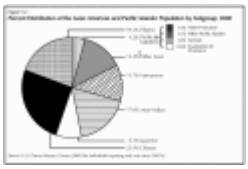
Chapter 5 Mental Health Care for Asian Americans and Pacific Islanders: http://www.ncbi.nlm.nih.gov/books/NBK44245/

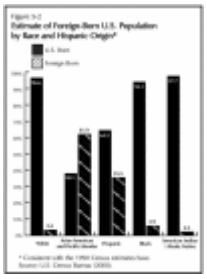
Introduction

Asian Americans and Pacific Islanders (AA/PIs) are diverse in ethnicity (See Figure 5-1) and in their historical experiences in the United States. As many as 43 different ethnic groups (Lee, 1998) have struggled as immigrants, refugees, or American-born Asian Americans to overcome prejudice and discrimination on the path to achievements ranging from the building of the first transcontinental railroad to innovations in medicine and technology. Asian immigrants now account for about 4 percent of the U. S. population. The majority of AA/PIs were born overseas (See Figure 5-2), and Asian Americans constitute more than one-quarter of the foreign-born population in the United States.



Figure

Figure 5-1. Percent Distribution of the Asian American and Pacific Islander Population by Subgroup: 2000.



Figure

Figure 5-2. Estimate of Foreign-Born U.S. Population by Race and Hispanic Origin.

AA/PIs are a fast-growing racial group in the United States. The population grew 95 percent from 3.7 in 1980 to 7.2 in 1990. From 1990 to 2000[1], the number of people identifying as Asian American, or Native Hawaiian or Other Pacific Islander grew another 44 percent to 10 million for Asian Americans and 350,000 for Native Hawaiian or Other Pacific Islander (U.S. Census Bureau, 2001b). It is projected that by the year 2020, the combined AA/PI population will reach approximately 20 million, or about 6 percent of the total U.S. population. American-born Asian and Pacific Island Americans will outnumber the foreign-born ones by 2020 (U.S. Census Bureau, 2000).

Given the high proportion of recent immigrants, Asian Americans and Pacific Islanders in the United States have, as a group, great linguistic diversity. They speak over 100 languages and dialects. Estimates from reports covering the 1990s indicate that 35 percent of Asian Americans

and Pacific Islanders live in linguistically isolated households, where no one age 14 or older speaks English "very well." For some Asian American ethnic groups, this rate is much higher. For example, 61 percent of Hmong American, 56 percent of Cambodian American, 52 percent of Laotian American, 44 percent of Vietnamese American, 41 percent of Korean American, and 40 percent of Chinese American house-holds are linguistically isolated (President's Advisory Commission on Asian Americans and Pacific Islanders, 2001).

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Historical Context

Asian Americans

The Chinese were among the first Asians to come to the United States. Small numbers came as early as the late 1700s on trade and educational missions, but the discovery of gold in California brought 300,000 more Chinese immigrants between 1848 and 1882 (Huang, 1991). Most were indentured to work in the mining and railroad industries. Later in the 1800s, Japanese immigrants filled the need for cheap contract laborers on Hawaiian sugar plantations. Many left Hawaii and settled in California, where they contributed substantially to the state's agricultural success. Then the U.S. Government began passing various laws to strictly control the flow of Asian immigrants and restrict their rights. For example, the Chinese Exclusion Act of 1882 limited the admission of unskilled Chinese workers. In 1907 and 1908, a Gentlemen's Agreement placed similar limits on Japanese and Koreans, and in 1917, another Immigration Act restricted the entry of Asian Indians. In response to a growing population of Filipino immigrants who worked as daily wage laborers in California agriculture, the Tydings-McDuffie Act of 1934 denied entry to Filipinos. During World War II, President Franklin Roosevelt signed Executive Order 9066, which incarcerated over 120,000 people of Japanese heritage, including more than 70,000 U.S.-born citizens, in internment camps and Federal prisons. This order was a reaction to the public's strong anti-Japanese sentiment and to mistaken beliefs that Japanese Americans presented a threat to national security during the War.

With the passage of the 1965 Immigration Act, which favored family reunification and discouraged systematic discrimination against Asians, Asian immigration to the United States grew rapidly. While Asians comprised less than 7 percent of total immigrants to the United States in 1965, they accounted for nearly 25 percent in 1970. In 1971, new legislation eliminated all quotas on countries of origin and replaced them with a general limit of 290,000 immigrants a year. Although the proportion of Asian immigration to the United States is now relatively large, it must be noted that Asians comprise about 60 percent of the world's population.

Today immigrants come from China, India, the Philippines, Vietnam, Korea, and other Asian countries in search of better educational and economic opportunities. For example, most Korean Americans are not American-born descendants of the first wave of immigration from the early 1900s. Rather, they are part of the tens of thousands of immigrants that have entered the United States every year since 1965. Similar numbers of Filipinos have immigrated annually since 1965, so most Korean and Filipino Americans today are first or second generation. Because of the U.S. military presence in the Philippines until 1992, Filipino immigrants are more likely than other Asian immigrants to be acculturated to American ways and to speak English. During the late 1970s and 1980s, many Southeast Asian refugees from Vietnam, Cambodia, and Laos were accepted by the United States for political and humanitarian reasons. This brief history of Asian immigration reveals the heterogeneity of the Asian American population in the United States.

Pacific Islanders

Unlike Asian Americans, most Pacific Islanders are not immigrants, but are descendants of the original inhabitants of land claimed by the United States. Thus, Pacific Islanders share the history of American Indians and Alaska Natives, whose lives dramatically changed upon contact with various European explorers. In the late 1760s, for example, Captain James Cook and his crew arrived in Hawaii and brought with them formerly unknown diseases that devastated much of the indigenous population. By the late 1840s, after colonists had taken and redistributed the land in Hawaii, American missionaries and businessmen controlled most of the land and trade of these islands. A similar fate befell the Tongans. When Cook discovered the Tonga islands in 1773, English missionaries followed. Tonga became a British protectorate in 1900 and gained its independence in 1970.

Guam was under U.S. Navy control from the time it was acquired during the Spanish American War in 1898 until its transfer to the Office of Insular Affairs in 1950. American Samoa was ceded to the United States in 1900 and transferred to the Office of Insular Affairs in 1951. In 1947, the United Nations grouped the Northern Mariana Islands, the Marshall Islands, and the Caroline Islands into the Trust Territory of the Pacific Islands. Authority over these islands was given to the U.S. Secretary of the Interior in 1951. The Northern Mariana Islands became a U.S. Commonwealth in 1976. In 1986, the Republic of the Marshall Islands and the Federated States of Micronesia became sovereign states and now maintain relations with the United States through the Department of State. In 1994, Palau joined the freely associated States.

Until recently, the Secretary of the Interior held broad authority over these islands, but the people living there now have their own elected legislatures and governors. Today the U.S.-Associated Pacific Basin jurisdictions remain as freely associated States affiliated with the United States. Each area is responsible for the administration of local government functions. Under the Compacts of Free Association, the U.S. Department of the Interior has administrative responsibility for coordinating Federal policy in the Pacific territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, where most residents have U.S. citizenship. The Department of Interior also has over-sight of Federal programs and funds in the freely associated states of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Go to:

Current Status

Asian Americans and Pacific Islanders represent very diverse populations in terms of ethnicity, language, culture, education, income level, English proficiency, and sociopolitical experience. Although cultural ties exist among the different AA/PI communities, it is important to recognize the differences among the groups.

Geographic Distribution

Asian Americans and Pacific Islanders are heavily concentrated in the western United States; more than half of this group (54%) lived in the West in 2000 (U.S Census Bureau, 2001b). However, a good number of AA/PIs also live in the South Guam was under U.S. Navy control from the time it was acquired during the Spanish American War in 1898 until its transfer to the Office of Insular Affairs in 1950. American Samoa was ceded to the United States in 1900 and

transferred to the Office of Insular Affairs in 1951. In 1947, the United Nations grouped the Northern Mariana Islands, the Marshall Islands, and the Caroline Islands into the Trust Territory of the Pacific Islands. Authority over these islands was given to the U.S. Secretary of the Interior in 1951. The Northern Mariana Islands became a U.S. Commonwealth in 1976. In 1986, the Republic of the Marshall Islands and the Federated States of Micronesia became sovereign states and now maintain relations with the United States through the Department of State. In 1994, Palau joined the freely associated States.

Until recently, the Secretary of the Interior held broad authority over these islands, but the people living there now have their own elected legislatures and governors. Today the U.S.-Associated Pacific Basin jurisdictions remain as freely associated States affiliated with the (17%) and Northeast (18%). A growing number of AA/PIs live in the Midwest (11%). One reason for this distribution is that some Asian Americans are descendants of the Chinese laborers who came in the mid-1800s to work on the transcontinental railroad. Other Asian Americans are descendants of the Japanese immigrants who came to California in the late 19th and early 20th centuries. Since 1965, when Asians began arriving in greater numbers, more entered the United States through New York as well as California. According to 1997 data, 37 percent of all Asian Americans and Pacific Islanders lived in California, 10 percent lived in New York, and 7 percent lived in Hawaii (Population Reference Bureau, 1999).

The largest proportion of nearly every major Asian American ethnic group lives in California. The 1990 census showed that three-fifths of Chinese Americans lived in California or New York, while about two-thirds of Filipinos and Japanese lived in California and Hawaii. Asian Indian (or South Asians) and Korean populations are somewhat less concentrated geographically, although large communities have emerged in a handful of States, including Illinois, New Jersey, and Texas, as well as California and New York. Approximately 75 percent of Pacific Islanders lived in Hawaii and California. Southeast Asians are distributed in a different pattern because of Federal resettlement programs that created pockets of Southeast Asian refugees in a few States. Nearly two-fifths of the Hmong population, for example, lived in Minnesota and Wisconsin in 1990. One-tenth of Vietnamese Americans live in Texas-the largest concentration of Vietnamese Americans outside of California (Population Reference Bureau, 1999). The overwhelming majority (96%) of Asian Americans and Pacific Islanders live in metropolitan areas (U.S. Census Bureau, 2001b).

