Providing Culturally Responsive Care to Asian Immigrants

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
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Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, therapists, mental health counselors, and other members of the interdisciplinary team who work with immigrants, particularly Asian immigrants.

Accreditations & Approvals

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This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

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American Psychological Association

Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

Designations of Credit

Social workers completing this intermediate-to-advanced course receive 10 Cultural Competency continuing education credits.

NetCE designates this continuing education activity for 7 NBCC clock hours.

NetCE designates this continuing education activity for 10 continuing education hours for addiction professionals.

NetCE designates this continuing education activity for 10 CE credits.

Individual State Behavioral Health Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Disclosure Statement

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Course Objective

The purpose of this course is to expand the level of awareness and knowledge base of practitioners in providing culturally relevant, sensitive, and responsive mental health and health services to immigrant populations, specifically Asian immigrants in the United States.

Learning Objectives

Upon completion of this course, you should be able to:

1. Describe the demographic shifts and factors that have influenced the need for culturally competent health and mental health services.
2. Discuss some of the historical forces that impacted the helping fields in moving toward the examination of culture and diversity.
3. Define the terms culture, race, ethnicity, assimilation, and acculturation.
4. Discuss the major immigration histories and demographic characteristics of Asian American immigrants.
5. Describe the prevalence or scope of different types of psychiatric disorders in the Asian immigrant community.
6. Discuss how culture influences concepts of mental illness and beliefs about the causes of mental illness.
7. Identify factors that play a role in the process of Asian immigrants' help-seeking decisions.
8. Describe various healthcare needs in the Asian immigrant community.
9. Discuss the role of culture in affecting health beliefs and practices among Asian immigrants.
10. Identify components of culturally sensitive communication skills.
11. List characteristics of culturally sensitive assessment.
12. Discuss cultural factors that affect the informed consent process with Asian immigrants.
13. Discuss guidelines in working with interpreters and interprofessional collaboration.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

The United States has become increasingly heterogeneous and diverse. With the quickly changing, multi-textured landscape, terms such as "culturally competent," "ethnically sensitive," "culturally relevant, responsive, or informed," "cultural humility," and "multicultural practice" have become more than buzzwords in the professional literature. Service providers such as social workers, mental health counselors, family therapists, and healthcare professionals are required to have skills to accommodate the needs of ethnic minority clients and patients. Such skills entail having knowledge and frameworks to conduct assessments and implement interventions or treatments that harness clients' or patients' cultural belief systems, strengths, and values, and ensuring that interventions are aligned with clients' or patients' beliefs about health, illness, mental illness, and indigenous solutions to problems.

ETHNIC MINORITY POPULATIONS IN THE UNITED STATES

The U.S. Census Bureau projects that the non-Hispanic White population in the United States will decline from 198 million in 2014 to 182 million in 2060 [125]. This 182 million will represent 43% of the total population, making the United States a majority-minority country [125].

Hawaii, New Mexico, California, the District of Columbia, and Texas are regions in the United States that already consist of a "majority-minority," meaning that more than half of the areas' populations consist of individuals who are an ethnicity other than non-Hispanic White [189]. By 2060, it is expected that there will be 119 million Hispanics in the U.S. population; by that same year, African or Black Americans will comprise 18.4% of the U.S. population [10; 11]. By 2065, Asians will be the largest immigrant group (38% of new immigrants) in the United States, surpassing Hispanic immigrants (31%) [12].

These data, in part, argue for the need for culturally competent practices. Betancourt et al. identified three other reasons [21]. First, clients and patients often present with problems or symptoms that do not necessarily conform to textbooks; this may, at least in part, be attributed to the presentation and manifestation of symptoms being influenced by cultural and social backgrounds. This may be more pronounced if clients'/patients' ability to communicate their problems is impeded due to limited English proficiency. Second, practitioner-client/patient relationships and communication strongly influence treatment outcome. When communication styles, patterns, and differences are perceived to be irreconcilable, clients/patients are more likely to terminate treatment prematurely. Finally, there has been a concerted movement in the general health and mental health fields to decrease the disparities and inequities in the access and delivery of care and services [21].

Cultural competence is a professional mandate and a dynamic process [14]. It entails an understanding of cultural context in shaping health beliefs and behaviors [51]. Cultural competence involves more than reviewing a specific culture or ethnicity [91]. Instead, it requires that care and services are provided in such a way that the patient/client is central and is allowed and encouraged to express themselves and their experiences [91]. It is also not merely completing a curriculum or training to be "culturally competent." Rather, cultural competence involves continual learning throughout one's professional career in four different areas [13; 112]:

- Cultural awareness
- Knowledge acquisition
- Skills development
- Inductive learning

Expanding on this paradigm, Fong describes cultural awareness as the practitioner's ability to identify key cultural values of the client/patient; understand how these cultural values influence the client/patient and his/her environment; develop skills in order to apply and implement services that are congruent to the client's/patient's value systems;

and acknowledge that this is an inductive learning process that involves a continual journey and quest to learn about different cultural value systems and beliefs and apply them to Western intervention models [25].

The goal of cultural competence is to reduce the gap between the norms and belief systems of clients/patients from diverse cultural groups and the institutional cultural norms of service delivery agents. Ultimately, this will mitigate the disparities that exist in mental health and healthcare systems [190].

MULTICULTURAL COUNSELING AND CULTURAL COMPETENCE IN PSYCHOLOGY, SOCIAL WORK, AND THE COUNSELING FIELDS

The terms "multiculturalism" and "diversity" are often used interchangeably. Multiculturalism "reflects the nature of American society, which entails the coexistence of many cultures within one society" [112]. Diversity, on the other hand, "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [112]. Diversity is often thought of in singular dimensions as opposed to multiple and intersecting factors [15]. Race, class, gender, and ethnicity are the most commonly identified components of diversity.

Historically, the term "multiculturalism" came into public discourse in the educational arena during the 1980s. Advocates for multiculturalism argued that educational curricula were Eurocentric and androcentric; that is, much of the philosophical assumptions were based on Western norms and American tenets of individualism and self-determination. As a result, much of the educational materials in schools did not reflect the social realities of ethnic minority groups and women [45]. The term eventually came to include other minority groups based on sexual orientation, social class, mental and physical ability, religious/spiritual beliefs, and age [45].

The multicultural movement in education influenced other disciplines. Many asserted that fields such as psychology, counseling, mental health, and clinical social practice were also Eurocentric [158]. Prior to the middle of the 20th century, universal validity was applied to theories and practice; cultural context was mainly viewed as a nuisance [105]. Talking to cure problems, with an emphasis on disclosing private and intimate information to a nonfamily member, is primarily a Euro-American value [9]. Goals for self-improvement and self-actualization are very much Western tenets that are dissonant to the collectivistic orientations in many other cultures in which individual needs are relegated, and the group's (e.g., family's) needs are paramount [158].

In the field of psychology, three forces, or perspectives, have historically been predominant in explaining human behavior: psychoanalysis (the first force), behaviorism (the second force), and humanism (the third force). Pedersen asserted that there was a fourth force: multiculturalism [139]. As noted, the concept of multiculturalism is based on the belief that culture pervades every aspect of our lives, which makes it a dominant fourth force. Pedersen was not arguing that the other psychological perspectives should be dismissed or that they had outlived their purposes; rather, he asserted that it is important for practitioners to understand and interpret human behavior within a cultural context [139].

The 1960s in the United States was a period of civil unrest that ultimately sparked much activism. Various minority groups demanded that counseling, social work, health, and mental health disciplines meet their specific needs. African Americans voiced their outrage at discrimination in the educational system. On the one hand, the educational system maintained that education was for the masses; yet, they primarily targeted White students. Similarly, psychotherapy was available primarily to elite segments of society [39]. These outcries fueled other groups (e.g., women, Asian Americans, Hispanics, Native Americans, handicapped persons, the elderly, etc.) to question the discrepancies they observed between the philosophy espoused and

actual practices [39]. The passing of Title VII of the Civil Rights Act of 1964, which made it unlawful to discriminate based on sex, race, religion, and national origin, further galvanized psychologists to focus on racial and ethnic minority groups in their work [231]. Consequently, by the late 1960s, racial and ethnic minority psychologists began pressuring the American Psychological Association (APA) to endorse their interests, which eventually led to the creation of the Association of Black Psychologists in 1968, the Association of Psychologists por la Raza in 1970, the Asian American Psychological Association in 1972, and the Society of Indian Psychologists in 1975 [3]. In 1972, an international group of psychologists convened to examine the role of culture in the human experience. This led to the formation of the International Association for Cross-Cultural Psychology [105]. As psychologists recognized that culture was not being addressed in mainstream peer-reviewed journals, new journals with this focus began to emerge in the mid-1970s, including the *Journal of Black Psychology, Hispanic Journal of Behavioral Sciences, Asian American Journal of Psychology,* and *American Indian and Alaskan Native Mental Health Research* [105].

In the 1980s, there was an emphasis on focusing on specific identifiable competencies with respect to multicultural counseling [149]. An ethical mandate was made concerning the need to incorporate issues of cultural diversity in education and training. With ethnic minority psychologists continuing to pressure the APA, the Office of Ethnic Minority Affairs was established in 1979, the Board of Ethnic Minority Affairs in 1981, and the Division of Ethnic Minority Affairs in 1986 [3]. By contrast, the first international congress of psychology meeting was held in 1889 [169]. In 2002, the APA's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* were published. In 2017, it was revised to the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality, 2017*. The focus of the updated guidelines is recognition of clients' experiences and perspectives as stemming from multiple and intersecting identities and contexts, each of which may be associated with oppression [37]. Furthermore, it maintains that psychologists should take micro, mezzo, and macro systems into account when providing care [37].

Social work was no different; the profession was influenced by the advocacies and activism prevalent during the 1960s. In 1973, the Council on Social Work Education (CSWE) made indirect statements that the United States was indeed a pluralistic society, which has implications for social work, and thereby social work education must address racial, ethnic, and cultural diversity [65]. In the 1973 guidelines, the CSWE asserted that social work curricula should reflect the experiences and needs of racial and ethnic minority groups, with an emphasis on social workers' knowledge base as the mechanism to increase cultural competence [160]. By the 1970s and 1980s, much of the social work literature began to feature such terms as "ethnic sensitive practice," "cultural awareness," "ethnic competence," and "cross-cultural social work" [25]. In the 1980s, the CSWE expanded the definition of cultural competence to include sex, gender, sexual orientation, age, ability, and other groups to reflect social diversity [160].

In their standards for social work education, the CSWE developed mandates for the inclusion of cultural competence in social work curricula. Four common themes about multiculturalism have surfaced in the social work literature [170]:

- Social workers require cultural knowledge about the groups with which they are working.
- There is a need for cultural sensitivity.
- There is a need for specific cultural competency skills in order to work in the micro, mezzo, and macro systems.
- An emphasis on social justice would improve access of services to marginalized groups.

There have been many critiques of cultural competency. Critics do not necessarily argue that cultural competency is irrelevant. Rather, criticisms tend to focus on its lack of theoretical base and lack of clarity. Some critics assert that cultural competence as it is currently defined is not achievable, because it is not realistic to become completely knowledgeable and competent in another culture [14].

In 2015, the National Association of Social Workers incorporated the concept of cultural humility and intersectionality into their *Standards and Indicators for Cultural Competence in Social Work Practice*. It defines cultural humility as "the attitude and practice of working with clients at the micro, mezzo, and macro levels with a presence of humility while learning, communicating, offering help, and making decisions in professional practice and settings" [57].

The field of counseling and its educational programs, which are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), are also mandated to include multicultural components. In 1972, the Association for Multicultural Counseling and Development (AMCD), dedicated to developing a professional knowledge base in multiculturalism and counseling, became a part of the American Counseling Association. An academic peer-reviewed periodical, *Journal of Multicultural Counseling and Development*, was established to publish scholarly articles on counseling issues in a pluralistic society [59]. By 1991, the AMCD approved a document addressing the need for multicultural counseling, which later led to thirty-one multicultural competencies being required in the mental health counseling accreditation criteria [25; 159]. Nine of these competencies revolved around the practitioner's attitude/beliefs, 11 were knowledge, and the remaining 11 were the skills component [159]. These competencies must now be infused into Master's-level curricula. In 2015, the American Counseling Association published its *Competencies for Counseling the Multiracial Population* [83]. The guideline is [83]:

> ...intended for use by counselors and other helping professionals; individuals who educate, train, and/or supervise current and future counseling and other helping professionals; as well as individuals who may conduct research and/or other professional activities with members of the multiracial population. To this end, the goal is for these competencies to serve as a resource and provide a framework for how counseling and other helping professionals can competently and effectively work with and advocate for members of the multiracial population.

The sociopolitical landscape of the 2020s has lent further voice to women and Black Americans. The #MeToo Movement and #BlackLivesMatter vocalize concerns about injustices related to sexual abuse and harassment, police violence, and institutional racism. During the coronavirus disease (COVID-19) pandemic, racial, ethnic, and economic disparities became clearer [275]. Social justice counseling and advocacy have added extra dimensions regarding power, privilege, and oppression [231].

To date, the definitions of multiculturalism and diversity continue to be debated [275]. This controversy hinges on the extent to which the concept of multiculturalism should be inclusive to all groups who are marginalized. If one takes an inclusive stance, multicultural would encompass: age, culture, disability, educational level, religion, sexual orientation, race, gender, and socioeconomic status [175]. Conversely, to what extent should multiculturalism be exclusive to only the dimensions of race and ethnicity? An exclusive stance posits the importance of focusing only on racial, cultural, and ethnic differences [110]. According to this perspective, students in the fields of social work, counseling, and psychology would be educated about the role of white privilege and how it affects their work. White privilege is a construct that refers to an expression of White American's power over racial/ethnic minorities as evidenced by differential access to resources [124].

A similar debate occurs in anthropology, which is highly relevant in psychology, counseling, and social work. The discussion centers on the etic and emic perspectives. The term "etic" is derived from the term phonetic, which refers to sounds assumed to be universal across all languages [20]. Therefore, the etic perspective maintains that, along important dimensions, all humans are basically similar. Helping professionals can employ basic fundamental helping skills in order to work effectively with individuals from all cultures. These basic skills transcend cultural diversity [128]. On the other hand, the emic perspective argues that it is vital for professionals to begin from the paradigm that unique cultural characteristics exist in various cultural groups. This emic orientation acknowledges individual differences within culturally different groups while simultaneously viewing clients/patients within the context of their primary cultural group [110]. Therefore, practitioners would intensely study a specific culture and adapt techniques that work with clients/patients from that group. This debate continues.

OVERVIEW OF KEY CONCEPTS

CULTURE, RACE, AND ETHNICITY

Culture is a complex concept, and its common conflation with race and national origin can be confusing [160]. Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [64; 112]. Culture involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations [74]. Culture can also represent worldviews, encompassing assumptions and perceptions about the world and how it works [158]. Some have defined culture as "the growth, development, and expressions of a client system's worldview through an interaction with its biopsychosocial and spiritual environments" [160]. Culture helps to elucidate why groups of people act and respond to the environment as they do [84]. Culture has been conceptualized as a diversity domain characterized by different value systems, norms, and social and behavioral patterns [277]. Kluckhohn and Strodtbeck proposed five different dimensions that comprise a worldview [97]:

- Human nature: How individuals view human nature
- Man and nature: How individuals view themselves in relation to nature
- Time: How individuals view the past, present, and future
- Activity: How individuals view "doing" and "being"
- Relational: How individuals view social relations such as family and other social networks

Experts have asserted that culture has two components: the observable and the unobservable [285]. The observable include language, customs, and specific practices, while the unobservable include beliefs, norms, and value systems.

Some experts argue it is also necessary to understand epistemological bases of groups' knowledge when defining culture [191]. In other words, it is important to ask: what is knowledge and where is it derived from? For example, some cultural groups' beliefs or knowledge about health and mental health are derived from shamanistic traditions or religious orientations, such as Buddhism or Taoism. This knowledge is therefore rooted in cultural beliefs, which dictate behaviors [191]. Therefore, culture is deeply tied to epistemology.

Current perspectives note that culture is not static; it is not merely inherited nor are groups of people passive recipients of culture. Rather, "culture and people negotiate and interact, thus transforming and developing each other. It is a process of continuous modification" [35].

On the other hand, race is linked to biology. Race is partially defined by physical markers such as skin or hair color [94]. It does not refer to cultural institutions or patterns, but it is generally utilized as a mechanism for classification. In modern history, skin color has been used to classify people and to imply that there are distinct biologic differences within populations [134]. Historically, the census in the United States defined race according to ancestry and blood quantum; today, it is based on self-classification [134]. However, some assert that race is socially constructed, without any biologic component [189]. For example, racial characteristics are also assigned differential power and privilege, lending to different statuses among groups [181]. The American Anthropological Association has described race as "an ideology of human differences," which then "became a strategy for dividing, ranking, and controlling colonized people used by colonial powers everywhere" [288].

Ethnicity is also a complex phenomenon and has been defined in many different ways. Alba categorized ethnicity into four groups [5]:

- Social class
- Political process
- Traditions
- Symbolic token

When ethnicity is viewed as social class, the individual's ethnicity is compared or equated with their socioeconomic class (e.g., working class or lower class). This is most clear in ethnic enclaves, the residents of which have strong cultural and familial ties [66].

Ethnicity may also be associated with persecution, both political and social. Ethnic unity may serve as a tool for social change and political reform [66]. Several famous ethnic movements took place in the 1960s, such as the unification of farm workers headed by César Chávez [66]. Ethnicity has also been viewed as a return to traditions, characterized by a renewed interest in ethnic foods, traditional religious practices, native language, and folklore [66]. Finally, ethnicity is also acknowledged as being a symbolic token, a way for individuals to maintain a nostalgic connection to their homeland [66].

Although these three terms are often employed interchangeably, it is important to consider the impact of the words chosen. Gregory writes the following, which should cause us to reflect on how practitioners use various terminology and its effect [171]:

> Within the "language of difference," however, race, ethnicity, and culture have come to be used interchangeably, which, on the one hand, can create an easier or less confrontational way of introducing a discussion that may include race; on the other hand, it is worth considering how, at times, the use of terms such as "difference" or "culture" merely creates a more palatable means to articulate the experience of "difference" without mentioning the word "race." Thus, the language of difference reveals an uneasy tension for psychotherapists who seek to move away from employing language and concepts that may serve to "essentialize" their clients but, in doing so, they may end up engaging language which has the potential to "neutralize" the potency of actual experience.

ASSIMILATION AND ACCULTURATION

Acculturation refers to a dynamic process that involves cultural change triggered when two cultural groups come in direct contact [4; 9; 19]. For example, when immigrants come to the host country, they may adapt to the values, behaviors, and belief systems of the dominant group. According to Berry, ethnic minority immigrants culturally adapt utilizing one of four different strategies: integration, assimilation, separation, or marginalization [19]. An individual can opt to integrate, adopting part of the values, beliefs, and behaviors of the dominant

culture while retaining his/her own cultural identity [4]. Assimilation, on the other hand, is defined as an individual choosing to abandon his/her own cultural identity in favor of completely incorporating the value systems of the dominant culture. An individual can select to separate completely from the dominant culture and decide not to adopt any of the cultural values of the dominant culture. This is known as cultural assimilation [251]. The other dimension of assimilation is structural, specifically the process by which immigrants become fully integrated and incorporated into the host country's social institutions [251]. Finally, an immigrant can be marginalized, a process by which he/she loses both his/her cultural identity as well as that of the dominant culture. When this is the case, alienation and isolation ensue [4; 19].

For the most part, scholars assume acculturation is linear or unidirectional. With a unidirectional or unidimensional model of acculturation, immigrants either remain ensconced in their cultural traditions or are integrated into the host country [187]. The concern with unidirectional acculturation theories is that they assume that equal opportunity can be accessed by all. Furthermore, they tend to rely on a Eurocentric benchmark that should be achieved by all immigrants; those who do not achieve this level are viewed inferior, lazy, or inassimilable [289]. In other words, unidirectional acculturation theories are reductionistic, assuming dichotomous outcomes (pathological vs. normal) [291].

There is also some research that indicates the acculturation process is not linear but multidimensional [187]. Immigrants may retain elements of both cultures and move back and forth. In one study with Korean American youths and their parents, Korean American youths who spent most of their time in the United States displayed an integrated bicultural strategy [254]. They were integrating well into the United States but still professed a strong allegiance to their Korean heritage. No participants in the study identified as completely assimilated. A study of Filipinos in the Philippines, Filipino immigrants in the United States, and American-born Filipinos compared gender role beliefs among the three groups [192]. If acculturation always occurred in a linear pattern, then one would assume that American-born Filipinos would hold more egalitarian or liberal attitudes toward women. However, immigrant Filipinos in the study indicated more liberal attitudes toward women than native Filipinos in the Philippines but similar attitudes to American-born Filipinos. Interestingly, American-born Filipino men appeared to have returned to more conservative or traditional attitudes, similar to those of Filipinos in the Philippines. The researchers speculated that cultural attitudes are not static; rather, the process is dynamic, and immigrants may feel they have to adapt their attitudes in order to survive. In a study of Chinese immigrant adolescents, researchers found that Chinese immigrant adolescents who had low proficiency in English were concerned with learning to relate to others within their own ethnic group and other racial groups [193]. Adolescents who had more family obligations also expressed more acculturative concerns. It was deduced that adolescents with more family chores and obligations to fulfill are more immersed in the traditional environment and have less time to learn and engage in new situations.

