Asian American Mental Health Disparities & Cultural Psychiatry

March 2015

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Outline

● Health & healthcare disparities
● Asian American mental health
  o Prevalence/rates
  o Roles of stigma & discrimination
  o Mental health underutilization
● Cultural considerations in treatment of depression among Chinese Americans
● Public health & policy considerations
But first...

- Caution with overgeneralization
- Individual experiences and identities also important
- Caution with comparison between different racial/ethnic groups
- Chinese American is not the same population as Chinese living in China
Definition:

- “Health disparity” - refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group.

- A “health care disparity” - refers to differences between groups in health coverage, access to care, and quality of care.

Definition:

- **Race**
  - Not biological, but a social category (i.e. Asian & Pacific Islander Americans)

- **Ethnicity**
  - Refers to a common heritage (include history, language, rituals, preferences for music & food) shared by a particular group (Native Hawaiians vs. Vietnamese Americans)

Should race/ethnicity be measured?

Winker (2004):

- Measuring race is initial step
- Is important indicator of health disparities and health care delivery - different quality of care
- Poor proxy for unmeasured confounders, like cultural, social, environmental influences
- Researchers should define how race is measured, by whom, and why

Why Health Care Disparities Matter

- Racial/ethnic minority
  - are growing population
  - are less like to have access to available mental health services and to receive needed mental health care
  - often receive poorer quality of care
  - significantly under-represented in mental health research

Why Health Care Disparities Matter

- Racial/ethnic minorities also experience
  - Mistrust & fear of treatment
  - Different cultural ideas about illnesses and health
  - Differences in help-seeking behaviors, language, and communication patterns
  - Racism, discrimination by individuals and institutions
  - Varying rates of being uninsured

Why Health Care Disparities Matter

- Estimates that 30% of direct medical costs for Blacks, Hispanics, and Asian Americans are excess costs due to health inequities
- Loses an estimated $309 billion per year due to direct and indirect costs of disparities
- Estimates include self reported mental-health status

Figure 1
Excess Medical Expenditures Due to Health Inequities

- Other Expenditures 69%
- Blacks 18%
- Hispanics 11%
- Asians 2%
- Excess Expenditures Due to Inequities 31%

Total Expenditures 2003-2006 = $749 Billion

Asian American Mental Health
“Wu gets beyond the black-white debate and takes us into the 21st century.”
BUSEINESS WEEK

YELLOW
Race in America
Beyond Black and White
FRANK H. WU
Model Minority Myth:

- Misperception that Asian Americans are well adjusted and thriving in the US
- Overlooks variations in differences within Asian Americans
- Cost of aspiring to succeed academically may deteriorate parent-child relation and increase likelihood of anxiety/depression
- Model minority label creates social isolation (can lead others to misunderstand or alienate them)

Asian American Population

- **> 320 million** = total US census
- **17.3 million** = estimated number of U.S. residents of Asian descent (2010)
- **46% percentage growth** = of Asian alone or in combination (2000-2010)

Chinese-Americans were the largest Asian group (3.8 million in 2009), followed by Filipinos (3.2 million), Asian Indians (2.8 million), Vietnamese (1.7 million), Koreans (1.6 million) and Japanese (1.3 million).

Asian category consist of about 43 different ethnic groups and >100 different languages and dialects.
Asian American Mental Health: How many are affected?
## Percentage of Adults Reporting Poor Mental Health by Race/Ethnicity

<table>
<thead>
<tr>
<th>Location</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian/Native Hawaiian &amp; Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>35%</td>
<td>36.5%</td>
<td>36.8%</td>
<td>32.2%</td>
<td>42.1%</td>
<td>43.7%</td>
</tr>
<tr>
<td>DC</td>
<td>36.2%</td>
<td>39.5%</td>
<td>NSD</td>
<td>NSD</td>
<td>NSD</td>
<td>NSD</td>
</tr>
<tr>
<td>NY</td>
<td>37.1%</td>
<td>41.8%</td>
<td>40.9%</td>
<td>33.9%</td>
<td>NSD</td>
<td>NSD</td>
</tr>
</tbody>
</table>

Data represents adults who reported that their mental health was “not good” between one and 30 days in the past 30 days. NSD = Not sufficient data.

