Published in final edited form as:

Asian Am J Psychol. 2010 September ; 1(3): 212–223. doi:10.1037/a0020951.

Loss, Psychosis, and Chronic Suicidality in a Korean American Immigrant Man: Integration of Cultural Formulation Model and Multicultural Case Conceptualization

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Abstract

Culture shapes the nature, experience, and expression of psychopathology and help-seeking behavior across ethnically diverse groups. Although the study of psychopathology among Asian Americans has advanced, clinicians remain in need of culturally appropriate tools for the assessment and diagnosis of severe mental disorders including psychotic symptoms among Asian Americans. In this article, we present a brief overview of two culturally relevant conceptual tools: a) the Cultural Formulation Model, and b) the Multicultural Case Conceptualization approach. We use a case scenario to illustrate the integration of these two approaches in providing culturally responsive clinical conceptualization, assessment and treatment of a Korean American immigrant suffering from prominent psychiatric symptoms. We intend this discussion to engender further empirical work to advance our knowledge of the manifestation and experience of severe mental illness including psychotic disorders among Asian Americans, and contribute to culturally competent prevention and intervention of chronic and persistent mental illness within this group.

Keywords

Asian American; severe mental illness; psychosis; cultural formulation; multicultural case conceptualization

Approach

The growing number of immigrants and ethnic minorities in the United States warrant culturally appropriate psychological assessment and treatment. Research reports on Asian American mental health—such as the surgeon general’s *Supplement to Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health & Human Service, 2001)—have described how central forces, such as race, ethnicity, acculturation, and social stressors associated with immigration impact the manifestation of psychiatric disorders within the Asian American community. Accounting for the influence of cultural forces on mental illness remains crucial because such dynamics suffuse experiences of distress with meaning and pattern distress in understandable ways to others within the social context (Kleinman,

1981). Awareness and interpretation of cultural factors also inform clinicians' case formulation and treatment approaches (Constantine, Miville, Kindaichi, & Owens, 2010).

Cultural Influences Upon Experience of Distress Among Asian Immigrants

The Asian American population represents one of the fastest growing ethnic minority groups in the United States. In 2003, immigrants from Asian countries constitute 35% of the foreign-born population in the United States (U.S. Department of Homeland Security, 2004), with a large segment consisting of families and children (Logan, Zhang, & Alba, 2002). However, immigration and acculturation processes influence mental health (Organista, Organista, & Kurasaki, 2002). Asian immigrant families, particularly those of low income, are likely to encounter a host of contextual and cultural challenges, such as language barriers, intense work demands, racism and discrimination, and acculturative stress (Yeh, Kim, Pituc, & Atkins, 2008). Asian immigrant youth may undergo intense challenges in their academic, social, and cultural adjustment (Shea, Ma, Yeh, Lee, & Pituc, 2009; Yeh, 2003). Although Asian American youths tend to excel academically compared with their European American counterparts, they also tend to report higher levels of depressive symptoms (Lorenzo, Frost, & Reinherz, 2000). Furthermore, research suggests that the recency of immigration and level of acculturation may influence the emotional distress and suicidal behavior in Asian American youths (Lau, Zane, & Myers, 2002).

Cultural Influences Upon Expression of Distress Among Asian Immigrants

Culture shapes the expression of psychological distress in myriad ways. One significant area of intersection between culture and manifestation of mental illness is somatization, or the tendency for certain groups to express distress due to psychiatric symptoms as bodily or psychological discomfort. Somatization might be described as a clinical presentation whereby somatic symptoms are emphasized to the exclusion of psychological or emotional difficulties (even when emotional and somatic symptoms are both present; Yang & Wonpat-Borja, 2006). Although somatization is prevalent among all cultural groups (Kirmayer & Young, 1998), cultural preferences among Asian societies exist in terms of how emotions are experienced and expressed by emphasizing metaphors that are connected with the body (Cheung, 1995).

Cultural Influences Upon Understanding of Self and Social Processes

Culture also shapes one's orientation toward self and others. Collectivist culture emphasizes emotional restraint, deference to authority, interdependence over independence (Uba, 1994); these values may encourage individuals to define self in relation to others in their social contexts and derive self-esteem from fitting in (Markus & Kitayama, 1991). Asian Americans tend to have more interdependent self-construals than European Americans, and are more concerned about maintaining and achieving interpersonal harmony (Singelis, 1994). Individuals with interdependent self-construal may avoid the experience and expression of strong emotions—especially negative ones—and decide against seeking professional help as such behaviors may bring shame to the family and disrupt in-group harmony (Markus & Kitayama, 1991; Yang, Phillips, Lo, Chou, Zhang, & Hopper, 2010).