Acculturation is an ongoing process involving continuous learning about the environment [9]. Certainly, it is not linear nor does it occur on a single level. At the macrolevel, acculturation processes influence value systems, arts, and language [9]. At the exosystem, informal and formal social structures (e.g., communities, neighborhoods, schools, peer groups) can affect individual behavior [188]. At the mesolevel, acculturation impacts families and social interactions. Finally, at the microlevel, acculturation affects individuals' emotions, mental health, health, beliefs, and other human functioning [9].

There have been criticisms of bidirectional acculturation theories as well. These approaches do not take into account social injustices and how cultural identity is a continual process that requires constant negotiation, construction, and redefinition. It would also benefit these theories to consider the effect of the new immigrant(s) on the host country [289].

Assimilation was a term first conceptualized by Robert Park as a linear process, whereby immigrants slowly adopt an American way of life [32]. "Melting pot" is another term frequently heard, and it is often equated with assimilation. The term surfaced in the early 1900s. The melting pot concept was an idealistic goal whereby people of all races would peacefully unite, ultimately integrating, intermarrying, and blending—yielding a new people called "Americans" [94]. The traditional model of assimilation assumed that immigrants would discard their cultural values for the traditions of the host country, the ultimate goal being complete incorporation into the host culture [32]. The traditional hypothesis was based on the belief that as immigrants become more educated and more economically mobile, they would eventually assimilate. However, over time, scholars realized that assimilation was not unilinear. Immigrants can retain their ethnic identity and cultural traditions and still adjust to the norms of the host country [56]. Other scholars noted that some immigrant groups achieved upward mobility without completely assimilating to the dominant culture [142]. Consequently, there is no one simple assimilation trajectory; each ethnic immigrant group is very diverse.

In addition, the segmented assimilation theory has been used to describe immigrants who do not easily adapt to their new country [198]. According to this theory, immigrants do not follow a linear path to assimilation. There are a host of factors that contribute to different rates of assimilation, including age, gender, and socioeconomic status [198]. For example, poorer immigrants experience more obstacles to social mobility. They may only be able to obtain low-wage employment with no benefits, which could then have a series of ripple effects such as poor health and lack of access to transportation [198; 199].

In another study using segmented assimilation theory and using an archival dataset, researchers found that migrant children from rural areas who moved to an urban area in China performed better in terms of adjustment and academic outcomes when they entered formal urban schools compared to children who were segregated into informal migrant schools [250]. The latter group had more challenges in adjusting to the urban area and experienced more prejudice and discrimination.

RACISM, PREJUDICE, AND DISCRIMINATION

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power…by members of the agent racial group who have relatively more social power" [178]. Racism is perpetuated and reinforced by social values, norms, and institutions. There is also controversy regarding whether unconscious (implicit) racism exists. Quillian argues that images that are embedded in our unconscious are the result of socializations and personal observations, and negative attributes may be unconsciously applied to racial minority groups [194]. These unconscious attributes affect individuals' thoughts and behaviors without a conscious awareness.

Prejudice, on the other hand, is a general negative feeling, attitude, or stereotype against members of another group [46]. Personality theory (i.e., authoritarian personality facilitates higher levels of prejudice) and cognitive theory (i.e., prejudice is a type of bias stemming from stereotypical thinking) are common theoretical frameworks for understanding prejudice [251]. All humans have prejudices, but not all individuals adhere to racist attitudes. The following equation helps to distinguish between racism and prejudice: "prejudice plus power equals racism" [46]. Gordon argues that prejudice stems from the process of ascribing every member of a racial group with the same attribute, which is the Principle of Least Effort [252]. Furthermore, Gordon's principle of Belief in Essence asserts that whatever good or bad that resides in the group is also attributed to the individual, allowing for rapid negative judgments.

Discrimination has traditionally been viewed as the outcome of prejudice [6]. Discrimination encompasses overt or hidden actions, behaviors, or practices that are executed by members in a dominant group against members of a subordinate group [49]. The perpetrator of discrimination may be an individual, organization, or group, and similarly, the victim of discrimination may fall under the same categories [49]. Discrimination has also been categorized into two groups: everyday discrimination, which is subtle, continual, and part of day-to-day life and can have a cumulate effect on individuals, and lifetime discrimination, which consists of major discreet discriminatory events [195]. Discrimination is believed to be a stress-mediated pathway, and there may be a relationship between discrimination and negative health effects, such as cardiovascular and respiratory problems [196]. Furthermore, discrimination adversely affects access to healthcare services [259].

Experiences of Asian Americans and immigrants are rooted in a long historical backdrop of racism, prejudice, and discrimination in the United States. Asian Americans and immigrants have long been viewed as "perpetual foreigners," and in the 1800s, the term "Yellow Peril" was coined to describe the perceived danger associated with these individuals [310; 362]. During this period, and continuing to today, stereotypes persisted that Asian individuals were diseased, unclean, and/or depraved [362]. These prejudices were codified in law with the Chinese Exclusion Act of 1882 and the Immigration Act of 1924, which restricted Asians from entering the United States and reinforced the view of Asian Americans being perpetual foreigners [362].

In 2020–2021, there was a documented rise in anti-Asian sentiment, coinciding with the COVID-19 pandemic, with similar sentiments to historical stereotypes and discrimination. According to a 2020 study conducted by the Pew Research Center, 31% of Asian adults reported experiencing slurs or jokes because of their ethnicity during the pandemic [363]. In a survey of 211 Asian and Asian American respondents, half indicated they had heard a comment about Chinese people being the source of the virus, almost one-quarter heard comments about Chinese people being "dirty," and one-third reported hearing comments regarding avoidance of Chinese or Asian food as a means to prevent infection [364].

CULTURAL COMPETENCE

The term "cultural competence" is utilized so frequently that the definition of this term is a bit nebulous. Consequently, it is vital to look at some definitions framed within various theoretical paradigms.

A modernist or positivist perspective maintains that concepts of culture and cultural characteristics of a specific group are stable and can be observed and measured because they endure over time [43]. Therefore, practitioners can learn about the specific sets of beliefs, value systems, behaviors, and norms of particular cultural or ethnic groups and apply them to their clients/patients. Inventories that measure individuals' belief systems and values and instruments or tools that evaluate one's own cultural competence or an organization's level of cultural competence reflect this positivistic philosophy.

On the other hand, a postmodernist perspective argues that culture is dynamic and continually changing [43]. Because there are multiple realities that cannot be easily grasped and understood, it is not possible to measure concepts of culture. In other words, culture is socially constructed [43]. They also reject binary classifications of culture. These dichotomies are believed to perpetuate the marginalization of Asian Americans [181]. As a result, when working with diverse clients/patients, practitioners must come into the clinical process with a "not-knowing" position [43]. Laird further asserts that practitioners must be "informed not-knowers" [43].

A psychoanalytic perspective takes cultural competence and focuses on the practitioner's own journey exploring his/her self-knowledge or self-awareness. The practitioner's feelings, values, knowledge, beliefs, and biases are inextricably tied into the clinical process, which ultimately affects the client/patient [43]. The psychoanalytic perspective focuses on the practitioner's transference of cultural experiences [53]. Practitioners are asked to be aware of their cultural baggage, notions, and biases. Consequently, self-awareness is a preintervention task that practitioners must be willing to undertake, in which they examine their own cultural biases and perceptions of their client's/patient's cultural background [112].

A developmental perspective maintains that various disciplines should move towards cultural competence. It assumes that practitioners and the field can move in a stage-like fashion, where the end point is the achievement of cultural competency. McPhatter conceptualized the Cultural Competence Attainment Model as an ongoing process of developmental learning involving [122; 278]:

- Analyzing the current knowledge base, identifying gaps, and reformulating the knowledge base to include information about different cultural groups and diverse communities
- Shifting practitioners' worldview consciousness
- Developing process-oriented skills, including cross-cultural communication and respect for other worldviews, to establish a collaborative relationship

Regardless of the theoretical model, cultural competence does not necessarily mean that practitioners will move toward an integration of beliefs and values from non-Western contexts. Rather, cultural competence involves the ability to identify the ways in which Western and American culture influence individual belief and value systems and how these norms influence practitioners' worldviews and interactions with clients [191].

Cultural competence exists on many different levels—on the individual level (practitioner's self-awareness) and on the practitioner-client/patient relationship level. On an individual level, cultural competence training might focus on what culturally diverse clients expect, prefer, and desire or on practitioners' worldviews and experiences [201]. However, to focus on just the individual or micro level would neglect the macro level, the community level, and organizational levels. Training that addresses the macro level would focus on how social, economic, and political forces influence client/provider relationships and clients' access to resources [201].

Definitions and orientations toward cultural competence remain complex, multifaceted, and contradictory at times. To illustrate this, researchers identified four contradictions with this notion of cultural competence [197]. First, there is conflict regarding whether knowledge about traditions, cultural beliefs, norms, and values of any particular group can ever be obtained. Practitioners may have pieces of information but true knowledge may not be possible; the client is the expert. Furthermore, much of the knowledge gleaned about cultural groups is not necessarily "empirical," and practitioners may have broad anecdotal information, which, if misapplied, can lead to stereotyping [197]. Second, categorizations are not able to capture the multifaceted and multilayered complexities of culture. When a particular cultural group is referred to as being collectivistic rather than individualistic, these categorizations may end up obscuring individual differences of clients. Third, the emphasis on privileging group differences may be dissonant with many of the helping professions' ethical mandates to promote self-determination and autonomy. Fourth, it is unclear if cultural competence is truly a goal that can be attained due to lack of empirical measurement.

Furthermore, it is unclear what the benefit would be to the patient/client if cultural competence was able to be measured within subgroups [197]. The final consideration is how a practitioner is able to assess mastery of cultural competence [365].

Despite more than 40 years of multicultural counseling competence and associated research, questions remain [231]. For example, how does demonstrating cultural competence affect therapeutic change? How is cultural competence actually manifested in clinical practice? Is multicultural counseling competence culturally specific or culturally general?

However, it is clear that clients need to feel safe. Studies indicate that minority and immigrant clients feel their cultural differences are pathologized, which then ultimately leads them to feel unsafe in the therapeutic environment [282]. Counselors should be able to determine when culture is or is not impacting a presenting issue [282]. The term cultural competence may not be totally appropriate; "competence" implies an endpoint, while in reality it is a lifelong journey of learning [366]. Instead, the terms "cultural humility," "cultural respect," and "cultural safety" may be more suitable. Cultural humility conveys the need for ongoing reflection, learning, and self-critique; cultural respect involves a commitment to hearing patients'/clients' stories, and cultural safety entails practitioners recognizing the power differentials and making the environment safe for patients and clients.

DEMOGRAPHIC LANDSCAPE: ASIAN AMERICANS AND IMMIGRANTS IN THE UNITED STATES

The term "Asian" is widely used to describe individuals who have kinship and identity ties to Asia, which includes the Far East, Southeast Asia, and the Indian subcontinent [106]. The U.S. Census defines Asian as [202]:

> A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as "Asian" or reported entries such as "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian" or provided other detailed Asian responses.

"Asian American" (and sometimes "Asian/Pacific Islander American") is a term that has been employed for statistical purposes, and although Asian Americans share some physical and cultural similarities, in no way does this term capture the tremendous diversity within this group. There are more than 25 Asian/Pacific Islander groups, each with a different migration history to the United States and widely varying sociopolitical contexts of their homeland [167]. Asian Americans are also different in terms of their acculturation levels, length of residency in the United States, language, English-speaking proficiency, education attainment, socioeconomic statuses, and religion. For example, there are approximately 32 different languages spoken within this Asian American category group; within each Asian subgroup (e.g., Chinese), multiple dialects may be present [104; 167].

As of 2019, there were 22.9 million persons who identify as Asian in the United States [367]. This group grew by 72% between 2000 and 2015, from 11.9 million to 20.4 million. Between 2000 and 2019, this group grew by 81%, more than any other racial or ethnic minority group [368]. The majority of Asian individuals live in the West. An estimated 31% live in California, and they make up 16% of the population in California. New Jersey, Nevada, and Washington have the next greatest Asian populations among the states [284]. In 2019, California had the largest Asian American population (5.9 million) [368]. It is estimated that there will be 46 million Asian Americans by 2060 [369].

In general, Asians as an overall group are young, with a median age of 34 years, compared with the national median age of 38 years [369]. However, the median age of U.S.-born Asian Americans is 19 years of age, younger than the national median age of 36 years [369]. Interestingly, in terms of distribution of age segments, the Japanese as a group are the "oldest" and the Hmong are the "youngest." The median age for the Japanese population in the United States is 43 years, and for the Hmong, the median age is 16 years [168].

Next to Spanish, Chinese is the most widely spoken non-English language in the United States [168; 369]. Only 34% of Asian households report speaking only English at home [369]. More specifically, more than one-half of Japanese persons in the United States indicate that they speak English at home, while more than 90% of the Vietnamese, Laotians, Cambodians, and Hmong indicate they speak a language other than English at home [168]. This is not surprising given the fact that Japanese Americans are one of the older immigrant groups, with their immigration history dating back to the 1800s [104]. Vietnamese, Laotians, Cambodians, and Hmong are the most recent Asian immigrants to the United States.

Stereotypically, Asian Americans and immigrants have been portrayed as "model minorities," and U.S. Census data appear to reinforce this depiction [40]. It is estimated that in 2019, 54.6% of Asians in the United States 25 years of age and older have completed college or higher [367]. In 2019, the median household income of Asian Americans is $85,800, which is much higher compared than the national average of $61,800 [369]. However, Asian Americans are affected by poverty. In 2019, the poverty rate for Asians in the United States was 10%, compared with 13% for the total U.S. population [369]. Poverty appears to be more prevalent among some Asian ethnic groups; the highest rates are among Hmong (27%) and Bangladeshi Americans (21%) [286]. The lowest median annual incomes among Asian groups in the United States are among Bangladeshi ($49,800), Hmong ($48,000), Nepalese ($43,500), and Burmese ($36,000) groups [284].

ASIAN IMMIGRANT SUBGROUPS: DIVERSITY IN IMMIGRATION HISTORY

The Asian immigrant population is very diverse, and the reasons why immigrants come to the United States reflect these differences. One stereotype is that immigrants come to the United States to escape poverty. Evidence contradicts this prevailing misconception, as there are proportionally more professionals and technicians among immigrants coming into the United States than there are professionals and technicians in the U.S. labor force [141]. Furthermore, the stereotype that many immigrants are uneducated is far from true, as data shows they are well represented in college and graduate levels [141].

Asian immigrants who come to the United States tend to be highly educated. Generally, they enter the country through family connections or their place of employment; they are three times more likely to obtain permanent residency through their employer [287].

Portes and Rumbaut conceptualized a typology of the different types of immigrants in order to help understand the reasons for their immigration [141]. Any typology is an oversimplification, as there are always exceptions to the case [141]. Yet, their typology demonstrates the tremendous diversity within the immigrant population, and the Asian American and immigrant population is no exception. Understanding the reasons why they chose to immigrate to a foreign land will help practitioners understand the social and economic adjustments immigrants experience in their new homeland.

The first classification of immigrants is labor migrants [141]. This group comprises both documented and undocumented immigrants. Their primary motivation for coming to the United States is to earn higher wages compared to the wages available in their homeland [141]. When they arrive in the United States, labor migrants find themselves in low-wage jobs. Many eventually return home because the wages they earn in the United States go further in their homelands both in tangible (e.g., purchasing power) and intangible (e.g., social respectability) terms [141]. Again, despite popular notions that manual labor immigration is a one-way flow of immigrants who are motivated primarily to escape poverty, this phenomenon is actually a two-way process involving both employers and laborers who have specific sets of labor expectations [141].

The second classification of immigrants is comprised of professional immigrants [141]. They constitute highly trained professionals and their spouses. The countries of origin view these immigrants as "brain drains," a term that refers to the emigration of highly trained and educated professionals, resulting in a loss of human capital for the country of origin. However, the receiving country clearly benefits from the social capital (e.g., skills, talent, and expertise) to the labor market. In the United States, the science, engineering, and computer technology sectors rely on these highly skilled professional immigrants [82]. This outflow and inflow may be perceived as advantageous from both the sending and receiving countries' perspectives. From the sending countries' vantage point, these emigrants serve as safety valves to alleviate unemployment. From the receiving countries' viewpoint, these immigrants contribute necessary skills to the labor market [48]. Professional immigrants come to the United States not because of the differential level of income between the United States and their homeland, but as a result of the gap in available salaries and working conditions in their homeland despite their level of education [141]. Upon arriving to the United States, they accept professional jobs, but due to different licensing standards, they often start at the bottom rung and work their way up. These immigrants, despite having minimal English proficiency, tend to obtain jobs that are not English-speaking intensive [82]. For example, highly skilled emigrants from China will find jobs in business, computers, engineering and the sciences rather than health care. Persons emigrating from Indochina are more likely to work in computers, an occupation in which it is not necessarily vital to be proficient in English [82].

The third classification of immigrants includes entrepreneurial immigrants, and they can usually be found concentrated in ethnic enclaves in their new host country [141]. These immigrants usually enter with financial capital or pool earnings with relatives and/or other networks to start businesses [123]. They usually hire within the family system to save expenses of hiring outside workers to work long, arduous hours [123]. Furthermore, once they have established stable businesses, they promote new business development with their co-nationals [141].

The fourth classification of immigrants is comprised of refugees and asylees [141]. Refugees constitute individuals who are persecuted in their homeland and fear for their well-being. Once they are granted asylum, they have legal status in the United States. Historically, many of the refugees who entered the United States came from communist countries. In 1987 alone, 91,474 refugees arrived and were admitted legally in the U.S. [141]. The top sending countries included Vietnam, Cambodia, Laos, and Cuba [141].

The next sections will describe the historical and social context triggering immigration for each of the Asian subgroups. Most of the earlier emigration from Asia was spurred by economic factors, as many of the immigrants at this time fell in the category of labor migrants. However, more recent Asian immigrants can be classified as entrepreneurial immigrants as well as refugees and asylees, as witnessed by the large influx of Southeast Asian migration to the United States in the 1980s.

CHINESE IMMIGRATION TO THE UNITED STATES

Chinese Americans are the largest Asian American group in the United States. Their immigration history is long and can be distinguished by five different waves. The first wave of Chinese immigration dates back to 1785 [104]. It was only between the period of 1850 and 1919, with the discovery of gold in California, that a large influx of Chinese immigrants to the United States was triggered—primarily Chinese male peasant farmers who left their homelands with dreams of finding a new fortune [104]. In 1864, the building of the transcontinental railroad triggered further recruitment of Chinese immigrants from Canton [104]. The railroad construction promoted an open immigration policy, which gave unrestricted access of Chinese immigrants to the United States, spurred primarily for reasons of cheap labor [104].

In 1882, the United States implemented the Chinese Exclusion Act, as a result of racial conflict and anti-Chinese sentiment. Due to a general lack of understanding, the Chinese were categorized as Mongolians, and there was a concern about the amount of cheap labor and the fact that there were so many Chinese men who came to the United States without families, relying on prostitution for companionship [73; 78]. The U.S. government felt that this antifamily tendency would adversely affect the United States [73]. With the implementation of the Chinese Exclusion Act, Chinese laborers were barred from entering the United States. Furthermore, the Act prohibited Chinese immigrants who were already residing in the United States from being naturalized [104]. Despite these restrictions, many Chinese immigrants found loopholes to enter; one major strategy was utilizing the "paper son" system [78]. Despite these new restrictions, U.S. immigration laws did allow relatives of American citizens of Chinese descent to enter the country. In 1906, in San Francisco, a major earthquake and fire destroyed much of the city's legal documents. Many Chinese immigrants used these circumstances to their advantage. Chinese who were born in the United States, or who claimed they were, visited China and came back reporting the birth of a son [104]. Due to the fire, there were no records to prove otherwise. This created an opportunity for an individual to come to the United States, implementing a system known as "paper sons" [78].

The second wave of Chinese immigrants came after the implementation of the Immigration and Naturalization Act. This act imposed a numerical limit on immigration and favored northern and western European immigration. However, in 1930, this law was changed to permit wives of Chinese merchants and Asian wives of American citizens married before 1924 to immigrate to the United States [104]. Therefore, during the periods of 1930 and 1942, as more Chinese women entered the United States, stable family units emerged in Chinatowns [104].

The third wave of Chinese immigration took place between 1943 and 1964. This was strengthened by passage of the War Brides Act in 1945, which allowed Chinese women to immigrate as brides of men in the U.S. military. In 1953, the Refugee Relief Act permitted educated Chinese into the United States as refugees. In 1965, the immigration quota laws were repealed, which spurred a large influx of Chinese women to the United States and reunited many Chinese families that had been separated for decades [104].

During the period between 1965 and 1977, the fourth wave brought Chinese immigrants to the United States under the Immigration Act of 1965. These immigrants were primarily working-class families who settled in large urban areas, primarily in cities with Chinatowns. Immigrants who arrived during this period worked long hours trying to achieve the American dream.

Finally, the fifth wave began in 1978, after three decades of the closed-door policy, and immigrants from China were allowed to join their relatives. A large number of students and professionals also immigrated to the United States to pursue their education. Furthermore, there was a large group of Chinese ethnics from Cambodia, Laos, and Vietnam who fled Southeast Asia to escape torture during the Khmer Rouge regime in the 1970s [104]. In 1989, with the student protests in Tiananmen Square and subsequent public outrage at the military force used, Congress was concerned for the safety of students from China studying in the United States who would have to eventually return back to their homeland. In 1992, Congress enacted the Chinese Student Protection Act, which offered permanent residency status to student immigrants from China [200].