### Prevalence of Current Depression by Type

Among US Adults by Selected Characteristics, 2006 and 2008

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Major depression % (95% CI)</th>
<th>Other depression % (95% CI)</th>
<th>Any depression % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>235,067</td>
<td>4.1 (3.9-4.2)</td>
<td>5.2 (4.9-5.3)</td>
<td>9.1 (8.9-9.4)</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White, non-hispanic</td>
<td>183,563</td>
<td>3.7 (3.6-3.9)</td>
<td>4.2 (4.1-4.4)</td>
<td>8.0 (7.7-8.2)</td>
</tr>
<tr>
<td>Black, non-hispanic</td>
<td>17,604</td>
<td>5.0 (4.5-5.6)</td>
<td>7.9 (7.1-8.8)</td>
<td>12.9 (11.9-14.0)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>18,391</td>
<td>4.7 (4.1-5.4)</td>
<td>7.0 (6.2-7.8)</td>
<td>11.7 (10.8-12.7)</td>
</tr>
<tr>
<td>Other, non-hispanic</td>
<td>13,528</td>
<td>5.1 (4.4-6.0)</td>
<td>5.6 (4.8 - 6.5)</td>
<td>10.7 (9.6-11.9)</td>
</tr>
</tbody>
</table>

Other = Asian, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, multirace

Where’s the data?

- NLAAS
  - National sample, face-to-face interview (or telephone) in different languages (English, Chinese, Spanish, Tagalog, Vietnamese)
  - DSM-IV-TR criteria: anxiety, mood disorder, depressive disorder, substance use disorder
### Table 2