Cultural Influences Upon Clinical Assessment, Diagnosis, and Treatment

Cultural values and meanings also influence clinicians' interpretation and judgment of a client's reported symptoms, such as feelings, cognitions, or experiences. For example, racial and cultural factors—such as client racial differences leading to increased clinician observations of hallucinations—have been implicated when European American clinicians consistently “overdiagnose” schizophrenia among African American clients (Trierweiler et

al., 2000). While clinicians are charged with objectively fitting symptom criteria with the client's presentation, these findings suggest a bias in the application of DSM criteria to culturally diverse groups (Yang & Link, 2009). The most frequently cited problem is the potential lack of clinician cultural competence when interpreting client behaviors (Blow et al., 2004). Hence, treatment models that negate racial cultural issues (known as the "color-blind attitude") could leave ethnically diverse clients feeling invalidated or reexperiencing everyday racial-cultural traumas (Constantine et al., 2010). These factors could lead to premature treatment termination and aggravation of existing problems.

Cultural Formulation and Multicultural Case Conceptualization

Although several clinical cases studies have highlighted culturally specific factors in symptom expression within the Asian community (Cheung & Lin, 1997; Hwang, 2007; Hwang, Miranda, & Chung, 2007; Yeung & Chang, 2002), few have addressed severe and persistent mental health issues such as psychotic symptoms (Hwang, 2007; Hwang et al., 2007) and chronic suicidality. Because culturally appropriate means of assessment and diagnosis of severe mental illness among Asian Americans remain largely unarticulated, clinicians remain in need of such tools for formulation of culturally valid clinical assessment and treatment.

In this paper, we present two culturally responsive conceptual tools. One is the Cultural Formulation Model (CFM; described in Appendix I of *DSM-IV*; American Psychiatric Association [APA], 1994; *DSM-IV-TR*; APA, 2000) that is recommended for use during initial assessment. This model emphasizes how culture impacts an individual's symptoms, explanatory models of illness, help-seeking behaviors, and expectations of outcomes. Use of this model is particularly important when the clinician and client are from different cultural backgrounds so that cultural dynamics can be highlighted to most effectively orient clinical intervention (Lewis-Fernandez & Diaz, 2002).

The second tool is the Multicultural Case Conceptualization (MCC) approach, which emphasizes a therapist's ability to identify and integrate cultural factors into his or her conceptualizations of the etiology and treatment of clients' presenting issues (Constantine et al., 2010; Ladney, Inman, Constantine, & Hofheinz, 1997). Although the two approaches converge in their emphasis on multiculturally competent assessment and treatment, the CFM emphasizes how culture shapes clients' experience and expression of mental health problems whereas the MCC focuses on the therapist's consideration of racial-cultural dynamics in the therapeutic relationship, as well as between the client and his or her surrounding environment including the treatment milieu.

The two conceptual frameworks offer great potential for clinical use in Asian American groups, however, they have yet to be concurrently applied via any means, including case study. We utilize these two theoretical frameworks to provide an analysis of a Korean immigrant man whose expression of severe mental illness is closely intertwined with his socialization of self and acculturative experience. We first describe a detailed case history, followed by an in-depth discussion of the distinct contributions to cultural analyses provided by each framework.

Clinical History for Mr. K

Patient Identification

Mr. K was a 22-year-old, single, unemployed, Korean immigrant male.¹ He was discharged from an inpatient psychiatric unit and admitted to a partial hospital day treatment program with behavioral therapy orientation. This case study focuses on the 6-month treatment period where Mr. K was seen by the first author as his primary clinician.

History of Present Illness

The precipitating event to his most recent hospitalization was related to his participation in an outpatient group therapy session. Mr. K was asked to discuss his substance abuse, which led to increasing anger, agitation, and suicidal ideation with a plan to kill himself by drinking liquid detergent. Mr. K was admitted to a psychiatric inpatient unit.

Psychiatric History and Previous Treatment

Mr. K reported chronic sadness, guilty ruminations, auditory hallucinations, suicidal ideation, self-injurious behaviors, and decreased appetite, energy, and concentration. His first episode of major depression dated from age 14. Self-injurious behaviors include banging his head against the wall and bunk bed, drinking shampoo, and swallowing small objects.

