, & Fleck, 1985). Many new immigrants are of childbearing age and begin having children in the United States. They do not have the family support of elders to assist and guide them. In 1990, 6±8% of the total minority population was age 65 and older, whereas 14% of the white population was age 65 and older (Aponte et al., 1995). For most Asian people, the family is the basis of society. Families are traditionally patriarchal, with the oldest male making decisions about health care. "Social support, resources, and tangible aid are sought first from extended family and peers of similar background. Parents who are cut off from that type of support feel profoundly isolated" (Lawson, 1990, p. 78).

CONCEPTUAL MODELS TO USE IN CARING FOR ASIAN-AMERICANS
We have developed an integrated conceptual model for culturally sensitive care based on Campinha-Bacote's (1997) cultural competence and health care delivery models and Becker and Maiman's (1975) health belief model. MHPs can become competent to care for clients whose values and beliefs may differ from the majority of citizens residing in the United States by using this integrated conceptual model to guide assessment and planning.
ESTABLISHING A CULTURALLY SENSITIVE THERAPEUTIC RELATIONSHIP: A CONCEPTUAL FRAMEWORK (FIGURE 1)

*Campinha-Bacote's (1997) Models of Cultural Competence and Health Care Delivery*
Underutilization of mental health services by all ethnic groups, not just Asians, is a continuing problem for community mental health centers. Campinha-Bacote (1997) stated that mental health agencies must be "available, accessible, affordable, acceptable, appropriate and adoptable" (p. 87) to enable clients from diverse groups and from lower socioeconomic levels to obtain mental health services. They must be flexible enough to change therapeutic strategies to meet the needs of different ethnic groups, and they must be culturally relevant to be accepted. Cultural competence involves the behaviors, attitudes, and policies that enable MHPs to work effectively with diverse populations. Cultural competence includes being nonjudgmental; having an awareness of different cultures, values, and beliefs; being flexible enough to change mental health strategies to meet individual needs, and having an awareness of the stereotyping of certain clients and ethnic groups.

Professionals who are culturally competent are sensitive to cultural issues, are aware of their own attitudes and biases, and are willing to work within the client's culture in what have been identified by CampinhaBacote (1997) as "cultural encounters" (p. 85). The culturally competent MHP conveys respect for values and norms of different cultures and can apply his or her skills with sensitivity to the client's environment, family, or cultural group (Campinha-Bacote, 1997). The MHP may be more knowledgeable about one culture than another. If he or she does not know much about a certain culture but has been assigned a client from that particular culture, then the MHP should be willing to do the research necessary to become knowledgeable about the client's views of the world,
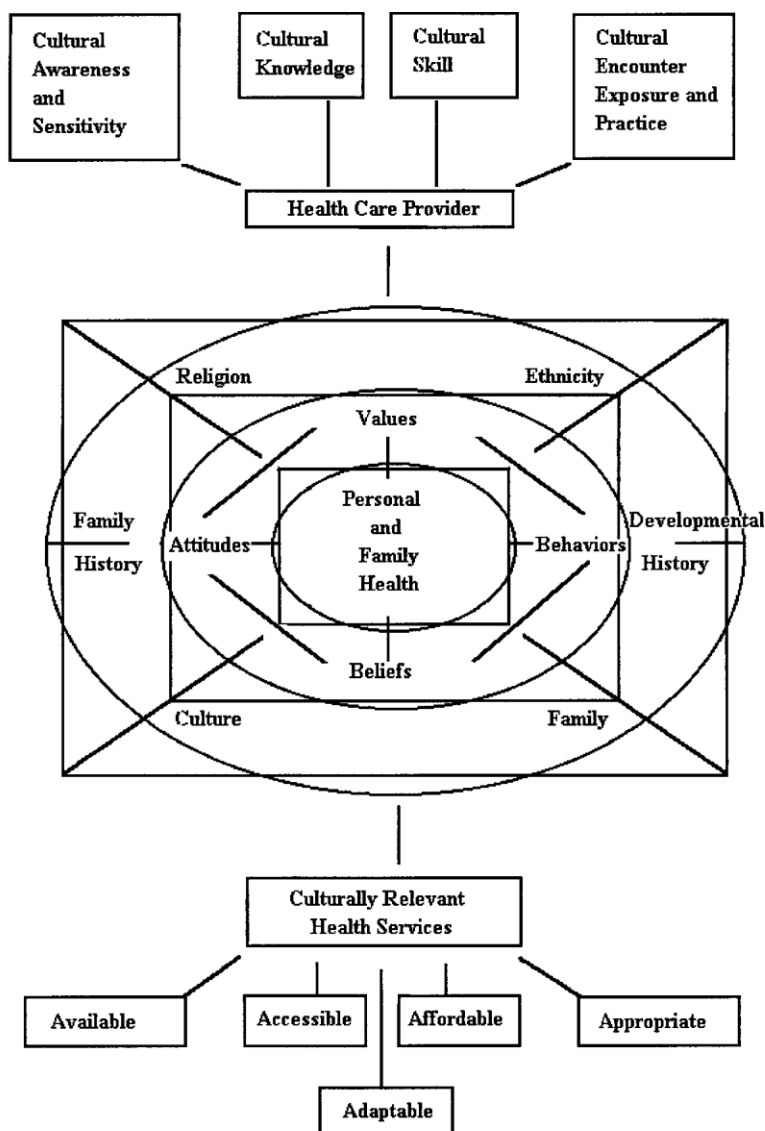
**Figure 1. Conceptual Framework for the Delivery of Health and Mental Health Services to Asian Americans**