Family Structure

Compared with white Americans and African Americans, AA/PIs are more likely to live in households that are comprised exclusively of family members, an arrangement referred to as "family households." In 2000, family households made up 75 percent of Asian American households, compared to 67 percent of non-Hispanic white and African American households (U.S. Census Bureau, 2001b). Asian Americans also have a relatively low percentage of female-headed households (13%), which is comparable to the rate for white Americans but much lower than the rates for other groups. Asian Indian, Chinese, Korean, and Japanese Americans all tend to have lower percentages of female-headed households, from 7 to 13 percent, while Vietnamese, Filipinos, and other Southeast Asians each have a rate of 18 percent (Lee, 1998). Pacific Islanders have larger families than most Asian Americans and other Americans. Pacific Islander family size averages 4.1 persons, compared to 3.8 for Asian American families and 3.2 for all American families (U.S. Census Bureau, 1990).

While subgroup differences exist, Asian Americans tend to wait longer to have children and to have fewer children than other major ethnic groups. Only 6 percent of all live births occur to

Asian American women under the age of 20 years. This is strikingly different from the percentages for white Americans (10%), African Americans (23%), and Latinos (18%) (Lee, 1998). Fertility rate data suggest that the AA/PI population will change, and that some ethnic group numbers will decrease over time. The fertility rates of Chinese American women (1.4 children per woman) and Japanese American women (1.1) are lower than the replacement level of 2.1 (the number of children needed for a generation to replace itself). Among Southeast Asian Americans, however, women have high fertility rates and tend to have children at earlier ages than Chinese and Japanese Americans (Lee, 1998). If fertility becomes a more dominant factor than immigration, the proportion of Southeast Asian Americans can be expected to rise compared to that of Chinese and Japanese Americans.

Education

On average, Asian Americans have attained more education than any other ethnic group in the United States. In 2000, 44 percent of Asian Americans age 25 years or older had a college or professional degree, whereas only 28 percent of the white population had achieved that level of education (U.S. Census Bureau, 2001b). According to 1997 data, 58 percent of Americans who descended from natives of the Indian subcontinent (India, Pakistan, Bangladesh, and Sri Lanka) had undergraduate, graduate, or professional degrees.

Some groups of AA/PIs did not have high educational attainment, however. In 1990, only 12 percent of Hawaiians and 10 percent of non-Hawaiian Pacific Islanders had achieved a bachelor's degree or more. Furthermore, almost two-thirds of Cambodians, Hmong, and Laotians had not completed high school. Many of these Southeast Asians were not able to complete school, but their offspring are clearly taking advantage of the academic opportunities in the United States. In 1990, 49 percent of Vietnamese, 45 percent of Cambodian, 32 percent of Hmong, and 26 percent of Laotians between the ages of 18 and 24 years were enrolled in college.

Income

Three factors are important to note when examining the income characteristics of AA/PIs. First, there are substantial ethnic group differences in average income. Second, it is important to control for family size because AA/PIs tend to have large extended families. Finally, in some groups, income averages may disguise the bimodal income distribution within a population.

In 1998, the per capita income of AA/PIs was $18,709, compared to $22,952 for non-Hispanic whites. The average family income for AA/PIs tends to be higher than the national average. About one-third of Asian American and Pacific Islander families had incomes of $75,000 or more, compared with 29 percent for non-Hispanic white families. However, because Asian families often include extended family members, per capita income (i.e., income per each member of the family) is highest for whites, followed by Asian Americans.

Approximately 25 percent of the Asian Indian population had household incomes that exceeded $75,000, while less than 5 percent of the Cambodian, Hmong, and Laotian populations had similar household incomes.

In 1990, for which detailed information on specific AA/PI groups is available, approximately 14 percent of all Asian Americans were living in poverty. Again, variations in poverty rates were evident when specific Asian ethnic groups were compared. The rates of poverty were Chinese Americans (14%), Korean Americans (14%), Thai Americans (13%), Asian Indian Americans

(10%), Japanese Americans (7%), and Filipino Americans (6 %). Southeast Asians experienced much higher rates of poverty: Vietnamese (26%), Laotian (35%), Cambodian (43%), and Hmong (64%). Rates of poverty were also high among Pacific Islanders. In 1990, approximately 17 percent of Pacific Islanders were living in poverty, with Samoans (26%) and Tongans (23%) reporting the highest levels of poverty.

Physical Health Status

The small number of studies that report health status by different subgroups limits an examination of overall physical health among Asian Americans and Pacific Islanders. While administrative data and health surveys include AA/PIs as a category, more often than not they do not have adequate comparable data for specific ethnic subgroups. Accordingly, an overall assessment of the AA/PI ethnic category leads to simple but misleading conclusions.

When it is reported that Asian Americans and Pacific Islanders have lower death rates attributable to cancer and heart disease than other minority groups, some might be misled and conclude that AA/PIs enjoy better health than other groups in the United States. However, when subgroup data are available, more accurate statements about the health profile of AA/PIs can be made (Zane, et al., 1994). For example, Native Hawaiian men have higher rates of lung cancer than white men do, and the incidence of cervical cancer among Vietnamese women in the United States is more than five times greater than that among white women (Kuo & Porter, 1998). While coronary heart disease and stroke kill nearly as many Americans as all other diseases combined, mortality from heart disease for Asian Americans and Pacific Islanders is 40 percent lower than that for whites.

Go to:

The Need For Mental Health Care

Historical and Sociocultural Factors That Relate to Mental Health

Historical events and circumstances shape the mental health profile of any racial and ethnic group. For example, refugees from Cambodia were exposed to trauma before migrating to the United States because of persecution by the Khmer Rouge Communists under Pol Pot. During the four years of Pol Pot's regime (1975-1979), between 1 and 3 million of the 7 million people in Cambodia died through starvation, disease, or mass executions. This national trauma, as well as the stressors associated with relocation, including English language difficulties and cultural conflicts, continues to affect the emotional health of many Cambodian refugees and other immigrants.

Somatization

Another important factor related to mental health is culture. Culture shapes the expression and recognition of psychiatric problems. Western culture makes a distinction between the mind and body, but many Asian cultures do not (Lin, 1996). Therefore, it has long been hypothesized that Asians express more somatic symptoms of distress than white Americans. The influence of the teachings and philosophies of a Confucian, collectivist tradition discourages open displays of emotions, in order to maintain social and familial harmony or to avoid exposure of personal weakness. Mental illness is highly stigmatizing in many Asian cultures. In these societies, mental illness reflects poorly on one's family lineage and can influence others' beliefs about how

suitable someone is for marriage if he or she comes from a family with a history of mental illness. Thus, either consciously or unconsciously, Asians are thought to deny the experience and expression of emotions. These factors make it more acceptable for psychological distress to be expressed through the body rather than the mind Tseng, 1975; Kleinman, 1977; Nguyen, 1982; Gaw, 1993; Chun et al., 1996. It has been found that Chinese Americans are more likely to exhibit somatic complaints of depression than are African Americans or whites (Chang, 1985), and Chinese Americans with mood disorders exhibit more somatic symptoms than do white Americans (Hsu & Folstein, 1997).

Hsu and Folstein (1997) and Leff (1988) also suggest that psychological expression of distress is a relatively recent Western phenomenon, and that physical expression of psychological distress is normal in many cultures. Others have argued that somatization is often under the control of display rules that dictate when, where, and what symptoms are shown (Cheung, 1982). In this view, it is not so much that Chinese suppress or repress affective symptoms, but that the context of the situation influences what is presented. Chinese may display somatic symptoms to mental health workers but show depressive symptoms to others. Mental health professionals who rely solely on the standard psychiatric diagnoses used in the United States may not identify these somatic expressions of distress.

Key Issues for Understanding the Research

Methodology

The history of AA/PI groups reveals the tremendous diversity within the population. Unfortunately, in the past, research studies have typically classified Asian and Pacific Islander Americans as belonging to a homogenous ethnic category. Chapter 1 outlined some of the serious methodological problems (e.g., the high cost of screening rare populations) that partially explain why AA/PIs are often lumped together or into an "other" category. Despite the practical basis for creating a single racial designation for AA/PIs, using it has had real scientific and policy consequences. One consequence, as demonstrated later in this chapter, is that very little is known about the rates of mental illness, access to care, quality of care, and outcomes of treatment for different groups of Asian Americans and Pacific Islanders. The AA/PI category is a social and political convenience because the use of the term allows researchers, service providers, and policymakers to easily describe and discuss groups who seemingly share similar backgrounds. Unfortunately, this classification masks the social, cultural, and psychological variations that exist among AA/PI ethnic groups and constrains analyses of the interethnic differences in mental illness, help-seeking, and service use. The conclusions drawn from analyses using AA/PIs as a single racial category may be substantively different than ones made when specific AA/PI ethnic groups are examined (Uehara et al., 1994).

A second consequence of using a single ethnic category in research analyses is that it can lead to the conclusion that AA/PIs are a model minority. On average, AA/PIs have relatively high levels of educational, occupational, and economic achievement, and low rates of certain health problems. A simple interpretation of these types of data has resulted in portrayals of AA/PIs as extraordinarily successful, which justifies the lack of research attention and resources allocated to this population. However, recognition of the diverse ethnic groups that comprise the AA/PI category helps to cast doubt on the model minority image. It should be noted that occasionally research on an aggregate group (e.g., Asian Americans) might be appropriate, particularly when the characteristic under observation is common to many Asian American groups. Nevertheless, care must be exercised to avoid stereotyping this population. The needs of specific AA/PI ethnic

groups must be considered in order to fully understand the mental health of Asian Americans and Pacific Islanders.