Immigration is influenced by the economic forces occurring in the receiving country. With industries in the United States moving more and more to high technology, there was a demand for professional and technical workers with postgraduate degrees. As a result, the Immigration Act of 1990 was passed, which revised the definitions of the H-1B visa, a non-immigrant visa category that allows American employers to hire skilled immigrants who have at least a bachelor's degree in areas where there is a shortage in the U.S. labor market [200]. Many highly educated Chinese immigrants came into the United States under this act in the early 1990s. In 2017, China accounted for 32.5% of the 1,079,000 international students who came to the United States to study. In 2019, China accounted for 13% of the H-1B petitions for skilled workers in specialized occupational sections to receive approval to reside in the United States to work [370]. Furthermore, some Chinese nationals have established households in the United States, from which their children may be educated, and maintain a home in China, where the adults continue to work [104]. Today, Chinese immigrants who are educated, hard-working, and ambitious tend to be considered "model minorities" and are viewed positively by the governments of United States and Canada as they help to fill gaps in the skilled labor market [200]. In 2019, China and Hong Kong represented 18% of Asian immigrants to the United States [371].

As a result of differences among the various immigration waves, Chinese immigrants in the United States are tremendously diverse in terms of a variety of social factors, including educational level, English proficiency, socioeconomic status, and acculturation. For example, there are many Chinese immigrants who originated from rural areas in Canton who came to the United States in the early 20th century, but who remain in Chinese enclaves and speak minimal English [180]. They differ tremendously from more recent Chinese immigrants from Hong Kong or Singapore who are very westernized and highly proficient in English [180].

In 2019, there were 5.4 million Chinese Americans (excluding those of Taiwanese descent) in the United States, making them the largest Asian subgroup in the United States [372]. If language is an indicator to level of acculturation, Chinese Americans are diverse in their level of acculturation. An estimated 14.6% of Chinese American households speak primarily English at home, while almost 50% do not speak English at home and speak minimal English outside of the home [168]. They have high labor force participation at 61% for Chinese individuals 16 years of age and older [372].

FILIPINO IMMIGRATION TO THE UNITED STATES

In 2019, there were 4.2 million Filipinos living in the United States, residing primarily in California [373; 374]. They, too, are a very diverse group. Approximately half of Filipino Americans and immigrants have at least an undergraduate college degree, which is higher than the rate for all Americans in the United States (38%) and all Asian Americans (31%) [373]. The three main Filipino cultural subgroups are Tagalogs, Ilocanos, and Visayans, and their diversity reflects their immigration patterns [180].

Emigration from the Philippines to the United States is marked by four waves [104]. The first wave was triggered in 1763, when Spain started trade between Manila and Cebu. Filipino slaves and laborers were said to have jumped off the vessels on the way back to Spain, ending up in Louisiana [104]. The second wave began in the early 1900s and ended in 1934 [104]. This group was comprised of nonmarried male farmers who were recruited to work on pineapple plantations in Hawaii and various parts of California, where they experienced much discrimination [7; 104]. Between 1945 and 1965, the third wave included Filipino service men and their brides, as the United States granted citizenship for Filipinos who fought in World War II [180]. This group had difficulty adjusting to the United States and generally ended up with menial jobs [7]. The fourth wave of Filipino immigrants came after 1965, when the Immigration and Nationality Act was modified to ease its original immigration quotas [180]. During the 1960s, the United States witnessed a large influx of well-educated, professional Filipino immigrants, especially healthcare professionals, who left the Philippines due to displeasure with the government [94; 180]. This period has been called the "brain drain" because many doctors, nurses, and engineers came to the United States to further their training and/or obtain better employment opportunities [104]. Today, the majority of Filipinos in the United States have lawful permanent residence primarily through family reunification and employment-sponsored visas [374]. The Philippines ranked second for these two immigration entry vehicles [370]. Documented residents in the United States can sponsor their spouses and unmarried children for permanent residency, and U.S. citizens scan sponsor parents, married children, and adult siblings [375].

JAPANESE IMMIGRATION TO THE UNITED STATES

Japanese Americans have a long history in the United States, dating back more than 100 years. Japanese immigration was at its highest during the years between 1880 and 1920 [104]. Because Chinese laborers were viewed as a threat by many, the Japanese government made agreements with the United States to allow Japanese workers to work on sugar plantations in Hawaii [26; 104]. As Japanese laborers continued to immigrate to Hawaii, and as they gradually moved to the mainland, anti-Japanese sentiment mounted, and eventually, in 1907, President Theodore Roosevelt issued the Gentleman's Agreement to curtail Japanese immigration [26]. The Gentleman's Agreement stated that only those Japanese who had a parent, husband, or child already living in the United States were allowed to come to join their relative [85]. Therefore, the Japanese government actively encouraged Japanese women to immigrate to the United States, hoping to promote marriage and families of these laborers. They believed that the presence of these women would serve to prevent gambling, prostitution, and various vices among the Japanese laborers [104]. As a result, Japanese women started coming to the United States as "picture brides." Brides were matched based upon family background, and once the initial match was made, a photograph was mailed to the potential groom [26]. In Japan, merely entering a woman's name in the groom's family registry constituted legal

marriage [127]. Therefore, Japanese women often came to the United States to join their new husbands without knowing anything about the man they had married [104]. Despite the implementation of the Gentleman's Agreement, Japanese immigration continued to flourish as a result of these so-called "picture brides." Consequently, a movement to completely prohibit Japanese immigration resulted in the Immigration Act of 1924 [127].

When World War II began, the Japanese in the United States experienced great discrimination. When President Roosevelt signed an executive order in 1942 to permit military authorities to remove any persons from any location without a trial, many of the Japanese who remained in the United States were moved to internment camps in remote areas of California, Arizona, Idaho, Utah, Wyoming, Colorado, and Arkansas [7; 104]. Within six months, more than 120,000 Japanese Americans were sent to relocation camps [7]. After World War II, Japanese immigration resumed, the majority of which consisted of Japanese war brides who married American servicemen stationed in Japan [104].

As of 2019, Japanese Americans are the sixth largest Asian American group, numbering 1.5 million [367; 376]. According to the U.S. Census, they constitute 7.8% of the Asian American population [168]. This group tends to be highly educated, with 52% Japanese Americans and immigrants 25 years and older having a Bachelor's degree or higher [376]. In 2019, 63% of foreign-born Japanese Americans had lived in the country for more than 10 years [376].

The Japanese have coined terms to describe different generations. *Issei* are first generation immigrants, the majority of which having immigrated between 1870 and 1924. Most *Issei* are not very acculturated or assimilated into the United States, preferring to let their American-born children become more acculturated [94]. *Nisei* are the American-born children of the *Issei*, born between 1910 and 1924, making them now senior citizens [94]. This group experienced tremendous discrimination and prejudice growing up in the United States. *Sansei* are the third generation, or children of the *Nisei*. With each generation, they become more acculturated, and each generation becomes more assimilated to the norms of the region in which they were raised [94].

KOREAN IMMIGRATION TO THE UNITED STATES

Korean immigration to the United States occurred in three distinct waves [7; 104]. As with the Japanese and Filipinos, Korean immigrants were initially introduced to Hawaii as laborers. The first wave of immigration occurred between 1903 and 1905, during which time poverty-stricken Korean farmers came to Hawaii as contracted laborers [7]. Similar to the Japanese, "picture brides" eventually joined the laborers [104]. Many of these Korean immigrants came to the United States to seek a haven from the Japanese occupation of Korea [33]. Until 1945, other Korean immigrants included students, exiles, and intellectuals [104]. During this time, immigration to the United States was allotted for only 100 students at any given year [152]. The Immigration Act of 1924 halted much of Korean immigration to the United States.

When the Immigration Act was lifted, the second wave of immigration began between 1951 and 1964 and consisted of Korean War orphans and children adopted by Americans [7]. Additionally, a large number of Korean women married American service men who were stationed in Korea and came to the United States with their new husbands [104]. The third wave coincided with the 1965 Amendment to the Immigration and Naturalization Service Act of 1955. This opened the gates to Korean immigrants, and between 1970 and 1990, the United States witnessed more than 30,000 Koreans immigrating annually [7]. In 1975, Korea was among the top five nations in the world in terms of immigrants coming to the United States [152]. Today, the majority of Koreans living in the United States are from South Korea [248]. In 2012, the Deferred Action for Childhood Arrivals Program (DACA) was implemented.

It allows some individuals who entered the United States as children to defer deportation and become eligible for a work permit. There were 29,000 Korean immigrant youths who were eligible for the DACA program in 2018 [377].

Korean Americans are the fifth largest Asian group in the United States, and as of 2019, they numbered 1.8 million [367; 378]. Because the third wave of immigration was the largest, the Korean American population primarily consists of those who are foreign born [168]. It is estimated that approximately one of every four Korean immigrants arrived in the United States in 2000 or later [248]. Korean children who came with their families to the United States are referred to as "1.5 generation," as they will have been predominantly socialized in the United States [94]. Approximately half of Korean Americans live in California, New York, or New Jersey. An estimated 57% of all Korean Americans and immigrants 25 years and older have attained a Bachelor's degree or higher [378].

Korean immigrants are unique in the sense that they quickly established economic stability in the United States. They are referred to as the "middleman minorities," meaning a group serving as the buffer between a dominant and a subordinate group (e.g., White and Black Americans in the United States) [94]. Upon coming to the United States, Koreans, as middleman minorities, brought with them a high level of education, capital, and skills. They found a niche in small business sectors such as retail shops, serving Korean clientele and other ethnic minority groups [94]. They often rely on family members for labor and financially support new Korean immigrants so they, too, can start small businesses [94]. According to the Pew Research Center, they have the highest rate of self-employment among Asian Americans in the United States. The number of Korean immigrants has not increased in recent years, partially due to the fact that economic conditions in South Korea have improved [290].

SOUTHEAST ASIAN IMMIGRATION TO THE UNITED STATES

Thailand, Cambodia, Vietnam, Laos, Indonesia, Malaysia, Singapore, and Burma (Myanmar) make up most of Southeast Asia. Southeast Asians are the most recent immigrant Asian group to the United States. Each Southeast Asian immigrant subgroup's immigration experience is diverse and is influenced by their homeland's unique sociopolitical factors. This section will focus primarily on Vietnamese, Cambodian, and Laotian immigrants and refugees. These groups share the common experience of leaving their homelands due to repressive political regimes [33]. They are assigned the status of refugees because they fled their homeland for reasons of survival and safety during a politically unstable and corrupt government, and to return to their homeland would mean persecution [94].

Vietnamese Immigration

The French occupied and colonized Vietnam in the years between 1883 and 1954 [33]. During World War II, the Japanese occupied Vietnam as well, and Ho Chi Minh, a Communist leader, organized a movement to fight the Japanese and oppose French occupation [94]. However, when the war ended, the French resumed their rule and reoccupied Southern Vietnam, while Ho Chi Minh and his movement took over Northern Vietnam [33]. Civil war continued despite efforts to reunify the country. China and the Soviet Union provided aid to communist Northern Vietnam, while the United States entered helping Southern Vietnam [33].

Millions of Vietnamese were uprooted as a result of the war, and in 1975, the first wave of refugees was airlifted out of South Vietnam, seeking haven in the United States [104]. This first wave of refugees consisted predominately of well-educated, middle-class professionals who left Vietnam because, under Communist regime, they would have faced negative repercussions [94]. When they arrived in the United States, they were initially placed at various camps, and once sponsors were found, they were dispersed throughout the country [33].

The second wave, between 1975 and 1978, was comprised of family members of the first wave of Vietnamese refugees [33]. They fled because they, too, were at high risk, having fought for South Vietnam or having been associated with the United States [33]. Finally, the third wave occurred between 1978 and 1980, comprised mostly of "boat people," who were ethnic Chinese from Vietnam who faced persecution [33].

Based on 2019 U.S. Census data, Vietnamese are the fourth largest Asian group in the United States, numbering 2.1 million [367; 379]. It is predicted that by 2030 this number will grow to 4 million, potentially making them the second largest Asian American subgroup in the United States [28]. An estimated 39% of Vietnamese immigrants live in California; 13% reside in Texas [309]. These immigrants tend to have lower educational attainment than other Asian immigrant groups, with 32% of Vietnamese Americans and immigrants 25 years of age and older having earned a Bachelor's degree or higher [379].

Cambodian Immigration

Cambodia is a country nestled between Thailand, Laos, and Vietnam. The term "Khmer" refers to the language and the dominant ethnic group in Cambodia [7]. Cambodia was deeply affected by U.S. military assistance to South Vietnam. Covert bombings in the Eastern part of their country with the purpose of destroying communist supply routes and camps resulted in many deaths and left many Cambodians homeless [7]. In 1975, after the fall of Saigon in Vietnam, the Cambodian government fell into the hands of the Khmer Rouge, a communist regime led by Pol Pot [7]. Between 1975 and 1979, Pol Pot led the country by use of force, intimidation, persecution, and torture. Using Maoist principles, Pol Pot placed the Khmers under forced labor [121]. Pol Pot wanted to purge the country of individuals perceived to be enemies (e.g., those who were influenced by Western norms, including former government officials, intellectuals, doctors, professionals, artists, dancers, members of the royal family, and Buddhist monks) [121]. Those who were not instantly killed were sent to forced labor camps, where they experienced hunger, torture, beatings, and indescribable inhumanities [121]. It is estimated that approximately two million Cambodians, mostly from the wealthy and/or educated classes, died during this period [7].

When the Khmer Rouge regime fell in 1979, masses of Cambodians fled to neighboring Thailand, and others fled to the United States, Canada, Great Britain, France, and Australia [121]. In 2019, there were 339,000 Cambodians in the United States [380]. The majority (84%) of foreign-born Cambodians have lived in the country for at least 10 years, and 63% of all Cambodians 5 years and older report being proficient in English. Only 16% of Cambodian Americans and immigrants 25 years of age and older have earned a Bachelor's degree of higher [380].

Laotian Immigration

Laos was also deeply affected by the war in Vietnam. Because the Ho Chi Minh trail, a supply line for North Vietnam, ran across eastern Laos, Laotians became involved in the war [94]. The Hmong, an Asian ethnic group whose homeland includes mountainous areas of Laos, became a counterguerrilla force, aiding the United States by rescuing American personnel [94]. When the United States left Vietnam, many Hmong fled for Thai border camps, the United States, and France [94]. In 2019, there were 254,000 Hmong individuals in the United States [381]. This group tends to experience more poverty than other Asian subgroups. The poverty rate is 13% for this group, compared with 10% for all Asians in the United States [381].

ASIAN INDIAN IMMIGRATION TO THE UNITED STATES

Asian Indian immigration can be traced back to the mid-1800s, when they came and settled in California. These immigrants were primarily farmers [7; 104]. Due to open hostility and discrimination, many left to return to India. Some of those who did stay married local Mexican immigrants [104]. There was minimal Asian Indian immigration between 1917 and 1965 due to the Immigration and Naturalization Act, which placed quotas on the amount of Asian immigrants coming into the United States. In 1965, when an amendment altered immigration policy, race was less of a determinant for entering the United States. Instead, immigrants' skill sets and potential to contribute to the economy became the primary criteria for entrance [104]. Therefore, the second wave of Asian Indian immigration was comprised largely of professionals such as engineers, technicians, and physicians. The third wave occurred after the Family Reunification Act of 1990, which served to reunite family members and relatives of those immigrants who had already come to the United States. This third wave of Asian Indian immigrants was sponsored by family members who had already immigrated to the United States. Unlike their family members who came in the second wave, this third wave of immigrants were generally not as highly educated, had lower English proficiency, and lacked highly technical or professional skills [104]. Upon settling in the United States, many opened small businesses or entered vocational trades [104].

As of 2019, Asian Indians are the second largest Asian American group in the United States, with a population of 4.6 million [382]. The majority (54%) are relatively recent immigrants, having come to the United States between 1990 and 2000. Asian Indians are one of the largest groups to obtain H-1B temporary visas, which allow employers to hire workers from outside the country to enter the United States for highly skilled and specialized jobs [311]. They account for 71.7% of H-1B visas [370]. In 2019, 75% of Asian Indian Americans and immigrants 25 years of age and older had a Bachelor's degree or higher [382].

MENTAL HEALTH AND PSYCHOSOCIAL ISSUES IN THE ASIAN AMERICAN AND IMMIGRANT COMMUNITY

PREVALENCE OF MENTAL DISORDERS

Only a handful of large-scale, federally funded epidemiological studies have been completed using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to establish prevalence rates of psychiatric disorders. Smaller scale studies using nonprobability sampling designs do not provide overall prevalence or incidence rates. However, they do provide a glimpse of a phenomenon at any given point in time within a specific population. In the following sections, some major psychiatric disorders among the different Asian American subgroups will be reviewed. It is impossible to cover every psychiatric diagnosis and every configuration of Asian American subgroups. The goal of this section is to provide a brief overview.

Mood Disorders

Depression is a common psychiatric disorder. It is estimated that between 5% and 10% of adults in the United States experience severe depression in any given year, and an additional 3% to 5% suffer from mild forms of depression [88]. The Epidemiologic Catchment Area (ECA) study and the National Comorbidity Study (NCS) examined mental health needs and prevalence rates of psychiatric disorders in the United States [172]. Both research studies placed all Asian American/Pacific Islander subgroups together into one large category, and the final sample sizes were small. As a result, it was difficult to discern with more specificity who actually participated in the study [172]. However, researchers have begun to acknowledge the role of culture in mental health and recognize that there is tremendous diversity within Asian subgroups.

In the United States, prevalence estimates for depression among Asian Americans and immigrants have varied. A meta-analysis of 58 studies found that the prevalence rates ranged from 4.5% to 11.3% among adults [292]. In a large-scale study conducted in Los Angeles focusing on 1,700 Chinese Americans and immigrants, the researchers found that approximately 7% of the respondents disclosed experiencing depression during their lifetime, and about 3% stated they were depressed in the past year [163]. These prevalence rates are much lower compared to the rates of depression in a national epidemiological study, which found a lifetime prevalence rate for the general population of 16.2% and 6.6% for the last 12-month period [87]. A study with 487 Chinese American adults found a lifetime prevalence rate of 18.3% for major depression disorder and a past-year rate of 7.2% [293].

Other studies have utilized self-reported measures such as the Center for Epidemiologic Studies Depression Scale (CES-D). The CES-D is a popular and well-validated 20-item instrument measuring depressive symptoms. Typically, the clinical cutoff score of 16 or greater signifies clinical depression [144]. One study found that 19% of the study sample of Asian Americans reported depression [100]. Oh, Koeske, and Sales found a 40% rate of depression in a Korean immigrant sample in the United States [131]. They also found that those who were more acculturated experienced less acculturative stress, which in turn was associated with lower levels of depression. In another study of 121 Vietnamese American college students, 34% of the sample reportedly experienced depression [133]. A 2017 study found that among a sample of 1,639 Asian immigrants, about 8% of women and men reported experiencing major depression during their lifetimes [312]. Acculturative stress stemming from legal issues and discrimination was correlated with depression, even after controlling for demographic variables. Specifically, acculturative stress stemming from discrimination, seeking employment, having an accent, and feeling isolated and disrespected contributed to poorer mental health. Depression is also correlated with lack of health insurance, lower neighborhood cohesion, and having a language-discordant healthcare provider, and these variables may also be related to acculturative stress [383]. In general, southeast Asian Americans have the highest levels of depression (19%); specifically, Cambodians reported the highest prevalence (39.1%). Conversely, east Asian Americans report the lowest rates (9.3%), with Japanese Americans being the least affected (3.3%) [383].

A 2010 study examined the 12-month antidepressant use for major depression among Asian Americans [253]. Asian Americans had an antidepressant usage of 10.9%, compared with 32.4% of non-Hispanic Whites. The percentage varied by ethnic subgroup, with 8.7% of Vietnamese Americans and 17% of Chinese Americans reporting previous year antidepressant use.

A meta-analysis study found that how one measures acculturation is crucial [294]. When acculturation is defined as adopting the values of the new culture, depression is less likely. Asian Americans who were more acculturated to their host country's values experienced less depression than those with lower levels of acculturation. Situational factors will contribute to depression as well.

According to the American Academy of Child and Adolescent Psychiatry, common patterns of symptomatology displayed by children from diverse populations can differ significantly from those in Euro-Americans due in part to the influence of their culture. For example, emotional reactivity during depression is greater in Asian-origin individuals than in whites.

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Strength of Recommendation: Expert Opinion/ Consensus Statement

A large-scale study of 1.3 million participating adults was conducted by the U.S. Census Bureau to screen for depression and anxiety during the COVID-19 pandemic and related isolation and lockdowns [384]. Adults were four times more likely to screen positive for depression and anxiety in 2020 compared with 2019 [384]. By summer 2020, depression and anxiety had increased the most for Asian Americans, which corresponded to COVID-19 cases rising, increasing instances of violence against Asian Americans, and the racial protests [384].

Schizophrenia and Psychotic Disorders

Schizophrenia is a debilitating psychiatric disorder that can be difficult to treat. The tremendous stigma associated with this disorder seems to be greater than other psychiatric disorders and can elicit feelings of shame and guilt among family members. This is particularly the case with Asian families, who traditionally believe that private matters should not be shared outside the family and that psychiatric disorders are shameful and reflect on the entire family system. Thus, they often delay seeking psychiatric services until a crisis state has been reached [151].

