

Issues to Consider When Engaging Asian American and Pacific Islander (AAPI) Youth in Psychiatric Care

This document was developed by AACAP's 2012-2013 CMHS-AACAP Fellow Ronald Lee, M.D. in collaboration with the Committee on Community-based Systems of Care. AACAP's Youth Advisory Group also provided assistance in drafting, reviewing and editing this document to ensure that the Youth Voice was appropriately communicated. The document focuses on issues that relate to Southeast Asian and Pacific Islanders (Cambodian, Chinese, Filipino, Hmong, Indonesian, Japanese, Korean, Laotian, Thai, Vietnamese, Polynesians and Native Hawaiians). This document does not focus on issues relating to the South Asian population (Afghani, Bangladeshi, Bhutanese, Indian, Maldivians, Nepalese, Pakistani and Sri Lankan).

What are ways to effectively engage AAPI youth in psychiatric care? What are the unique characteristics of AAPI youth? What are the cultural and family dynamics of AAPI youth? These are some of the questions that are important to consider when working with the AAPI youth population. AAPI are among the fastest growing ethnic minority groups, but child and adolescent psychiatrists (CAPs) are not necessarily trained or equipped to provide care that reflects the cultural and linguistic needs of this population.

The stigma associated with mental health in the AAPI population and the limited number of AAPI service providers may prevent these AAPI youth from receiving the services they need. While this is a challenging group to engage in psychiatric care, there are also strengths that AAPI families possess that providers should use as part of their strategy to engage this population of youth. The following 10 principles will help CAPs with a framework for engaging AAPI youth at the individual, family and community levels.

Principle 1: Clinicians should consider and address language and communication challenges that may act as barriers for AAPI youth to seek out psychiatric care.

- By the year 2050, it is projected that Asian Americans will be 9% (40.6 million) of the total population, up from 5.6% in 2010 (US Census Bureau, 2010).
- According to the same 2010 US Census Bureau data, among AAPI youth who are under 18 living with either both parents or one parent, about 82% had at least one foreign-born parent. 77% of AAPI youth were born in the US and 23% were foreign-born
- Due to limited English proficiency of parents, some AAPI youth may be called up to assume a translator role, creating a dependence on the children that can lead to conflict and role reversal (Tseng, 2004)
- There are more than 100 spoken languages spoken among the AAPI population which makes this a particularly difficult barrier (One World Nations Online, 2013)
- To address language challenges, the CAP should pursue the use of translators for both linguistic support and cultural consultation

Principle 2: Clinicians should learn about the importance of acculturation and immigration status in regards to AAPI youth.

- Acculturation is the process of absorbing the new culture that can be a challenging process and source of stress for many AAPI youth and their families
- A unique feature of AAPI youth is the amount of diversity in this population despite often being viewed as a single group, suggesting that clinical understanding and strategies need to take into account these differences

- Some AAPI youth arrive in the U.S. as children, others as adolescents and still others are born in the U.S., all of which require a developmental approach to understanding cultural background and experience
- The more recent the immigration has occurred, the greater the amount of acculturative stress may likely be present (Berry, Phinney, Sam and Vedder, 2006)
- Providers need to take into account the changes that occur when different cultural groups are brought together and this balancing of the heritage culture of the country of origin with the culture of the new country can be a challenging task

Principle 3: Clinicians should recognize culture-specific stressors experienced by AAPI youth and avoid negative stereotypes.

- Compared to other adolescents, Asian Americans reported high levels of family conflicts, stress, discrimination and somatic complaints and low levels of family cohesion, self-esteem and coping (Choi, Meininger and Roberts, 2006)
- Southeast Asian refugees have high rates of depression, anxiety and posttraumatic stress disorder (Nicholson, 2007) and this can have a negative impact on the academic and emotional functioning of their children
- The familial cultural focus of AAPI youth to succeed can fuel maladaptive perfectionism+ characterized by fear of failure, self-doubt and excessive concern over mistakes (Bieling, Israeli & Antony, 2004)
- %Perceptual foreigner syndrome+(Wu, 2002) has been identified, whereby negative stereotypes and racism can lead to identity conflicts as well as problems such as bullying, harassment and discrimination

Principle 4: Clinicians should demonstrate humility and respect when they address cultural difference in clinical encounters with AAPI youth.