Diagnosis

Establishing the rates of psychiatric disorders among AA/PIs is important in determining the need for mental health care in this population. As mentioned earlier, a common standard in setting the criteria for different mental disorders is the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*(1994). A critical issue is whether or not AA/PIs manifest symptoms similar to those found in Western societies as defined by the DSM-IV. Marsella and colleagues (1985) note that there is a tendency in the mental health field to overlook cultural variations in the expression of mental disorder when developing nosological categories. Groups vary in how they define such constructs as "distress," "normality," and "abnormality." These variations affect definitions of mental health and mental illness, expressions of psychopathology, and coping mechanisms (Marsella, 1982).

In addition, ethnic and cultural groups may have unique ways of expressing distress. As discussed later, neurasthenia, a condition often characterized by fatigue, weakness, poor concentration, memory loss, irritability, aches and pains, and sleep disturbances, is recognized in China. It is an official category in the International Classification of Diseases (Version 10) but not in the DSM-IV. Neurasthenia is a common diagnosis in China (Yamamoto, 1992), although it is not an official category in the DSM-IV. It is sometimes classified as undifferentiated somatoform disorder (if symptoms last at least six months) or as a rheumatological disorder. Some of the symptoms found in neurasthenia (loss of energy, inability to concentrate, sleep disturbances, etc.) overlap with those in depressive disorders. However, in neurasthenia, the somatic symptoms rather than depressed moods are critical, and any depressive symptoms are not sufficiently persistent and severe to warrant a diagnosis of a mood disorder.

Acculturation

An important factor in understanding the symptom expression, rates of illness, and use of services by immigrants and refugees is their *acculturation*, or adoption of the worldviews and living patterns of a new culture. Asian Americans differ in how they are integrated within the dominant U.S. culture, how they remain tied to the cultures of their ethnic origins, or how they are able to negotiate life in multiple cultures. Although many advances have been made in measuring acculturation, this area of research still has unresolved conceptual and methodological problems. Many factors affect the way and extent to which immigrants become involved in a new culture and remain connected with their earlier heritage. For example, age at time of immigration, presence of similar immigrants, and interaction with others from the new environment all influence adaptation. The influence of acculturation on mental health has not been clearly identified, in part because of problems with measuring acculturation. Nonetheless, the level of exposure to and involvement in U.S. culture is important when examining mental health factors for Asian Americans.

Mental Disorders

Adults

Less is known about the rates of psychiatric disorders using DSM categories for AA/PIs than for most of the other major ethnic groups. Even when AA/PIs are included as part of the sample of

large-scale studies, it is not often possible to make estimates of mental disorders for this population. Two major studies, the Epidemiologic Catchment Area (ECA) study and the National Comorbidity Study (NCS), examined the need for mental health care in the U.S. population. In the 1980s, researchers who were conducting the Epidemiologic Catchment Area study (Regier et al., 1993) included residents of Baltimore, St. Louis, Durham, Los Angeles, and New Haven in their sample. English-speaking Asian Americans, who were classified in a single ethnic category, comprised less than 2 percent of the total sample (*N* = 242). Because of the limited sample size and the unclear composition of the AA/PI category, accurate conclusions could not be drawn about this population's need for mental health care (Zhang & Snowden, 1999).

While the ECA study was limited to samples from five U.S. cities, the NCS (Kessler et al., 1994) estimated the rates of psychiatric disorders in a representative sample of the entire U.S. population. Just as in the ECA study, the NCS included a small sample of English-speaking Asian Americans and classified all ethnic groups into a single AA/PI category. Again, the group of Asian American respondents in the NCS was small, extremely diverse, and not representative of any particular Asian American subgroup.

The Chinese American Psychiatric Epidemiological Study (CAPES), was a large-scale investigation of the prevalence of selected disorders using DSM-IIIR (APA, 1987) criteria. This study, conducted in 1993 and 1994, examined rates of depression among more than 1,700 Chinese Americans in Los Angeles County Sue et al., 1995; Takeuchi et al., 1998. The CAPES sample was comprised predominantly of Chinese immigrants; 90 percent of the sample was born outside the United States. Researchers conducted interviews in Cantonese, Mandarin, and English, and they used a multistage sampling procedure to select respondents. CAPES was similar in some ways to the ECA and NCS. Like the ECA, CAPES used one geographic site rather than a national sample. To measure depression, CAPES used the Composite International Diagnostic Interview Schedule-the University of Michigan version (UM-CIDI)-which is similar to the diagnostic instrument used in the NCS.

CAPES results showed that Chinese Americans had moderate levels of depressive disorders (Table 5-1). About 7 percent of the respondents reported experiencing depression in their lifetimes, and a little over 3 percent had been depressed during the past year. These rates were lower than those found in the NCS (Kessler et al., 1994). On the other hand, the rate for dysthymia more nearly matched the NCS estimates. It should be noted that the rates of lifetime and 12-month depression and dysthymia were very similar to the prevalence rates found in the Los Angeles site for the ECA. The implications of these findings are reviewed at the end of the discussion of other studies using symptom scales.

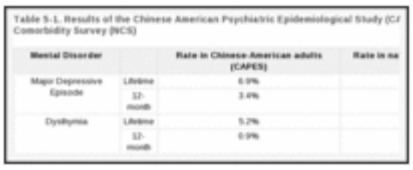

Table 5-1. Results of the Chinese American Psychiatric Epidemiological Study (C Comorbidity Survey (NCS)

Mental Disorder		Rate in Chinese American adults (CAPES)	Rate in na
Major Depressive Episode	Lifetime	6.9%	
	12-month	3.4%	
Dysthymia	Lifetime	5.2%	
	12-month	0.9%	

Table

Table 5-1. Results of the Chinese American Psychiatric Epidemiological Study (CAPES) and the National Comorbidity Survey (NCS).

No study has addressed the rates of mental disorders for Pacific Islander American ethnic groups.

Children and Youth

Very little is known about the mental health needs of the diverse populations of Asian American and Pacific Islander children and adolescents. No large studies documenting rates of psychiatric disorders in these youth have been conducted. However, several studies of symptoms of emotional distress have been conducted in small group samples of Asian American and Pacific Islander youth. Most of these studies find few differences between Asian American and Pacific Islander youth and white youth. For example, Filipino youth (Edman et al., 1998) and Hawaiian youth (Makini et al., 1996) attending high schools in Hawaii were found to have rates of depressive symptoms similar to those of white youth in the same schools. On the other hand, Chinese immigrant students have reported high rates of anxiety (Sue & Zane, 1985).

Older Adults

Little information is available on the prevalence of psychiatric disorders among older Asian Americans. Yamamoto and colleagues (1994) found a relatively low lifetime prevalence of most psychiatric disorders according to DSM-III (APA, 1980) criteria among a sample (N = 100) of older Koreans drawn from the Korean Senior Citizens Association in Los Angeles (Yamamoto et al., 1994). Researchers also compared older Koreans in Los Angeles with community epidemiological studies conducted in Korea. The prevalence of almost all psychiatric disorders was similar for older Koreans in Los Angeles and those in Korea (Yamamoto et al., 1994).

Four other studies have examined the psychological well-being of older Asian Americans. These studies are weak from a methodological standpoint because they involve small, non-random samples and use general measures of distress rather than measures of psychiatric disorders. Three studies used the translated version of the Geriatric Depression Scale (GDS). A convenience sample of Japanese American older adults in Los Angeles (N = 86) was found to be relatively healthy and not depressed (Iwamasa et al., 1998). In a sample of older Chinese American adults in Minneapolis-St. Paul (N = 45) between the ages of 59 and 89 years, 20 percent were found to have significant depressive symptoms. A study of older, community-dwelling Chinese immigrants (N =50) in a Northeast urban area revealed that 18 percent of respondents were mildly to severely depressed (Mui, 1996). These rates are similar to those found in other community samples of older people. Raskin and colleagues (1992) compared Chinese and white Americans between the ages of 60 and 99 from senior citizen housing complexes, senior citizen centers, senior citizen clubs at churches, and other community locations. Chinese Americans reported somatic psychiatric distress similar to what their white American counter-parts reported. Finally, White and colleagues (1996) found a 9 percent prevalence for dementia among Japanese American men living in institutions or in the community in Honolulu, a rate lower than that for Japanese men in Japan, but similar to that for other American men in their age group.

In sum, researchers must be cautious about generalizations based on the limited findings on the mental health of older Asian Americans. Subjects for these studies are often recruited through Asian American senior organizations; the extent to which these findings can be generalized to less active older adults is limited. However, these results do not reveal high rates of psychopathology among older Asian adults.

Mental Health Problems

Symptoms

Much more is known about mental health problems measured by symptom scales as opposed to DSM criteria. In these studies, AA/PIs do appear to have an increased risk for symptoms of depression. Diagnoses of psychiatric disorders rely both on the presence of symptoms and on additional strict guidelines about the intensity and duration of symptoms. In studies of depressive symptoms, individuals are often asked to indicate whether or not they have specific depressive symptoms and how many days in the past week they experienced these symptoms. In several studies, Chinese Americans, Japanese Americans, Filipino Americans, and Korean Americans in Seattle Kuo, 1984; Kuo & Tsai, 1986, Korean immigrants in Chicago (Hurh & Kim, 1990), and Chinese Americans in San Francisco (Ying, 1988) reported more depressive symptoms than did whites in those cities. One interpretation of the findings suggests that AA/PIs show high rates of depression, or simply have more symptoms but not necessarily higher rates of depression. Few studies exist on the mental health needs of other large ethnic groups such as Indian, Hmong, and Pacific Islander Americans.

Culture-Bound Syndromes

Even if Asian Americans are not at high risk for a few of the psychiatric disorders that are common in the United States, they may experience so-called culture-bound syndromes (APA, 1994). Two such syndromes are neurasthenia and *hwa-byung*.