**Lifetime Prevalence of DSM-IV/WMH-CIDI Disorders by Gender and Nativity**

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>Immigrant (n = 1,641)</th>
<th>U.S. born (n = 454)</th>
<th>Men (n = 998)</th>
<th>Women (n = 1,097)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 95% CI</td>
<td>% 95% CI</td>
<td>% 95% CI</td>
<td>% 95% CI</td>
</tr>
<tr>
<td>I. Anxiety disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic disorder</td>
<td>2.1 [1.2, 3.8]</td>
<td>1.6 [0.6, 4.0]</td>
<td>4.0 [2.4, 6.6]</td>
<td>2.2 [0.8, 6.4]</td>
</tr>
<tr>
<td>Agoraphobia without panic</td>
<td>0.4 [0.2, 0.8]</td>
<td>0.4 [0.2, 0.9]</td>
<td>0.4 [0.1, 1.3]</td>
<td>0.2 [0.1, 0.6]</td>
</tr>
<tr>
<td>Social phobia</td>
<td>5.3 [4.2, 6.8]</td>
<td>4.5 [3.5, 5.9]</td>
<td>8.1 [4.6, 14.0]</td>
<td>5.7 [4.2, 7.6]</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2.5 [2.0, 3.2]</td>
<td>2.5 [1.8, 3.5]</td>
<td>2.6 [1.4, 4.8]</td>
<td>1.4 [0.8, 2.6]</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>2.0 [1.2, 3.3]</td>
<td>1.7 [0.9, 3.2]</td>
<td>3.1 [1.4, 6.5]</td>
<td>1.4 [0.8, 2.6]</td>
</tr>
<tr>
<td>II. Mood disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysthymia</td>
<td>2.2 [1.4, 3.4]</td>
<td>2.0 [1.2, 3.6]</td>
<td>2.7 [1.4, 5.1]</td>
<td>2.0 [1.0, 4.0]</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>9.5 [7.8, 11.4]</td>
<td>8.3 [6.8, 10.1]</td>
<td>13.4 [9.8, 17.9]**</td>
<td>8.3 [6.1, 11.1]</td>
</tr>
<tr>
<td>VI. Substance disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse or dependence</td>
<td>3.4 [2.3, 5.2]</td>
<td>2.0 [0.9, 4.2]</td>
<td>8.3 [5.6, 12.0]**</td>
<td>6.0 [3.6, 9.8]</td>
</tr>
<tr>
<td>Drug abuse or dependence</td>
<td>2.1 [1.4, 3.0]</td>
<td>1.0 [0.5, 2.0]</td>
<td>5.5 [3.7, 8.2]**</td>
<td>3.1 [1.9, 5.0]</td>
</tr>
<tr>
<td>Any substance disorder</td>
<td>4.0 [2.8, 5.6]</td>
<td>2.2 [1.1, 4.4]</td>
<td>9.7 [7.1, 13.1]***</td>
<td>6.5 [4.1, 10.1]</td>
</tr>
<tr>
<td>V. Any mental disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>Total</th>
<th>Immigrant</th>
<th>U.S. born</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>95% CI</td>
<td>%</td>
</tr>
<tr>
<td>I. Anxiety Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic disorder</td>
<td>2.1</td>
<td>[1.2, 3.8]</td>
<td>2.1</td>
</tr>
<tr>
<td>Agoraphobia without panic</td>
<td>0.4</td>
<td>[0.2, 0.8]</td>
<td>0.3</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2.5</td>
<td>[2.0, 3.2]</td>
<td>1.6</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>2.0</td>
<td>[1.2, 3.3]</td>
<td>1.7</td>
</tr>
<tr>
<td>II. Mood disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>9.1</td>
<td>[7.5, 11.1]</td>
<td>8.0</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>2.2</td>
<td>[1.4, 3.4]</td>
<td>2.3</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>9.5</td>
<td>[7.8, 11.4]</td>
<td>8.0</td>
</tr>
<tr>
<td>III. Substance disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse or dependence</td>
<td>3.4</td>
<td>[2.3, 5.2]</td>
<td>3.8</td>
</tr>
<tr>
<td>Drug abuse or dependence</td>
<td>2.1</td>
<td>[1.4, 3.0]</td>
<td>1.8</td>
</tr>
<tr>
<td>Any substance disorder</td>
<td>4.0</td>
<td>[2.8, 5.6]</td>
<td>4.1</td>
</tr>
<tr>
<td>IV. Any mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 2,095. DSM–IV = Diagnostic and Statistical Manual of Mental Disorders; WMH–CIDI = World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview.

* Significantly different from immigrant men.  ** Significantly different from immigrant women.  *** Significantly different from U.S.-born men.  **** Significantly different from U.S.-born women.

* p < .05.  ** p < .01.  *** p < .001.
Summary of study by Hong et al. (2014):

- Ethnically include Vietnamese, Filipino, Chinese and “Other Asian” (N=2095)
- Lifetime prevalence of any mental disorder was 18.1%
- In total sample, most prevalent class of disorders:
  - anxiety disorder (10.2%)
  - mood disorder (9.5%)
  - and substance use disorder (4.0%)
- Within disorder classes, most prevalent were
  - MDD (9.1%)
  - Social phobia (5.3%)
  - Alcohol abuse (3.4%)
Men had significantly higher rates of lifetime substance use disorder (alcohol and drug abuse)

Rates of any mood disorders for U.S. born women were significantly higher than all other groups

Rates of any anxiety disorders for U.S. born women were significantly higher than immigrants
  - Panic disorder (5.5 %)
  - Social phobia (8.0 %)
  - PTSD (5.7%)
Higher Rates of Mental Health Disorders Associated with Other Socioeconomic factors:

a. **Anxiety disorder** - among immigrant men: older age, poor/fair English proficiency

a. **Mood disorder**
   i. Among Immigrant women-young, never married
   ii. Among immigrants - men and women who never married
   iii. Among US born men and women - widowed/separated/divorced
   iv. Immigrant men- with low household incomes or poor/fair English proficiency
   v. Among US born - Chinese women (vs. Filipino and other Asians)

a. **Substance use disorder** - never married; immigrant men with HS degree

a. **Any mental disorder** - youngest age, immigrant women; immigrant women and US born men who have never married ; Chinese US born women; immigrant men who spoke poor/fair English

