Published in final edited form as:

Asian J Psychiatr. 2010 December ; 3(4): 169–172. doi:10.1016/j.ajp.2010.08.008.

Engaging Asian American Youth and Their Families in Quality Mental Health Services

Huijun Li and Larry Seidman

Harvard Medical School Department of Psychiatry Massachusetts Mental Health Center Public Psychiatry Division of the Beth Israel Deaconess Medical Center

Abstract

Asian American youth have a higher level of unmet mental health needs and lower level of mental health service engagement than White youth. We presented reasons for lack of engagement in mental health services among Asian American youth and families. Practical strategies to enhance their engagement in mental health services were provided.

Research indicates that Asian American youth have similar community rates of mental health problems in comparison to non-Hispanic White youth in the United States (U.S.) (Edman *et al.*, 1998; Makini *et al.*, 1996, U.S. Department of Health and Human Services, 2001). However, Asian Americans are among the least to utilize mental health services (U.S. Department of Health and Human Services 2001) and Asian American youth have a higher level of unmet mental health needs than White youth (Hough *et al.*, 2002; Sturm *et al.* 2000). For example, Yeh and colleagues (2003) found that 72% of Asian/Pacific Islander at-risk youth had unmet mental health needs compared to 31% of their Non-Hispanic White counterparts. A study on racial/ethnic minority children's use of psychiatric emergency care found that Asian American children were more likely than White children to visit hospitals only when they experienced the most troubling crises, but made fewer visits after the initial hospital-based crisis stabilization services (Snowden *et al.*, 2008).

Furthermore, the Asian American population is the fastest growing racial group in the United States and the population growth between 1995 and 2015 is expected to be 74% for Asian American youth (U.S. Bureau of the Census, 2004), suggesting that many of these youth will need services but not seek them out proportionately if current trends continue. Therefore, this paper purports to examine reasons for the lack of engagement in mental health services of Asian American families and to explore strategies to enhance their treatment engagement.

Different factors contribute to the unmet mental health needs of Asian American youth, and difficulty in treatment engagement is one of them. There exist different models of the process of engagement of children and youth and their families in mental health care. For example, engagement in mental health services has been defined as a "process that begins with a child being identified as experiencing mental health difficulties and ending with a child receiving mental health care" (McKay & Bannon, 2004, p. 905). Within this model, engagement in services is divided into initial attendance and ongoing engagement. Engagement in or adherence to treatment is also referred to as "the extent to which a

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

person's behavior coincides with medical or health advice" (Horwitz & Horwitz, 2009, p. 1863). Regardless of the different engagement conceptualizations, lack of engagement in services may leave a mental illness untreated or cause delayed treatment, which can be costly to the family, the school, and the society. Untreated mental illnesses or delayed treatment are related to adverse consequences such as truncated educational achievement, drug abuse, poverty, unemployment, fragmented personal and social relationships, and even suicide.

The purpose of this article is to twofold. First, we will present to readers the reasons for Asian American families' lack of engagement in mental health services in the U.S. Second, we will provide guidelines to promote the mental health service engagement among Asian American families.

Reasons for Asian American Families' Lack of Engagement in Mental Health Services

We searched the literature on engagement in services among Asian families from PubMed and PsycINFO databases. The following were often cited as major reasons for Asian American families' lack of engagement in mental health services in the U.S. They are a) stigma, b) different illness explanatory models, and c) logistic and perceived barriers. It should be noted that these reasons may apply to minority populations in general.

First, research indicates that stigma is felt more deeply by the Asian populations than by the White population (Ho, Yeh, McMabe, & Hough, 2007). Stigma is the "most formidable obstacle to future progress in the arena of mental illness and health" (US Department of Health and Human Services [USDHHS], 1999). It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, shame, and avoidance. Furthermore, it may reduce a family's access to resources and increase isolation and hopelessness among patients and their family members (Ho et al., 2007). In order to minimize stigma and shame and preserve self-esteem, some Asian American family members may discourage treatment of their children in mental health facilities for fear of a mental health professional's breaching confidentiality and fear of destroying a family reputation. Consequently, the family may delay or abort treatment prematurely, which may affect the child's well-being and increase morbidity and mortality (Ho et al., 2007). Second, different explanatory models of mental illnesses may affect how long an Asian American youth may stay in treatment (Kleinman, 1980). First, some people of Asian backgrounds believe in Karma, the law of cause and effect in eastern spirituality—there is a consequence for every action. Some parents may believe that the reason why their son or daughter has a mental illness is because they or the grandparents have conducted some unforgivable sin in their life. Second, bad blood from the mother is also blamed by some Asian families for a child's mental illness (Wynaden et al., 2005). And third, supernatural, somatomedical, and societal explanations in rural areas of countries like China are used to account for mental illness (Wong, 2007).

A case study presented in *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* illustrates a Vietnamese American family's belief about schizophrenia and their way to help their oldest child (U.S. Department of Health and Human Services 2001: 118).

"...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 a recent heat wave. They believed that they themselves could help by providing him with their own food and making him

return to school. These ...differences in beliefs caused the parents to avoid the use of mental health services.”