As described earlier, Chinese societies recognize a disorder called neurasthenia. In a study of Chinese Americans in Los Angeles, Zheng and his colleagues (1997) found that nearly 7 percent of a random sample of respondents reported that they had experienced neurasthenia. The neurasthenic symptoms often occurred in the absence of symptoms of other disorders, which raises doubt that neurasthenia is simply another disorder (e.g., depression) in disguise. Furthermore, more than half of those with this syndrome did not have a concomitant Western psychiatric diagnosis from the DSM-III-R. Thus, although Chinese Americans are likely to experience neurasthenia, mental health professionals using the standard U.S. diagnostic system may not identify their need for mental health care.

Koreans may experience *hwa-byung*, a culture-bound disorder with both somatic and psychological symptoms. *Hwa-byung*, or "suppressed anger syndrome," is characterized by sensations of constriction in the chest, palpitations, sensations of heat, flushing, headache, dysphoria, anxiety, irritability, and problems with concentration Lin, 1983; Prince, 1989. A community survey in Los Angeles found that 12 percent of Korean Americans (total $N = 109$), the majority of whom were recent immigrants, suffered from this disorder Lin, 1983; Lin et al., 1992; this rate is higher than that found in Korea (4%) (Min, 1990).

Suicide

Little research is available to shed light on the mental health needs of Asian Americans, but some information may be obtained by looking at suicide rates (Table 5-2). It is thought that Asian Americans are generally less likely to commit suicide than whites. A study by Lester (1994) compared suicide rates (per 100,000 per year) in the United States for various groups. Chinese (8.3), Japanese (9.1), and Filipino (3.5) Americans had lower suicide rates than whites (12.8). However, other sub-groups of Asian Americans and Pacific Islanders may be at higher risk for suicide. For example, Native Hawaiian adolescents have a higher risk of suicide than other adolescents in Hawaii.

Table 5-2. Suicide Rates

POPULATION	SUICIDES PER 100,000 PEOPLE PER YEAR
Asian Americans	7
White Americans	12.8
Native Hawaiian adolescents	12.9
Non-native Hawaiian adolescents in Hawaii	9.6

Source: Lester, 1994

Table

Table 5-2. Suicide Rates.

Concerns have been raised regarding high rates of suicide among young women who immigrate to the United States from the Indian subcontinent (Patel & Gaw, 1996) and among Micronesian adolescents (Rubinstein, 1983), but these groups have not been well studied. Finally, older Asian American women have the highest suicide rate of all women over the age of 65 in the United States (DHHS, 1999). Clearly, more information is needed on suicide among subgroups of Asian Americans.

High-Need Populations

Refugees

The mental health needs of a population may be indicated by rates of mental disorders in the population as a whole, or by the existence of smaller subpopulations that have a particularly high need for mental health care. The relationship between poverty, poor health, and mental health is very consistent in the mental health literature. Given the relative economic status of Asian Americans and Pacific Islanders, it is not surprising that they are not present in large numbers among the Nation's homeless (U.S. Census Bureau, 1996). Furthermore, they make up less than 1 percent of the national incarcerated population (Bureau of Justice Statistics, 1999). Although there are inadequate data to draw conclusions about how often Asian American and Pacific Islander children are exposed to violence, this exposure is often related to socioeconomic deprivation. Most studies indicate that Asian Americans are less likely to have substance abuse problems than are other Americans (Makimoto, 1998). In sum, Asian Americans and Pacific Islanders are not heavily represented in many of the groups known to have high need for mental health care. However, many do experience difficulties, such as the lack of English proficiency, acculturative stress, prejudice, discrimination, and racial hate crimes, which place them at risk for emotional and behavioral problems. Southeast Asian refugees, in particular, are considered to be at high risk.

Many Southeast Asian refugees are at risk for post-traumatic stress disorder (PTSD) associated with the trauma they experienced before they immigrated to the United States. Refugees who fled Vietnam after the fall of Saigon in 1975 were mainly well-educated Vietnamese who were often able to speak some English and prosper financially. Although subsequent Vietnamese refugees were less educated and less financially secure, they were able to join established communities of other Vietnamese in the United States. Cambodians and Laotians became the second wave of refugees from Indochina. The Cambodians were survivors of Pol Pot's holocaust of killing fields. Several groups of Laotians, including the Mien and Hmong, had cooperated with American forces and left Laos after the war from fear of retribution. One-third of the Laotian population had been killed during the war, and many others fled to escape the devastation.

Studies document high rates of mental disorders among these refugees. A large community sample of Southeast Asian refugees in the United States (Chung & Kagawa-Singer, 1993) found that premigration trauma events and refugee camp experiences were significant predictors of psychological distress even five years or more after migration. Significant subgroup differences were also found. Cambodians reported the highest levels of distress, Laotians were next, then Vietnamese. Studies of Southeast Asian refugees receiving mental health care uniformly find high rates of PTSD. One study found 70 percent met diagnostic criterion for the disorder, with Mien from the highlands of Laos and Cambodians having the highest rates Kinzie et al., 1990; Carlson & Rosser-Hogan, 1991; Moore & Boehnlein, 1991.

Another study examined the mental health of 404 Southeast Asian refugees during an initial clinical evaluation of patients seen for psychiatric assessment at a Southeast Asian mental health clinic in Minnesota. The sample was Hmong, Laotian, Cambodian, and Vietnamese. Clinical diagnoses were made according to DSM-III by two psychiatrists, who also used information from a symptom checklist. In this sample, 73 percent had major depression, 14 percent had post-traumatic stress disorder, and 6 percent had anxiety and somatoform disorders (Kroll et al., 1989). Blair (2000) found that a random, community sample of Cambodian adults (*N* =124) had high rates of trauma-related stress and depression. This study, which used a standard diagnostic interview, found that 45 percent had PTSD, and 81 percent experienced five or more symptoms. Furthermore, 51 percent suffered from depression. Most of these individuals (85%) had experienced horrible traumas prior to immigrating to the United States, including starvation, torture, and losing family members to the war. On average, individuals in the sample experienced 20 war traumas (Blair, 2000). Similarly, 168 adults, recruited from a community of resettled Cambodian refugees in Massachusetts, were interviewed for a study of trauma, physical and emotional health, and functioning. Of the 161 participants who had ever had children, 70 parents (43%) reported the death of between 1 and 6 of their children. Child loss was positively associated with health-related concerns, a variety of somatic symptoms, and culture-bound conditions of emotional distress such as "a deep worrying sadness not visible to others" (Caspi et al., 1998).

Some subgroups of Vietnamese refugees may also be at high risk for mental health problems. Hinton and colleagues (1997) compared Vietnamese and Chinese refugees from Vietnam 6 months after their arrival in the United States and 12 to 18 months later. The ethnic Vietnamese had higher depression at the second assessment than did the Chinese immigrants.

Two studies have found high rates of distress among refugee youth. Cambodian high school students had symptoms of PTSD and mild, but prolonged, depressive symptoms (Kinzie et al. 1986). Researchers also have noted high levels of anxiety among unaccompanied minors, adolescents, and young adult refugees from Vietnam (Felsman et al., 1990). Likewise, in a study of Cambodian adolescents who survived Pol Pot's concentration camps, Kinzie and colleagues (1989) found that nearly half suffered from PTSD, and 41 percent experienced depression approximately 10 years after this traumatic period. Clearly, because many Southeast Asian refugees experienced significant trauma prior to immigration, rates of PTSD and depression are extraordinarily high among both adult and youth refugees.

Researchers conducting the next generation of studies need not only to derive accurate estimates of psychopathology among AA/PIs, but also to identify the specific ways that social and cultural factors influence the expression of mental disorders among AA/PIs. The results might then prove or disprove several of the general hypotheses that are currently made about the prevalence of mental disorders among Asian Americans.

Box 5-1: The Plight of Southeast Asian Refugees

A Khmer woman (mid-40's)

Because of premigration traumas and the adjustment to relocation in the United States, many Southeast Asian refugees are experiencing great stress. The following excerpts were elicited in a mental health interview of a mid-40-year-old, Khmer woman from Cambodia by Rumbaut (1985).

"I lost my husband, I lost my country, I lost every property/fortune we owned. And coming over here, I can't learn to speak English and the way of life here is different; my mother and oldest son are very sick; I feel crippled, I can do nothing, I can't control what's going on. I don't know what I'm going to do once my public assistance expires. I may feel safe in a way- there is no war here, no Communist to kill or to torture you-but deep down inside me, I still don't feel safe or secure. I feel scared. I get scared so easily." (p. 475)

The first hypothesis suggests that rates of disorders will be high because many Asian Americans are immigrants who undergo difficult transitions in their adjustment to American society, and many have experienced prejudice, discrimination, and major trauma in their homelands. Indeed, as reported earlier, studies have found that some Asian American ethnic groups do have higher symptom scores than whites. A second hypothesis argues that the rates of mood disorders will be low because Asian Americans, like Asians in other countries, are likely to express their problems in behavioral or somatic terms rather than in emotional terms. Available evidence, for example, does suggest that the rates of mood disorders are low in Taiwan, Hong Kong, and China (Hwu et al., 1989). A third hypothesis maintains that the rates of mental disorders will be lowest for recent immigrants and highest for native-born residents. Low rates of mental disorders have been found among recent Mexican immigrants, for whom culture may be protective against mental health problems at first; but these low rates erode over time as Mexican immigrants acculturate. With Asian Americans, however, the preliminary evidence suggests that acculturation is directly related to well-being, at least in the case of Asian American students Abe & Zane, 1990; Sue et al., 1996

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Availability, Accessibility, and Utilization of Mental Health Services

Disparities exist in the provision of adequate and effective mental health care to Asian Americans. Culturally competent and effective services are often unavailable or inaccessible.