- Strive to understand one's own personal perspectives about diversity based on one's prior life experiences and cultural backgrounds
- While there can be commonalities between AAPI cultural groups, it is important to recognize the heterogeneity in this population and that AAPI youth and their families have their own distinctive cultural values
- Appreciate the particularly strong negative stigma against mental health services that exist among AAPI youth and their families
- By demonstrating culturally competent welcoming behavior, CAPs can provide individualized care that incorporates the priorities of AAPI youth and their family
- An example of such welcoming behavior may be to ask a Chinese patient who is depressed what other approaches such as herbal medicine or acupuncture that the family may also be pursuing besides Western medicine

Principle 5: Clinicians should understand the parent-child relationship dynamics and family characteristics that contribute to both strengths and vulnerabilities of AAPI families.

- A protective factor may be that a greater proportion of AAPI youth belong to households maintained by married couples (86% vs. 67% of general US population) according to the US Census Bureau. Also note that there are important within group variations (Cambodian, Filipino, Thai, Laotian and Vietnamese had higher proportions headed by single females)
- A vulnerability may be that some groups (Cambodian, Hmong and Laotian) rank among the lowest income brackets and educational levels
- Research has shown that greater discrepancies between Chinese American adolescents and their parents on parental control related to greater adolescent depressive symptoms (Juang, Syed & Takagi, 2007)
- Unsupportive parenting, issues with family cohesion and infrequent monitoring of AAPI youth can lead to a barrier preventing these youth from seeking out care and so these issues need to be addressed by CAPs in the treatment plan

Principle 6: Clinicians should appreciate the role of intracultural coping in AAPI youth.

- Intracultural coping is the use of supportive networks made up of individuals from the same ethnic-racial group, which is often preferred by AAPI youth
- The issue of ~~having face~~ is important with many AAPI youth, so sharing personal problems with people outside of the family is difficult and therefore they will tend to use more coping practices that include talking to the family instead of mental health professionals (Yeh and Wang, 2000)
- Prior research has revealed that AAPI young adults rely heavily on peer support to cope with intergenerational and intercultural family stress (Ahn, Kim and Park, 2009)
- Studies have shown that compared to seeking professional mental health care such as psychiatric consultation, AAPI often youth prefer accessing social networks for help (Yeh and Inose, 2002)

Principle 7: Clinicians should determine how home and community-based therapeutic interventions can be used as alternatives to hospitalization if possible with AAPI youth.

- Hospitalization for mental health reasons is highly stigmatizing for Asian Americans (Chen, Kramer & Chen, 2003), often correlating with long-term feelings of guilt and shame
- Hospitalization may also run against the preference of these families who have a strong investment in maintaining their children within the family setting (Pumariega & Rothe, 2003) so the principle of treatment in the least restrictive setting is very important
- Multisystemic therapy (MST) and other wraparound care services are consistent with AAPI cultural beliefs about the importance of family and may be a promising alternative strategy when possible to engage these youth in psychiatric care, but only if the wraparound services are viewed as culturally compatible by the AAPI community
- If hospitalization is warranted due to suicidal behavior or other crisis situations, CAPs should reflect understanding of the cultural context and include the family in the shared decision-making process regarding the proposed treatment plan

Principle 8: Clinicians should discover how ethnic-specific institutions can be used to engage AAPI youth in psychiatric care.

- Many Asian immigrant communities have formed institutions such as faith-based groups, language schools and cultural centers to cultivate a sense of community and to foster pride in their cultural background (Zhou, 1992)
- It is important to consult elders and leaders in the AAPI communities regarding how to best deliver care the AAPI youth in the community
- One way to make entering psychiatric treatment more acceptable and accessible may be for CAPs to partner with a community institution and provide training about mental health issues. Such educational training can help reduce stigma and offer a safer setting for AAPI youth to discuss issues
- A potential challenge is that many AAPI parents are reluctant to allow their children in these settings to participate in programs that focus on mental health issues and substance abuse due to the idea of family shame and not wanting their children to be labeled as ~~problem children~~
- AAPI training activities should be culturally sensitive and reflect understanding and respect for the diversity of AAPI experiences

Principle 9: Clinicians should be aware of the need to adapt evidence-based treatments (EBTs) with AAPI youth and seek ways to include AAPI youth in mental health research.