time, space, nature, and the supernatural, as well as interpersonal and family relationships, health, and illness. The culturally competent professional is willing to experience clinical situations in an environment that is different from his or her own (Campinha-Bacote, 1997).

### Becker and Maiman's (1975) Health Belief Model
Understanding cultural beliefs about health and illness is key to understanding how best to serve diverse populations, including Asian-Americans and Asian immigrants. Becker and Maiman's (1975) health belief model (HBM) includes factors influencing patient compliance as well as factors that contribute to health promotion and disease prevention. Health- seeking behaviors are influenced by perceptions of a threat to health. Health beliefs include personal estimates of vulnerability and faith in the efficacy of the health care being provided (Becker & Maiman, 1975). Health-seeking behaviors include activities that are goal directed, aimed at reducing a perceived threat, and indicate that health is valued (Odom et al., 1997). The basic tenet of the model is that a disorder or disease is a threat to a person if the person believes that he or she is

susceptible to it and believes that a cure is possible if certain health-promoting strategies are enacted.

The modifying factors in the HBM include demographics, sociopsychological factors, and structural variables. Demographics include race and ethnicity, which may influence the professional's and client's definition of illness. Sociopsychological factors include peers and reference groups. The MHP's reference group consists of professional peers who know the latest research about mental health and illness, but the client's reference group—his or her friends and family—has knowledge about illness that is steeped in tradition. Because of these differences between the two reference groups, peer pressure from professionals and pressure from the client's family and community may result in a therapeutic impasse. Structural factors involve knowledge about the disease and its cure and the institutions or structures that assist patients in coping with disease. The client may believe that mental health is maintained by participating in family and social support systems, praying, and participating in spiritual rituals, whereas the MHP believes that medications and various psychotherapies are appropriate ways to deal with mental illness.

Spector (1996) applied the HBM to health care providers and to their clients and examined differences in how they perceived health and illness. According to Spector, demographics, sociopsychological variables, and structural factors are the areas of greatest difference between providers and clients, and these differences contribute to conflicting attitudes and values that interfere with the provision of effective mental health care. To design a mental health program that is culturally competent and relevant to diverse clients, these differences in values and beliefs must be recognized.

### Guidelines for Culturally Sensitive Mental Health Care

Culturally sensitive strategies must be developed to meet future mental health needs in the United States, or many Asian-Americans will continue to suffer in silence. To provide culturally sensitive mental health care, the MHP must (a) examine his or her own values, biases, and beliefs; (b) perform an agency assessment to determine if the agency has the resources to meet the needs of clients from varying ethnic backgrounds; and (c) assess the client within the context of his or her culture, using culturally appropriate assessment tools.

**Self-Awareness**

MHPs must become familiar with their own heritage and the cultural norms, values, and beliefs that they assume are truths. Table 3 is a guide for self examination. According to Spector (1996), health care professionals have been socialized into a particular culture as part of their academic training, which includes beliefs, norms, and values regarding health and illness. MHPs are part of an ethnic group with its own language and cultural rituals. Spector believes that the reason for difficulties in establishing therapeutic alliances with ethnic minorities is that "health-care providers, with few exceptions, adhere rigidly to the Western system of health care delivery" (p. 77). Self-awareness is imperative for MHPs to establish rapport with clients from different cultures.

Agencies need to design programs to meet the mental health needs of children and families from various ethnic backgrounds. An agency assessment tool is presented in Table 4.

The next step in the assessment process is to become acquainted with the client's culture and the client's values and beliefs that may affect the health care plan (Price & Cordell, 1994). Generalizations about Asian culture may guide inquiry, but they should be examined in the context of the individual's subculture and migration experience, which may not necessarily apply to all clients who are Asian-American.