Availability of Mental Health Services

Nearly half of the Asian American and Pacific Islander population's ability to use the mental health care system is limited due to lack of English proficiency, as well as to the shortage of providers who possess appropriate language skills. No reliable information is available regarding the Asian language capabilities of providers. Of the mental health care professionals who were practicing in the late 1990s, approximately 70 Asian American providers were available for every 100,000 Asian Americans in the United States; this is about half the ratio for whites (Manderscheid & Henderson, 1998).

Accessibility of Mental Health Services

Access to mental health care often depends on health insurance coverage. About 21 percent of Asian Americans and Pacific Islanders lack health insurance. However, within Asian American subgroups, the rate varies significantly. For instance, 34 percent of Korean Americans have no health insurance, whereas 20 percent of Chinese Americans and Filipino Americans lack such insurance. Furthermore, the rate of Medicaid coverage for most Asian American and Pacific Islander subgroups is well below that of whites. It has been suggested that lower Medicaid participation rates are, in part, due to widespread but mistaken concerns[2] among immigrants that enrolling themselves or their children in Medicaid would jeopardize their applications for citizenship (Brown et al., 2000). Nevertheless, even among U.S. citizens who live in families with children and have family incomes below 200 percent of the Federal poverty level (i.e., those who are most likely to be eligible for Medicaid), only 13 percent of Chinese Americans have Medicaid coverage, compared to 24 percent of whites in the same income bracket (Brown et al., 2000). These findings are important to consider because there is evidence that the lack of insurance coverage is associated with lower access to and utilization of health care (Chin et al., 2000).

Utilization of Mental Health Services

Community Studies

The Chinese American Psychiatric Epidemiological Study (CAPES) did not include a large enough sample of Asian Americans and Pacific Islanders to determine an accurate percentage of how many use care. In the study, participants with and without mental disorders indicated whether or not they had sought help for problems with emotions, anxiety, drugs, alcohol, or mental health in the past six months. Unfortunately, few of those experiencing problems (17%) sought care. Less than 6 percent of those who did seek care saw a mental health professional; 4 percent saw a medical doctor; and 8 percent saw a minister or priest (Young, 1998). Likewise, in the small sample of Asian Americans who participated in the National Comorbidity Study (NCS), less than 25 percent of those who had experienced a mood or anxiety disorder had sought care.

Zhang and colleagues (1998) compared Asian Americans and whites from a randomly selected sample based on the first wave of the Epidemiologic Catchment Area study on help seeking for psychological problems. Asian Americans were significantly less likely than whites to mention their mental health problems to a friend or relative (12 versus 25%), psychiatrist or mental health specialist (4 versus 26%), or physician (3 versus 13%). Asian Americans used health services less frequently in the past 6 months than whites (36 versus 56%). Compared with white Americans, Asian Americans less frequently visited a mental health center, a psychiatric outpatient clinic in a general hospital, an emergency unit, or a community mental health program, natural therapist, or self-help group. However, Asian Americans and whites did not differ in their use of out-patient clinics located in psychiatric or Vetrans' Administration hospitals (Zhang et al., 1998).

Box 5-2: Avoidance of Mental Health Service

An (age 30)

Gee and Ishii (1997) describe a case that illustrates the difficulties that some Asian Americans have in using mental health services. An was a 30-year-old bilingual, Vietnamese male who was placed in involuntary psychiatric hold for psychotic disorganization. After neighbors found him screaming and smelling of urine and feces, they called the police, who escorted him to a

psychiatric emergency room. An had been hospitalized several previous times for psychotic episodes. He was the oldest of five children and was living at home while attending college.

His parents had a poor understanding of schizophrenia and were extremely distrustful of mental health providers. They thought that his psychosis was caused by mental weakness and poor tolerance of the recent heat wave. They believed that they themselves could help An by providing him with their own food and making him return to school. Furthermore, the family incorrectly attributed An's facial injury, sustained while in the locked facility, to beatings from the mental health staff.

These misconceptions and differences in beliefs caused the parents to avoid the use of mental health services.

Mental Health Systems Studies

Another way to determine whether Asian Americans and Pacific Islanders are using mental health care is to look at mental health systems of care. What must be determined is whether individuals from different groups served by the same system use care in proportion to their representation in the community. A problem with this approach is that it assumes, perhaps incorrectly, that groups have identical needs for mental health care. Three comprehensive studies that examined the entire formal mental health system found that Asian Americans used fewer services per capita than did other groups Snowden & Cheung, 1990; Cheung & Snowden, 1990; Matsuoka et al., 1997.

Results consistent with the findings of these national studies were found in studies of many local mental health systems, such as Los Angeles County. The proportion of Asian Americans among those who use psychiatric clinics and hospitals was found to be lower than their proportion of the general population Kitano, 1969; Brown et al., 1973; Sue, 1977; Los Angeles County Department of Mental Health, 1984; Cheung, 1989; Snowden & Cheung, 1990; Sue et al., 1991; Uba, 1994; Durvasula & Sue, 1996; Snowden & Hu, 1997; Shiang et al., 1998. This disparity occurred whether the Asian American groups considered were students or nonstudents, inpatients or outpatients, children or adults, or whether they were living in neighborhoods with many or few other Asians. One exception to this finding has been published (O'Sullivan et al., 1989). Asian Americans in Seattle were found to use services at rates similar to their representation in the community. However, representation in the community was based on earlier census data, and the Asian American population grew rapidly during the subsequent period.

Another large-scale study focused on use of mental health services by Asian Americans and Pacific Islanders in Hawaii (Leong, 1994). This study examined outpatient and inpatient utilization rates from 1971 to 1981. Consistent with the findings of mainland studies, all Asian American and Pacific Islander groups used fewer inpatient services than would be expected given their representation in the population. However, lower utilization of outpatient care was not consistent across different groups of Asian Americans. Although both Chinese and Japanese Americans used less outpatient care than would be expected, Filipino Americans used these services at rates similar to their proportion in the population.

Many studies demonstrate that Asian Americans who use mental health services are more severely ill than white Americans who use the same services. This pattern is true in many community mental health centers Brown et al., 1973; Sue, 1977, county mental health systems (Durvasula & Sue, 1996, for adults; Bui & Takeuchi, 1992, for adolescents), and student

psychiatric clinics (Sue & Sue, 1974). Two explanations for this finding are that (1) Asian Americans are reluctant to use mental health care, so they seek care only when they have severe illness, and (2) families tend to discourage the use of mental health facilities among family members until disturbed members become unmanageable. Sue and Sue have found evidence that the reluctance to use services is attributable to factors such as the shame and stigma accompanying use of mental health services, cultural conceptions of mental health and treatment that may be inconsistent with Western forms of treatment, and the cultural or linguistic inappropriateness of services (Sue & Sue, 1999).

Complementary Therapies

Asian Americans and Pacific Islanders are not represented in the national studies that report on use of alternative or complementary health care sources (both home-based and alternative providers) to supplement or substitute for care received from mainstream sources Eisenberg et al., 1998; Astin, 1998; Druss & Rosenheck, 2000. Nevertheless, some smaller studies conducted within subgroups of Asian Americans and Pacific Islanders suggest use of complementary therapies at rates equal to or higher than those used by white Americans. For example, one study of first- and second-generation Chinese Americans seeking care in an emergency department near New York City's Chinatown found that 43 percent had used Chinese therapies within one week of the visit (Pearl et al., 1995). Another study found that 95 percent of Chinese immigrants in Houston and Los Angeles used home remedies and self-treatments, including dietary and other approaches. Of this group, a substantial number of immigrants consulted traditional healers (Ma, 1999). Similarly, 90 percent of Vietnamese immigrants in the San Francisco Bay area used indigenous health practices (Jenkins et al., 1996). Almost half of the older Korean immigrant participants in Los Angeles County reported seeing a traditional healer (Pourat et al., 1999). Like members of other ethnic groups, these individuals generally use traditional therapies and healers to complement care from mainstream sources.

Asian Americans use a range of healing methods. For example, traditional Chinese medicine has existed for almost 3,000 years, and traditional Vietnamese healing derives from these historical roots. However, the healing practices of Laotians and Cambodians are influenced more by India and South Asia and have origins in ayurvedic medicine. Polynesian culture and healing practices are influential in Hawaii and other Pacific Islands.

Little is known about how Asian Americans and Pacific Islanders use indigenous therapies specifically for mental illness. Nevertheless, medications prescribed by mainstream health care providers can interact with herbal remedies or other forms of traditional medicine, so an awareness of the potential use of complementary methods of healing is essential.

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Appropriateness and Outcomes of Mental Health Services

Limited evidence is available regarding the response of Asian Americans to mental health treatment. One study of outpatient individual psychotherapy in a San Francisco clinic found that Asian American clients had poorer short-term outcomes and less satisfaction with care than white Americans (Zane et al., 1994). In a recent pilot study using cognitive-behavioral therapy to treat depressive symptoms (Dai et al., 1999), older Chinese Americans appeared to respond in the same manner as a previously studied multiethnic population had. In two large-scale studies of mental health systems, there was evidence that the treatment outcomes for Asian American clients were either similar to, or poorer than those for whites Sue, 1977; Sue et al., 1991.

Researchers have not compared the relative likelihood of Asian Americans and others to receive appropriate psychiatric care. One study suggested that primary care doctors may not identify depression in their Asian American clients as often as they identify depression in white clients (Borowsky et al., 2000). However, the study sample was too small to draw strong conclusions.