Mental Health Disorders by Subethnic Groups

Su Yeon Lee et al. (2014)

- Survey of noninstitutionalized participants >=18 yrs old from NESARC (National Epidemiologic Survey on Alcohol & Related Conditions)
- NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule- DSM-IV (AUDADIS-IV).
- Asian subsample (N=1,431)
  - East Asians (China, Japan, Korea, Taiwan) (n=648)
  - Southeast Asians (Indonesia, Malaysia, Vietnam, Thai, Laos, Cambodia, Burma, Pacific Islands) (n=495)
  - South Asian (India, Afghanistan, Pakistan, Iran) (n=298)
Table 2: Lifetime prevalence of mental disorders among Asian American subethnic groups

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>East Asians (n = 648)</th>
<th>Southeast Asians (n = 485)</th>
<th>South Asians (n = 298)</th>
<th>χ²</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>SE</td>
<td>N</td>
<td>%</td>
<td>SE</td>
</tr>
<tr>
<td><strong>Mood disorders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depression</td>
<td>72</td>
<td>11.1</td>
<td>1.2</td>
<td>59</td>
<td>12.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>15</td>
<td>2.3</td>
<td>0.6</td>
<td>18</td>
<td>3.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Bipolar disorder (I/II)</td>
<td>25</td>
<td>3.8</td>
<td>0.8</td>
<td>30</td>
<td>6.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>87</td>
<td>13.4</td>
<td>1.3</td>
<td>82</td>
<td><strong>16.9</strong></td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Anxiety disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social phobia</td>
<td>27</td>
<td>4.2</td>
<td>0.8</td>
<td>20</td>
<td>4.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>17</td>
<td>2.6</td>
<td>0.6</td>
<td>10</td>
<td>2.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Agoraphobia or panic disorder</td>
<td>16</td>
<td>2.4</td>
<td>0.6</td>
<td>16</td>
<td>3.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>40</td>
<td>6.2</td>
<td>0.9</td>
<td>38</td>
<td>7.8</td>
<td>1.2</td>
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<tr>
<td>Any anxiety disorder</td>
<td>74</td>
<td>11.4</td>
<td>1.2</td>
<td>65</td>
<td>13.4</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Substance use disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol disorder</td>
<td>35</td>
<td>5.4</td>
<td>0.1</td>
<td>21</td>
<td>4.3</td>
<td>0.01</td>
</tr>
<tr>
<td>Drug disorder</td>
<td>66</td>
<td>10.2</td>
<td>0.01</td>
<td>75</td>
<td>15.5</td>
<td>0.02</td>
</tr>
<tr>
<td>Any substance use disorder</td>
<td>85</td>
<td>13.1</td>
<td>0.01</td>
<td>81</td>
<td><strong>16.7</strong></td>
<td>0.02</td>
</tr>
<tr>
<td>Any DSM-IV psychiatric disorder</td>
<td>178</td>
<td>22.5</td>
<td>0.02</td>
<td>168</td>
<td><strong>34.6</strong></td>
<td>0.02</td>
</tr>
</tbody>
</table>

* p < 0.05, ** p < 0.01, *** p < 0.001
Mental Health Disorders by subethnic groups

Southeast Asians had

- a higher prevalence of any DSM-IV psychiatric disorders (34.6 %) compared to East Asians (22.5 %) and South Asians (24.5 %)
- highest prevalence of substance use disorders (16.7 %), mainly due to their higher prevalence of drug use disorders (15.5 %) compared to East Asians (10.2 %) and South Asians (10.4 %; p = 0.02)

South Asians had the lowest prevalence of substance use disorders (11.1 %) followed by East Asians (13.1 %; p = 0.06).
Prevalence of Depression among Chinese Americans