Mr. K had an extensive psychiatric history with close to 20 hospitalizations. Five of them occurred in the same year prior to his admission to the day treatment program. Mr. K also reported a myriad of physical symptoms, mostly related to gastrointestinal irritations. Prior diagnoses included Bipolar Disorder and Schizoaffective Disorder, and he had been prescribed a variety of antipsychotic and antidepressant medications, as well as electroconvulsive therapy (ECT). Mr. K's depressive symptoms were alleviated immediately after the ECT. However, his auditory hallucinations persisted in spite of the antipsychotic medication and the ECT.

Social and Developmental History

Mr. K was born in South Korea. He is the younger of two children with a brother two years older. His father was a communications officer in the military, and his mother was a homemaker. Mr. K came to the United States with his mother and brother on travel visas when he was 12 years old, while his father remained in Korea. The family did not return to Korea after their visas had expired. The decision to live in two different countries was not due to any marital problems between the parents; however, it was never clearly explained to Mr. K.

Mr. K began to attend a predominantly White middle school. He maintained steady academic progress. In contrast, Mr. K's family life was tumultuous. The family was struggling financially to make ends meet. Since the mother could not legally work in the United States, their only income came from a stipend from Mr. K's father. Mr. K's mother became depressed and limited in her ability to care for her children. Mr. K's brother frequently argued with the mother about financial problems. Mr. K was distraught about his parents' decision to migrate, his mother's limited functioning, and his brother's belligerent manner. He began drinking alcohol at age 13 and became increasingly despondent and suicidal in the next few years. He attempted to kill himself by engaging in a variety of self-injurious behaviors, such as drinking shampoo and banging his head against a bunk bed.

¹The patient has been deidentified in various ways to ensure confidentiality.

When Mr. K was 15, his father died of liver cancer in Korea. The father's medical condition deteriorated rapidly and the father asked the family to keep his terminal illness from Mr. K, lest the news would aggravate his son's emotional problems. Shortly after the father's death, Mr. K's mother unexpectedly left home and disappeared. Since then, Mr. K has not been in contact with her.

Mr. K dropped out of school due to his chronic suicidal ideation. He has been living in a group home and receiving outpatient treatment at a community mental health clinic. Mr. K had worked intermittently in several Korean restaurants and grocery stores. He resented the labor-intensive work and felt hopeless about his future. His depression and anger were often compounded by his alcohol use, which increased the vulnerability for his self-injurious behaviors. Mr. K was hospitalized close to 20 times from ages 14 to 22, and he eventually lost his job.

Two years ago, Mr. K was approached by a member of the Jehovah's Witnesses. He decided to leave the Korean Protestant church (which he had not been regularly attending). The decision led to a heightened tension between Mr. K and his older brother. Consequently, they grew apart.

Family Psychiatric History

Mr. K reported that his mother was depressed after their migration, but never sought professional help. No other psychiatric disorders in the family were reported.

Course and Outcomes

During the first meeting with the therapist (the first author), Mr. K presented as reserved with sporadic eye contact. He stated in a stereotypic manner, "I am a schizophrenic and I have auditory hallucinations. The voices tell me to kill myself." Mr. K said that there were several voices in his head—usually male voices—criticizing him for being "useless" and "worthless." These voices, however, only occurred between the hour after Mr. K had taken his evening medication and before he went to bed.

During the initial treatment stage, Mr. K did not focus on his chief complaint—auditory hallucinations. Instead, he frequently talked about feeling depressed and "useless." He was worried about that he had not been a good support to his older brother and they had drifted apart. He also felt unsafe living in the community by himself due to his suicidal risk. Mr. K expressed skepticism toward therapy, "It is not going to work." He presented an array of somatic complaints, such as stomach pain, nausea, vomiting, fatigue, and shortness of breath. He reported having gastrointestinal problems for the last few years. But no organic causes had been identified.

To explore the pattern of Mr. K's gastrointestinal problems, the therapist asked Mr. K to engage in self monitoring—a technique used in behavioral assessment—of his target behavior (i.e., vomiting), and keep a log of his feelings, thoughts, behaviors, and contexts that preceded his vomiting. Mr. K was very resistant toward the assignment, and adamantly denied that there was any association between his feelings and his physical symptoms. After a few sessions, however, Mr. K began to notice a pattern. When he felt anxious, he became acutely aware of "a fluid" moving up from his stomach through his chest, which then triggered nausea and vomiting.