The fact that further research is needed on treatment outcomes for AA/PIs is especially evident in the use of psychotropic medicines. Recent research indicates that Asian Americans may respond clinically to psychotropic medicines in a manner similar to white Americans but at lower dosages (Lin & Cheung, 1999). These studies are based on very small samples and should be considered preliminary. However, consistent findings are appearing with regard to Asian Americans' response to neuroleptics, tricyclic antidepressants, lithium, and benzodiazepines Chin, 1998; Lin et al., 1997. These findings suggest that, in the treatment of mental disorders among Asian Americans, care must be taken not to over-medicate. Initial doses of medication for these individuals should be as low as is appropriate, with gradual increases in order to obtain therapeutic effects (Du & Lu, 1997).

Under the assumption that AA/PI clients may respond better to therapists of the same ethnicity because of a better cultural match, Sue and colleagues (1991) examined whether treatment outcomes were better with ethnically matched versus unmatched therapists. They found that Asian American clients who are matched with Asian American therapists are less likely to leave treatment prematurely than Asian American clients who are not matched ethnically with their therapists (Sue et al., 1991). Ethnic match also increased length of treatment, even after other sociodemographic and clinical variables were controlled. Not surprisingly, an ethnic and linguistic match between the client and provider was more important for clients who were relatively less acculturated to U.S. society than for those clients who were more immersed in American society.

Hu and colleagues found that Asian Americans used services at a higher rate in Santa Clara County and San Francisco County where community mental health out-patient service centers specifically oriented to Asian Americans and Latinos had been established (Hu et al., 1991). Likewise, Yeh and colleagues found that Asian American children who attended Asian-oriented mental health centers in Los Angeles received more care and functioned better at the end of care than Asian American children who attended mainstream centers (Yeh et al., 1994).

These Asian-oriented or ethnic-specific services provide cultural elements that may welcome AA/PIs, such as notices or announcements written in Asian or pacific Island languages, tea served to clients in addition to coffee, and bilingual and bicultural therapists. Thus, matching the ethnicity of the client and the mental health care provider and providing care within settings specifically developed to treat this group may be important aspects of providing appropriate care for Asian Americans. Speaking the Asian language of patients whose English is limited, understanding the cultural experiences of clients, and having bicultural skills (i.e., being proficient in working with Asians who have different levels of acculturation) are also important.

Finally, in view of the shame and stigma felt by AA/PIs over mental health problems, and the lack of health care coverage that many AA/PIs experience, it is important to intervene at other levels. For example, community education about the nature of mental disorders may help to reduce shame and stereotypes about the mentally ill. Increasing health insurance coverage for mental disorders is important to increase the accessibility of services. Also, the introduction of prevention efforts in AA/PI communities is beneficial. A number of newer programs are working to promote mental health. For example, parent training programs, bicultural adjustment

strategies, and culturally oriented self-help groups have been initiated to promote mental health and well-being in AA/PI communities.

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Conclusions

Asian Americans and Pacific Islanders can be characterized in *four* important ways. First, their population in the United States is increasing rapidly, primarily due to the recent large influx of immigrants. Second, they are diverse, with some subgroups experiencing higher rates of social, health, and mental health problems than others. For example, poverty rates are higher among Southeast Asians and Pacific Islanders than among AA/PIs as a whole. Third, AA/PIs may collectively exhibit a wide range of strengths (e.g., family cohesion, educational achievements, motivation for upward mobility, and willingness to work hard) and risk factors (e.g., premigration traumas, English language difficulties, minority group status, and culture conflict), which again point to the diversity within the population. Fourth, very little national data are available that describe the prevalence of mental disorders using standardized DSM criteria. In terms of what is known about mental health issues among AA/PIs, several conclusions are warranted:

1. Our knowledge of the mental health needs of Asian Americans is very limited. Two of the most prominent psychiatric epidemiological studies, the ECA and the NCS, included extremely small samples of AA/PIs and were not conducted in any of the Asian languages. The only contemporary study of AA/PIs using DSM criteria is CAPES, but it is limited to one Asian ethnic group and focuses primarily on mood disorders. No study has addressed the rates of mental disorders for Pacific Islander American ethnic groups. When symptom scales are used, Asian Americans do show an elevated level of depressive symptoms compared to white Americans. Although these studies have been informative, most of them have focused on Chinese Americans, Japanese Americans, and Southeast Asians. Few studies exist on the mental health needs of other large ethnic groups such as Filipino Americans, Hmong Americans, and Pacific Islanders.
2. Available mental health studies suggest that the overall prevalence of mental health problems and disorders does not significantly differ from the prevalence rates for other Americans, although the distribution of disorders may be different. This means that AA/PIs are not "mentally healthier" than other populations. For example, they may have lower rates of some disorders but higher rates of others, such as neurasthenia. Types of mental health problems appear to depend on level of acculturation. Those who are less Westernized appear to exhibit culture- bound syndromes more frequently than those who are more acculturated. The acculturated population shows more Western types of disorders. Furthermore, the rates of disorders vary according to within-group differences. Rates tend to be higher among Southeast Asian refugees, for instance.
3. Without greater knowledge of the rate and distribution of particular disorders and the factors associated with mental health, care providers have a difficult time devising optimal intervention to treat mental disorders and promote well-being.
4. AA/PIs have the lowest rates of utilization of mental health services among ethnic populations. This underrepresentation is characteristic of most AA/PI groups, regardless of gender, age, and geographic location. Among those who use services, severity of disturbance is high. The explanation for this seems to be that individuals delay using services until problems are very serious. The unmet need for services among AA/PIs is unfortunate, because mental health treatment can be very beneficial.

5. The low utilization of mental health services is attributable to stigma and shame over using services, lack of financial resources, conceptions of health and treatment that differ from those underlying Western mental health services, cultural inappropriateness of services (e.g., lack of providers who speak the same languages as limited english proficiency clients), and the use of alternative resources within the AA/PI communities.
6. Attention to ethnic or culture-specific forms of intervention and to racial or ethnic differences in treatment response is warranted to effect greater service utilization and more positive mental health outcomes. The ethnic matching of therapists with clients and the services of ethnic-specific programs have been found to be associated with increased use of services and favorable treatment outcomes. The development of culturally and linguistically competent services should be of the highest priority in providing mental health care for Asian Americans and Pacific Islanders. Attention must also be paid to differences in responses to medication because effective dosage levels of psychotropic medication may vary considerably among Asian Americans, with many people requiring lower than average doses to achieve therapeutic effects.
7. It is imperative that more research be conducted on the AA/PI population. Priority should be given to investigations that focus on particular AA/PI groups, the rate and distribution of mental health problems (including culture-bound syndromes), culturally competent forms of intervention, and preventive strategies that can promote mental health.

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References

1. Abe, J. S., & Zane, N. (1990)Psychological maladjustment among Asian and Caucasian American college students. Controlling for confounds *Journal of Counseling Psychology, 37*437–444.
2. American Psychiatric Association. (1980) *Diagnostic and statistical manual of mental disorders* (3rd ed.), Washington,, DC.
3. American Psychiatric Association. (1987) *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.), Washington,, DC.
4. American Psychiatric Association. (1994) *Diagnostic and statistical manual of mental disorders* (4th ed.), Washington,, DC.
5. Astin, J. A. (1998) Why patients use alternative medicine: Results of a national study *Journal of the American Medical Association, 279,* 1548–1553. [PubMed]
6. Blair, R. G. (2000) Risk factors associated with PTSD and major depression among Cambodian refugees *Health and Social Work, 25,* 23–30. [PubMed]
7. Borowsky, S. J., Rubenstein, L. V., Meredith, L. S., Camp, P., Jackson-Triche, M., & Wells, K. B. (2000)Who is at risk of nondetection of mental health problems in primary care? *Journal of General Internal Medicine, 15*381–388. [PMC free article] [PubMed]
8. Brown, E. R., Ojeda, V. D., Wyn, R., & Levan, R. (2000) *Racial and ethnic disparities in access to health insurance and health care* , Los Angeles,, CA. UCLA Center for Health Policy and Research and The Henry J. Kaiser Family Foundation.
9. Brown, T. R., Huang, K., Harris, D. E., & Stein, K. M. (1973)In S. Sue & N. Wagner (Eds.), *Asian-American: Psychological perspectives* (pp. 212–231)., Palo Alto,, CA. Science and Behavior Books.
10. Bui, K. V., & Takeuchi, D. T. (1992) Ethnic minority adolescents and the use of community mental health care services *American Journal of Community Psychology, 20* (4)403–417. [PubMed]