● Sample
  o 1993-1994 survey 1,747 Chinese American households in Los Angeles area

● Measurements
  o translated University of Michigan’s Composite International Diagnostic Interview into Chinese

● Findings
  o Major depression episode
    ▪ lifetime: 6.9%
    ▪ in the past 12 months: 3.4%
  o Lifetime rate of dysthymia: 5.2%, with 0.9% in the past 12 months

Asian American Mental Health:
Role of Stigma

● Definition of stigma:
  ○ Refers to negative and discrediting markers that society attributes to people who are different, in the context of social, political, cultural factors and standards of which individuals have little control (Goffman, 1963)

Conceptual Model of Stigma

FIGURE 1 Four types of stigma (based on Pryor & Reeder, 2011).

Stigma in Asian American communities

- Asian American communities feel even more stigmatized by mental illness
- Many believe that mental health disorders are due to lack of willpower
- It is shameful to seek help or admit that one has mental health problem
- To preserve the family name and save “face,” may often look first to families for help than admit their problems to a stranger → intense family involvement but longest delay in seeking mental health care → may turn patient over to facility and disengage when psychiatric help is finally sought

Asian American Mental Health

Role of Discrimination

Do you speak English?
☐ Yes
☐ No
Role of discrimination

- Racial or ethnic discrimination
  - defined as unfair treatment received because of one’s racial or ethnic characteristics
  - has been associated with variety of mental and physical health outcome
A literature review examined relationships between discrimination and Asian American health, finding that:

- Lack consistent, clear conceptual definition of discrimination among 14 articles reviewed.
- Discrimination significantly associated with depressive symptoms in 7 studies.
- Association between discrimination and physical health (i.e., cardiovascular disease, respiratory condition, obesity, diabetes) in 3 studies.

Perceived Racism or Discrimination & Minority Health

Brondolo et al. (2011)

- 53% of the Asian participants, 54% of the Black participants, and 44% of the Latino(a) participants had experienced race-related threat and harassment over the course of their lifetimes at least occasionally.
- No racial/ethnic group differences
  - in self-reported health
  - in symptoms of depression or anxiety

Perceived Racism or Discrimination & Minority Health

Brondolo et al. (2011)

- Significant association of lifetime exposure to perceived discrimination (subscales of social exclusion and threat) with overall self-reported health among Asian Americans, African Americans and Latinos
- Depression, anxiety, cynical hostility all positively associated with discrimination, negatively associated with self-reported health
Effect of discrimination on mental health service use among Chinese Americans

Spencer et al. (2004)


● Measured discrimination
  o Race discrimination - having ever been treated unfairly or badly because of one’s race/ethnicity
  o Language discrimination - treated unfairly or badly because “you speak a different language or you speak with an accent”

Effect of discrimination on mental health service use among Chinese Americans

- Measured psychiatric disorder:
  - University of Michigan version of the Composite International Diagnostic Interview.
  - Computer algorithms are used to construct clinical diagnoses
  - Limited analyses to affective disorders and anxiety disorders.

- Measured mental health utilization:
  - a) use of formal services,
  - b) use of informal services (i.e. minister, priest, temple, spiritualist, herbalist, or fortune-teller), and
  - c) seeking help from friends or relatives.
Effect of discrimination on mental health service use among Chinese Americans

- Race discrimination: 18% of respondents reported having been treated badly or unfairly because of their racial/ethnic status
- Language discrimination: 13% reported such treatment because they speak a different language or speak with an accent
  - 2.2 more likely to use informal services and 2.4 more likely to seek help from friends or relatives compared to those who did not report such treatment

Asian American Mental Health Disparity

Mental Health Underutilization
Health Care Disparities in Utilization

- **Low admission rates** to state hospitals and **low utilization** of outpatient mental health services
- Initially thought as “model minority” - but Asian patients had **more severe and chronic conditions**
  - Did not reach service system until very late in the help seeking process
  - Asian patients with schizophrenia typically contained within the family and community, generally did not reach the mental health system **until 3 yrs after initial onset of psychotic symptoms**

NLAAS data

- Findings
  - Asian Americans have lower rates of mental health-related service use (8.6%) compared to the general population (17.9%)
  - Lower percentage of Asian Americans (34.1%) who had a probably DSM-IV diagnosis during a 12-month period sought any service compared with counterparts (41.1%)
  - US-born individuals used mental health services at higher rates than did immigrants.