The therapist then asked Mr. K to attend to the triggers of his anxiety and depressive feelings. Although Mr. K's attitude was initially dismissive, he realized that his negative emotions and suicidal ideation were often triggered by interpersonal interactions. For instance, he was not able to tell his group therapist that he did not wish to openly discuss his

mental illness and alcohol use. Instead he tried to tolerate his negative feelings, “I don’t want to cause trouble for anyone and I always listen to my doctor.” The therapist acknowledged Mr. K’s difficulty in expressing his negative emotions toward others, and explored with him the different social expectations associated with the two cultural contexts (i.e., Korean and American) he had lived in. The therapist also role-played with Mr. K to anticipate potential interpersonal disagreements and disappointments (e.g., rejection) and rehearsed adaptive coping responses.

As therapy progressed, Mr. K continued to express his desire to be more connected with his brother. After deliberating with Mr. K about the pros and cons of including family members in his treatment, the therapist invited Mr. K’s older brother to attend a family meeting. The brother came to the session with a few friends from the Korean church, and expressed eagerness to help Mr. K reconnect with the community. Mr. K, felt encouraged by his brother and the church friends, stated that he would consider returning to the Korean church.

Mr. K also, for the first time, spoke about his ambivalent feelings toward his mother and his future career. He wanted to locate his mother, but was unsure if a reunion was also desired by the mother. He wanted to find a job in the United States, but his career prospects were circumscribed by his immigration status. Further, he felt apprehensive about returning to South Korea because of his mental health problems and the possibility of mandatory military service.

The therapist, together with Mr. K, contacted a few immigration lawyers and an Asian American community group to discuss his immigration status and vocational options. Although at treatment termination, Mr. K had not made a decision about his future direction—whether to return to Korea or remain in the United States—he was committed to improving his physical and mental health.

Through structured behavioral interventions such as self-monitoring, mindfulness exercises, and role-plays; discussion of differing sociocultural and interpersonal expectations; family work; social advocacy, and psychopharmacological management; Mr. K’s physical symptoms, substance abuse, and suicidal ideation quickly abated over a 6-month span. There were no inpatient hospitalizations during that period, compared to the five hospitalizations Mr. K had in the prior year. Mr. K presented with more stable mood and reported feeling more hopeful toward his future. It is interesting that the symptom of “auditory hallucinations” never became the focus of the therapy. Mr. K claimed that it was “useless” to talk about his voices, because they never went away. He instead wanted to focus on the present and his immediate goal was to find a job.²

Diagnostic Formulation

Axis I

Major Depressive Disorder Recurrent with Psychotic Features

Axis II

Deferred

Axis III

Gastrointestinal distress

²Three months later, Mr. K found a job at a Korean grocery store.

Axis IV

Trauma of being abandoned by mother and death of father; education and vocational difficulties due to undocumented immigration status; limited social support

Differential Diagnosis

Mr. K's case raises interesting questions concerning differential diagnosis. He had been diagnosed with Bipolar Disorder or Schizoaffective Disorder. The diagnosis of Bipolar Disorder was debatable. There was no documentation for a clear manic episode. Mr. K's agitation and aggressive actions tended to be short-lived. He also did not report or endorse any other symptoms such as grandiosity, flight of ideas, or excessive risk-taking behaviors, besides irritable mood and difficulty in concentration. The diagnosis of Schizoaffective Disorder was also questionable. Mr. K's "auditory hallucinations" occurred only in the evening after he took his medication and before he went to sleep. Coincidentally, it was a time period when most clinicians and staff were off-duty. Mr. K did not present bizarre delusions or negative symptoms. Further, there had not been a period when Mr. K experienced psychotic symptoms while his mood symptoms were absent, a prerequisite for schizoaffective disorder.

The symptoms of sad mood, fatigue, anhedonia, sense of worthlessness and hopelessness, suicidal ideation, auditory hallucinations, and the duration of these symptoms suggest a diagnosis of Major Depressive Disorder Recurrent with Psychotic Features. In addition, the diagnosis of Posttraumatic Stress Disorder was considered with respect to Mr. K's experiences; however, he did not meet sufficient clinical criteria to establish this diagnosis.