Understanding the prevalence of schizophrenia among Asian Americans and immigrants is difficult, as there are no large-scale epidemiologic studies. The 1984 ECA study, sponsored by the National Institutes of Health, was hailed as the first to examine prevalence rates of psychiatric disorders. However, researchers did not actively sample or recruit Asian American groups and, therefore, whatever data was collected could not be adequately analyzed. It is feasible to examine studies conducted in Asian countries, and although it is not possible to generalize findings from these countries to the United States, they may offer a slight glimpse into the phenomenon of schizophrenia and the experiences of Asians [104]. For example, in the mid-1980s, a study conducted in Taiwan with 11,004 respondents from urban and rural areas found an overall lifetime prevalence of schizophrenia of 0.27% [104]. Around the same time, another study was conducted in urban and rural areas in Korea. A total sample of 5,100 participants was included, and the lifetime prevalence rate was 0.47% [104]. A 2014 study using data from the Second China National Sample Survey on Disability indicated that 0.37% of Chinese men and 0.44% of Chinese women had schizophrenia [295]. In China, several studies have been done with different Chinese ethnic groups including the Han Chinese, Baima Tibetans, and Uygurs, with lifetime rates ranging from 0.19% to 0.47% [104]. The lifetime prevalence of schizophrenia in China is 0.54%, which is higher than 46 other countries [313]. In a systematic review focusing on South Asian Indians and schizophrenia, rates ranging from 0.04% to 0.2% were identified, with limited research [385].

Post-Traumatic Stress Disorder

Many Southeast Asians have experienced tremendous amounts of trauma and many hardships ranging from having been displaced from their homes to being imprisoned in forced labor camps and separated from family members. Some have witnessed their family and friends executed and raped; many were tortured. At labor camps, many suffered from starvation and received no medical care. In 2005, a large-scale study funded by the National Institute of Mental Health (NIMH) was conducted in California, where a high proportion of Cambodians reside. Researchers found that this population experienced highly traumatic and inhuman atrocities during the Khmer Rouge regime [126]. Of the 35 types of traumas assessed, 99% of the sample reported they nearly starved to death, 96% were forced into labor camps, 90% had a family member murdered, and 54% were tortured [126]. These figures are not unique, as other studies have also found that Cambodian refugees experienced great suffering during the Khmer Rouge era. A study conducted by Blair found that, in a sample of 124 adult Cambodian refugees in Salt Lake City, Utah, the average number of war traumas each individual experienced was 20.1 [24]. A large majority (85%) stated they lost at least one relative during the Khmer

Rouge era; 78% lost more than one family member; and 62% were displaced to work camps and were there for at least six months [24]. While at these war camps, 39% were beaten, witnessed a family member being beaten, or both. These experiences place many Southeast Asian refugees at risk for a range of psychiatric disorders, including post-traumatic stress disorder (PTSD). PTSD is a specific disorder, falling under the general category of anxiety disorders [38]. Re-experiencing the traumatic event in the form of flashback is common, and other symptoms include increased arousal, anxiety, guilt, exaggerated startled responses, and sleep difficulties [38]. PTSD is common among war veterans, disaster survivors, and other trauma victims [38]. One study found that 56.4% of Cambodian refugees who were exposed to the genocide had PTSD [204]. The researchers noted that the severity of the PTSD symptoms was significant given the amount of time that had lapsed between the genocide and the study participation.

The NIMH-funded study found that 62% of the Southeast Asians in the sample had suffered from PTSD in the last year [126]. Another study utilizing a sample of 322 Southeast Asian clients/patients at a psychiatric clinic, found that 70% were diagnosed with PTSD [93]. In a community-based study, Carlson and Rosser-Hogan randomly selected from the 500 Cambodian refugees who settled in Greensboro, North Carolina, between 1983 and 1985 [29]. The resultant sample was 50 Cambodian men and women. They found that 86% of the Cambodians in their sample met the modified criteria of the DSM-III-R, the most current DSM at the time, for PTSD and 80% were clinically depressed. However, Kroll et al. found a much lower rate of 14% for PTSD among a community clinic sample of Southeast Asians, including Hmong, Cambodians, Laotians, and Vietnamese [98]. Some of these discrepancies are due to differences in the instruments utilized to assess for PTSD.

In a study to help differentiate and identify factors that may lead to the development of PTSD, Abe, Zane, and Chun compared a group of 154 Southeast Asian refugees who were diagnosed with PTSD and 440 Southeast Asian refugees who were not diagnosed with PTSD [1]. Both groups shared similar trauma histories and demographic backgrounds. Results indicated that the PTSD group was much more likely to experience and express verbal and physical anger, were more likely to rely on public assistance, and were less likely to remain engaged in their cultural traditions and ties compared to the non-PTSD group. Interestingly, anger was the most powerful predictor of PTSD. Expressing direct emotions, such as anger, is not culturally congruent among Southeast Asians [36]. It is possible that the cultural dissonance exacerbated pre-existing stressors. In another study with 378 Cambodian mothers, 21.7% were diagnosed with PTSD and 8.5% of offspring were also diagnosed with PTSD [314]. However, maternal traumatic exposure did not predict PTSD among the children.

Anger can trigger traumatic recall, and much of Cambodian refugees' anger is directed at family members such as spouses and children [255]. Given this, a 2009 study examined factors that evoked Cambodian refugee individuals' anger and how this was related to PTSD [255]. Cambodian refugee adults reported being angry at their spouse for infidelity, continual nagging about unemployment, and not taking care of household chores. They were angry at their children when they were disrespectful and disobeyed curfews. This anger triggered somatic panic symptoms. Trauma recall symptoms (e.g., flashbacks) then followed for many of the study participants.

In another study by Blair, resettlement stressors experienced by immigrants living in the United States were associated with PTSD and particularly depression [24]. Cambodian refugees who, in their first year in the United States, were diagnosed with major depression rated many more resettlement stress factors, particularly financial stress, compared to Cambodian refugees who did not have major

depression [24]. Blair concluded that psychiatric disorders may not always be immediate but can have a long-lasting effect, potentially triggered by current stressors. Changes in lifestyle and the process of adaption can cause many worries [256]. The stress of worrying can generate psychopathology among individuals who have a trauma history. In the case of 201 adult Cambodian refugees, the top three reasons given for their worry were financial (e.g., lack of money), concerns about children (e.g., school performance, gang involvement), and health concerns. These worries triggered panic attacks, which then resulted in catastrophic beliefs and recall of trauma, including flashbacks.

In a study of 97 North Korean women who defected to a third country (e.g., China, Thailand, Cambodia), the women were found to be vulnerable to forced prostitution, extreme poverty, forced marriages, and sexual abuse, which increased their PTSD symptoms [296]. In addition to using a common instrument to measure PTSD, this study also examined their levels of cytokine, a stress hormone. The women in the sample had much higher levels of cytokine—2.5 times the normal value [296]. A large-scale study with 16,032 Chinese adults in Beijing, China, found that 0.3% met the diagnostic criteria for PTSD [315]. Variables that predicted PTSD included older age, low educational level, urban residence, unemployment, and farming occupation.

Over the years, the issue of whether PTSD is a culture-specific disorder has been controversial. In a study of 643 survivors of the 2004 tsunami in a southern state of India, researchers found that 15% had post-traumatic stress symptoms but did not necessarily meet the diagnostic criteria of PTSD [297]. Avoidance is one criterion for PTSD diagnosis, but avoidance is not a coping strategy among this population, with many study participants relying on family, social, and spiritual coping resources [297].

The COVID-19 pandemic also increased discrimination-related stressors for Asian Americans. In an online survey of 221 Asian immigrant and Asian American young adults, 15% reported experiencing verbal and/or physical assault as a result of COVID-19. PTSD symptoms were correlated with COVID-19-related discrimination after controlling for pre-existing mental health disorders [364].

Alcohol and Substance Use Disorders

In general, alcohol consumption rates among Asian Americans are lower than the overall general population. The lifetime prevalence for alcohol use disorders is 15% for Asian American adults, compared with 32.6% for White American adults [386]. This is in part due to Asian cultural beliefs regarding drinking in prescribed social situations. For example, drinking is viewed as a sign of prestige in certain cases, such as business social settings, when refusing a drink would be considered an affront [257].

The lifetime alcohol use rate is 85% among the general U.S. population [115]. When comparing Asian American groups, Japanese Americans have the highest alcohol usage, while Chinese Americans have the lowest [186]. In a study conducted in California in the 1990s, 69% of Japanese Americans, 49% of Korean Americans, 38% of Filipino Americans, 36% of Vietnamese Americans, and 25% of Chinese Americans reported consuming 10 or more drinks in their lifetime [186]. In general, Asian men tend to use alcohol more than women. In a study of Filipino Americans conducted by Lubben, Chi, and Kitano including 145 men and 85 women in Los Angeles, 80% of men were found to be heavy drinkers, while 50% of the women tended to be abstainers [111]. The researchers concluded that these gender differences stemmed from traditional gender roles, which prescribe drinking as more socially acceptable among men.

However, research conducted with college populations differs. In a 2006 study, consisting of 248 Asian American college students attending an Asian American and Pacific Islander leadership conference, lifetime alcohol usage prevalence was 94.5% [205]. For the past 30 days, the prevalence rate was 78.6%. The lifetime prevalence rate for illicit drug use was 37%, with a past 30 day usage rate of 9.5% [205]. In a 2014 study with 258 Asian American college students, 17.7% of men and 8.9% of women were found to have alcohol use disorders [298]. In general, Chinese and Vietnamese male college students were more likely to have alcohol problems than their female counterparts, but this trend was reversed among Korean students (33% of women and 11% of men) [298]. In one study, 37% of Asian American young adults fell in the category of high-risk and monthly binge drinkers [387]. Fraternity or sorority membership was correlated to higher risk drinking.

Traditionally, Western Europe and North America have had higher alcohol consumption rates compared to Asia, but alcohol consumption rates in Asian countries are becoming more comparable to Western countries [206]. A telephone survey in Hong Kong with a random sampling of 9,860 Chinese adults found that among adult men, 14.4% were classified as binge drinkers, 5.3% abused alcohol, and 2.3% were alcohol dependent [206]. Among women, the figures were much lower. The survey determined that 3.6% of female participants were binge drinkers, 1.4% abused alcohol, and 0.7% were dependent on alcohol.

Level of acculturation also appears to play a role in alcohol and substance abuse among Asian Americans. In one meta-analysis, level of acculturation predicted alcohol use [316]. It appears that higher levels of acculturation are associated with higher levels of drinking. Some speculate that as immigrants become more acculturated, they are more influenced by norms in the United States that emphasize individualism and self-expression. Enculturation, or the adherence to traditional Asian norms and lifestyle, appears to be protective against problematic alcohol use [316]. The extended family system becomes less of a primary focus [156]. In a study by Hahm, Lahiff, and Guterman using a dataset from the National Longitudinal Study of Adolescent Health including 714 Asian American adolescents, they found that Asian American adolescents who were more acculturated were more likely to binge drink [67]. However, the pathway is not as simple or linear. Their study showed that peer association with drinking mediated this relationship. In other words, if their best friend used alcohol and tobacco, then the relationship between acculturation and drinking no longer existed. Researchers in this study concluded that acculturation did not necessarily lead to or cause drinking as there are some complex social processes regarding group norms [67]. Even this factor may not be uniformly applied to all Asian subgroups. For example, Hendershot, Dillworth, Neighbors, and George found there was a relationship between acculturation and alcohol drinking behavior among Korean young adults but acculturation was negligibly related to Chinese young adults' drinking behaviors [258].

Historically, Asian American and Pacific Islanders have lower substance use rates and lower admissions rates to substance treatment services. Asian Americans are more likely to identify language barriers as a reason for low utilization of alcohol and drug use disorder treatments [388]. However, this may be changing. Between 2000 and 2012, Asian Americans and Pacific Islanders had the greatest increase in substance treatment admissions to public-funded treatment centers among all racial/ethnic groups [317]. This increase was linked to prescription opioids and homelessness [317].

In a study of 2,744 Korean youths, a total of 12.6% of adolescents and 21.2% of university students reported having ever tried e-cigarettes [318]. Among e-cigarette users, almost all (95% and 96%, respectively) reported having also used conventional cigarettes. Factors that increased the likelihood of cigarette use included male sex, having friends or siblings who smoked, and having observed a teacher smoke. Generally, smoking seems to be decreasing;

however, a study in New York City found that the prevalence of smoking was greater among Asian American men (23.5%) compared with the general male population (17.5%) [389]. English speaking predicted lower rates of smoking, while Chinese speaking predicted higher rates [389]. On a college campus, a group of 412 Vietnamese students were surveyed about their use of cigarettes and/or marijuana [183]. Only 11% of the Vietnamese students reported they were current smokers; less than 10% stated they had used or tried marijuana during their lifetime. However, more acculturated students were more likely to smoke than their less acculturated counterparts. Furthermore, students who were raised primarily in the United States were more likely to smoke cigarettes than those who were raised mostly in Vietnam or equally in Vietnam and the United States [183]. In a study of 207 Chinese college students, 49.3% were considered social smokers [319]. Social smokers were at increased risk of depression and were less likely to quit.

Some have proposed that other factors associated with immigration, such as feelings of marginalization and isolation and experiences with discrimination and prejudice, are related to alcohol use and even cigarette use. Therefore, given all the war atrocities Southeast Asian refugees have experienced, this may be a highly vulnerable group for alcohol abuse [115]. As discussed earlier, depression and PTSD are prevalent, and substances like alcohol are frequently used to alleviate these symptoms and traumatic memories. It is also important to understand how the client/patient perceives the substance, as many Southeast Asians do not view alcohol as a drug; rather, they consider it a healing agent [115]. Furthermore, Asian Americans who reported experiencing high levels of racial discrimination were more likely to be current smokers compared to Asian Americans who reported no racial discrimination. Those who stated they experienced high levels of unfair treatment were 2.62 times more likely to be a current smoker compared to those who did not experience unfair treatment [207].

Acculturation may also influence smoking behaviors. Studies have found that higher levels of acculturation are related to greater nicotine and illicit substance use among Asian Americans. Those who are assimilated along several domains (i.e., separated, partial bilingual/bicultural, English dominant/Asian oriented, full bilingual/bicultural, and assimilated) have the highest usage of nicotine and illicit drugs compared with those with lower levels of acculturation [299]. However, in a 2018 study, acculturation level alone did not correlate with substance abuse [390]. Instead, the researchers found that the dimensions of acculturation were essential. For example, having weak ties with one's own ethnic community was associated with an increased likelihood of substance use disorder.

In terms of substance abuse service utilization, researchers have found that among those who had been admitted to substance abuse treatment services, those who identify as Asian have a low likelihood of a second admission compared to other racial and ethnic minority groups [300]. This may be the reflection of treatment efficacy or, perhaps more likely, patients finding services to be unhelpful and culturally insensitive [300].

Ja and Yuen advocate for culturally sensitive treatment for Asian substance users [104]. For example, 12-step programs have been tremendously beneficial for many; however, their emphasis on public disclosure and acknowledgment of a substance abuse problem is not culturally congruent with Asian values of emotional inhibition and privacy issues [104]. They argue for a model that incorporates the following factors into the delivery of substance abuse treatment and services: a one-stop service center, involvement of the family, accessibility of nonstigmatized services, and extensive contact with the client's/patient's support network [104].

ACCULTURATIVE STRESS: EMPLOYMENT AND GENDER ROLE REVERSALS

Typically, many immigrants leave their familiar surroundings and family in hopes of a better life. Yet, on a short-term basis, the immigration and adjustment processes are very stressful and often have ramifications on overall family dynamics and individual well-being. Immigration is associated with numerous life changes and adjustments for the immigrant, including economic changes (e.g., unemployment or underemployment); changes in social supports and networks; adjustment to new customs, the environment, and nutrition differences; and acquiring new language competencies and life skills [18]. Typically, those immigrants coming to a more developed country will experience a more difficult adjustment process [157]. Immigrants with children experience a more pronounced need to navigate between two cultures. Children will often be the first to experience the contrast in norms, values, and behaviors in school settings and with peers. They may acculturate more quickly than their parents, which could produce family stress and feelings of isolation between parents and children [208]. A focus group of 22 Chinese immigrant parents found that differences in Western and Chinese cultural practices at home and at school were predominant stressors [320]. Discrepancies in English language skills among Chinese immigrant parents and children can also promote stress [320]. Parents may also rely on children to help them navigate their new environment and to interpret. This can unwittingly produce challenges in role boundaries.

Obtaining employment upon arrival is vital to survival, but it is difficult for many immigrants due to lack of training, limited English proficiency, different licensing requirements, discrimination, and lower educational level [260]. In a study conducted by Mangiafico, unemployment and underemployment were pronounced in a Chinese immigrant sample [116]. Despite their high levels of education, Chinese immigrants found that securing employment was difficult upon arrival in their new host country. More than half (65.3%) of the Taiwanese immigrants in the sample, 25% of the Hong Kong immigrants, and 17.6% of the immigrants from mainland China had four or more years in college. However, during the period of the survey, one-third (33.8%) of the immigrants from mainland China were unemployed although only 3.4% were unemployed in their homeland. Though not as drastic, Taiwanese immigrants showed similar trends; one-fifth (20.4%) were unemployed in Taiwan, but approximately one-third (32.7%) were unemployed in the United States [116]. In a 2014 ethnographic study with 15 Korean immigrant women who immigrated to Canada, the participants discussed the challenges with employment upon settling into their host country [301]. Most were professionals in Korea but found themselves in low-skilled jobs such as cleaners, kitchen helpers, and cashiers in Canada. Despite the challenges of underemployment, their jobs helped them to improve their English, which they believed was vital to their survival [301]. Not only is employment essential for survival, but employment is tied to sense of self. For immigrants, this is even more significant because many left everything familiar in order to improve their socioeconomic status [260]. Ultimately, this has negative health and mental health effects.

Shifts in family dynamics and gender role reversals often result upon immigration. It has been noted that many rules and values that were once endorsed and deemed effective in an immigrant's homeland are no longer effective in the new host country [155]. Family rules dictate the overall functioning of the household, behaviors and dynamics between family members, and family roles. Family rules can implicitly prescribe and sanction gender roles; that is, which family member assumes the breadwinner position and which family member fulfills nurturing responsibilities. In many cases, unskilled jobs are more readily accessible to immigrant women than to immigrant men, thereby challenging family structure and roles [155]. Consequently, female immigrants' private and public statures are often enhanced due to immigration [153]. Many female immigrants, for example, join the labor force more quickly than male

immigrants, and female immigrants earn more than men in the early years of immigration [153]. As a result, many female immigrants experience elevated status and greater visibility in their new host country compared to that in their homeland [153]. For some, these drastic changes produce family conflict [155].

In a 2011 interview study with 30 Iranian immigrants to Canada, men discussed difficulties adjusting to their wives' new freedoms in their new country. They also reported feeling their identities of being "good husbands" were threatened because they could no longer provide for their families adequately [261]. In a study of Asian Indian women who came to study in the United States, participants reported having an expectation of greater freedom. However, they often found themselves under the supervision of distant relatives in order to maintain traditional gender role expectations [321]. In Vietnamese families, women often were required to enter the labor force to ensure economic survival. In many cases, it was the women who became the primary breadwinners, because low-skill jobs such as maids, food service workers, and housecleaners were more readily available for women. However, the logistics of caring for a household can also impede Asian American women from entering the labor market. Based on data from the 2009–2011 American Community Survey, Asian immigrant women who lived in extended households (e.g., with a mother or mother-in-law) were more likely to work outside the home [391].

There can be negative family consequences as a result of women's paid labor participation. Service providers, for example, revealed that extreme family problems such as violence tended to occur when men felt they were unable to fulfill their traditional responsibilities in caring for their families. These men were often reluctant to accept menial jobs because it signaled a status loss, and with no other recourse, their wives often had to assume the role of breadwinners [60]. Asian men who immigrate later in life often report difficulties obtaining employment as a result of lower English proficiency. This affects social position and is counter to traditional Asian values and is correlated with higher levels of acculturative stress [392].

Another ethnographic study with Vietnamese immigrant families found similar patterns of redefinitions of patriarchal gender relations [89]. In order to ensure economic survival, patchworking was a strategy employed by many Vietnamese families. This strategy involved combining resources from all family members, and the "patchwork" of these collective resources promised a greater likelihood of economic survival in a new country. According to Kibria, the process of immigrating to the United States and the strategy of patchworking resulted in families negotiating new family rules such as gender roles and relations [89]. Because Vietnamese men were periodically or chronically unemployed, women had to step in to contribute to the household's income. This resulted in a shift in power, which challenged traditional authority, an integral characteristic of Asian family structure. Family conflict is often a direct consequence [89]. Any time established family hierarchies are disrupted due to one family member (e.g., child or wife) being perceived to have more power (e.g., access to language or resources), it is inevitable that the boundaries in a family will change. These changes could produce conflict, resulting in mental health and behavioral changes [208]. Acculturative stress often stems from culture conflict [393]. For example, South Asian women who lived in Canada for at least two years often reported acculturative stress due to intergenerational conflict at home [393].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Academy of Child and Adolescent Psychiatry notes that differential acculturation is a predictor of negative mental health consequences for youth, such as school difficulties, gang involvement, depression, and suicidality, in some Asian-American families.

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Strength of Recommendation: Expert Opinion/ Consensus Statement

CULTURE-BASED SUBJECTIVE EXPERIENCES: CONCEPTIONS OF MENTAL ILLNESS

Terminology

Castillo maintains that cultural meaning systems shape clinical reality. Cultural meaning systems are cognitive structures that influence how individuals in society perceive or view social phenomena [31]. Presentation of symptoms does not exist in a vacuum; rather, they represent complex layers of meanings. Good and Good observed that symptoms or illnesses "represent a network of meanings for the sufferer: personal trauma, life stresses, fears and expectations about the illness, social reactions of friends and authorities, and therapeutic experiences" [63]. Consequently, cultural meaning systems can shape clinical reality in two ways: through culture-based subjective experiences and through culture-based idioms of distress. Cultural belief systems influence how mental illness is viewed, and these perceptions will then influence behaviors. The next section will focus on idioms of distress, which are the ways in which individuals behave to express that they are ill and how this is culturally congruent to their belief systems [31].