Mental Health Underutilization among Asians

Su Yeon Lee et al. (2011)

- National sample of survey of noninstitutionalized participants >=18 yrs old from NESARC (National Epidemiologic Survey on Alcohol & Related Conditions)
- Aim: compare lifetime mental health service utilization among Asians to that of other racial/ethnic groups (whites, blacks, Hispanics)
Mental Health Underutilization among Asians

- Diagnosis = Alcohol Use disorder and Associated Disabilities Interview Schedule DSM-IV (AUDADIS-IV) for mood disorder, anxiety disorder, alcohol use
- Mental health service utilization = outpatient services, inpatient services, emergency services, use of prescribed medication

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>Asian (N=1,332)</th>
<th>White (N=24,507)</th>
<th>Black (N=8,245)</th>
<th>Hispanic (N=8,308)</th>
<th>Native American (N=701)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total N</td>
<td>N used services</td>
<td>N used services</td>
<td>Total N</td>
<td>N used services</td>
</tr>
<tr>
<td>Mood disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depression</td>
<td>144</td>
<td>61</td>
<td>38.8</td>
<td>4,596</td>
<td>3,021</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>30</td>
<td>20</td>
<td>66.3</td>
<td>1,235</td>
<td>981</td>
</tr>
<tr>
<td>Bipolar disorder (I, II)</td>
<td>60</td>
<td>16</td>
<td>18.8</td>
<td>1,361</td>
<td>759</td>
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<tr>
<td>Any mood disorder</td>
<td>188</td>
<td>70</td>
<td>34.2</td>
<td>5,286</td>
<td>3,250</td>
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<tr>
<td>Anxiety disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social phobia</td>
<td>49</td>
<td>10</td>
<td>17.9</td>
<td>1,318</td>
<td>458</td>
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<tr>
<td>Generalized anxiety disorder</td>
<td>30</td>
<td>19</td>
<td>61.8</td>
<td>1,300</td>
<td>792</td>
</tr>
<tr>
<td>Agoraphobia or panic disorder</td>
<td>32</td>
<td>17</td>
<td>49.8</td>
<td>1,428</td>
<td>1,010</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>88</td>
<td>10</td>
<td>10.5</td>
<td>2,413</td>
<td>671</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>155</td>
<td>37</td>
<td>24.3</td>
<td>4,545</td>
<td>1,689</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol disorder</td>
<td>53</td>
<td>7</td>
<td>14.1</td>
<td>1,881</td>
<td>337</td>
</tr>
<tr>
<td>Drug disorder</td>
<td>151</td>
<td>13</td>
<td>7.6</td>
<td>6,085</td>
<td>420</td>
</tr>
<tr>
<td>Any DSM-IV psychiatric disorder</td>
<td>384</td>
<td>101</td>
<td>25.0</td>
<td>11,146</td>
<td>4,953</td>
</tr>
</tbody>
</table>

* Prevalence is expressed as weighted percentages.
Table 3
Comparison of lifetime utilization of mental health services for mental disorders among Asians and other racial and ethnic groups

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Mood disorder</th>
<th>Anxiety disorder</th>
<th>Substance use disorder</th>
<th>Any disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Asian versus white</td>
<td>.31</td>
<td>.21–.46</td>
<td>.64</td>
<td>.37–1.13</td>
</tr>
<tr>
<td>Asian versus black</td>
<td>.73</td>
<td>.50–1.06</td>
<td>1.04</td>
<td>.54–2.04</td>
</tr>
<tr>
<td>Asian versus Hispanic</td>
<td>.49</td>
<td>.33–.71</td>
<td>.70</td>
<td>.33–1.47</td>
</tr>
<tr>
<td>Asian versus Native American</td>
<td>.27</td>
<td>.15–.48</td>
<td>.70</td>
<td>.30–1.59</td>
</tr>
</tbody>
</table>