- A large percentage of EBTs are developed in the context of Western philosophy and tested on homogenous sample populations. It is important to consider how cultural factors that are unique to AAPI can be incorporated as part of the intervention (Hwang, 2006) and to consider modalities such as brief strategic family therapy which seeks to engage families into treatment
- A randomized trial (Rowland et al., 2005) studying the effectiveness of MST with Hawaiian youths with serious emotional disturbances and at risk for out-of-home placement included a diverse treatment team and specific work with families to develop indigenous supports. Results showed a significant decrease in Child Behavior Checklist externalizing symptoms, a decrease in days spent in out-of-home placement and reduced minor offenses suggesting that MST may be worth studying in other AAPI youth populations

- There is a great need to include AAPI youth in clinical trials research in mental health in order to better understand the overall effects of specific treatment interventions on this population given the paucity of current data

Principle 10: Clinicians should promote the use of media and social media to engage AAPI youth in psychiatric care.

- There have been positive effects of online support groups for AAPI adults, which showed that they can decrease feelings of shame and stigma that are usually associated with help-seeking behaviors in this population (Yeh et al., 2008) so this may prove promising with AAPI youth as well
- Social media such as Facebook, YouTube and Twitter could be an effective avenue to get the message across when addressing age-appropriate information to AAPI youth
- One model program called Youth Media Force in Minnesota attempts to address risky behavior among AAPI youth 14-18 years old through media to discuss relevant issues such as substance use, homelessness, body image and gang violence in the community
- Moving forward it will be important to utilize media and social media to discuss mental health issues with AAPI youth in order to seem more relevant and to connect on their level

Conclusion

It is clear that working with AAPI youth and their families to engage in psychiatric care is challenging, but it is also very rewarding work for CAPs. It is important to develop cultural competence expertise when working with this diverse population of patients in order to be an effective practitioner. The above guidelines provide only an overview of this topic and much more research still needs to be conducted in this area. Please refer to Appendix A for a list of resources that CAPs may consider using when trying to effectively engage AAPI youth in psychiatric care.

Clinical Vignette #1

Victor is a 17 year old high school senior who is in a very competitive high school and his parents are very proud of his academic achievements. He moved from China to the United States when he was 10 years old. Both of his parents only speak minimal English, but he is expected to do well in school and get accepted into a top college. Victor becomes overwhelmed as he has to help out at the Chinese restaurant that his parents own as well as maintain top grades. He finds that the only way that he can maintain some control in his life is by cutting and so he secretly makes light cuts on his upper arm with a razor. He is scared to tell his parents about what is happening and also feels too ashamed to share what is going on with his friends.

Things to consider: acculturation, language as a barrier, addressing intergenerational differences

Clinical Vignette #2

Janet is a 9 year old Korean American female who is struggling to make friends in her elementary school. Her mother has noticed that Janet was socially awkward from a very early age and that she had a hard time connecting with peers, often displaying poor eye contact when interacting with others. Janet was always described as bright and intelligent by her teachers, but they also noticed that she only enjoyed playing by herself. The two things that she is most interested in are cars and cats, which again seems a bit strange to her mother. Janet's pediatrician has brought up the possibility of an autism spectrum disorder, but Janet's father gets angry when this is suggested. Her father believes that she is a typically developing young girl and that this is simply a phase she will outgrow in the years to come.