Cultural Formulation Model

The Cultural Formulation consists of the following subsections (*DSM-IV*, pp. 843–44; APA, 1994): 1) Cultural identity of the individual; 2) Cultural explanations of the illness; 3) Cultural factors related to psychosocial environment and functioning; 4) Cultural elements of the relationship between patient and clinician; and 5) Overall cultural formulation for diagnosis and care, which allows for a synthesis of how these cultural elements might enhance culturally appropriate assessment and intervention.

Cultural Identity

Cultural reference group—Mr. K identified himself as Korean. He was born in South Korea, and came to the United States with his mother and older brother when he was 12.

Language—He speaks fluent Korean and rather fluent English with an accent. He knew very little English when he first came to the United States, but studied hard to catch up to his classmates in school. His preferred language is Korean. Therapy was conducted in English.

Cultural factors in development—Mr. K grew up in a collectivist society that emphasizes group conformity, adapting to the needs of others, indirect communication, emotional restraint and suppression of conflict to preserve family and group harmony (Uba, 1994). Mr. K stated that his parents—like many Korean parents—were very "strict" and authoritarian. He was not encouraged to voice his feelings and view-points, but was told to obey and focus on his studies. These values and experiences might have shaped Mr. K's current interpersonal style and coping. For instance, Mr. K was deferent to clinicians and staff, and never questioned his treatment plans and decisions. He tended to avoid conflict and disagreement by suppressing and concealing his negative feelings, sometimes with the aid of alcohol.

Involvement with culture of origin—Mr. K did not celebrate any Korean holidays or traditions. Mr. K prefers to eat Korean food. Mr. K maintained some contact with his older brother. Mr. K had not returned to Korea to visit his relatives due to his undocumented status.

Involvement with host culture—Mr. K's acquired English language proficiency enabled him to connect with people in his school, treatment setting, and community (e.g., group home, church). He participated in United States holidays (e.g., Thanksgiving) when the celebrations took place in his treatment milieu or group home.

Cultural Explanations of Illness

Predominant idioms of distress and local illness categories—Mr. K seemed to be well versed in conventional Western psychiatric terminology. Whenever he was interviewed, Mr. K eloquently introduced himself in this manner, "I am a schizophrenic. I have command auditory hallucinations. My voices tell me to kill myself." He would also talk about his substance abuse. Nevertheless, these chief complaints never became the focus of the therapy, making the therapist wonder if Mr. K truly embraced those diagnoses and explanations. In contrast, Mr. K's concerns and idioms of distress were internally oriented toward his depression and anxiety; and centered on interpersonal and somatic themes.

At first, Mr. K did not see a connection among his physical distress, psychological experiences, and interpersonal relationships. He was dismissive of the behavioral self-monitoring and diary card assignments, and only wanted to receive physical exams. As he became more mindful of the various triggers of his emotions and bodily experiences, he began to see how his mood and physical distress were intertwined. For instance, his urge to hurt himself was highest on the days when he felt very ill and hopeless about his family estrangement, and the "voices" became most intense when he experienced an interpersonal frustration. These realizations made him more willing to engage in individual therapy to discuss his feelings.

Meaning and severity of symptoms in relation to cultural norms—Mr. K presented a range of physical problems primarily related to gastrointestinal distress. He preferred medical treatment to psychological approaches. Somatization is a culturally congruent way of managing and expressing underlying psychological processes among Asian clients (Yang & Wonpat-Borja, 2006). It is also viewed as a construction of illness meaning to avert severe stigma attached to psychiatric treatment and to obtain help that is deemed acceptable (Yang, Phelan, & Link, 2008; Yang, Corsini-Munt, Link, & Phelan, 2009).

Perceived causes and explanatory models—Mr. K attributed his depression and suicidality to immigration and family discord. However, he perceived that the decline of his mental health preceded the "abandonment" by both parents and believed that he was to blame for the traumatic losses and estrangements. If he had fulfilled his duties as a son—being successful and honoring the family's name (Yang, Kleinman, Link, Phelan, Lee, & Good, 2007)—his family would not have fallen apart.

As discussed earlier, individuals with interdependent self-construals tend to be concerned about the impacts of their behaviors on their in-group members, and want to share resources and feel involved in the lives of in-group members (Markus & Kitayama, 1991). It is possible that Mr. K's auditory hallucinations—the "male voices" calling him "useless" and "worthless"—were internalized criticism by the father condemning his inadequacy and failures. Moreover, the shattering of the social/familial contexts and interpersonal

relationships may contribute to his feelings of confusion, hopelessness, fragmentation of self, and possibly result in brief psychosis.