*Odds ratio (OR) controlled for age, sex, education, family income, marital status, current insurance status, and disorder severity as indicated by number of symptoms.*
Summary of Study:

- Proportion of Asians making use of mental health services for mood or anxiety disorder was lowest among the racial/ethnic groups

- Asians with lifetime diagnosis of mood disorder were significantly less likely to use mental health services for the disorder than whites, Hispanics, and Native Americans but equally likely as blacks after adjustment for socioeconomic factors and severity of mood disorder

Mental Health Service Use Across Asian American Subethnic Groups

Su Yeon Lee et al. (2014)

● Goal: examine the differences in mental health needs and patterns of mental health service use across 3 Asian American subethnic groups (East Asian, Southeast Asian, South Asian) using NESARC

● Findings:
  o **SE Asians had higher prevalence of overall psychiatric disorders** compared to East Asians & South Asians, mostly due to a high prevalence of drug use disorders
  o **East Asians had a significantly lower odds of mental health service use** (OR=0.25 CI = 0.08=0.84) compared to South Asian

SE Asians = (Indonesia, Malaysia, Vietnam, Thai, Laos, Cambodia, Burma, Pacific Islands)
East Asians = (China, Japan, Korea, Taiwan)
Su Yeon Lee et al. (2013)  
● Aim: examine the relationship between subtypes of depressive symptoms and mental health service use across racial/ethnic groups based on survey  
● Depressive subtypes  
  ○ mild, cognitive, psychosomatic, severe
Racial & Ethnic Differences in Depressive Subtypes

Four depressive subtypes:
1. “mild” (i.e., lower probabilities of endorsing all depressive symptoms)
2. “cognitive” (i.e., high probabilities of endorsing worthlessness and concentration difficulties)
3. “psychosomatic” (i.e., high probabilities of endorsing sleep, fatigue, and impaired concentration),
4. “severe” (i.e., high probabilities of all depressive symptoms).
Fig. 3. Proportions of mental health service use for depressive subtypes by race.
Behavioral Model of Health Service Utilization

Figure 3: Andersen’s Behavioral Model of Health Services Utilization (adapted from Wolinsky, 1988b)

Predisposing Characteristics
• Demographics
• Social structure
• Health beliefs

Enabling Characteristics
• Family resources
• Community resources

Need Based Characteristics
• Perceived needs
• Clinically evaluated needs

Utilize Health Services

Barriers to Health Utilization

- Demographic factors
  - Acculturation, Nativity (Immigrant vs. US-born, or Generation), English proficiency, Legal immigration status, Poverty Rate

- Cultural factors
  - Stigma, loss of face, causal beliefs; Perceived stigma/discrimination
  - Lack of awareness or understanding of services
  - Some may somaticize mental health problems or underreport symptoms

- System issues
  - Poor culturally responsive services
  - Limited access to care (cost, lack of insurance, location)
Cultural Considerations in treating Chinese Americans

Clip from Practicing Cultural Psychiatry in San Francisco’s Chinatown
https://www.youtube.com/watch?v=8NrJPxNexvw (5:10 - 5:59)

Above photo Courtesy: http://accidentalchinesehipsters.tumblr.com/
<table>
<thead>
<tr>
<th>Western Culture</th>
<th>Eastern/Chinese Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared clinical decision-making model that emphasizes patients’ autonomy and encourages them to act as full participants in the treatment process.</td>
<td>Clinicians expected to ‘protect’ patients from psychiatric diagnosis - viewed with great fear and shame</td>
</tr>
<tr>
<td>Individualism, autonomy, independence</td>
<td>Family involvement and interdependence</td>
</tr>
<tr>
<td>Biomedical model - isolable disease processes (depression: neurotransmitter deficiency, unresolved psychic conflict, distorted thought patterns)</td>
<td>Chinese medical model - patterns of harmony/disharmony, interpret symptoms within a larger context (Qi, Yin Yang, 5 organ systems)</td>
</tr>
<tr>
<td>Dualistic distinction between mind and body</td>
<td>No distinction between mind and body</td>
</tr>
</tbody>
</table>