In Western societies such as the United States, alcoholism is viewed primarily as a disease. However, it is not clear how other cultures view alcoholism. It is possible that alcoholism can be viewed as a culturally specific disease, meaning that the concept of "alcoholism" may emerge in different forms in different societies [34]. Even the terms used and their definitions will influence conceptions of illness. In Korean, the term for alcoholism literally means "being poisoned by alcohol" [34]. The word "poison" is obviously biased and will, therefore, influence conceptions of alcoholism among Koreans. In Cho and Faulkner's study, they compared conceptions of alcoholism among Koreans and White Americans [34]. Their findings showed that both samples viewed alcoholism as a disease, although the proportion of Koreans defining alcoholism as a disease was lower than that of White Americans. Using a vignette describing a Korean man with behaviors from the Michigan Alcoholism Screening Test (MAST), nearly all of the Americans stated the man in the vignette was an alcoholic, but only three-quarters of the Korean sample came to the same conclusion. Finally, Americans in the sample were more likely to attribute interpersonal and other social problems (e.g., family problems) as consequences of alcoholism while the Koreans did not. According to Cho and Faulkner, in Korean language there are two terms for "alcoholic" [34]. One means heavy drinker, but these individuals behave well and do not cause any troubles. There is another term for those who drink heavily and engage in negative behaviors.

Clearly, the meanings of terms utilized by particular groups affect cultural meaning systems, which then color clinical reality. In some cultures, there are no direct translations for psychiatric terms commonplace in the United States. For example, in the Pakistani language (i.e., Urdu/Punjabi and Mirpuri), the word "mental" is employed, but when translated, it means "lunatic" or "mad or crazy person" [176]. Similarly, in Vietnamese, mental illness is often labeled as *khung dien* or "crazy" [302]. Unlike in English, in which there are psychiatric terms that connote different degrees of severity and dysfunction (e.g., psychosis is much more severe than dysthymia, a chronic form of depression), in Pakistani culture, "mental" is negative and an individual may be hospitalized regardless of clear cutwhether he/she has dysthymia or a psychotic disorder [176]. In Vietnamese, the word "depression" is not defined as an emotional disorder as in Western society. Rather,

depression is defined in terms of discouragement, sadness, and sorrow [166].

Similarly, some cultural groups might not use the term "depression" or "sad," relying rather on metaphors or symbolisms that may be embedded in cultural ideologies. For example, South Asians may use the term "sinking heart" or "the heart falls" to mean distress or sadness [209]. In an in-depth ethnographic interview of 17 Korean women, a recurrent theme that emerged was Korean women's feeling of emotional entrapment [210]. They tended not to discuss depression in emotional terms; rather, they spoke about feelings of being clogged up in their chests and feeling trapped. They talked about their depression in bodily or somatic terms using metaphors. In Western culture, when professionals hear the word "heart" they might assume the client is referring to cardiovascular problems and would not think to assess for mood disorders [209]. Similar findings were noted in an ethnographic study conducted with 43 Chinese patients in Guangzhou, China, in which the use of the term "heart" was an expression of affective distress. Interestingly, even the Chinese character for sadness is the character of heart [211].

Similarly, the word "schizophrenia" in Chinese is interpreted as meaning "catastrophe of the mind" [92]. Because the Chinese lexicon is utilized in many Asian countries, this meaning ultimately influences how mental illness, particularly schizophrenia, is conceptualized in Asia [92]. In Japan, the term literally translates to "split-mind disease" and the word "split" conveys "catastrophic disorganization" [92]. Again, these terms are highly stigmatizing. However, there has been effort to reduce societal misconceptions by using different terminology. For example, in 2002, the Japanese term *togo-shicchosho* was adopted, which means integration disorder [322; 394].

Notions of Etiology

The communication of information about mental illness and notions about what causes it are also influenced by a cultural framework. It is important for professionals not to dichotomize causal factors into science and superstition. It would be simple to merely assume that Western notions about mental illness are rooted in science and natural or organic causes while other cultures' belief systems about mental illness are rooted in magical beliefs and/or supernatural forces [50]. However, this is simplistic.

Young asserted that a typology classifying explanatory models of illness, based on externalizing and internalizing systems, is helpful in understanding belief systems about the etiology of illness [50]. Internalizing belief systems include assumptions about equilibrium such as hot/cold balances; beliefs about a dynamic relation between parts; internal equilibrium that is organic; or a reduction of the wholeness of an individual, such as soul loss [50]. On the other hand, externalizing explanatory systems of illness reflect the notion that pathogenic agencies are rooted in specific circumstances or individuals, who are believed to be responsible. An individual believed to hold a grudge or an ancestor who is believed to be angry are examples of externalizing explanatory systems [50].

In a focus group study with Korean American immigrants, participants attributed the development of depression to environmental stressors, such as stress emanating from immigration, language problems, and changes in socioeconomic status [262]. In a qualitative study of 10 Asian Indian women in the United Kingdom regarding their perceptions and beliefs about depression, externalizing attribution systems were found to color the women's worldviews [80]. One major theme that emerged was the belief that spiritual problems or issues could lead to physical and emotional symptoms. This was primarily attributed to spiritual causes such as the evil eye, spirit possession, or black magic [323]. The overlap of emotional and physical symptoms was

very confusing to these women; some attributed the depressive symptoms to spiritual factors, while others acknowledged the role of social factors such as marital problems, social isolation, and acculturative stress. Typically, the women in the sample would identify a primary cause of the depression and then attempt to interpret a secondary cause; however, it was the primary cause that would dictate the type of treatment sought. So, if the primary cause was spiritual in nature, they would consult with religious healers [80].

Other Asian groups, including the Chinese, Filipinos, and Southeast Asians, frequently attribute organic factors to psychiatric problems, which then leads to an underutilization of mental health services [167]. Furthermore, many Asian groups' belief systems about causal factors revolve around imbalances of yin and yang, supernatural forces, or punishment invoked by a dead ancestor [167; 395]. In a quantitative survey study of 175 British and Sri Lankan participants, the Sri Lankans were more likely to identify social or superstitious factors as root causes of schizophrenia, while the British favored biological causes [212]. Similarly, in Malaysian culture, mental illness is believed to be caused by loss of the soul substance (*semangat*) or possession by the devil [263]. Similar themes emerged in in-depth interviews with Vietnamese American Buddhist leaders, who stated that mental illness was triggered by karma, lack of virtuous deeds, and spiritual possession [302]. In one study, 20% of Taiwanese participants believed that mental illness was caused by disruption of and insulting the dead or the gods [324]. In collectivistic cultures, the role of interconnectivity with others is believed to play a role in illnesses. Interpersonal relationships in families, for example, are intertwined with the functioning of an individual; therefore, a conflict rooted in relationships can cause psychiatric problems [182]. In a small interview study of parents, the majority of Chinese parents attributed depression in their children to stress emanating from school or peer relationships [396]. Similarly, many Asian Indians traced the root of mental illness to problematic issues in childhood, poverty, and pregnancy complications [325]. Mental disorders are sometimes viewed as a punishment for family members' past misdeeds or a reflection of a household leader's poor judgment or weak moral character [101; 395]. These attributions of illness encompass both internalizing and externalizing explanatory systems. Therefore, it is not always simple to dichotomize these etiological explanations. This is reflected in a study conducted by Kurumatani et al., in which they examined Japanese and Taiwanese teachers' attitudes toward mental illness [102]. They asked respondents to review a vignette about an individual with schizophrenia. The majority of both Japanese and Taiwanese respondents attributed stress from interpersonal relationships to be the cause of mental illness. The Taiwanese were more likely to state that weakness of character, hereditary, and/or stress from disasters triggered mental illness compared to their Japanese counterparts. The Japanese respondents' causal attributions were not as clear-cut, as both aspects of internalizing and externalizing explanatory factors were present. However, their explanations were more psychosocial in nature [102]. Many Taiwanese individuals believe that Chinese herbal medicine is beneficial treatment for mental disorders [326].

Western and Eastern Philosophies

Overall, cultural schemas about the mind-body, health/mental health, and religion affect clinical experiences. In Western societies, there is an emphasis on the demarcation or dichotomy between the mind and body. This dichotomy stems from philosophical beliefs about knowledge acquisition. Western societies emphasize the use of rationalism—reason, measurement, and standardization—in order to obtain knowledge. Descartes, for example, focused on distinguishing mind from matter [50]. However, this is in direct opposition to Eastern cultures, in which rationality is viewed as illusory [50].

The yin/yang theory, a common Eastern belief system, captures a holistic systems view that the whole cannot be reduced into parts as the component parts are interrelated to the whole [50]. Similarly, in Asian Indian culture, Ayurveda, a Hindu science about health and longevity, argues that well-being also rests on balance of three major humors: bile, wind, and phlegm [264]. Consequently, in Western societies, feeling "sad," "depressed," "anxious," or "stressed" may be discussed, and a nonphysical cause is linked to these emotional states [9]. However, in other cultures, there is no distinction between the psychological and the physical [9]. Furthermore, psychiatric explanations in Western societies are divorced from religion, spirituality, and ethics. Again, this is not the case in Eastern traditions [50].

CULTURE-BASED SUBJECTIVE EXPERIENCES: CULTURE-BASED IDIOMS OF DISTRESS AND CULTURE-BOUND SYNDROMES

The DSM is the most commonly used reference to define and establish psychiatric disorders. However, one of the major questions about the DSM is whether its diagnostic categories are valid across cultures [31]. PTSD as a diagnostic category, for example, has been quite controversial. In part, this stems from measurement issues. In order to accurately capture the amount of stress experienced, it is first necessary to inquire regarding the culturally appropriate traumatic precipitators. Terheggen, Stroebe, and Kleber, for example, noted that in Tibet, the destruction of temples and other religious symbols were regarded as extremely traumatic [165]. It would be necessary to inquire about these events in order to fully capture the traumatic stress experienced. Another aspect of the controversy regarding PTSD as a valid cross-cultural category revolves around how symptoms are displayed within cultures. Guilt, for example, is characteristic of survivors of trauma; yet, in many Asian cultures, shame is expressed rather than guilt. In the Tibetan language, for example, there is no word for guilt. Furthermore, somatic symptoms are also more frequently exhibited in Asian cultures. In Terheggen, Stroebe, and Kleber's study, Tibetans were more likely to endorse the somatically phrased items for depression and anxiety as opposed to psychologically phrased question items for these symptoms [165]. An earlier study conducted by Matkin, Nickles, and Demos found some evidence to suggest that at least some PTSD diagnostic criteria appear to have cross-cultural validity with Cambodians, who tended to manifest more somatic symptoms than some of the other PTSD criteria, such as flashbacks, hypervigilance, and emotional attachment [117]. Similarly, Vietnamese refugees expressed more somatic presentations of PTSD as opposed to the general symptoms typically associated with the disorder [117]. This controversy continues, and it raises questions about the applicability of all DSM-defined entities in all cultural contexts.

It has also been questioned whether psychiatric symptoms expressed in ethnic minority patients or patients from other cultural groups are similar to individuals in Western societies and whether the DSM can detect any cultural variations in the manifestation of symptoms [172]. It is possible that culture-based idioms of distress, or "socially and culturally resonant means of experiencing and expressing distress in local worlds," may not be captured by Western definitions of various psychiatric disorders [265]. In other words, idioms of distress can be mechanisms by which groups express symptoms in a culturally and socially sanctioned manner [397].

These behaviors or symptoms can include different mannerisms, figures of speech, and emphases on certain symptoms while ignoring others [31]. The most common culture-based idioms of distress are somatic symptoms. Some groups tend not to psychologize emotional problems; instead, they experience psychological conflicts as bodily sensations (e.g., headaches, bodily aches, gastrointestinal problems, and dizziness) [136]. It has been argued that the presentation of somatic symptoms for many psychiatric conditions is less stigmatizing and more culturally congruent in cultures that value or emphasize inhibition of emotions. Many Asian groups are

encouraged to keep silent and not verbally communicate emotions so as to preserve harmony in interpersonal relationships [136]. Pang, for example, notes that some Koreans may even consider it unfilial to emotionally express conflict with parents, children, and elders [136].

It would be simple to state the somatization of emotional problems is straightforward and clearly exhibits physical symptoms. According to Pang's study of Korean elders in the United States, their somatic expressions of distress are interspersed with not only physical, but also emotional, spiritual, cognitive, affective, behavioral, and supernatural components [136]. Somatization is not simply about the denial of psychologic complaints, because emotions are not the root of mental illness [327]. The language utilized to describe their feelings is somatically oriented, but the physical symptoms are merely metaphors. For example, to describe jealousy, they may say that they have a stomach ache. To describe how they feel when they are affronted, they might say, "I have been injured and wounded all over my body" [136]. In other words, they may not necessarily be presenting somatic symptoms; rather, they are merely metaphorically describing their emotions [136].

While it is not feasible for the DSM to address every culture for every diagnosis, the fifth edition of the DSM (DSM-5), published in 2013, includes an expanded outline for cultural formulation and a newly added assessment tool, the Cultural Formulation Interview (CFI). The CFI is a set of 16 questions addressing cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking. This assessment has been field-tested for usefulness among clinicians and acceptability among patients [8].

It is important to consider that the existence of cultural idioms of distress remains a topic of debate. Experts continue to question whether these idioms are linguistic expressions or actual behaviors, if they reflect broader social structures, and if there are boundaries dictating their appropriate use [398].

Culture-Bound Syndromes

The DSM also acknowledges the existence of culture-bound syndromes. Culture-bound syndromes are distinct entities of mental illness existing in a particular cultural context and precipitated by specific triggers [31]. These syndromes are localized to specific societies or cultures, and they have specific local names. They are a set of recurrent symptoms, and these diagnostic entities have specific cultural meanings [8]. The DSM-5 has a listing of culture-bound syndromes in the appendix. Some culture-bound syndromes are highlighted in this course as it relates specifically to Asian immigrants.

Neurasthenia or *shenjing shuairuo* is a widely used diagnosis in China; the core symptoms include headaches, dizziness, and insomnia [95]. It has been noted that depression is less prevalent in Chinese society compared to Western societies. It is plausible that the diagnostic category of major depression or dysthymia as defined by the DSM is expressed differently in China. Kleinman argues that, in China, the core set of symptoms relating to depression are somatic, unlike in Western societies, where the symptoms of depression are affective, such as sadness or dysphoria [95]. This presentation of somatic symptoms is more culturally congruent to Chinese cultural values, which emphasize organic causation of psychologic problems as well as the cultural focus on inhibition of emotions [162]. Therefore, when the criterion for neurasthenia is utilized, it is possible that it is being diagnosed instead of depression [95]. In Japan, neurasthenia is known as *shinkeisuijaku*, which means nervous disposition; patients with this condition are prescribed rest, nutrition therapy, and lifestyle changes, as well as medication [213].

In Vietnam, individuals with symptoms of general anxiety disorder often present with neurasthenia [327]. A diagnosis of neurasthenia gives legitimization to their experience, but the focus on physical symptoms reduces the stigma of mental illness [327]. It is argued that a diagnosis of neurasthenia is less stigmatizing and more acceptable to patients and their family members. However, some Western mental health professionals believe that neurasthenia as a diagnosis could minimize the existence of more serious psychiatric disorders [213].

Another cultural bound syndrome is *taijin kyofusho*. In Western societies, social phobia as defined by the DSM-5 is an anxiety disorder that causes an individual to avoid social or performance situations in which embarrassment might occur [8]. Similar to social phobia, in which an individual develops a persistent fear of social situations, in Korea and Japan *taijin kyofusho* stems from a fear of giving offense to someone versus fear of embarrassing oneself [9]. There have been some studies that have shown that *taijin kyofusho* exists outside of Japan and Korea, including in the United States, which then raises the question of whether or not this syndrome is culturally bound (or to what degree) [303]. The individual with *taijin kyofusho* is concerned that one's appearance and actions during social interactions will offend someone [8; 9]. It is believed that there are two subtypes of *taijin kyofusho*: sensitive type, which falls under the general category of social anxiety disorder, and another offensive type, which is characterized by quasi-delusions [214]. These delusions include the beliefs that the individual has a specific bodily defect, that the individual may harm another person by his/her physical characteristics, or that others are avoiding him/her [215]. A clinical study has found that fluvoxamine, a medication for social anxiety disorders, was effective for this disorder [214].

In several Asian countries, including Japan and Korea, a disorder called *hikikomori* has emerged. Some regard it as a modern-type of reclusive depression, precipitated by a shift from collectivistic to more individualistic value systems [266]. It generally affects those born after the 1970s and occurs mainly while one is at work. It is unclear whether this is syndrome specific to Asia [266]. In India, *dhat* is a culture-bound syndrome that refers to severe anxiety or hypochondria-like concerns about excessive discharge of semen or whitish color urine. *Dhat* has been classified as a culture-bound anxiety state, a symptom of depression, and hypochondriacal neurosis [216]. Other symptoms include physical exhaustion, sleeplessness, and palpitations [9; 216]. Many Indians believe the condition is the result of masturbation or sex outside of marriage [216; 267]. There is some controversy over whether *dhat* is truly a culture-bound disorder of depression and whether it occurs in other countries/cultures [304; 305].

In Korea, there is a condition called *hwa-byung*, characterized by symptoms including pain in the upper abdomen, an intense fear of death, exhaustion, depressed affect, indigestion, aches and pains, and palpitations. The Koreans attribute this disorder to anger suppression [9; 328; 329]. Because Asian values emphasize harmony in interpersonal relationships, it is believed that anger is suppressed, and this condition may be a passive vehicle for exhibiting the anger [217]. It appears to occur more often among Korean women and those from lower socioeconomic and educational backgrounds, and external stressors (e.g., marital conflict, and difficulties with mother-in-law) are risk factors [306; 328]. Prevalence rates for *hwa-byung* range from 4.2% to 13.3% [329].

Traditionally, the fields of medicine, psychiatry, and mental health embrace the disease model, in which diagnosis and treatment revolves around the disease and the symptoms exhibited. However, as previously discussed, diagnosis may be difficult across cultural differences. Instead, Castillo advocates for a client/patient-centered model, whereby diagnosis and treatment are guided by the client/patient, a complex human operating and interacting within a sociocultural context [31]. It is vital that clinicians take into account variability across ethnicities and cultures in body language, eye contact, styles of emotional expressions, and use of terms to describe symptoms [8].

ATTITUDES TOWARD HELP-SEEKING

The process of help-seeking is not linear; rather, it is a complex web of factors that influence whether an individual will seek formal or informal assistance for their problem [330]. This includes demographic factors, cultural beliefs and norms, perceptions of barriers to help-seeking, individual and family appraisals of the problem, and constellation of ecologic factors [330].

Understanding individuals' patterns of help-seeking also provides a window to understanding attitudes toward mental health and the role of cultural schemas. Asking for either formal or informal assistance implies different meanings in different cultures. Although Western societies pride themselves on individualism and self-sufficiency, there is also less of a stigma in obtaining psychological or therapeutic help. Particularly in the United States, obtaining counseling or therapy is viewed positively, as it is regarded as a mechanism to promote insight and personal growth. However, in many Asian cultures, emotional and psychological problems are in part attributed to bad luck, misfortunes from displeased ancestors, and/or a lack of personal willpower, self-control, or maturity [167]. Furthermore, personal problems are viewed as private and are not to be expressed to outsiders; these problems should be kept within the family. This ultimately serves to prevent loss of face not only for the individual experiencing the problem, but for the entire family system [104]. Religious beliefs about fate, acceptance, and perseverance can also impede Asian immigrants from seeking formal assistance. Help-seeking is very complicated, as there are a host of variables that can affect the process.

Demographic factors are an important predictor to help-seeking. In Kung's study of 1,747 Chinese Americans and immigrants in Los Angeles County, the majority (75%) stated they had never sought formal help for emotional problems, but 25% stated they had sought help from family and friends [99]. Gender and age were good predictors of seeking formal help. Women and younger Chinese Americans and immigrants, for example, were more likely to seek mental health services [99]. Not surprisingly, higher levels of English proficiency predict mental health treatment receipt [399].

Acculturation is another key variable in influencing help-seeking. Because mental health theories and counseling techniques are primarily rooted in Western ideologies (e.g., values emphasizing verbal and emotional expressiveness and direct communication), it would make sense that those ethnic minority immigrants who are more acculturated would be more likely to seek mental health services. DeVitre and Pan examined the role of enculturation (defined as degree of adherence to Asian cultural norms such as collectivism, emotional self-control, humility, and family orientation around achievement) and acculturation in attitudes toward seeking mental health treatment among 75 Asian American adults [400]. In this study, higher levels of enculturation negatively correlated with positive attitudes toward seeking mental health treatment; acculturation only partially predicted help-seeking attitudes. In a study of Asian Indian university students in the United States, higher levels of personal stigma were correlated with more negative views about seeking psychologic help [331]. The need for achievement and honoring family were paramount and may override perceptions about help-seeking. However, another study found that Asian American college students who are more acculturated were more tolerant of the stigma of seeking formal help, more likely to recognize a personal need for counseling, and more receptive to talking about personal problems with counselors than their less acculturated counterparts [16]. Similarly, a study of 107 Asian American college students found that Asian American students who were more tolerant of the stigma were more likely to seek formal mental health assistance [218].