Mr. K's physical illness may be related to interpersonal distress. There is a term "sok tuh juh" in Korean, which means that individuals feel so interpersonally disconnected or frustrated about the "wall" between themselves and others that their stomachs are about to explode. Mr. K was estranged from his family and ethnic community. He sometimes felt misunderstood by his clinicians. Using this culturally based idiom, it is as if Mr. K has been bottling up all the interpersonal disappointments and conflicts that he is about to explode internally.

Help-seeking experiences and plans—Mr. K's case illustrates the help-seeking trajectory and challenges faced by many recent Asian immigrants who battle with severe mental illness. Asian American clients, especially those of lower socioeconomic status, tend to under-utilize mental health services and delay service use until symptoms are serious (U.S. Department of Health & Human Services, 2001). By the time Mr. K received psychiatric intervention, his symptoms were severe (including psychotic symptomatology), thus making remission more difficult to achieve (Opler, Yang, Caleo, & Alberti, 2007). Mr. K might be more accepting of the Western explanatory model of his illness, as he was in great distress, had no other support systems, and desired instant relief by medication. Hence, the presentations of severe and persistent symptoms may be illness expressions to convey meanings to others requesting help and care. His acceptance of the Western explanatory model might also be related to the traditional Korean values and emphasis on respect and deference to authority.

Cultural Factors Related to Psychosocial Environment and Levels of Functioning

Social stressors—Mr. K's life in South Korea was suddenly uprooted when his family decided to split and live in two different countries. This type of arrangement is known as the "wild geese families" or "penguin fathers," which refers to Korean fathers choosing to live alone and sending their children abroad for better education (Cho, 2008). This turning point, however, brought great distress to Mr. K's family. They lost community and extended family support; encountered linguistic and cultural barriers; experienced poverty, and had limited access to social welfare due to their undocumented status.

Social supports—Mr. K went to a predominantly White middle school; most of his friends were White. However, Mr. K has not maintained contact with those friends since he left school. One important source of support for Mr. K has been his church community—the Jehovah's Witnesses. Mr. K felt cared for and accepted by the group in spite of his mental illness.

Mr. K attended Korean church with his family when he first came to the United States, but stopped attending consistently when he was 16. Mr. K reported feeling rejected by the Korean church due to his low socioeconomic status. "They were all wearing nice clothing, but we were not," Mr. K stated, "When they passed the offering bowl and saw that we did not put in any money, they [the usher] gave us a [contemptuous] look." In addition, Mr. K believed the Korean congregation would be taken aback if he disclosed his mental health problems. Thus, his decision to leave the Korean church and the ethnic community may have been related to the secrecy of his mental illness. Attending a predominantly White church may be instrumental in helping him to keep a safe distance from his ethnic community, so that he would not bring shame to his older brother by association.

Levels of functioning and disability—Although his acute symptoms of suicidal ideation, self-injurious behaviors, and substance abuse had abated after the 6-month partial hospital treatment, Mr. K continued to hear “voices.” Moreover, Mr. K continues to experience limited social support, and tremendous acculturative stress, which are likely to exacerbate his depressive symptoms and suicidality, hence warrant further interventions.

Cultural elements of the clinician-patient relationship—Both Mr. K and the therapist are Asians born outside of the United States. However, the therapist was aware of the stark contrast in her experience and Mr. K’s. The therapist comes from a privileged socioeconomic background, has received advanced education and training in the United States, and is rather acculturated to the mainstream culture and society. The therapist was mindful of how her biases and assumptions of normality (e.g., emphasis on family connectedness and educational achievements) might influence her understanding of Mr. K’s symptoms and expectations toward Mr. K’s treatment progress (or lack of). On the other hand, the therapist’s adherence to Asian values and orientation to interdependent self-construals (e.g., filial piety, concerns for others’ feelings and needs) helped her to connect with Mr. K and acknowledge the complexity of the etiological explanations for Mr. K’s presenting concerns. Moreover, the therapist is female and older. Unlike her other clients (who were mostly White), Mr. K chose to address the therapist by her last name, and vice versa. The choices of both parties were likely to stem from the traditional values placed upon more hierarchical social structure and respect for authority in Asian societies.