**Generalizations About Asian Values and Beliefs**
The psychiatric nurse or MHP needs to listen attentively to the client's concerns, observe all behaviors, and check and recheck the client's beliefs with others from the same culture. A consultant from the same or a similar culture is beneficial. The consultant may be a community leader, or the local spiritual leader, an indigenous healer, or an interpreter, who could serve as both a language expert and a consultant. If at all possible, the

**Table 3. The mental health professional's cultural self-awareness**

- Define your own ethic/cultural group and its beliefs, attitudes, values, and rituals
- Identify your cultural values about:
  Time: past, present, and future
  Space: Intimate, personal, social, and public distance
  Territoriality = ownership of space
  Interpersonal relationships: Collateral, lineal, or individualistic
  Family relationships: Boundaries, structure (patriarchal or matriarchal), extended family, communication, and decision-making styles
  Nature: Dominance over nature, in harmony with nature, subjugated by nature
  The supernatural: Good, evil, or mixed
  Beliefs about health and mental health
    Definitions of disease, methods to prevent or cope with illness
    Causes of disease: Imbalance among the person, the physical, social, and spiritual worlds; reflection of an angry deity. Mental illness is due to poor parenting, immorality, psychological and emotional distress, neurobiological disorder
  Man's purpose: Being, becoming, or doing
- Identify the assumptions you hold about people: People are basically good or bad
- Describe the experiences that you have had with different cultural groups
- Define the messages you received when you were growing up about people who were different from you
- Describe a situation in which you were rejected and did not know why. Identify the feelings that you experienced.
- Review your professional values and your professional code of ethics.
- Describe your current relationship with other ethnic, cultural, socioeconomic, or religious groups.
- Identify your own cultural competencies and limitations.
- Describe peer and social pressures that have influenced your attitudes and behaviors.

*Note.* Adapted from Campinha-Bacote (1997), Hutchinson (1992), and Slaughter & Flint (1993)

consultant should be someone identified by the client or family as a person whom they trust.

## Communication

Misunderstandings are common when two people do not speak the same language. Determine if the client can read, write, or speak English. If not,

**Table 4. Agency assessment of multicultural orientation**

**Conduct a self-study regarding the agency's commitment to one or more minority populations and its ability to devote resources to that commitment.**

- Assess the degree of successful collaboration among different ethnic groups within the agency
- Identify how effective the agency is in developing programs to meet the needs of a diverse population
- Compare services: How do services focused on minorities differ from the usual services?
- Assess the agency's vision and mission to serve minorities
- Assess the agency's plan to evaluate outcomes and know when the goal of serving minorities has been achieved

*Note.* Adapted from Campinha-Bacote (1997), Mason (1997).

an interpreter is imperative when doing a cultural and mental health assessment. Meet with the interpreter before the session and between sessions, so that the two collaborators share the same understanding of what is being observed and stated by the client. Often, communication becomes distorted in the translation. Good communication between the interpreter and the MHP is vital.

Interpret nonverbal communication as a message. Do not expect the expression of strong affect among Asian-Americans. It is improper to display emotions publicly. When communicating with an Asian-American client, always begin by asking about his or her family, because family values are a high priority. Do not use direct questions, because that is considered impolite. The use of stories or metaphors may be helpful. Stay away from medical or psychiatric jargon, and discuss one topic at a time. Pantomime words and actions as they are verbalized. If the MHP knows words in the client's language, they should be used. Seek the possibility of using a language common to both the client and the MHP; for example, many Vietnamese clients speak and understand French, as do some Americans.

The MHP may be considered the authority figure, so the communication may be one way. Reflection may not be as appropriate a communication strategy as direct clear communication, spoken with authority. Silence may be encountered out of respect for authority. The Asian-American client will expect the MHP or psychiatric nurse to prescribe helpful interventions, medications, or both, so be direct and specific about recommendations (Andrews, 1993; Hutchinson, 1992).

## Cultural Assessment

A cultural assessment (Table 5) can be a part of establishing rapport because it conveys an interest in understanding the client and his or her

**Table 5. Cultural assessment**

**Identify:**

- Ethnicity: Cultural group, subgroup, degree of identification with the group, citizenship or immigrant status, length of time in the United States, degree of acculturation.
- Life style: Recurring life patterns—compare with cultural norms; meaning of the observed behavior
- Cultural values and norms: For example, filial piety, stigma of mental illness, authority of the eldest male, respect for elders
- Family relationships and family structure: The extended family lives with the nuclear family, patriarchal family structure, autocratic decision making
- Taboos and myths: For example, the balance of yin & yang
- Worldview: Life is a balance between man and nature—both are viewed as "good"; the supernatural is also good, if you are "in balance" or "in harmony"; man's purpose is "to be." Ancestors are highly regarded.
- Cultural diversities: Similarities and variations among subgroups
- Religious beliefs: Rituals and rites of passage
- Cultural stressors: Adaptations that have been made to adjust to living in the United States. Were they egosyntonic or dystonic? What does the client need to achieve mental health?
- Folk and professional health–illness structural systems: Definitions of health and illness and the causes; perceptions regarding the acuity of the illness; common coping strategies include acupuncture, moxibustion, and herbal medicines. Define how well the delivery system meets the needs of the client. Can Far-Eastern strategies be integrated into current mental health interventions?