The researchers point out that personally feeling stigmatized may not be the sole reason for not seeking mental health services; rather, it is the concern that close family members will be stigmatized. Yet, there has been some debate about the role of acculturation in help-seeking, as it is possible that those who are more acculturated have more psychosocial problems and, by extension, are more receptive to seeking formal assistance [99]. However, Kung found that those who were more acculturated and who had a diagnosable mental disorder were less likely to seek informal help from family and friends [99]. A 2014 study found that Asian Americans employed less family support than White Americans and Latinos and relied less on friends than White individuals [307]. Although Asian cultures are collectivistic and family oriented, it is possible that individuals avoid seeking help from family in order to preserve group harmony and reduce conflicts [307].

However, acculturation is not the only factor. It has been speculated that level of family cohesion could affect help-seeking of mental health services. For example, those with high levels of family cohesion might not turn to mainstream mental health services, relying instead on family. In one study, for each point increase in family cohesion, there was a lower odds ratio of receiving mental health services [268]. The researchers found the variable that influenced help-seeking was generational status. Second-generation and third-generation Asian Americans who had similar levels of family cohesion to first-generation individuals were 1.7 and 2.67 times more likely to receive mental health services, respectively [268]. Other research has found that stronger identification and commitment to one's ethnic group are related to less favorable attitudes toward formal help-seeking [332]. It has been posited that adhering to an Asian cultural orientation creates dissonance with perceived notions of Western values of seeking help with mental health professionals. It is clear that the complexities of the phenomenon of acculturation should be studied further.

Religiosity and spirituality also affect help-seeking patterns. It can be argued that those who are religious or spiritual are more likely to seek help from the clergy than mental health professionals because their worldviews are more congruent with those of clergy. One study with 2,285 Filipino Americans examined the role of religiosity and spirituality [2]. Given the fact that many Filipinos are Catholic and the literature demonstrates that this population underutilizes mental health services, it was speculated that they would be more likely to seek help from religious leaders [2; 108; 167]. Findings showed that their rates of help-seeking from clergy and mental health professionals were comparable. Not surprisingly, those who exhibited higher levels of religiosity were more likely to seek assistance from clergy when emotionally distressed. However, level of religiosity did not only affect seeking help from mental health professionals; those with higher levels of spirituality were less likely to get assistance from both mental health professionals and clergy [2].

Among some Southeast Asian groups, including Cambodians, sleep paralysis or "ghost oppression phenomenon" is common [219]. This sleep paralysis consists of hallucinations and panic attacks and is believed to be caused by a ghost who is discontent with the individual. Therefore, a monk will splash holy water or offer food to the ancestors to appease the ghost [219]. Seeking assistance from a monk, shaman, fortune-teller, acupuncturists, or herbalist is more religiously and culturally aligned with the belief systems than seeking help from a professional health or mental healthcare provider [269]. More research is needed to flesh out the interaction of religiosity and spirituality and its influence in help-seeking patterns in the Asian American communities.

Stigma and the fear of losing face also affect help-seeking [269]. As discussed earlier, the terms used for mental illness are often pejorative and stigmatizing, and therefore, seeking mental health services may be regarded as negative with long-lasting adverse repercussions. Pakistani women stated that the word

"mental" meant "crazy" and to seek mental health services had extreme aversive ramifications [176]. In this community, a husband may use the stigmatization as grounds for divorce, making the argument that he must seek a wife and mother who is more stable and fit [176]. It also has marginalizing day-to-day effects within the family. Women who have been diagnosed with psychiatric conditions are made to feel as if their opinions do not matter; they have difficulty disciplining their children as respect is lost. Overall, they experience loss of status within the family [176]. These outcomes are inextricably tied to the cornerstone of Pakistani value systems that emphasizes the importance of family, with women's identities rooted to their core values of being a wife and mother [176]. Therefore, it is not uncommon among Asian Indian women to reframe any feelings of sadness or depression to a discussion about physical symptoms of weakness (*kamzori*) [264]. This is research indicating that individuals who view mental health conditions as physical disorders with recognizable symptoms are more likely to seek formal services [333].

The Chinese concept of "face" has two components: *mianzi* and *lian* [62]. *Mianzi* is one's worth as can be claimed within a social network. *Lian* has to do with internal and external moral sanctions [62]. Therefore, *mianzi* is lost when one's performance fails to live up to the standards one has claimed within the social network, and *lian* is lost when one transgresses moral boundaries leading to guilt and shame [62]. Both *lian* and *mianzi* work together to create the concept of "face." It has been speculated that fear of losing face is one reason why Asians underutilize mental health services. Gong, Gage, and Tacata's study examined the role of concern with face and language use with help-seeking among various sectors of care among Filipino Americans [62]. Their findings are interesting. First, Filipinos who speak primarily the Filipino language and who are concerned with issues of face are more likely to use the lay system (e.g., family and friends) and less likely to use general medical services. The authors speculated that because they are concerned with losing face and seeking outside help is stigmatizing, they would prefer to keep their personal problems at home. The opposite occurred for bilingual Filipinos. Those who were more concerned with face were less likely to seek help from family and friends but were more likely to utilize the general medical system. The authors posited that bilingual Filipinos are more familiar with both Western and traditional Asian sectors of care and have access to formal systems of care without having to worry about language barriers. Furthermore, seeking help from family and friends would ultimately expose their families to shame. Consequently, it is easier to hide their problems by seeking outside assistance [62].

The concept of "face" may also be linked to the internalized model minority myth. This myth is the societal perception that Asian Americans have achieved the American dream that hard work leads to success. Those who have internalized this myth may not seek professional help for fear of losing face, stigmatizing their family, and failing to live up to the attainable dream. In a study with 106 Asian American college students, those who scored higher on measures of internalizing the model minority myth had less favorable help-seeking attitudes [308]. Those who adhered to internalized model minority were more likely to value emotional self-control as opposed to seeking outside help [308].

Help-seeking is a complex social phenomenon. It is not simply a rational decision whereby individuals respond to a given personal problem, evaluate their resources and options, and then make a decision [88]. Rather, help-seeking is embedded within a larger sociocultural context including a host of factors ranging from personal variables (e.g., religiosity) to family variables (e.g., perception of loss of face), environmental (e.g., lack of culturally sensitive services, transportation issues, finance/cost, insurance status, etc.) and structural variables (e.g., racism and discrimination).

HEALTH ISSUES IN THE ASIAN AMERICAN AND IMMIGRANT COMMUNITIES

HEALTHCARE NEEDS

Asian Americans and immigrants have traditionally been an invisible group in relation to studies on health. This invisibility stems from several factors. First, care frequently takes place within families and communities. In part, this stems from a collectivistic orientation and general reluctance to seek outside help in order to keep private matters within the family. Second, national data examining health conditions pool or aggregate findings of ethnic minorities; that is, the data is not analyzed by specific ethnic subgroups [173]. The National Center for Health Statistics, for example, reported that the incidence of breast cancer among minority women are lower than White women, and one might conclude from this statement that this holds true for all ethnic minority women, which is not necessarily the case [173]. Even when data are analyzed for specific ethnic groups, it is not broken down into their subgroups. Therefore, it is not possible to extrapolate incidences and risk factors for specific Asian subgroups in most health data [61].

Yet, it is imperative to specifically focus on the health needs of Asian Americans and immigrants. This group is less likely to have a primary care provider compared with White Americans (68% compared with 77%), with level of acculturation a predictor of using a usual care provider [55]. Specifically, lower levels of acculturation (as measured by proficiency of English and length of time in the United States) were predictive of both Asian and White Americans not having a health provider for consistent care and seeking usual care in the emergency department. This was reinforced by a 2019 study that found the likelihood of seeking help decreased twofold in those without a usual place of care and fivefold in those with communication issues in healthcare settings [401].

Variations in acculturation and foreign-born status also significantly impact health concerns. Immigrants who enter the United States can potentially bring illnesses native to their homeland; acculturative stress can exacerbate pre-existing conditions and/or trigger illnesses and vulnerability to new diseases can be heightened [44]. Tuberculosis (TB), for example, is disproportionately high in foreign populations in the United States and Canada [270]. This is complicated by a general reluctance to seek medical attention due to language issues, traditional health beliefs and practices being incongruent with Western medicine, and lack of insurance [44]. Asian Americans, Native Hawaiians, and Pacific Islanders are more likely to be uninsured compared with non-Hispanic White individuals [271]. Much of this is due to the fact that they tend to be employed in small businesses that do not offer health insurance.

There are also erroneous health beliefs that could place groups at risk. In the past, prior to increased community education about human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), some Asian American groups believed that HIV was a culturally foreign disease and that they were genetically immune to it [44]. It will not be possible to cover every medical condition and examine every Asian group. Instead, this section is meant to provide an overview, which will hopefully stimulate readers to do more in-depth study.

DIABETES AND OBESITY

Over the last decade, diabetes and the issue of obesity, particularly among children, have been much publicized in educational awareness campaigns. In general, Asian Americans and immigrants tend to have lower body mass index (BMI) [402]. For example, non-Hispanic White Americans are 60% more likely to be obese than their Asian American counterparts [402]. Therefore, one might speculate that this population has lower rates of diabetes, but it is important to consider within-group diversity among Asian Americans. While Asian Americans overall are less likely to be obese, some subpopulations (e.g., Filipinos) are more likely to be obese [402].

The prevalence rate of diagnosed diabetes among Asian Americans was 11.2% in 2013–2016; the rate among White Americans was 9.4% [403]. Some subgroups, such as Native Hawaiians and Japanese Americans, are two times more likely to have diabetes compared with their White counterparts [272]. Among Cambodian refugees, the rate of diabetes is more than twice the national average (27.6% vs. 12.4%) [334]. In the Asian Indian population in the United States, type 2 diabetes prevalence rates range from 17.4% to 29% [335].

According to the Racial and Ethnic Approaches to Community Health (REACH) Risk Factor Survey data, the prevalence of diabetes is 19% among Asian Indians, 10.8% among Koreans, and 9.3% among Chinese [41]. In general, Asian Americans have poor diabetes management practices compared to other groups (e.g., less likely to do weekly self-glucose checks). Korean Americans were less likely to have had a physical exam within the last year compared with Chinese and Asian Indian Americans [41].

There also seems to be an intergenerational effect of diabetes. Second- and third-generation Japanese Americans, for example, have higher prevalence of diabetes compared with their counterparts residing in Japan [75]. It is possible that as immigrants become more westernized, they also adopt a more sedentary lifestyle and consume foods higher in fat [75]. However, in another study, acculturation was positively correlated with reaching blood glucose level goals among Asian Americans [404]. In a study using data from the National Health Interview Survey, researchers found that Asian Indians in the United States had lower BMIs than non-Hispanic Whites, but that they were also less physically active [220]. However, Asian Indians have a higher likelihood of becoming diabetic despite their lower rates of obesity compared to their non-Hispanic White counterparts [220].

CARDIOVASCULAR DISEASE

Risks of coronary heart and cardiovascular diseases have become a pressing issue in many developing countries. In 2015, there were an estimated 422 million cases of cardiovascular disease worldwide, and one-third of all deaths were attributed to cardiovascular disease [405]. Countries in South Asia represent at least one-quarter of developing countries worldwide, and among all Asian subgroups, Asian Indian immigrants and those born in the United States reported the highest rates of ischemic disease [52; 68]. Smoking is a risk factor for all groups, and it is actually lower among South Asian Indians compared to their European counterparts [68]. Yet, because tobacco is used for both smoking and chewing in South Asia, many public health advocates maintain the importance of education that teaches the adverse effects of smoking and chewing tobacco and their correlation to cardiovascular conditions [129]. Socioeconomic status also appears to be a risk factor for South Asian Indians. In a study conducted in a semi-urban area in India examining the role of social class and coronary heart disease, Reddy, Rao, and Reddy found that as social class increased so did levels of sedentary life styles, cholesterol, hypertension, and obesity, all of which are risk factors for coronary heart disease [148]. There is also data that shows that Asian Indians tend to have lower high-density lipoprotein (HDL) cholesterol and high triglyceride levels [68]. Others have concluded that coronary heart disease may also be genetically influenced [129]. Unfortunately, it is not yet clear which risk factors significantly contribute to this disease among Asian Indians. There is some indication that psychosocial risk factors may heighten Asian Indians' vulnerability to cardiovascular issues. In the United Kingdom, Asian Indians have higher coronary heart disease mortality compared to White Europeans [221]. A study of 105 Asian Indian men in the United Kingdom found that, compared to White Europeans, Asian Indians experienced more chronic stress in the areas of work, finances, and residential overcrowding. Findings also showed that these stressors were not necessarily buffered

by social support, despite the common myth that large extended family structures serve as that social support [221].

According to the Office of Minority Health, Asian Americans are 50% less likely to die from heart disease compared with White Americans [406]. However, specific Asian American subgroups are affected disproportionately. According to 2009 data, Native Hawaiians and Pacific Islanders are three times more likely to be diagnosed with coronary heart disease than their non-Hispanic White counterparts [273]. Filipino Americans are one of the highest risk groups among Asian Americans for hypertension [223]. South Asians are also at high risk of cardiovascular disease in part because of the increased prevalence of risk factors, such as hypertension, high cholesterol, diabetes, and hyperglycemia [407]. In California, Filipino Americans had a prevalence rate of 26.6% for hypertension, compared to 24.4% for Whites, and Filipino Americans are the ethnic group at greatest risk for hypertension following African Americans [223]. In a study of Filipino Americans in Philadelphia, 67.5% self-reported high blood pressure and 57.1% reported high cholesterol levels [336]. Cambodian refugees also have high rates of hypertension compared with national averages (47.9% vs. 20%) [334]. Experienced trauma and acculturative stress may contribute to the risk of hypertension. The risk of hemorrhagic stroke is higher in every Asian American subgroup compared to non-Hispanic White Americans [52]. There is also some evidence that immigrants' longer residence in the United States increases the odds for obesity and hyperlipidemia (high cholesterol) [274]. This trend seemingly applies to Chinese Australian immigrants as well. A study found that those who immigrated to Australia before 18 years of age were more likely to experience cardiovascular disease, obesity, and diabetes than those who immigrated later in life [337].

There are some trends indicating a decrease in physical activity among Asian Americans, with 32.4% reporting no physical activity in 2015–2016, compared with 21.5% in 2011–2012 [408]. In some cases, cultural factors may impede physical activity. For example, South Asian immigrants may view exercise as leisure activity—as putting oneself first over the family unit and their needs [407]. Cultural norms regarding modesty and going out alone may further hinder some immigrant women from engaging in physical activity outside the home [407].

INFECTIOUS DISEASES

COVID-19

There is some evidence that the COVID-19 pandemic disproportionally affected racial and ethnic minorities in the United States. Asian Americans and immigrants are no exception. Because many Asian Americans and immigrants work in sectors that are considered to be essential, they are at increased risk of exposure to COVID-19. An estimated 2 million of Asian Americans work in the health care, transportation, and service sectors [409]. According to the Centers for Disease Control and Prevention (CDC), 3.1% of COVID-19 cases and 3.7% of COVID-19-related deaths occurred in Asian Americans [410].

Asian Americans are also less likely to be tested, with 345 tests per 10,000 population, compared with 423 tests per 10,000 general population [411]. This has been partially attributed to testing sites being less likely to be available in areas that are predominantly Asian. Fear of stigmatization and racism are additional barriers to testing [411].

Tuberculosis

According to the CDC, there were 7,163 new cases of active TB in the United States in 2020 [338]. Although it is on the decline among U.S.-born individuals, it is a highly common disease among foreign-born immigrants, whose rate of TB is 15 times higher than those born in the United States [338]. Foreign-born Asians in the United States

have the highest incidence of TB compared with other immigrant groups [338]. In 2014, the TB rate among Asians in the United States was 28.5 times higher than the rate in non-Hispanic Whites [58]. As of 2019, those of Asian descent in the United States have the highest rates of TB [412]. In 2020, in California, more than half of the TB cases occurred among Asians, a 47% increase compared with 2010 [413].

In 2010, 80% of TB cases in New York City were among foreign-born individuals [76]. Foreign-born Asians (regardless of birthplace) have the highest rate of latent (asymptomatic) TB in the United States [414]. Among this group, the top 10 countries of origin were all located in South Asia [76]. This is also the case in Los Angeles and Orange Counties, California, where there is a high proportion of Vietnamese population, a recent immigrant group. Consistent with national statistics, TB among foreign-born Vietnamese settled in this area has increased [77]. TB among newly arrived Asians is higher compared to U.S.-born Asians. However, Vietnamese individuals in California had TB at a rate 100 times higher compared to the overall nation and had the highest case rate compared to Koreans, Chinese, and Filipinos [77]. They are at great risk of infecting others and exacerbating their condition, as they are more likely to utilize traditional forms of healing. It is only when traditional healing practices fail that they will resort to Western medical treatment [77].

Unfortunately, a disproportionate number of South Asians are affected by TB. In an analysis of 45,504 TB cases in the United States between 2000 and 2007, rates were the highest among Cambodians (73.5 cases per 100,000 people), Vietnamese (54 cases per 100,000 people), and Filipinos (52.1 cases per 100,000 people) [276]. Origin countries associated with the highest rates of TB include the Philippines, India, Vietnam, China, and Myanmar [415]. In a large-scale study examining all TB cases between 1993 and 2004, researchers found a total of 224,101 of TB cases in the United States, 3.4% of which occurred in individuals who were born in a South Asian country [224]. Half of TB cases among South Asians were among individuals 25 to 44 years of age.

Hepatitis B

Between 2013 and 2016, 30% of Asian and Pacific Islanders were diagnosed with chronic hepatitis B, compared with 13.5% non-Hispanic White individuals [416]. For Asian American and Pacific Islanders, approximately 1 out of 12 have been infected with hepatitis B virus [339]. It is estimated that the incidence of hepatitis B, a common disease among Southeast Asians, ranges from 7% to 14% among Vietnamese adults [28]. As a result, Vietnamese men have the highest rate of liver cancer, at 41.8 per 100,000 cases, compared with White men, who have a rate of 3.7 per 100,000 cases [28]. Analysis of birth data for 2014–2015 found that Chinese American mothers are 10 times more likely to get the hepatitis B virus compared to Japanese or Asian Indian mothers [339]. This may be a key factor in the disparities in liver cancer rates in this population. In another study, 53.2% of Vietnam-born residents had exposure to hepatitis B, followed by those born in Korea (43.4%) and China (34.8%) [340].

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are a concern in American communities. In general, the rates for many sexually transmitted diseases are lower in Asian American populations compared to other groups. In 2018, the rates for gonorrhea, chlamydia, and syphilis among Asian Americans and Pacific Islanders were 35.1, 132.1, and 4.6 cases per 100,000 population, respectively [341]. Because of the model minority myth, there have been misconceptions in both the general community as well as among helping professionals that Asian Americans are a "healthy" minority group. Consequently, there are minimal public awareness and prevention services for this group.

HIV/AIDS

Overall, Asian Americans have lower rates of HIV infection than the general public, constituting only 2% of new infections in the United States [90]. Between 2011 and 2015, the number of Asian Americans diagnosed with HIV grew by 28%, largely driven by increases among gay and bisexual men [90]. Between 2014 and 2018, the rate of HIV infection for this population remained stable [90]. Asian Americans tend to delay screening, with a median of four years from the time of infection to diagnosis, compared with two years for White Americans [343]. However, only 2% of all AIDS diagnoses in the United States were among Asian Americans [90].

There are some limited studies that indicate that Asian American/Pacific Islanders are more likely to be at advanced stages of the illness when diagnosed compared to other ethnic minority groups [179]. This may be due in part to overall underutilization rates of HIV screening. In a study of South Asians in Washington, DC, researchers found that the HIV testing rate was 30.8%, which was lower than the median HIV testing rate [227]. The utilization rate was even lower for South Asian refugees. The study also found that HIV knowledge was extremely low despite the fact the study sample was educated and lived in the United States for at least a decade. One of the most at-risk groups is Asian men who have sex with men, as they are less likely to have been tested for HIV compared to other ethnic group minorities [179]. In a longitudinal study of 908 Asian and Pacific Islander men who have sex with other men, researchers found that Asian and Pacific Islander men were more likely to be tested if they were knowledgeable and comfortable with the testing and screening site and if they were comfortable with their gay identity [228].

Prevention efforts and community education are vital strategies to curb HIV/AIDS, but there are a host of cultural taboos that make it difficult to openly discuss the disease. In general, HIV/AIDS is highly stigmatizing, but this is particularly true for Asians. The focus on individual responsibility for fulfilling family obligations and enhancing the family reputation impedes open communication about HIV/AIDS [229].

Cultural norms about family and marriage could serve as a false sense of security for some. In Asian Indian culture, for example, parents play a role in their children's marriages in order to maintain family lineage [22]. Bhattacharya observes that some Asian Indian women feel they are protected against HIV/AIDS because they regard marriage as a protection [22]. Because discussion about the use of condoms with their husbands is culturally dissonant, they could be exposed to HIV/AIDS because they assume their husbands are also monogamous. Cultural taboos about discussing sexual matters to outsiders may also be barriers to general discussions about this disease. In a Canadian focus group study with South Asians, participants reported that discussions of HIV or AIDS were discouraged because this would implicitly endorse premarital sex, a taboo in many South Asian cultures [279]. It is also not uncommon for Asian Indian families to reject family members who are diagnosed with HIV. The stigma is particularly great for South Asian women with HIV, as they are marginalized by their families and community.