Overall cultural assessment—Prior to his referral to the day treatment program, Mr. K’s physical and psychiatric symptoms—gastrointestinal distress, auditory hallucinations, substance abuse, suicidal ideation—were managed by psychopharmacological approach, specialized interventions such as recovery groups, and medical interventions in an unintegrated manner. Previous treatments tended to minimize his physical concerns, as no organic causes had been identified.

In the day treatment program, Mr. K began to monitor his urge to vomit on a diary card, along with his urge to drink and urge to hurt himself. Further, functional analysis revealed the triggers, antecedents and consequences of his vomiting. Mr. K never used the term “sok tuh juh” to describe or explain his gastrointestinal distress, which may be related to the linguistic barrier on the clinicians’ part—none of the clinicians speak or understand Korean. However, he was physically experiencing “sok tuh juh” whenever he encountered interpersonal frustrations. The practice and strategies of incorporating his somatic distress and medical care as an integral part of his psychological treatment legitimize Mr. K’s somatic complaints and allow him to explore his anxiety and depression in the context of his physical illness.

Another key component in understanding Mr. K’s presentation and assessment was his cultural construction of self. Some clinicians, during group supervisions, described Mr. K’s indirect expression of negative emotions and his deference to others as “passive-aggressive”, “immature”; his vacillation between tolerance of negative affect and escalation of anger as “labile” and even “borderline.” Several clinicians suggested that Mr. K should receive assertiveness training. The suggestions may reflect clinicians’ tendency to pathologize culturally appropriate interdependence as dependence, and may create inconsistent expectations leading to incongruent experiences within the client. For instance, Mr. K once shared that he was unsure how to balance his own expectations for himself (e.g., “I should endure my unhappiness and not burden others”) and his psychiatrist’s expectations for him (e.g., “I should assert myself or my needs won’t be heard.”).

Mr. K's depressive feelings, guilty ruminations (as sometimes manifested in his auditory hallucinations), and sense of hopelessness are related to family estrangement and failure to fulfill his responsibility as a son and as a brother. This highlights a need for the therapist to attend to the roles and duties bestowed upon Mr. K by his group memberships. By including Mr. K's family and community members into his treatment; and by collaborating with Asian American agencies, the therapist facilitated a process of reconnecting Mr. K with his family, religious and ethnic-cultural contexts that define his "self-hood."

Multicultural Case Conceptualization Approach

While the Cultural Formulation Model delineates an in-depth and structured exploration and assessment of the cultural factors that impact Mr. K's experience and expression of distress, the Multicultural Case Conceptualization approach allows for a focused examination—on the therapist's part—of her cultural biases and assumptions, the racial-cultural dynamics between Mr. K and the therapist, and between Mr. K and his surroundings. Despite the conceptual overlaps, adding the Multicultural Case Conceptualization approach to the Cultural Formulation Model would enhance the diagnosis and assessment process and enable more culturally responsive treatments since the CFM focuses mainly on the client, whereas the MCC approach focuses on the therapist's ability to recognize and synthesize culturally relevant information into case conceptualization (Constantine et al., 2010).

Therapist's Beliefs of Clients' Etiologies of Difficulties and Effective Treatment Strategies

Treatment conceptualization and implementation should reflect understanding of clients' world views and therapists' multicultural knowledge. Instead of attributing Mr. K's symptoms of psychosis, depression, and suicidality to biological causes, intrapsychic factors, or simple social causes (e.g., lack of social support), the therapist conceptualized Mr. K's presenting concerns and developmental experiences within a larger sociopolitical context, and asked questions such as "What has led to Mr. K's estrangement from his family, ethnic, and religious communities?" "Why does he adopt a Western explanatory model of his psychiatric illness?" "What is my experience as an ethnic minority individual and a therapist in this milieu?" These questions and explorations made the therapist more aware of her own cognitions, emotions, and operations as a racial-cultural being. For instance, she noted her tendency to raise her hand and wait for permission to speak during group consultations and her discomfort and reluctance to articulate a disagreement. She had to explain her rationale for including Mr. K's physical concerns as an integral part of his psychological treatment and for keeping his vomiting as a target behavior on the diary card, when other clinicians suggested that Mr. K's gastrointestinal distress should be addressed by a medical doctor. She felt dismissed after hearing others labeling what would be culturally appropriate interdependence as "indirect", "dependent," or "passive-aggressive."