*Note.* Adapted from Andrews (1993), Campinha-Bacote (1997), Leininger (1978), Louie (1996) Price and Cordell (1994), Slaughter and Flint (1993), D.W. Sue and Sue (1990).

worldview. Asian-Americans are considered to be past and present oriented, and they prefer not to be intimate, except with family members. Filial piety is highly valued. Women do not have decision-making powers. The family is patriarchal, with the eldest son being responsible for the parents in their old age. He also inherits their estate and has decision- making powers over the family. Communication among family members tends to be quiet, with few words spoken. Elders are considered wise and are revered.

Illness is considered an imbalance among spiritual, social, and physical domains. Methods to cope with illness include acupuncture, moxibustion, doing penance for bad behaviors, and using herbal potions (D. W. Sue & Sue, 1990). These generalizations, however, may vary from one subculture to another.

**Mental Health Assessments**
Psychological tests may be ordered, but the results may be biased, because most of the tests have been normed on white middle-class Americans (D. Sue & Sue, 1987; D. W. Sue & Sue, 1990). Thus, the results must be carefully examined within the context of a cultural assessment. Be aware that labels may have serious and adverse consequences. The mental status examination should assess culturally sensitive areas.
1. Affect (the client's emotional state) may seem flat or blunted. Asian- Americans appear passive because of the cultural requirement to remain stoic.

2. Cognitive functioning may be difficult to assess because of language barriers or because of the immigrant's lack of formal education.
3. Reasoning and judgment may be value laden. For example, a Japanese client may attempt suicide to save face but may not in fact be severely depressed. In the United States it usually is assumed that a suicidal patient is depressed.
4. Abstract thinking is often assessed by using proverbs that are culturally bound and, consequently, may be difficult for the client to understand.
5. Memory should not be difficult to assess.

Once the mental status assessment is complete, along with other diagnostic studies, the MHP should determine the adaptations the client has already made in the acculturation process and what other adaptations will be needed to achieve mental health.

The final step in the assessment process is to adapt health teaching and other interventions on the basis of a holistic assessment of the client that is culturally competent (Price & Cordell, 1994).

TREATMENT
It is clear that Asian-Americans in the United States do not use mental health services, for a variety of reasons. Those reasons include their own cultural taboos about mental health and illness and perpetuation of the myth that Asian-Americans are the model minority, free of mental illness and therefore without need of mental health services. Mental health services that rely solely on individual psychotherapy, drug therapies, or both, may not be culturally relevant to the treatment of mental disorders in Asian people. Traditional therapies that involve the revelation of feelings are not sanctioned in Asian cultures, especially group therapies, which may be considered "public."

Psychotropic medications must be carefully titrated, and lower doses should be used, because many Asians experience uncomfortable side effects. Medication dosages have frequently been normed on white males, who weigh more than most Asian males and females, and whose metabolism is different from theirs. A culturally sensitive assessment of the agency, and the client as well as a self-assessment by the MHP will assist the health care provider in developing a mental health care plan that integrates the Eastern beliefs of the client with Western services. A "synthesis of Western psychiatric services and traditional Asian medicine" (Marsella & Higginbotham, 1994, p. 193) is most likely to meet the needs of this underserved population.

RECOMMENDATIONS
Involving indigenous healers as part of the treatment team will enhance the integration of Eastern and Western strategies for helping the mentally ill Asian-American client. Working with an interpreter is essential to overcoming language barriers.

Collaboration between the MHP and the interpreter is important to understand the client's and family's dynamics. Involving other people who are significant to the family may also assist the assessment process. A family-focused treatment plan rather than a focus on the individual may be important because of the individual's dependence on the family for emotional support. It also is necessary for the family to sanction the client's seeking of mental health services that involve Western therapeutic strategies, to obtain compliance. Psychopharmacotherapeutics should be

carefully monitored. The MHP should start with lower dosages and gradually increase the dosage to achieve an appropriate therapeutic window. Educating the Asian-American client in Western therapeutic strategies without using psychological interpretations is helpful. Teaching clients and their families about therapeutic options will also help with compliance, because they are included in the decision-making process. Integrating concepts from the health belief model and the cultural competence model will enable psychiatric mental health nurses and other MHPs to become more aware of their own cultural beliefs and values and the client's and family's beliefs and values. This understanding can be used to ensure that health services are available, accessible, affordable, acceptable, appropriate, and adoptable (Campinha-Bacote, 1997).

Respect for the use of Eastern therapeutic measures to deal with mental illness and a willingness to adapt Eastern interventions to Western strategies should be conveyed to the client to gain the trust of the client and family. Culturally competent family-centered care provides the best frame-work for planning mental health services for Asian-Americans seeking psychiatric care.

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