In a study conducted by Wong et al. examining Asian American and Pacific Islander knowledge about HIV testing, researchers found that 23% of Asian American/Pacific Islanders had an HIV test compared to 35% of White Americans [179]. They were also less aware of AIDS-related services such as counseling, transportation, and medical services in the community compared with White Americans. Within the Asian American/Pacific Islander sample, those who were born in the United States and who

had more than a high school education were more likely to be aware of these services compared to their counterparts [179]. These findings suggest that more concerted, culturally sensitive STI prevention strategies are needed to target Asian Americans/Pacific Islanders, particularly for those who are foreign-born and less educated.

CANCER

Cancer is a dreaded disease regardless of an individual's cultural background. However, culture does shape the meaning of the diagnosis, help-seeking patterns, and coping strategies. In general, Asian Americans have the lowest rate of cancers (3.9 per 100,000 population) compared with other racial groups (e.g., 9.9 per 100,000 population among White Americans) [417]. However, it remains the leading cause of death for this group in part due to disparities in seeking preventive care [280]. In 2016, there were 57,740 new cancer cases among Asian Americans, Native Hawaiians, and Pacific Islanders in the United States [344]. Asian and Pacific Islander men are 50% less likely to have prostate cancer but are twice as likely as their non-Hispanic White counterparts to have stomach cancer [417]. Asian American men are 1.7 times more likely than White men to die from liver cancer [417]. Liver cancer accounted for 22% of cancer deaths among Vietnamese-American men [345]. In the Filipino community, colorectal cancer is the leading cause of cancer death. Mortality rates from liver and stomach cancers are also high in this population [346]. Hmong have the highest cancer rates even compared with their Asian American counterparts; specifically, they have the highest incidence of cancers of the liver, stomach, pancreas, and nasopharynx compared to all races [281]. This trend was reproduced in a study that compared adjusted cancer rates for Hmong residents of Minnesota to the general population in Minnesota [347].

In general, Asian American women are more likely to survive cervical cancer compared with their White counterparts, with the exception of Korean and Japanese American women [348]. However, Asian American women tend to avoid screenings and be diagnosed at an older age. Possible barriers to help seeking include low English proficiency, preference for health providers from the same ethnic group, adherence to a cultural value of modesty, and a general mistrust of Western health systems [281].

Overall, Asian and Pacific Islander women are 30% less likely to have breast cancer than non-Hispanic White women [230]. However, Asian immigrant women who have lived in the United States for more than half of their lives are three times more likely to be diagnosed with breast cancer than those born in the United States [418]. A landmark study of Asian Americans in California found that Asian American women (except Japanese women) had experienced an increase in breast cancer diagnoses, with Korean women experiencing the largest increase [349]. Breast cancer also accounts for about 19.5% of all cancer deaths among Asian Indian women and Filipino women [345].

In a study of 196 Korean American women, 54% had obtained a mammogram in the past two years. Women who reported knowing where to get a mammogram, having a regular doctor, and greater trust in healthcare providers and healthcare system were more likely to adhere to breast cancer screening recommendations [350]. In a study of Asian American college women, women who were sexually active were nine times more likely to have had a clinical breast examination than non-sexually experienced women [232]. The researchers speculate that Asian college women who are sexually active are more likely to visit a gynecologist and therefore will receive such screenings. In addition, culturally appropriate education material about mammograms should be developed and should target Asian women and their spouses and family members, who can be influential in supporting healthy behaviors [107].

HEALTH BELIEFS AND PRACTICES: THE ROLE OF CULTURE

Illness is not just an event; it also encompasses the client's/patient's subjective experience, cultural beliefs, and expectations regarding the illness. The term "illness" is different from "disease," as the term "illness" refers to the client's/patient's subjective experience of the disease and its effects on different arenas of his/her life [177]. The biomedical model usually does not focus on the client's/patient's expressions of the illness concept and how culture might impact disease presentation [47]. Level of acculturation, education, and socioeconomic class also influence illness beliefs [47]. Baki-Miri, Gogi, and Baki observe that there are three major categories for health belief systems regarding etiology of illnesses: occult, holistic, and scientific traditions [283].

Occult

In the occult belief systems, the etiology of illness is generally supernatural. Sorcery, magic, casting of spells, evil spirits, and other spiritual forces are the cause of sickness [283; 419]. In some cases, an evil spirit is a consequence of an imbalance or lack of harmony, such as a sin or a conflictual personal relationship [79]. Southeast Asians, such as Laotians, believe that soul loss and ancestors play a role in diseases [130].

Some Cambodian immigrants also believe that diseases are triggered by ghosts or spirits; this is referred to as *neak ta* [86]. According to this tradition, the spirit is believed to have invaded the person's body and can provoke symptoms of blindness, hysteria, and paralysis [86]. If an evil spell is cast on an individual or if an individual does not properly execute a ritual, spirits can enter his/her body [86]. A *kathas*, or talisman displaying prayers that can be chanted to ward off or cure evil spirits, may be worn [86]. Some believe that medical interventions (e.g., surgery) can upset the patient's soul [419].

Research indicates that there is a traditional Filipino belief that spirits may be invoked to inflict illness on an individual [47]. Magos noted that, in Filipino culture, "illness is believed to be caused by *dungan*, or a weakened soul, which occurs after an individual comes in contact with an ancestral spirit or another human being with a stronger soul" [114]. Members of many cultural groups believe that they have no control over illness and disease [419].

Holistic

In holistic traditions, ideas about health and illness are based on the concept of the whole and how interdependent parts (e.g., physical, mental, spiritual, emotional) fit together to play a role in health [283]. "Energies" that work together to either achieve balance or disharmony fall into this holistic domain. The Chinese conceptualization of sickness is rooted in the principles of yin and yang, unlike Western conceptualizations of illness that are rooted in germ theory [164]. In addition to yin/yang, traditional Chinese medicine is concerned with the concept of *qi*, the basis of mind/body energy and activity within the body [174]. According to traditional beliefs, a lack of balance in an individual's yin/yang and flow of *qi* results in illness [174]. In Chinese tradition, qigong healing is utilized to establish balance and harmony; this involves techniques with breathing and movement to consciously control the flow of energies [182]. It also involves strengthening the body and eliminating evil. In the case of cancer, strengthening the body entails building the body's cancer-fighting ability, and eliminating evil means inhibiting cancer growth [420]. This, along with herbs and acupuncture, is one of the major components of traditional Chinese medicine [182]. Another factor is the concept of hot and cold elements in the body. Examples of "hot" illnesses include fever and joint pain, and "cold" illnesses include dysmenorrhea and diarrhea [164]. Furthermore, physical health is linked to social relationships [351].

The concept of "wind" is also believed by Southeast Asians to affect health, which is similar to Chinese health beliefs. For example, in Vietnamese, this concept is termed *phong* and can enter the body and trigger a host of illnesses [42]. This might be an actual weather change, such as heavy rains or winds, but it can also refer to an abstract concept involving changing energy flows in the environment [164]. Illnesses believed to be caused by *phong* include rheumatism, headache, sore throats, fevers, muscle aches, and upper respiratory diseases [42; 54]. Treatment entails eliminating the *phong* from the body, and may consist of a special diet or medicinal herbs [27]. Dermabrasion is another form of therapy to reduce *phong* from the body. Dermabrasion includes specific techniques such as coining, pinching the skin, cupping, and *cai gio*, all of which are believed to be effective in eliminating *phong*. Coining consists of a coin or metal piece being rubbed against the client's/patient's skin in order to remove the *phong*. Cupping is an intervention whereby one applies warm cups to the ailing individual's skin to draw the *phong* out [164]. *Cai gio* involves rubbing an ointment comprised of various oils including camphor, menthol, and wintergreen oil onto the body [42]. A spoon edge or a coin is then used to firmly rub the ointment on the body area for about 15 to 20 minutes, until a red mark is produced [42]. Healthcare professionals have at times misinterpreted results from these dermabrasion therapies as being abusive. Teachers who notice red marks on their students' arms or back have attributed them to child abuse and have reported it as such [42]. Healthcare providers and other professionals are increasingly becoming educated about these practices in order to understand the health beliefs that surround these practices; therefore, they may be less likely to construe the marks as evidence of abuse.

"Balance" emerged as a key theme in a study of diabetes among Hmong [234]. Hmong study participants indicated that diabetes was a result of being "out of balance."

Like other Asians, Asian Indians' views of health include social, environmental, and spiritual factors. Health is believed to be the result of harmony among physical, mental, spiritual, and emotional components [72; 145; 352]. Ayurveda is an ancient Indian philosophy of medicine that integrates religion with traditional medicine [23; 109]. It is based on the use of a variety of therapies, including dietary practices, interventions dealing with movement (e.g., yoga), and herbal remedies [235]. Ayurveda maintains that there is a relationship between the universe and the body, and therefore, the etiology of the symptoms may not necessarily be within the body [23]. According to Ayurveda, the universe is comprised of five elements, water, fire, earth, wind, and ether, three of which (fire, water, and wind) have corresponding influence in the body [145]. The goal of Ayurveda is to maintain equilibrium in the body [109].

It is unclear how many Asian Indians living in the United States practice Ayurveda. A small exploratory study found that more than half (59.4%) were using Ayurvedic remedies; sources to obtain these remedies varied from home-grown herbs to the Internet and Indian and natural product stores [235]. Participants tended to use Ayurvedic medicines for conditions such as colds, fevers, constipation, heartburn, and indigestion. However, only 18% who used Ayurvedic products informed their medical doctors of their use.

Just as health is not compartmentalized, neither is treatment. Asian Indians see treatment as a daily part of life, integrating holistic and traditional practices [72]. These traditional health practices are called "desi ways," passed down from one generation of women to another [72]. Desi ways are traditional health practices of the country of origin, and they include use of Ayurveda practitioners, various herbs, homeopathy, naturopathy, and spiritual rituals [72]. Desi ways are not employed exclusively, but are often used in conjunction with Western treatment [72].

Scientific Tradition

Scientific tradition focuses on empiricism and objectivity as the basis of health beliefs [283]. The biomedical perspective that dominates much of the health practices of Western medicine falls in this category. It does not take into account diversity and culture and its effect on illness. The biomedical perspective advocates the disease model, which focuses on biologic dysfunction and symptoms [177]. The physician handles the care of the client/patient and legitimizes that the disease is present [177]. This Western biomedical model has been criticized as not being sufficiently patient-centered—it may result in the patient being objectified and reduced to a set of symptoms, and it may not take into account the environmental, social, cultural, and religious factors that influence health [351].

It is important not to dismiss traditional forms of healing. Studies have found that traditional healers and the traditional health beliefs adhered to by many immigrants simply do not disappear. More and more, traditional ways of healing are being incorporated with Western medical treatment [72]. In many of these traditional healing practices, there is an emphasis on one's relation to the social environment and network [79; 182]. It is typical to find a client's/patient's social support network involved in the illness and problem solving. Community ties are also incorporated into the care of the client/patient. For example, spiritual and religious traditions and practices are integrated into the healing process. It is common to see an individual who is perceived to be wise (e.g., a longstanding member of the community) involved in the healing process [182].

CULTURALLY SENSITIVE PRACTICE ISSUES

PROMOTING CULTURALLY SENSITIVE COMMUNICATION

Communication, the process of sending a message from one party to another, consists of both verbal and nonverbal components. Verbal and nonverbal communications are embedded within the culture of the parties disseminating the information and within the culture of the parties receiving the information. Communication is complex and multilayered because it involves unstated, implicit rules about a variety of factors, including physical distance between parties, tone of voice, acceptable topics of discussion, physical contact, and amount of eye contact [132]. Each of these variables is influenced by the perception of the level of formality/informality of the situation. Frequently, misunderstandings occur because the decoding and interpretation of these nonverbal cues are not accurate.

The verbal component of communication is just as complicated. Certainly, similarity in language shared by both parties enhances communication, but assuming that both parties in a conversation speak the same language, how the information is interpreted is still influenced by a host of factors. Linguists have posited that approximately 14,000 different meanings and interpretations can be extracted from the 500 most common English words [33]. Consequently, practitioners must be aware of the different communication styles held by diverse ethnic minority clients/patients, as the clinical communication process is the primary vehicle by which problems and solutions are identified and conveyed [17].

Styles of communication can be classified from high- to low-context [154]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [33; 421]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [132; 154]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [33]. Consequently, low-context communicators listen with their ears and focus on what is being said [132; 154; 421]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and African Americans, are from high-context cultures [154]. A study of Asian American and White college students found that Asian American students reported using indirect styles of communication more frequently compared to their White counterparts [236]. The researchers also found a relationship between adhering to Asian cultural values of emotional self-control and higher usage of indirect communication styles among the Asian American students. Clearly, adherence to cultural values influences communication styles.

Communicators from high-context cultures generally display the following characteristics [33; 132; 237; 421]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [33; 132; 421]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices (more animated, dramatic)
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and storytelling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. A Chinese American man may not necessarily be a high-context communicator because he is Asian. A host of factors, such as level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate. Third, a major criticism of the discussion of low-/high-context cultures is that they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [113].

Some use the terms "passive" or "indirect" to describe the communication styles of persons from high-context cultures, but this connotes a deficit and should be avoided [353; 354]. It is also important not to assume that Asian American clients/patients desire practitioners to communicate in the same ways that they do [355]. People often expect mental health and healthcare communication to be rooted in Western values and principles and for communication patterns to be consistent with these values [355].

Learning to communicate effectively also requires an understanding of how different conversational traits influence the communication process, or how information is conveyed and interpreted. Again, the goal of this section is not to simply dichotomize individuals' conversational styles into categories, but rather to understand the factors that play a role in how someone makes a decision on how to communicate [132]. Readers should not merely stereotype Asians with certain conversational traits and assume these overarching observations apply to all Asians.

There are five different conversational traits: formality, intimacy, directness, acknowledgment, and tolerance of conflict [132]. Formality involves the degree of hierarchy acknowledged in the relationship during the communication. For example, are titles employed? Who is addressed first? Most high-context cultures are influenced by the social status and the expertise of the person. The background of the person informs perception of authority and hierarchy [421]. Furthermore, most Asian groups are patriarchal and hierarchal. For example, in Chinese, Korean, Cambodian, and Japanese cultures, men and elders are placed on the top of the authority structure. Therefore, when working with Asian American and immigrant individuals, particularly those who may be less acculturated, practitioners should convey authority, credibility, and legitimacy [104]. For example, when working with Hmong immigrants, practitioners should avoid using overly casual language because Hmong respect professionals and believe they deserve honor and deference [238]. Therefore, any unprofessional behavior on the part of the professional could jeopardize their credibility. Many Asian American or immigrant clients/patients come into counseling believing that the practitioner will quickly identify the problem and provide a solution [104]. When the practitioner does not do so, he/she loses legitimacy in the eyes of the client/patient. Therefore, the practitioner must overtly establish authority. Employing professional titles and displaying diplomas and professional licenses are some examples of overtly establishing legitimacy. Furthermore, by obtaining sufficient information about the client/patient and family, and offering some explanation to the cause of the client's/patient's problems can assist in facilitating credibility. It may also be important to bring in family members, particularly an elder who is considered to be the authority figure, as a sign of respect.

Intimacy refers to the amount of personal information that is disclosed [132]. Asian Americans and immigrants generally believe that family matters are highly private. Therefore, discussions regarding certain health and mental health issues are strictly limited to the family system and should not be aired to the public. Directness refers to the extent the message or content is explicit without any assumption that the party receiving the communication will understand any hidden meanings. Asian cultures, as discussed, tend to be high-context cultures. Furthermore, Asian cultures tend to emphasize the prohibition of direct disclosures of emotional expression [104]. As a result, Asian clients/patients may not have the skills to discuss problems and to express themselves openly. The practitioner will have to learn to become attuned to indirect forms of communication.

Acknowledgment and tolerance of conflict is another conversational trait [132]. It refers to the extent to which conflict is openly dealt with and the extent to which one is comfortable with conflict. Asian cultures emphasize harmony, which is an underlying value influencing much of the belief systems. The yin/yang theory is not only applied to health, but also personal relationships. It promotes the notion that when harmony is at the heart of all relationships and different components of one's social environment, personal development, satisfaction,

and growth are the end results [36]. Consequently, Asians tend to avoid conflict and any self-expressions that are confrontational [36].

As long as there are two parties involved in a conversation, nonverbal communication is inevitable, and it becomes salient particularly when it is processed from one culture to another. Nonverbal communication is any behavior (including gestures, posture, eye contact, facial expressions, and body positions) that transcends verbal or written forms of communication [71]. Nonverbal communication can enhance or reinforce what is said verbally, and conversely, it can completely contradict the message communicated verbally. It can also end up replacing what was verbally communicated if both parties do not share a native language [103].

In Western culture, communication is more direct and eye contact is highly valued. When eye contact is not maintained, many Westerners assume that the party is hiding pertinent information. However, in some cultures, including Asian cultures, reducing eye contact is a sign of respect [17]. In Asian culture, the practitioner is viewed as an authority figure, and avoiding eye contact is a symbol of respect, not dishonesty or lack of confidence [36]. Conversely, clients may interpret direct and indirect gazes differently. For example, in one study, Japanese individuals tended to rate faces with a direct gaze as angry and less pleasant compared with Finnish participants [118].

The amount of social space or distance between two communicating parties is culturally charged as well. Depending upon the social context, Westerners tend to maintain a distance of about three feet, or an arm's length, in conversations [33]. In a public setting, where both parties are engaged in a neutral, nonpersonal topic, Westerners will feel encroached upon and uncomfortable if an individual maintains a closer conversational distance. However, in other cultures, such as Latino and Middle Eastern, a closer distance would be the norm [33]. Asians tend to prefer more space between the two conversational parties until they have developed a relationship. Chung recommends that in a clinical setting the practitioner allow Asian clients/patients to set the tone and social distance [36]. The practitioner can sit first and permit the client/patient to select where he/she wants to sit.

Gestures and touch are often used to reinforce or supplement communication. Interestingly, although different cultures may recognize gestures, how the gesture is interpreted will vary. For example, studies have shown that different cultural groups maintain they recognize 70% to 100% of gestures from other groups, but their accuracy rate in terms of interpretation was as low as 30% [33]. White Americans, for example, may touch a child's head to connote affection. However, in Thailand, this is interpreted as an insult [103]. Nodding one's head typically signals understanding and agreement in the United States [33]. However, in Asian culture, it is only an indication that one hears the speaker [33]. Therefore, it does not connote agreement, but to disagree is impolite and considered rude, and therefore, they will nod their head. Consequently, practitioners cannot assume that an Asian client/patient agrees to something by a nod of the head.

It is important to take into account the role of deference and hierarchy of the parties involved. For example, even the use of "yes" is embedded in a cultural context. Because respect and deference are highly valued cultural norms in Asian culture, Asian immigrant clients may say "yes" to a practitioner despite the fact that they may not agree with or even understand the practitioner. The "yes" statement may be an acknowledgement rather than a statement of agreement [238]. Some nonverbal communications, such as smiling, bowing, and silence, may be interpreted as acquiescence when in fact they are conveyances of respect and saving face [119]. Taking into account other individual(s) in the room or in the clinical encounter is also necessary. In Asian cultures, there is a distinct adherence to the hierarchical structure. If a practitioner poses a question to an individual who is subordinate (in power, age, etc.) to the other individual in the room, the person in the lower position may feel uncomfortable answering the question [249].

CULTURALLY SENSITIVE ASSESSMENT DOMAINS
Domain 1: Self-Awareness of One's Own Cultural Identity • What are the practitioner's biases from his or her cultural background? • How are the practitioner's own cultural values different from and/or similar to that of the client/patient? • What are the dominant culture's values and belief systems?
Domain 2: Assessing the Client's/Patient's Cultural Orientation, Belief Systems, Level of Acculturation, and Language Preference • How acculturated is the client/patient? (There is great diversity within ethnic groups, and the length of time the client/patient has lived in the United States will influence his/her belief systems.) • To what extent does the client/patient navigate between the norms of the dominant culture and those of his or her own culture? • What is the client's/patient's language preference when communicating with medical professionals?
Domain 3: Assessing Stress and Functioning • What are the different adjustments and transitions the client/patient is coping with in the United States? • How are these transitions affecting emotional and physical health?
Domain 4: Assessing Client's/Patient's Family Relationships and Support Systems • How do cultural values and belief systems influence the client's/patient's family system or kin network? • What is the structure of the traditional family system within the client's/patient's culture? • Who has the power in the family? Who makes the primary decisions? • What gender roles exist within the client's/patient's culture? How are women regarded compared to men? • What are the client's/patient's social support systems?
Domain 5: Assessing Client's/Patient's Views and Concepts of Health and Illness • How does the client/patient define illness? How is health defined? • What are the client's/patient's beliefs about the cause of illness? • How does the client/patient describe the symptoms? • Where does the client/patient go for healing? Where does his/her family traditionally go for healing?
Source: [138] *Table 1*

Cross-cultural communication is by no means simple, and there is no set of rules to merely abide by. Instead, promoting culturally sensitive communication is an art that requires practitioners to self-reflect, be self-aware, and be willing to learn. Therefore, as practitioners become skilled in noticing nonverbal behaviors and how they relate to their own behaviors and emotions, they will be more able to understand their own level of discomfort and comprehend behavior from a cultural perspective [132].

ASSESSMENT GUIDELINES

Practitioners may be categorized as either disease-centric or client/patient-centric [31]. Disease-centered practitioners are concerned with sign/symptom observation and, ultimately, diagnosis. On the other hand, client/patient-centered practitioners focus more on the client's/patient's experience of the illness, subjective descriptions, and personal beliefs [31]. Client/patient-centered practice involves culturally sensitive assessment. It allows practitioners to move assessment and practice away from a pathology-oriented model and instead acknowledge the complex transactions of the individual's movement within, among, and between various systems [25].