These self-reflections contributed to the therapist's understanding of Mr. K's experiences. For instance, Mr. K's treatment team was predominantly White; the majority of them had been educated and trained in prominent universities or medical schools. Mr. K may not have thought that he could challenge or question their views of his diagnoses (e.g., schizophrenia) and treatment plans, given his status as an undocumented ethnic minority immigrant and a mental health client. Moreover, Mr. K was concerned about not being accepted by the clinicians and staff, who had been—to a large extent—his only support system. Thus, he avoided conflict for fear of severing a meaningful connection, thus creating a façade of being congenial and agreeable.

The therapist, however, was careful not to interpret Mr. K's agreeableness and compliance as signs of complacency or treatment improvement. Instead, she took a proactive stance and brought the culturally relevant issues, such as tensions between his public self (e.g., a "model" client who does not cause trouble) and private self (e.g., feelings of marginalization and frustration toward his treatment) into the clinical foreground. The therapist's openness and initiation earned Mr. K's trust and gave him a license to speak about his inner experiences.

The therapist also attempted to balance the dialectics of cultural effectiveness versus clinical effectiveness, and cultural responsiveness versus cultural stereotyping. For instance, Mr. K asked to be excused from the daily recovery group treatment due to his heightened sense of shame and anxiety in that setting (which tended to increase his vulnerability to self-injurious behaviors). Yet, having been trained in the mainstream model, the therapist could not help but wonder if Mr. K's reaction was merely a sign of treatment resistance. An in-depth exploration with Mr. K about his sense of alienation in an open group (members came and went), his cultural values on emotional restraint, his preferred model of help seeking and reluctance to disclose to "strangers" resulted in a decision to reduce the frequency of Mr. K's group treatment to a weekly basis. Furthermore, it would be erroneous to assume that all Asian clients welcome family and community involvement because of their collectivist orientation. Hence, the therapist did not suggest family meetings to Mr. K until she had explored with him the specific family risk and protective factors associated with his functioning and his treatment expectations.

In sum, the considerations of the socioeconomic and cultural factors underlying Mr. K's presenting concerns, as well as the racial-cultural dynamics between him and the surrounding systems ultimately contributed to a more refined assessment and treatment planning.

Conclusion

Given that little research has systematically examined the experience of severe mental illness among Asian Americans, we presented the Cultural Formulation Model and the Multicultural Case Conceptualization approach to illustrate: a) an in-depth, structured clinical assessment of the client, together with an analysis of his cultural identity, explanatory models of his illness and idioms of distress, sources of social stress and support, and the therapeutic relationship between the therapist and the client; b) the therapist's own understanding of the contributing factors to clients' etiologies of presenting concerns, and her reflections upon her values, biases, and assumptions. The integration of these two approaches led to a culturally comprehensive assessment and case conceptualization that resulted in a differential diagnosis, treatment, and outcome with a Korean American immigrant suffering from prominent mental health symptoms, multiple hospitalizations, and chronic disability.

In particular, this case depicts how a client's psychotic symptoms might be more accurately ascribed to interpersonal and cultural bases, rather than being interpreted as a core symptom attribution to justify a schizophrenia-spectrum disorder diagnosis, a bias that commonly occurs among diverse clients groups (Trierweiler et al., 2000). Further, this case illustrates the key use of somatization to express distress embedded in interpersonal and other social processes, and how this clinical presentation represents a culturally distinctive form of illness expression. Lastly, this case study illuminates how culturally conflicting conceptualizations of self might contribute to psychological distress and symptomatology, as well as impede effective treatment by fostering a misinterpretation of characterological presentation in the treatment relationship and milieu.

We have formulated a case study using two conceptually refined assessment tools to illustrate cultural processes that might be useful to clinicians working with Asian Americans with severe mental illness. The Cultural Formulation Model provides a structured format for considering and assessing cultural factors underlying clients' experience and expression of mental health problems. The Multicultural Case Conceptualization approach emphasizes the therapist's ability to integrate client's cultural factors and to examine the racial-cultural dynamics and biases in treatment conceptualization and implementation. We hope this discussion will spur further empirical work to advance our knowledge of how severe and persistent mental illnesses develop, are expressed, and are experienced among Asian Americans, and how these illnesses may be treated or prevented using culturally competent interventions within this group.

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