

The challenges of providing behavioral treatment to Asian Americans

Identifying the challenges is the first step in overcoming them

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A challenge exists in the current management of behavioral health problems. On the one hand, patients with these problems usually present first to primary care providers before ever receiving services from mental health specialists.¹ On the other, health professionals in primary care have difficulties recognizing, diagnosing, and treating psychiatric disorders effectively.²

This challenge is particularly relevant to Asian American patients. These patients prefer to seek help from their primary care practitioners rather than mental health specialists³ because of the shame and stigma they attach to receiving mental health services, their linguistic isolation, and the shortage of Asian bilingual mental health professionals. The traditional Asian view of health does not separate body and mind, so patients do not see the value of consulting a mental health specialist. Such a consultation would be tantamount to acknowledging that their symptoms are severe and not treatable, thereby jeopardizing future employment or marriage and conveying shame to the entire family.

The challenge is difficult to overcome even in major metropolitan areas—such as New York City, Los Angeles, or San Francisco—where Asian American patients are able to receive health services in their native language because of the high proportion of Asian health care providers practicing in these cities. Unfortunately, however, even Asian physicians acknowledge that psychiatric disorders in Asian American patients are difficult to identify and treat. Despite speaking the same language and cultural awareness, many do not believe they have sufficient training to provide adequate diagnosis and treatment.⁴ Consequently, primary care physicians frequently under-recognize psychiatric distress in their Asian American patients compared to Latino patients.⁵

What makes it so hard to recognize, diagnose, and treat the psychiatric problems of Asian Americans in the primary care setting?

STIGMA OF MENTAL ILLNESS

Asian Americans attach stigma to mental illness. They commonly seek alternative explanations for their symptoms rather than accept psychiatric diagnoses and treatment, because having a psychiatric disorder may invoke feelings of shame or inadequacy. Patients and their families may resist discussing emotional issues because they fear “airing their dirty laundry” in public or opening up to

strangers. Even if patients are willing to talk about their emotions, they may not consider them relevant to the medical visit, unless a physician specifically invites a discussion of emotions.

The stigma is often heightened by patients’ negative experiences in their native countries, where “psychiatric care” might decrease the chances of marrying and having children, lead to imprisonment for political beliefs, or result in long-term institutional care for being “crazy.”

The stigma is compounded further by a lack of knowledge of the high prevalence of psychiatric disorders within the Asian American community and of the availability of effective treatments, particularly in the earlier stages of the illness.

PROVIDER STIGMA

Many primary care practitioners unwittingly reinforce this stigma. Out of fear of embarrassing their patients, physicians fail to ask about mood, feelings, or personal stresses. They also do not ask patients about emotional problems to avoid opening a “Pandora’s box” and then not feeling competent to help patients with emotional difficulties. Unfortunately, some health professionals may harbor negative feelings and inaccurate myths about mental illness and its treatment.

DIAGNOSTIC COMPLEXITY

Asian patients often present with somatic symptoms and have often undergone multiple medical evaluations before a psychiatric or behavioral diagnosis is considered.⁶ In our clinical experience, many Asian patients have non-classic presentations of common psychiatric syndromes. For example, Asian patients with depression may not report a depressed mood or feeling sad, which are cardinal symptoms of depression. Unless the physician asks about the other cardinal symptom—lack of pleasure in usual activities (anhedonia)—the diagnosis may be missed. Similarly, Asian patients with panic or anxiety disorder may not present with classic symptoms of palpitations or other cardiovascular symptoms. Instead, they report hot and cold intolerance or excessive emotionality, as well as such problems as dyspepsia or diarrhea.

LANGUAGE AND CULTURE

The diagnostic complexity is heightened by linguistic and cultural complexities. Asian patients, sometimes even



Asian Americans experience barriers to care even in metropolitan areas

within the same ethnic group, are heterogeneous in ethnicity, acculturation, spirituality, and language. For example, in terms of etiology, symptom presentation, and treatment, an immigrant or refugee who is depressed is different from a third-generation Asian American who is depressed.

Even Asian American primary care providers who are bilingual often are unfamiliar with appropriate psychiatric terminology or lack an explanatory model that encourages patients to engage in treatment.

USE OF TRADITIONAL MEDICINES AND SELF-MEDICATION

In Asian communities, the use of traditional medicine is the rule, not the exception. These practices include herbal medicines, folk healers, acupuncture, massage, and *qi-gong* (deep breathing exercises for “life energy”). While some of these traditional treatments may help patients with psychiatric conditions,⁷ they can mask or worsen symptoms, thereby clouding the initial diagnostic picture.⁸

EXPECTATIONS OF PATIENTS

Many first and second-generation Asian American patients see their physician as an expert and an authoritarian. They expect him or her to arrive at a diagnosis and treatment plan at the initial visit. If a specific recommendation is not made at that time, patients may lose confidence in the provider. This view contrasts sharply with the prevailing new ideal in the United States that encourages patients to be “partners in their own care” and to assist the physician in prioritizing tasks.

OVERCOMING THESE BARRIERS

Although these barriers are formidable, they can be overcome. Primary care professionals are positioned to help by

providing care themselves and by referring patients to specialized care.⁹

The articles in this special issue of *wjm* have been written by mental health and primary care professionals who care for Asian American patients. Our goals are to help primary care providers improve their understanding of the diagnosis and treatment of psychiatric disorders in Asian patients, to encourage successful patient engagement in the treatment process, and to decrease stigma in the primary care encounter. We hope that this theme issue will help to bridge the gap in evidence until the necessary research can be performed. Our contributors share the desire to improve cultural competency of primary care practitioners when caring for and treating Asian patients with mental health disorders.

Readers seeking evidence-based material on Asian American behavioral health should be aware that few well-designed, large-scale studies exist on which to base recommendations. Articles in this issue are drawn from the extensive clinical experience of our contributors, plus review of the existing literature. Although we refer to the population discussed as Asian American, our expertise, and the material presented herein, mostly encompasses the Chinese, Korean, Vietnamese, and Japanese communities.

We and our contributors emphatically believe that improving the mental health status of Asian Americans must involve recognition and treatment by primary care clinicians. This remains the major and, for many vulnerable immigrant Asians, the only pathway for mental health care.

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