11. Bureau of Justice Statistics. (1999) *The sourcebook of criminal justice statistics.* , Washington,, DC.
12. Carlson, E. B., & Rosser-Hogan, R. (1991) Trauma experiences, post-traumatic stress, dissociation, and depression in Cambodian refugees *American Journal of Psychiatry, 148,* 1548–1551. [PubMed]
13. Caspi, Y., Poole, C., Mollica, R. F., & Frankel, M. (1998) Relationship of child loss to psychiatric and functional impairment in resettlements *Journal of Nervous and Mental Disease, 186*484–491. [PubMed]
14. Chang, W. (1985) A cross-cultural study of depressive symptomatology *Culture, Medicine, and Psychiatry, 9*295–317. [PubMed]
15. Cheung, F. K (1989, May) *Culture and mental health care for Asian Americans in the United States.* Paper presented at the Annual Meeting of the American Psychiatric Association, San Francisco.
16. Cheung, F. K., & Snowden, L. R. (1990) Community mental health and ethnic minority populations *Community Mental Health Journal. 26,* 277–291. [PubMed]
17. Cheung, F. M. (1982) Psychological symptoms among Chinese in urban Hong Kong *Social Science and Medicine, 16,* 1339–1344. [PubMed]
18. Chin, D., Takeuchi, D. T., & Suh, D. (2000)In C. Hogue, M. A. Hargraves, & K. S. Collins (Eds.), *Minority health in America* (pp. 77–98)., Baltimore Johns Hopkins University Press.
19. Chin, J. L. (1998)In L. C. Lee & N. W. S. Zane (Eds.), *Handbook of Asian American Psychology* (pp. 485–504)., Thousand Oaks,, CA. Sage.
20. Chun, C., Enomoto, K., & Sue, S. (1996)In P. M. Kato & T. Mann (Eds.), *Handbook of diversity issues in health psychology* (pp. 347–366)., New York Plenum.
21. Chung, R. C., & Kagawa-Singer, M. (1993) Predictors of psychological distress among Southeast Asian refugees *Social Science and Medicine, 36,* 631–639. [PubMed]
22. Dai, Y., Zhang, S., Yamamoto, J., Ao, M., Belin, T. R., Cheung, F., & Hifumi, S. S. (1999) Cognitive behavioral therapy of depressive symptoms in early Chinese Americans: A pilot study *Community Mental Health Journal, 35,* 537–542. [PubMed]
23. Druss, B. G., & Rosenheck, R. A. (2000) Use of practitioner based complementary therapies by persons reporting mental conditions in the United States *Archives of General Psychiatry, 57,* 708–714. [PubMed]
24. Du, N., & Lu, F. L. (1997)In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp. 275–294)., New YorkGuilford Press.
25. Durvasula, R. S., & Sue, S. (1996)Severity of disturbance among Asian American outpatients *Cultural Diversity and Mental Health, 2,* 43–52. [PubMed]
26. Edman, J. L., Andrade, N. N., Glipa, J., Foster, J., Danko, G. P., Yates, A., Johnson, R.C., McDermott, J.F., & Waldron, J.A. (1998) Depressive symptoms among Filipino American adolescents *Cultural Diversity and Mental Health, 4,* 45–54. [PubMed]
27. Edwards, J. R., Jr. (2001) *Public charge doctrine: A fundamental principle of American immigration policy.* , Washington,, DC. Center for Immigration Studies.
28. Eisenberg, D. M., Davis, R. B., Ettner, S. L., Appel, S., Wilkey, S., Van Rompay, M., & Kessler, R. C. (1998)Trends in alternative medicine use in the United States, 1990-1997: Results of a national survey *Journal of the American Medical Association, 280,* 1459–1475.
29. Felsman, J. K., Leong, F. T. L., Johnson, M. C., & Felsman, I. C. (1990) Estimates of psychological distress among Vietnamese refugees: Adolescents, unaccompanied minors and young adults *Social Science and Medicine, 31*1251–1256. [PubMed]
30. Fix, M., & Passel, J. S. (1999) *Trends in noncitizens' and citizens' use of public benefits following welfare reform: 1994-97* , Washington,, DC. The Urban Institute.

31. Gaw, A. C. (1993)In A. C. Gaw (Ed.), *Culture, ethnicity and mental illness* (pp. 245–280)., Washington,, DC. American Psychiatric Association.
32. Gee, K. K., & Ishii, M. M. (1997)In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp. 227–251)., New York Guilford Press.
33. Hinton, W. L., Tiet, Q., Tran, C. G., & Chesney, M. (1997) Predictors of depression among refugees from Vietnam: A longitudinal study *Journal of Nervous and Mental Disease, 185,* 39–45. [PubMed]
34. Hsu, L. K. G., & Folstein, M. F. (1997) Somatoform disorders in Caucasian and Chinese Americans *Journal of Nervous and Mental Disease, 185,* 382–387. [PubMed]
35. Hu, T. W., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991) Ethnic populations in public mental health: Services choice and level of use *American Journal of Public Health, 81,* 1429–1434. [PMC free article] [PubMed]
36. Huang, K. (1991)In N. Mokuau (Ed.), *Handbook of social services for Asian and Pacific Islanders* (pp. 79–96)., Westport,, CT. Greenwood Press.
37. Hurh, W. M., & Kim, K. C. (1990)Correlates of Korean immigrants' mental health *Journal of Nervous and Mental Disease, 178,* 703–711. [PubMed]
38. Hwu, H. G., Yeh, E. K., & Chang, L. Y. (1989) Prevalence of psychiatric disorders in Taiwan defined by the Chinese Diagnostic *Acta Psychiatrica Scandinavia, 79,* 136–147. [PubMed]
39. Iwamasa, G. Y., Hilliard, K. M., & Kost, C. (1998) The Geriatric Depression Scale and older Japanese American adults *Clinical Gerontologist, 19*13–26.
40. Jenkins, C. N. H., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1996) Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science and Medicine, 43,* 1049–1056. [PubMed]
41. Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H., & Kendler, K. S. (1994) Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States *Archives of General Psychiatry, 51,* 8–19. [PubMed]
42. Kinzie, J. D., Boehnlein, J. K., Leung, P. K., Moore, L. J., Riley, C., & Smith, D. (1990) The prevalence of post-traumatic stress disorder and its clinical significance among Southeast Asian refugees *American Journal of Psychiatry, 147,* 913–917. [PubMed]
43. Kinzie, J. D., Sack, W. H., Angell, R. H., Clarke, G., & Rath, B. (1989) A three-year follow-up on Cambodian young people traumatized as children *Journal of American Academy of Child and Adolescent Psychiatry, 28,* 501–504. [PubMed]
44. Kinzie, J. D., Sack, W. H., Angell, R. H., Manson, S., & Ben, R. (1986) The psychiatric effects of massive trauma on Cambodian children: I. The children *Journal of the American Academy of Child and Adolescent Psychiatry, 25,* 370–376.
45. Kitano, H. H. (1969)In S. C. Plog & R.B. Edgerton (Ed.), *Changing perspectives in mental illness* (pp. 256–284)., New York Holt, Rinehart & Winston.
46. Kleinman, A. (1977) Depression, somatization and the "new cross-cultural psychiatry." *Social Science and Medicine, 11*3–10. [PubMed]
47. Kroll, J., Habenicht, M., Mackenzie, T., Yang, M., Chan, S., Vang, T., Nguyen, T., Ly, M., Phommasouvanh, B., Nguyen, H., Vang, Y., Souvannasoth, L., & Cuagao, R. (1989) Depression and post-traumatic stress disorder in Southeast Asian refugees *American Journal of Psychiatry, 146*1592–1597. [PubMed]
48. Kuo, J. A., & Porter, K. (1998) *Advance Data,* No, 298. Hyattsville,, MD. National Center for Health Statistics. [PubMed]
49. Kuo, W. H. (1984) Prevalence of depression among Asian Americans *Journal of Nervous and Mental Disease, 172*449–457. [PubMed]
50. Kuo, W., & Tsai, Y. (1986)Social networking hardiness and immigrant's mental health *Journal of Health and Social Behavior, 27,* 133–149. [PubMed]

51. Lee, S. M. (1998) *Population Bulletin, 53(2)* , Washington,, DC. Population Reference Bureau. [PubMed]
52. Leff, J. (1988) *Psychiatry around the globe* , London Gaskell/Royal College of Psychiatrists.
53. Leong, F. T. L. (1994) Asian Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii *Journal of Community Psychology, 22,* 82–89.
54. Lester, D. (1994) Gender equality and the sex differential in suicide rates *Psychological Reports, 75,* –. [PubMed]
55. Lin, K. M. (1983) Hwa-byung: A Korean culture-bound syndrome? *American Journal of Psychiatry, 140,* 105–107. [PubMed]
56. Lin, K. M. (1996)In J. E. Mezzich, A. Kleinman, H. Fabrega, & D. L. Parron (Eds.), *Culture and psychiatric diagnosis: A DSM-IV perspective*, Washington,, DC. American Psychiatric Press.
57. Lin, K. M., & Cheung, F. (1999)Mental health issues for Asian Americans *Psychiatric Services, 50,* 774–780. [PubMed]
58. Lin, K. M., Cheung, F., Smith, M., & Poland, R. E. (1997)In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp. 388–399)., New YorkGuilford Press.
59. Lin, K. M., Lau, J. K. C., Yamamoto, J., Zheng, Y. P., Kim, H. S., Cho, K. H., & Nagasaki, G. (1992) *Hwa-byung*: A community study of Korean Americans *Journal of Nervous and Mental Disease, 180,* 386–391. [PubMed]
60. Los Angeles County Department of Mental Health. *Report on ethnic utilization of mental health services*. Unpublished manuscript. (1984).
61. Ma, G. X. (1999) Between two worlds: The use of traditional and Western health services by Chinese immigrants *Journal of Community Health, 24,* 421–443. [PubMed]
62. Makimoto, K. (1998) Drinking patterns and drinking problems among Asian-American and Pacific Islanders *Alcohol Health and Research World, 22*270–275. [PubMed]
63. Makini, G. K., Jr., Andrade, N. N., Nahulu, L. B., Yuen, N., Yates, A., McDermott, J. F., Jr., Danko, G. P., Nordquist, C. R., Johnson, R., & Waldron, J. A. (1996) Psychiatric symptoms of Hawaiian adolescents *Cultural Diversity and Mental Health, 2*183–191. [PubMed]
64. Manderscheid, R. W., & Henderson, M. J. (Eds.). (1998) *Mental health, United States: 1998.* , Rockville,, MD. Center for Mental Health Services.
65. Marsella, A. J. (1982)In A. J. Marsella & G. M. White (Eds.), *Cultural conceptions of mental health and therapy* (pp. 359–388)., Boston Reidel.
66. Marsella, A. J., Sartoriu, N., Jablensky, A., & Fenton, F. R. (1985)In A. Kleinman & B. Good (Eds.), *Culture and depression* (pp. 299–324)., Berkeley,, CA. University of California Press.
67. Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997) National utilization of mental health services by Asian Americans/Pacific Islanders *Journal of Community Psychology, 25* 141–146.
68. Min, P. G. (1990) Problems of Korean immigrant entrepreneurs *International Migration Review, 24*436–455.
69. Moore, L. J., & Boehnlein, J. K. (1991) Post-traumatic stress disorder, depression, and somatic symptoms in U.S. Mien patients *Journal of Nervous and Mental Disease, 179,* 728–733. [PubMed]
70. Mui, A. C. (1996) Depression among elderly Chinese immigrants: An exploratory study *Social Work, 41,* 633–645. [PubMed]
71. Nguyen, S. D. (1982) Psychiatric and psychosomatic problems among Southeast Asian refugees *Psychiatric Journal of the University of Ottawa, 7,* 163–172. [PubMed]