These different illness interpretation models may be related to the family’s suppression of awareness of the illness or disbelief that mental health professionals are able to help or understand their child/family’s struggles. Consequently their engagement in mental health treatment may be compromised, if they take their child to mental health services at all.

Third, families from Asian American backgrounds, especially those from economically disadvantaged communities, reported more barriers to mental health services (Chow et al., 2003). Kazdin and his colleagues classified the barriers into two categories—logistical barriers and perceived barriers (Kazdin et al, 1997). The logistical barriers include financial burden, an inconvenient clinic location, time spent on a waiting list and in a waiting room, work conflict, family illness, forgetting the appointment, feeling too ill or feeling well, and lack of transportation. The lack of mental health providers who can speak the same language of the youth or the youth’s parents or limited English proficiency of these families may also contribute to their premature dropout of treatment. For example, Sentell and colleagues (2007) found that non-English speaking Asian participants had significantly lower odds of using mental health care than Asian participants who spoke only English. In addition, some neighborhoods where inner city minority people reside are endangered with community violence. Thus, parents may feel it is unsafe to take their child to get services. Any one or a combination of these logistic barriers may affect a family’s engagement in mental health services.

The perceived barriers described by Kazdin and colleagues (1997) include the following. Some parents may not perceive the need for treatment, thus this affects their motivation to engage in treatment of their child’s mental illness. A perceived poor alliance with therapists or other mental health professionals may affect a family’s willingness and motivation to engage in treatment. The unfavorable alliances between the mental health providers and the help seekers may be affected by cultural and/or language mismatch; lack of mutual cultural knowledge, awareness and sensitivity; conscious/unconscious stereotyping and discrimination and racial microaggression (Gaertner & Dovidio, 2005; Sue et al, 2007). The racial microaggression refers to commonplace verbal or behavioral behaviors whether intentional or unintentional, which convey hostile, derogatory, or negative racial slights and insults (Sue et al, 2007). Some seemingly non-harmful behaviors may result in self-doubt, frustration, and isolation, which may affect an Asian family’s engagement behavior (Solorzano et al., 2000). Researchers (Burgess et al., 2008; Lee et al., 2009) examined the association between perceived provider discrimination and underutilization of needed mental health services. They found that Asian American participants reported a significantly higher level of perceived provider discrimination, fewer visits to mental health services, and poor health compared to White participants. In addition, medical/clinical factors like possible misdiagnosis, mistreatment, and inappropriate dosages of medication may lead to an Asian American family’s distrust of mental health professionals, and subsequent dropout of mental health services.

In a study looking at ethnic and cultural differences in family involvement in mental health treatment, Asian American mental health patients were found to be four times more likely than White patients to live with their families (Snowden, 2007). This was related to their lower level of mental health treatment engagement. One explanation was that these Asian American patients received good care at home from their family members who manifest low expressed emotion, thus suffering less from symptoms of mental illnesses. “Constructive family engagement reduces symptoms, prevents crisis, and promotes community adjustment, thereby reducing the need for treatment.” (Hopper and Wanderling 2000; Snowden, 2007, p. 339). On the other hand, Asian American patients and their families

might avoid the mental health treatment system because they did not know what would happen were they to seek help. Their concern might be triggered by stigma, or by disappointment and frustration in past attempts to participate in the treatment process (Snowden, 2007).

Strategies to Promote Engagement in Mental Health Services in Asian American Families

As discussed in the previous section, different reasons account for the underutilization of services and lack of engagement in mental health services among Asian American families, this following section explores strategies to promote service engagement among minority families in general and Asian American families in particular.

First, we should strive to provide mental health services in non-stigmatizing settings and provide culturally relevant diagnosis and treatment in a culturally sensitive manner.

Second, we should strive to form a close alliance among the referral source, the client/family, and the mental health provider in order to identify needed resources (Prinz, 1994).

Third, we should strive to address parental stress and perception of barriers, by conducting routine evaluation of therapeutic relationships, identifying and addressing treatment barriers across multiple levels, including individual, family, community, and systems levels (Kazdin & Whitley, 2003; Prinz & Miller, 1994). For example, mental health providers may provide information about practical aspects of appointment (e.g. parking, bus routes).

Fourth, we should and treat an intake session as a treatment session, in addition to its purpose of information gathering, as a high percentage of the families may not bring their child back to services. We should provide an exit interview with Asian American parents to evaluate their satisfaction with services and seek their feedback to improve services, empowering them and respecting their input.

Fifth, we should strive to educate primary care physicians and other health care providers about mental illness. Research indicates that Asian American clients who are referred by their primary care physicians to mental health agencies are more likely to seek and adhere to treatment (Yeung et al. 2006).