Things to consider: partnering with primary care and school system, reducing stigma by providing psychoeducation regarding autism, family expectations

Appendix A: Resources

- 1) California Academy of Family Physicians. "Addressing Language Access Toolkit"+
<http://www.familydocs.org/system/files/AddressingLanguageandCulture.pdf>
- 2) "The Suinn-Lew Self Identity Acculturation Scale (SL-ASIA)+"
http://www.columbia.edu/cu/ssw/projects/pmap/docs/suinn_slasia.pdf
- 3) National Asian American Pacific Islander Mental Health Association. "Friends Do Make a Difference"+
<http://naapimha.org/friends-do-make-a-difference/>
- 4) Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Behavioral Health Equity website. "Behavioral Health and Asian American Native Hawaiian and Pacific Islanders"+
www.samhsa.gov/obhe/aanhpi.aspx
- 5) AACAP Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice
http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters

Bibliography

- Ahn A, Kim B and Park Y. Asian cultural values gap, cognitive flexibility, coping strategies, and parent-child conflicts among Korean Americans+. *Cultural Diversity and Ethnic Minority Psychology*. 4:353-363. (2009)
- Berry J, Phinney J, Sam D and Vedder P. Immigrant youth: Acculturation, identity, and adaptation+. *Applied Psychology: An International Review*. 55(3):303-332. (2006)
- Bieling P, Israeli A and Antony M. Is perfectionism good, bad or both? Examining models of the perfectionism construct+. *Personality and Individual Differences*. 26:1373-1385. (2004)
- Chen H, Kramer E and Chen T. The bridge program: A model for reaching Asian Americans+. *Psychiatric Services*. 54:1411-1412. (2003)
- Choi H, Meininger J and Roberts R. Ethnic differences in adolescents' mental distress, social distress, and resources+. *Adolescence*. 41(162):263-283. (2006)
- Hwang W. Acculturative family distancing: Theory, research, and clinical practice+. *Psychotherapy: Theory, Research, Practice, Training*. 43:397-409. (2006)
- Juang L, Syed M and Takagi M. Intergenerational discrepancies of parental control among Chinese American families: Links to family conflict and adolescent depressive symptoms+. *Journal of Adolescence*. 30(6):965-975. (2007)
- Nicholson B and Walters T.K. The effects of trauma on acculturative stress: A study of Cambodian refugees+. *Journal of Multicultural Social Work*. 6:3-4. (2007)
- One World Nations Online. Official Spoken Languages of Asian Countries+. Retrieved January 14, 2013, from http://www.nationsonline.org/oneworld/asian_languages.htm. (2013)
- Pumariega A and Rothe E. Cultural considerations in child and adolescent psychiatric emergencies and crises+. *Child and Adolescent Psychiatric Clinics*. 12:723-744. (2003)
- Rowland M et al. A randomized trial of multisystemic therapy with Hawaii's Felix class youths+. *Journal of Emotional and Behavioral Disorders*. 13(1):13-23. (2005)
- Tseng V. Family interdependence and academic adjustment in college: Youth from immigrant and U.S. born families+. *Child Development*. 75:966-983. (2004)
- U.S. Census Bureau. Living arrangements of children: 2004+. Retrieved October 8, 2012, from <http://www.census.gov/prod/2008pubs/p70-114.pdf>. (2008)
- U.S. Census Bureau. Table FG1: Married couple family groups, by labor force status of both spouses, and race and Hispanic origin/1 of the reference person: 2009+. Retrieved October 8, 2012, from <http://www.census.gov/socdemo/hh-fam/cps2009/tabFG1-asianalone.xls>. (2010a, January)
- Wu F. *Yellow: Race in America beyond Black and White*. New York: Basic Books. (2002)
- Yeh C et al. Development, content, process and outcome of an online peer supervision group for counselor trainees+. *Computers in Human Behavior*. 24:2889-2903. (2008)
- Yeh C and Chao C. Difficulties and coping strategies of Chinese, Japanese, and Korean immigrant students+. *Adolescence*. 37(145):69-82. (2002)

Yeh C and Wang Y-W. Asian American coping attitudes, sources, and practices: Implications for indigenous counseling strategies. *Journal of College Students Development*. 41:94-103. (2000)

Zhou M. *Chinatown: The socioeconomic potential of an urban enclave*. Philadelphia: Temple University Press. (1992)