72. O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989) Ethnic populations: Community mental health services ten years later *American Journal of Community Psychology, 17,* 17–30. [PubMed]
73. Patel, S. P., & Gaw, A. C. (1996)Suicide among immigrants from the Indian subcontinent: A review *Psychiatric Services, 47,* 517–521. [PubMed]
74. Pearl, W. S., Leo, P., & Tsang, W. O. (1995) Use of Chinese therapies among Chinese patients seeking emergency department care *Annals of Emergency Medicine, 26,* 735–738. [PubMed]
75. Population Reference Bureau, America's racial and ethnic minorities. Population Bulletin, 54. Retrieved July 25, 2001, from http://www.prb.org/pubs/population_bulletin/bu54-3/54_3_intro.htm. (1999).
76. Pourat, N., Lubben, J., Wallace, S. P., & Moon, A. (1999) Predictors of use of traditional Korean healers among elderly Koreans in Los Angeles *The Gerontologist, 39,* 711–719. [PubMed]
77. President's Advisory Commission on Asian Americans andPacific Islanders. (2001) *A people looking forward: Action for access and partnerships in the 21st Century. An interim report to the President.* , Washington,, DC. Government Printing Office.
78. Prince, R (1989) Somatic complaint syndromes and depression: The problem of cultural effects on symptomatology *Mental Health Research, 8,* 104–117.
79. Raskin, A., Chien, C., & Lin, K. (1992) Elderly Chinese-Americans compared on measures of psychic distress, somatic complaints and social competence *International Journal of Geriatric Psychiatry, 7,* 191–198.
80. Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993)The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services *Archives of General Psychiatry, 50,* 85–94. [PubMed]
81. Rubinstein, D. H. (1983) Epidemic suicide among Micronesian adolescents *Social Science and Medicine, 17,* 657–665. [PubMed]
82. Rumbaut, R. (1985) . *In T. C. Owan (Ed.), Southeast Asian mental health: Treatment, prevention, services, training, and research* (pp. 433–486)., Washington,, DC. National Institute of Mental Health.
83. Shiang, J., Kjellander, C., Huang, K., & Bogumill, S. (1998) Developing cultural competency in clinical practice: Treatment considerations for Chinese cultural groups in the United States *Clinical Psychology, 5,* 182–210.
84. Snowden, L. R., & Cheung, F. K. (1990) Use of inpatient mental health services by members of ethnic minority groups *American Psychologist, 45,* 347–355. [PubMed]
85. Snowden, L. R., & Hu, T. W. (1997)Ethnic differences in mental health services use among the severely mentally ill *Journal of Community Psychology, 25,* 235–247.
86. Sue, D. W., & Sue, D. (1999) *Counseling the culturally different.* , New YorkWiley.
87. Sue, S. (1977) Community mental health services to minority groups: Some optimism, some pessimism *American Psychologist, 32*616–624. [PubMed]
88. Sue, S., Fujino, D., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991) Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis *Journal of Consulting and Clinical Psychology, 59* 533–540. [PubMed]
89. Sue, S., Keefe, K., Enomoto, K., Durvasula, R., & Chao, R. (1996)In J. N. Butcher (Ed.), *International adaptations of the MMPI: Research and clinical applications* (pp. 206–220)., Minneapolis University of Minnesota.
90. Sue, S., & Sue, D. W. (1974)MMPI comparisons between Asian- and non-Asian-American students utilizing a university psychiatric clinic *Journal of Counseling Psychology, 21,* 423–427.

91. Sue, S., Sue, D. W., Sue, L., & Takeuchi, D. T. (1995) Psychopathology among Asian Americans: A model minority? *Cultural Diversity and Mental Health, 1* 39–54. [PubMed]
92. Sue, S., & Zane, N. (1985)Academic achievement and socioemotional adjustment among Chinese university students *Journal of Counseling Psychology, 32*570–579.
93. Takeuchi, D. T., Chun, C. & Shen, H (1997, August) *Stress exposure and cultural expressions of distress*. Paper presented at the 91st meeting of the American Sociological Association, New York.
94. Takeuchi, D. T., Chung, R. C., Lin, K. M., Shen, H., Kurasaki, K., Chun, C., & Sue, S. (1998) Lifetime and twelve-month prevalence rates of major depressive episodes and dysthymia among Chinese Americans in Los Angeles *American Journal of Psychiatry, 155,* 1407–1414. [PubMed]
95. Tseng, W. (1975) The nature of somatic complaints among psychiatric patients: The Chinese case *Comprehensive Psychiatry, 16*237–245. [PubMed]
96. Uba, L. (1994) *Personality patterns, identity, and mental health* , New York Guilford Press.
97. Uehara, E. S., Takeuchi, D. T., & Smukler, M. (1994) Effects of combining disparate groups in the analysis of ethnic differences: Variations among Asian American mental health service consumers in level of community functioning *American Journal of Community Psychology, 22,* 83–99. [PubMed]
98. U.S. Census Bureau. (1990) *1990 profiles of Asians and Pacific Islanders: Selected characteristics*. (CPH-L-151), Washington,, DC. U.S. Government Printing Office.
99. U.S. Census Bureau. (1996) *National survey of homeless assistance providers and clients*. , Washington,, DC. U.S. Government Printing Office.
100. U.S. Census Bureau. (2000) *Projections of the resident population by race, Hispanic origin, and nativity: Middle series, 2001 to 2005*. , Washington,, DC. U.S. Government Printing Office.
101. U.S. Census Bureau. (2001a) *Profiles of general demographic characteristics: 2000 Census of Population and Housing, United States*. Retrieved June 22, 2001 http://www2.census.gov/census_2000/datasets/demographic_profile/0_National_Summary/.
102. U.S. Census Bureau. (2001b) *The Asian and Pacific Islander Population in the United States: March 2000 (Update)* (PPL-146) Retrieved June 28, 2001 http://www.census.gov/population/www/socdemo/race/api.html.
103. U.S. Department of Health and Human Services. (1999) *The Surgeon General's Call to Action to Prevent Suicide*. , Rockville,, MD.
104. U.S. Office of Management and Budget. (2000) Guidance on aggregation and allocation of data on race for use in civil rights monitoring and enforcement (OMB Bulletin No. 00-02) Retrieved July 20, 2001http://www.whitehouse.gov/omb/bulletins/b00-02.html.
105. White, L., Petrovitch, H., Ross, G. W., Masaki, K. H., Abbott, R. D., Teng, E. L., Rodriguez, B. L., Blanchette, P. L., Havlik, R. J., Wergowske, G., Chiu, D., Foley, D. J., Murdaugh, & Curb, J. D. (1996) Prevalence of dementia in older Japanese-American men in Hawaii: The Honolulu-Asia Aging Study *Journal of the American Medical Association, 276,* 955–960. [PubMed]
106. Yamamoto, J. (1992) Psychiatric diagnoses and neurasthenia *Psychiatric Annals, 22* 171–172.
107. Yamamoto, J., Rhee, S., & Chang, D. S. (1994) Psychiatric disorders among elderly Koreans in the United States *Community Mental Health Journal, 30*17–27. [PubMed]

108. Yeh, M., Takeuchi, D. T., & Sue, S. (1994) Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers *Journal of Clinical Child Psychology, 23*5–12.
109. Ying, Y. (1988) Depressive symptomatology among Chinese-Americans as measured by the CES-D *Journal of Clinical Psychology, 44,* 739–746. [PubMed]
110. Young, K. (1998) *Help seeking for emotional/psychological problems among Chinese Americans in the Los Angeles area: An examination of the effects of acculturation*. Unpublished doctoral dissertation, University of California, Los Angeles.
111. Zane, N., Enomoto, K., & Chun, C. (1994) Treatment out-comes of Asian- and White-American clients in outpatient therapy *Journal of Community Psychology, 22,* 177–191.
112. Zane, N., Takeuchi, D. T., &. Young, K. (Eds.). (1994) *Confronting critical health issues of Asian and Pacific Islander Americans* , Newbury Park,, CA. Sage.
113. Zhang, A. Y., & Snowden, L. R. (1999) Ethnic characteristics of mental disorders in five U.S. communities *Cultural Diversity and Ethnic Minority Psychology, 5* 134–146. [PubMed]
114. Zhang, A. Y., Snowden, L. R., & Sue, S. (1998) Differences between Asian- and White-Americans' help-seeking and utilization patterns in the Los Angeles area *Journal of Community Psychology, 26,* 317–326.
115. Zheng, Y. P, Lin, K. M., Takeuchi, D., Kurasaki, K. S., Wang, Y. X., & Cheung, F. (1997) An epidemiological study of neurasthenia in Chinese-Americans in Los Angeles *Comprehensive Psychiatry, 38,* 249–259. [PubMed]

Footnotes

1

Because the Office of Management and Budget has separated Asian Americans from Native Hawaiians and Other Pacific Islanders (OMB, 2000), Census 2000 lists "Asian" and "Native Hawaiian and Other Pacific Islander" as separate racial categories.

2

These concerns originate from, among other things, confusion on the part of immigrants and providers about who is eligible for benefits and in fears relating to the application of the public charge doctrine. "Public charge" is a term used by the Federal Government to describe someone who is, or is likely to become, dependent on public benefits (Fix & Passel, 1999). The Immigration and Naturalization Service does not include Medicaid or other public health benefits in public charge determinations. Furthermore, the public charge doctrine applies to admission and deportation , but not to the naturalization of immigrants (Edwards, 2001).

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