Sixth, mental health providers should strive to provide strategic structural system engagement BEFORE the initial session (Szapocznik et al, 1988). We can do the following:

- Making phone calls to clarify need for service, maximizing caregiver investment and efficacy, identifying attitudes about and previous experiences with services, and developing strategies to overcome barriers
- Contacting adult caregiver and build the alliance
- Inviting all family members to the intake (strengthening confidence in their attending intake and following appointments)

Lastly, we should strive to recruit and train Asian American mental health professionals, build cultural and linguistic competency among mental health providers, and encourage alternative, testable approaches to mental health care of Asian Americans.

Conclusion

In short, Asian American youth and families may encounter numerous hurdles in mental health services. Stigma, cultural beliefs and practices, and barriers to services may affect

their motivation to stay in treatment. Studies show that patients who engage in treatment, “even when that treatment is a placebo”, have better health outcomes than those who dropped out of treatment (Horwitz & Horwitz, 2009, p. 1863). Finally, we use the following quote to highlight the significance of promoting family engagement in health services:

“The effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when, and why families or caregivers are engaged in the delivery of care...it is becoming increasingly clear that family engagement is a key component not only of participation in care but also in the effective implementation of it” (Burns, Hoagwood, & Mrazek, 1999).

Acknowledgments

This manuscript was supported by a NIMH Research Supplements to Promote Diversity in Health-Related Research Program awarded to Huijiun Li (3P50MH080272-03S2, PI Robert McCarley)

References

- Burgess DJ, Ding Y, Hargreaves M, van Ryn M, Phelan S. The association between perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community sample. *J Health Care Poor Underserved*. 2008; 19(3):894–911. [PubMed: 18677077]
- Burns B, Hoagwood K, Mrazek P. Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*. 1999; 2(4):199–254. [PubMed: 11225935]
- Chow JC, Jaffee K, Snowden L. Racial/ethnic disparities in the use of mental health services in poverty areas. *Am J Public Health*. 2003; 93(5):792–7. [PubMed: 12721146]
- Edman JL, Andrade NN, Glipa J, Foster J, Danko GP, Yates A, Johnson RC, McDermott JF, Waldron J, A. Depressive symptoms among Filipino. *Am Adoles Cult Divers Mental Health*. 1998; 4:45–54.
- Gaetner SL, Dovidio JF. Understanding and addressing contemporary racism: From aversive racism to the common ingroup identity model. *J Social Issues*. 2005; 61:615–639.
- Ho J, Yeh M, McCabe K, Hough RL. Parental cultural affiliation and youth mental health service use. *J Youth Adolescence*. 2009; 36:529–542.
- Hopper K, Wanderling J. Revisiting the developed versus developing country distinction in course and outcome in schizophrenia: Results from ISOs, the WHO collaborative follow-up project. *Schizophrenia Bulletin*. 2000; 26:835–846. [PubMed: 11087016]
- Horwitz RI, Horwitz SM. Adherence to treatment and health outcomes. *Arch. Intern. Med*. 2009; 153:1863–1868. [PubMed: 8250647]
- Kazdin AE, Holland L, Crowley M. Family experience of barriers to treatment and premature termination from child therapy. *J Consult Clin Psychol*. 1997; 65:453–63. [PubMed: 9170769]
- Kleinman, A. *Patients and Healers in the Context of Culture: An Exploration of the Borderline Between Anthropology, Medicine, and Psychiatry*. University of California Press, Ltd; London: 1980.
- Lee C, Ayers SL, Kronenfeld JJ. The association between perceived provider discrimination, healthcare utilization and health status in racial and ethnic minorities. *Ethn Dis*. 2009; 19(3):330–7. [PubMed: 19769017]
- Makini GK Jr, Andrade NN, Nahulu LB, Yuen N, Yates A, McDermott JF Jr, Danko GP, Nordquist CR, Johnson R, Waldron JA. Psychiatric symptoms of Hawaiian adolescents. *Cult Divers Mental Health*. 1996; 2:183–191.
- Sentell T, Shumway M, Snowden L. Access to mental health treatment by English language proficiency and race/ethnicity. *J Gen Intern Med*. 2007; 22(Suppl 2):289–93. [PubMed: 17957413]
- Snowden LR, Masland MC, Libby AM, Wallace N, Fawley K. Racial/ethnic minority children use of psychiatric emergency care in California’s Public Mental Health System. *Am J Public Health*. 2008; 98(1):118–24. [PubMed: 18048783]

- Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder A, M B, Nadal KL, Esquilin M. Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*. 2007; 62:271–286. [PubMed: 17516773]
- U.S. Census Bureau. We the people: Asians in the United States. U.S. Government Printing Office; Washington, DC: 2004.
- U.S. Department of Health and Human Services. Mental health: A report of the Surgeon General. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.; Rockville, MD: 1999.
- U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General— Executive Summary. US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; Rockville, Md: 2001. 2001
- U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; Rockville, MD: 2001.
- Yeh M, McCabe K, Hough R, Dupuis D, Hazen A. Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research*. 2003; 5:65–77. [PubMed: 12801070]
- Yeung A, Shu-Ching Y, Fun F, et al. Recognizing and engaging depressed Chinese Americans in treatment in a primary care setting. *Int J Geriatr Psychiatry*. 2006; 21:819–823. [PubMed: 16955440]