Practitioners who engage in culturally sensitive assessment nonjudgementally obtain information related to the client's/patient's cultural beliefs, overall perspective, and specific health beliefs [138]. They also allow the client to control the timing [137].

The goal is to avoid the tendency to misinterpret health concerns of ethnic minority patients. Panos and Panos have developed a qualitative culturally sensitive assessment process that focuses on several domains (***Table 1***) [138]. Each domain includes several questions a practitioner may address in order to ensure that he or she is providing culturally responsive care.

Alternatively, Kleinman suggests that the practitioner ask the client/patient what he or she thinks is the nature of the problem [96]. He highlights the following types of questions that may be posed to the client/patient [96]:

- Why has the illness/problem affected you?
- Why has the illness had its onset now?
- What course do you think the illness will follow?
- How does the illness affect you?
- What do you think is the best or appropriate treatment? What treatment do you want?
- What do you fear most about the illness and its treatment?

Similar to Kleinman's culturally sensitive assessment questions, Galanti has proposed the 4 Cs of Culture [356]:

- What do you call the problem?
- What do you think caused it?
- How to you cope with the problem?
- What questions or concerns do you have about the problem or treatment?

Pachter proposed a dynamic model that involves several tiers and transactions, similar to Panos and Panos' model [135]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that he/she does not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups he/she comes in contact with. Reading and becoming familiar with medical anthropology is a good first step, and in the final section of this course, some useful resources will be provided.

The second component emphasizes the need for specifically tailored assessment [135]. Pachter advocates the notion that there is tremendous diversity within groups. For example, one cannot automatically assume that an Asian immigrant adheres to traditional beliefs. Often, there are many variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the client/patient and the professional [135]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. The professional might recommend a combination of alternative and Western treatments.

Beckerman and Corbett further recommend that recently immigrated families be assessed for [208]:

- Coping and adaptation strengths
- Issues of loss and adaptation
- The structure of the family in terms of boundaries and hierarchies after immigration
- Specific emotional needs
- Acculturative stress and conflict for each family member

Practitioners should seek to understand the sociopolitical context of the origin country [422]. A migration narrative is also recommended, whereby an individual provides a story of his or her migration history. Asking about how long the family has been in the United States, who immigrated first, who was left behind, and what support networks are lacking gives the practitioner an overview of the individual's present situation [239]. The theme of loss is very important to explore. Types of losses may include family and friends left behind, social status, social identity, financial resources, and familiarity [239].

For refugees and newly immigrated individuals and families, assessment of basic needs (e.g., food, housing, transportation) is necessary [422].

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. Similarly, culturally sensitive assessment entails recognizing that there are a host of factors that contribute to patients'/clients' multiple identities (e.g., race, gender, socioeconomic status, religion) [226]. The domains and related assessment questions are meant to provide an introduction to help practitioners recognize the range of dimensions, including physical, biological, social, and cultural factors, that affect Asian immigrants and their families.

INFORMED CONSENT

Informed consent is now the backbone of Western bioethics; however, it was not an ethical mandate until 1957, when it was explicitly formalized in the Code of Ethics of the American Medical Association [120]. The Code of Ethics requires physicians and any helping professionals to communicate diagnoses, prognoses, courses of treatment or intervention, and alternative options in such a manner that is understood, so an informed decision regarding treatment can be made by the client/patient [120]. An individual's ability and prerogative to make one's own decision about treatment is now seen as a vital expression of autonomy and is a prerequisite to participation in treatment or interventions.

Autonomy, individualism, and self-determination are values that are highly important in Western societies, especially in the United States. Autonomy may be organized into two categories: first-order autonomy and second-order autonomy [69]. First-order autonomy is what is espoused and valued in Western cultures: self-determination and autonomy in decision-making. Second-order autonomy, however, is prevalent in collectivistic societies where decision-making is group-oriented and takes into account another decision-maker who is accorded authority and respect [69]. In many Asian cultures, particularly if the family system is based on a patriarchal authority system, a male elder or male family head who is regarded as the primary decision-maker is key in this process of informed consent [423]. Therefore, the Western ideal of autonomy will have different connotations in cultures in which paternalism is valued [240].

As described, the process of informed consent entails the explicit communication of information in order for the individual to make a decision. Again, Western cultures value explicit information, which is centered on American consumerism; believing in having choices and being able to exercise choices in purchases extends to health care. Western values also support the idea that the more information given is better. Therefore, there are underlying dominant norms about the amount and content of information as well as how it is conveyed [241; 242]. Some cultures, for example, believe that language and information also shape reality [30]. In other words, explicit information, particularly if it is bad information, will affect the course of reality. The Japanese, for example, believe that it is important not to discuss terminal illnesses and death and dying. The Chinese believe that discussing illnesses will bring about bad fortune and bad luck, and such discussions ensure that illness will inevitably occur [120; 185]. For some Asian patients, a direct statement conveying bad news (e.g., a very poor prognosis) may be construed as rude. Instead, a more indirect way using euphemisms is preferred. Yet, for many Americans, this would not be acceptable [241; 242].

A signature is required on most Western informed consent forms to represent understanding and agreement on the part of the individual involved. This might be viewed as violation in social etiquette in some cultures. In some cultures (for example, Egypt), signatures are usually associated with major life events and legal matters. Therefore, requiring a signature outside these circumstances would imply a lack of trust, particularly when verbal consent has been given [146]. The traditional written consent forms may be replaced by oral consent, video or audio recordings, or even pictorial images [423].

Thumbprints may also be permissible in lieu of signatures. In a study of Muslim women, the researchers recorded the women's verbal consent and literate family members reviewed the consent form [357].

Some studies have explored the appropriateness of audio consent, particularly when institutional review boards require some form of consent. In India, audiovisual consent forms are now mandatory [358]. In one study, potential participants were given audio and written information about the study to review, and then they were invited to attend a meeting where the informed consent process was reviewed [140]. In an HIV prevention clinical trial in Tanzania, pictorial flipcharts were employed after having been developed in conjunction with community leaders and experts. The researchers recorded audio to provide information about the study and then invited participants to ask questions [143]. In a study of various delivery methods for obtaining informed consent, a slideshow with voiceover was the most effective in communicating the basic essence of the consent forms [359].

Consent forms often contain technical and legal jargon that may be overwhelming to the native English speaking individual, but can be much more daunting for immigrants who may not be English proficient or familiar with various legal concepts. It is important for professionals to recognize that some Asian immigrants may be reasonably fluent in English for day-to-day activities, but when they have to communicate about healthcare issues, they may not be able to communicate as comfortably in this arena [240]. It is incumbent upon the healthcare professional to determine if the client/patient has full understanding of presented options. For some Asian immigrants who have experienced political persecution in their homelands, asking for a signature on a consent form that contains foreign legal and technical terms can potentially place them at risk for secondary traumatization, as some were persecuted, tortured, and forced to sign documents in their homelands [184]. Undocumented immigrants may be fearful that if they do not consent to participate in a study they risk being deported. In this way, they can be viewed as a vulnerable population similar to incarcerated individuals [360].

This cultural dissonance can be a challenge to many general healthcare and mental health practitioners. Cultural experts are highly recommended for consultations to assist in the interpretation and navigation of the complex web of cultural interactions. Healthcare professionals must remember that the professional communication they are used to stems from a "medico-legal risk management" perspective, which is very foreign to those not from the dominant Western culture [241].

WORKING WITH INTERPRETERS

When there is an obvious disconnect in the communication process between the practitioner and client/patient due to the client's/patient's lack of proficiency in the English language, an interpreter is required. (In many cases, the terms "interpreting" and "translating" are used interchangeably, but interpreting is specifically associated with oral communication while translating refers to written text.) Frequently, this may be easier said than done, as there may be institutional or client/patient barriers. Depending upon the client's/patient's language, an interpreter may be difficult to locate. Or, an organization may not have the funds to bring in an interpreter. Also, bringing in an interpreter creates a triangular relationship with a host of communication dynamics that must be negotiated [17]. Many view interpreters merely as neutral individuals who communicate information back and forth. The most common belief about the role of the interpreter in healthcare settings is the "interpreter as a conduit" model, which views interpreters as machines or robots that remain in the background and merely relay information back and forth [243; 247; 424]. Many interpreters indicate that they are treated as voices representing both the professional and the patient [244]. They are often required to interpret without omission, revision, or addition [424]. Some interpreters feel they have to be invisible so that they reinforce the privacy of the provider-client/patient relationship [244].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Institute for Clinical Systems Improvement recommends that clinicians should follow the established best practices of utilizing professional medical interpreters when English is not a patient's first language or when there are gaps in understanding English.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed November 8, 2021.)

Strength of Recommendation/Level of Evidence: Low-Quality Evidence, Strong Recommendation

Another perspective is that the interpreter is an active agent or co-diagnostician, negotiating between two cultures and assisting in promoting culturally competent communication and practice [81; 244]. In a study with 27 healthcare interpreters, the participants summarized their work as "a complex mental and social activity that went beyond linguistic transformation and included deciphering body language, establishing trust with multiple stakeholders, and brokering cultural concepts and frameworks" [203]. As co-diagnosticians, interpreters determine what medical information is valuable, seek illness-related information outside of the providers questioning, and participate in the diagnostic process by identifying symptoms the provider may not have directly asked the client/patient about [244]. In this more active role, the interpreter's behavior is also influenced by a host of cultural variables such as gender, class, religion, educational differences, and power/authority perceptions of the client/patient [81]. In one study, some interpreters reported feeling that speaking out was part of their professional obligation to act as a cultural broker for the client [150]. The downside is that interpreters may overstep their roles [161]. Consequently, an intricate, triangular relationship develops between all three parties. Another factor affecting the communication process is the fact that many interpreters are not adequately trained in the art of interpretation in mental health and general health settings, as there are many technical and unfamiliar terms. An ideal interpreter goes beyond being merely proficient in the needed language/dialect [33]. Interpreters who are professionally trained have covered aspects of ethics, impartiality, accuracy, and completeness [70]. They are also well-versed in interpreting both the overt and latent content of information without changing any meanings and without interjecting their own biases and opinions [70]. Furthermore, knowledge about cross-cultural communication and all the subtle nuances of the dynamics of communicating in a mental health or general health setting is vital [33].

On the clients'/patients' side, they may be wary about utilizing interpreters for a host of reasons. They may find it difficult to express themselves through an interpreter [104]. If an interpreter is from the same community as the client/patient, the client/patient may have concerns about sharing private information with an individual who is known in the community and the extent to which the information disclosed would remain confidential. In some cases, raising the issue of obtaining an interpreter causes the client/patient to feel insulted that their language proficiency has been questioned. Finally, if an interpreter is from a conflicting ethnic group, the client/patient may refuse having interpreter services [17].

The ideal situation is to have a well-trained interpreter who is familiar with health and mental health concepts. However, this may not be realistic, as health and mental health settings are often underfunded. Consequently, different models of accessing interpreters have been utilized [104].

The Approximate-Interpreting Model

The approximate-interpreting model refers to the practice of obtaining an individual to serve as an interpreter who happens to be the most conveniently accessible. This may be a person who is currently on staff (e.g., receptionist, file clerk, etc.) in another department, or it may be a relative (adult or child) who accompanies the client/patient. However, it is important to note that in some states, such as California, there are laws that prohibit using a client's/patient's child as an interpreter.

These intermediaries can provide immediate assistance in interpreting, but as one can see, there are many limitations with this model. First, these intermediaries do not necessarily have the competencies or skills to interpret, particularly medical, psychological, and social terminologies. When eliciting interpreting assistance from staff persons who are not hired to do so, anger and resentment can follow over time, affecting staff morale [147]. Furthermore, informal interpreters are not necessarily bound to the same ethical code as the provider. Enlisting the help of a community member or even a staff person can increase clients'/patients' anxiety, as they may worry that the interpreter will reveal confidential information to other people in the community [361]. Although asking family members to serve as interpreters is not recommended, it often occurs, with some professions using specific criteria to determine when this practice is acceptable [425]. In an interview study with 69 healthcare professionals, more than half reported using family members to interpret basic, non-serious, non-confidential information. However, even in these cases, role conflicts may ensue. They may also feel embarrassed and uncomfortable in having to convey potentially intimate and private matters [33]. Relatives may unconsciously screen out or summarize information, which alters the original content or intent [70]. This is especially problematic when a child serves as an interpreter. The boundaries of the parent-child roles are crossed, and the child carries the unnecessary burden of learning information that may not necessarily be beneficial to them [33].

The Tele-Active and Video Remote Model

The tele-active and video remote model employs a telephone program or video conferencing platform whereby the client/patient selects from a menu offering different languages/dialect. There is no human interaction, and it is often used after hours, when an interpreter is not on site. There are also national organizations that provide interpreting services via phone to any provider at any geographic location. Handsets are installed in the rooms so a healthcare professional can use one handset and the client/patient can use another. An interpreter is on the line from another location, interpreting in real time [245]. There is now software that can ask initial questions in the client's/patient's language, then connect the provider and client/patient to an interpreter via the telephone [246].

For video remote interpreting, all parties appear on a video conferencing platform, allowing for visual and audio communication [426]. A computer/smartphone, Internet access, and possibly web cameras and microphones are needed [427]. Similar to telephone interpreting, video remote interpreting involves a shared network of interpreters who are dispersed geographically but who can interpret within minutes [428]. This approach offers real-time interpreting and can deliver good-quality images and audio. As with any technology, there can be challenges with the use of technology and adequate Internet quality. Video remote interpreting can be less expensive than in-person interpreting, but not significantly [427].

How individuals understand each other in conversation is a function of a variety of dimensions within the social process. In studies exploring individuals' comprehension of heard information, those who were involved in a conversational interaction comprehend the information differently than those who overhear the conversation [342]. This should be considered when employing the tele-active model.

The Bilingual Worker/Interpreter Model

The bilingual worker/interpreter model uses a staff person who is specifically hired to work with a practitioner or who sees clients/patients under close supervision. This person may or may not be professionally trained. This is an ideal model because it is less legally risky.

The Volunteer Interpreter Pool Model

The volunteer interpreter pool model utilizes a pool of individuals who can provide interpreting services when needed. Often, they are not professionally trained.

The Staff Interpreter Model

In the staff interpreter model, a paid staff person who is formally trained provides interpreting services. If an interpreter is required, the practitioner should acknowledge that an interpreter is more than a body serving as a vehicle to transmit information verbatim from one party to another [104]. Instead, the interpreter should be regarded as part of a collaborative team, bringing to the table a specific set of skills and expertise [104]. Several important guidelines should be adhered to in order to foster a beneficial working relationship and a positive atmosphere.

A briefing time between the practitioner and interpreter held prior to the meeting with the client/patient is crucial. The interpreter should understand the goal of the session, issues that will be discussed, specific terminology that may be used to allow for advance preparation, preferred translation formats, and sensitive topics that might arise [33; 104; 147]. It is important for the client/patient, interpreter, and practitioner to be seated in such a way that the practitioner can see both the interpreter and client/patient. Some experts recommend that the interpreter sit next to the client/patient, both parties facing the practitioner [70].

The practitioner should always address the client/patient directly. For example, the practitioner should query the client/patient, "How do you feel?" versus asking the interpreter, "How does she feel?" [70]. The practitioner should also always refer to the client/patient as "Mr./Mrs. D" rather than "he" or "she" [104]. This avoids objectifying the client/patient. While these behavioral tips are important, the key is to always focus on the interaction, which is always dynamic, complex, and ever-changing [320].

At the start of the session, the practitioner should clearly identify his/her role and the interpreter's role [104]. This will prevent the client/patient from developing a primary relationship or alliance with the interpreter, turning to the interpreter as the one who sets the intervention [33]. Conversely, practitioners should avoid having side conversations with the interpreter when the client/patient is present [225]. Practitioners should also discern any transference and countertransference issues between configurations of the triad [361].

The practitioner should also be attuned to the age, gender, class, and/or ethnic differences between the client/patient and the interpreter [104]. For example, if the client/patient is an older Asian male immigrant and the interpreter is a young, Asian woman, the practitioner must be sensitive to whether the client/patient is uncomfortable given the fact he may be more accustomed to patriarchal authority structures. At the conclusion of the session, it is advisable to have a debriefing time between the practitioner and the interpreter to review the session [33; 104; 147]. Overall, it is important to remember that clients/patients are an integral component of the active triad [225].

In this multicultural landscape, interpreters are a valuable resource to help bridge the communication and cultural gap between clients/patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When interpreters are enlisted and treated as part of the clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter.

INTERPROFESSIONAL COLLABORATION AND CULTURAL COMPETENCY

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients/patients and their families to improve health, mental health, and social and/or family outcomes [429]. It involves the collaborative interaction of two or more disciplines or professions with the client/patient on an identified issue [430]. With this approach, providers come together and view and discuss the same issue from different lenses, which can ultimately produce better solutions [431]. The client/patient is involved, with shared decision making [429].

Interprofessional collaboration is associated with positive outcomes on the individual and organizational levels. On the patient/client level, reduced mortality, increased safety and satisfaction, and improved health outcomes and quality of life have been demonstrated [432; 433; 434]. At the provider level, practitioners report increased job satisfaction, staff retention, improved working relationships, and greater levels of creativity [432; 434; 435].

One of the challenges to effective interprofessional collaborations is that professionals are typically socialized to their discipline's professional cultural norms and have not been exposed to other professional value systems [436; 437]. When professionals enter the workforce, they often continue to work in silos. Consequently, they are not familiar with the professional goals, language, roles, and tasks of their colleagues from other disciplines. This is particularly true of certain professions that are considered "outside" of traditional healthcare systems, such as practitioners in traditional, complementary, and integrative medicine (TCIM) [438]. However, many Asian immigrants employ TCIM practices. Both cultural competency and interprofessional collaboration require professionals to critically reflect on historical and sociopolitical factors that impact their professional relationships and practices. Cultural competency improves interprofessional collaboration and communication and vice versa [437].

Paraprofessionals are often employed to bridge gaps in the provision of health and mental health care to immigrants and members of racial and ethnic minority communities. These paraprofessionals include cultural experts, translators, interpreters, and other frontline workers. Professional divides often hinder the work of these professionals, as many providers are more familiar and reliant on hierarchal and vertical communications [437; 439]. This type of interaction is generally not aligned with the more relational types of communication employed by community workers and paraprofessionals [439]. This then results in power differentials and conflict, impeding effective interprofessional collaboration. A key common denominator in cultural competency training and interprofessional education is fostering sensitivity and awareness to alternative perspectives and cultural value systems in order to ultimately challenge stereotypes and reduce implicit and explicit bias [436].

CONCLUSION

Today, the Asian American and immigrant population in the United States is extremely diverse, with more than 25 different groups that continue to grow rapidly [167]. As the United States becomes increasingly heterogeneous, a key skill for healthcare practitioners is to learn to work effectively with clients/patients. This means being able to communicate, assess, and provide services that are culturally competent and culturally sensitive. However, the notion of cultural competence is more difficult to translate in day-to-day practice. Everyday demonstrations of cultural competency involve tapping into knowledge about Asians and their immigration histories and the effects of culture on the presentation of symptoms of health and mental health disorders, help-seeking behavior, and beliefs in the etiology of disorders. It also includes the relational competencies that promote culturally sensitive interactions

with Asian immigrants, such as understanding verbal and nonverbal cues; assessing, developing rapport, and joining; establishing credibility; and facilitating the process of interpreting.

Culture serves as a lens through which clients/patients and practitioners filter their experiences and perceptions. Clients/patients will bring their unique life stories and concerns to the practitioner, and their cultural values and belief systems will inevitably shape how the problem is defined and their beliefs about what is effective in solving the problem. However, the cultural backgrounds and values of clients/patients are not necessarily scripts that define behavior, and when practitioners view culture as a strength and not a pathology, practitioners will be able to more effectively join with clients/patients to mobilize change.

RESOURCES

Part of cultural competency and awareness deals with expanding one's knowledge base, particularly in the area of cultural diversity and how it affects mental health and healthcare practices, beliefs, and delivery systems. Cultural competency starts with knowledge. This section provides a preliminary set of resources for the practitioner to utilize.

The Asian American Diabetes Initiative
https://aadi.joslin.org

Asian and Pacific Islander American Health Forum
https://www.apiahf.org

Tufts University Selected Patient Information Resources in Asian Languages (SPIRAL)
http://spiral.tufts.edu

Apicha Community Health Center
https://www.apicha.org

California Pan-Ethnic Health Network
https://cpehn.org

Centers for Disease Control and Prevention Office of Minority Health and Health Disparities
https://www.cdc.gov/minorityhealth

The Cross Cultural Health Care Program
https://xculture.org

Stanford Culture Med: Ethnogeriatrics
https://geriatrics.stanford.edu/culturemed.html

DiversityRx
http://www.diversityrx.org

EthnoMed
http://ethnomed.org

International Medical Interpreters Association
http://www.imiaweb.org

MedlinePlus: Asian American Health
https://medlineplus.gov/asianamericanhealth.html

Minority Nurse
https://minoritynurse.com

National Asian Pacific Center on Aging
https://www.napca.org

National Asian Pacific American Families Against Substance Abuse
http://napafasa.org

National Center for Complementary and Integrative Health
https://nccih.nih.gov

National Center for Cultural Competence
https://nccc.georgetown.edu

National Council on Interpreting in Health Care
https://www.ncihc.org

National Minority AIDS Council
http://www.nmac.org

New York Coalition for Asian American Mental Health
http://www.asianmentalhealth.org

U.S. Department of Health and Human Services Office of Minority Health
https://minorityhealth.hhs.gov

U.S. Department of Health and Human Services Culture, Language, and Health Literacy
https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/resources/index.html

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

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