Caution with overgeneralization!
Some traditional beliefs

● Confucian: family is important; negative emotion harmful to social fabric
● Taoism: distress is part of life, not to be fought, but to be understood and harmonized

Buddhist meditation: detach from negative emotions and transcend them; isolate grief, fear, hostility, negative affect

● Traditional Chinese Medicine: Yin-Yang balance, and 5 Phases of the body (Wood=Liver, Earth=Spleen, Water=Kidney, Fire=Heart, Metal=Lungs)
Some Traditional Chinese Medicine beliefs

Excess anxiety
- related to stagnation in the Spleen organ Qi
- also associated with abdominal symptoms such as distention and poor digestion

Sadness and grief
- can weaken the Lung essence, which in turn can lead to a pale complexion and a weak voice

- Anxious or depressive feelings can be in excess or deficient, and will disturb the balance of Qi within the person.
- States are not in and of themselves conceptualized as disease entities

Some Cultural Concepts

- “Endure” = 忍 (ren)

- “Save face” - signifies a desire or strategy to avoid humiliation or embarrassment, to maintain dignity or preserve reputation
Somatization

Yeung et al. (2004)

- Examine illness beliefs of depressed Chinese Americans in primary care in Boston
- May 1998-Nov 1999
- Screened for depression using Beck Depression Inventory (BDI)
- Majority (n=22, 76%) of depressed Chinese Americans complained mainly of somatic symptoms


### TABLE 2-1. Chief complaints of depressed Chinese patients (N = 29)

<table>
<thead>
<tr>
<th>Chief complaints</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical symptoms</td>
<td>12 (41)</td>
</tr>
<tr>
<td>Headache</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Cough</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Pain</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Others</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Depressive neurovegetative symptoms</td>
<td>10 (34)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Depressive psychological symptoms</td>
<td>3 (14)</td>
</tr>
<tr>
<td>Irritability</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Ruminations</td>
<td>1 (3.5)</td>
</tr>
<tr>
<td>Poor memory</td>
<td>1 (3.5)</td>
</tr>
<tr>
<td>Nervousness</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Depressed mood</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No complaints</td>
<td>1 (3.5)</td>
</tr>
</tbody>
</table>
Reasons for somatization

- Stigma attached to psychiatric symptom, compared to relative acceptance of physical complaints
- Societal pressure to suppress and disguise negative feeling states
Somatization

- Leads to inadequate treatment of psychiatric disorders
- When depressed Chinese Americans are asked explicitly, they readily report their depressive symptoms without difficulty
Obtaining History
Engagement Interview Protocol (EIP) by Yeung et al. (2011)

- Integrate patients’ illness beliefs into psychiatric assessment and evaluation
- Based on Kleinman’s questions, DSM-IV Cultural Formulation model, and clinical experience

EIP model

- Can be completed within 1 hour
- Effective to facilitate enrollment of patients in treatment of depression
- Composed of 6 sections
  1. history of present illness - include illness beliefs
  2. psychosocial history
  3. mental status exam
  4. DSM-IV diagnoses
  5. culturally sensitive disclosure of diagnosis
  6. customized treatment negotiation
1. History of illness

A. Present illness

Patient’s narratives on personal illness experience

Patient’s cultural explanatory of his/her illness

1. What do you call your problem?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your sickness?
7. What are the chief problems the sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

B. Past psychiatric/medical history

C. Family history
2. Psychosocial history

A. Country of origin and childhood development
B. Education level
C. Immigration history: the date, purpose, and process of immigration; adjustment in the host country
D. Marital history
E. Spiritual/religious beliefs
F. Family support network:
   Whom do you live with?
   How’s your relationship with your spouse, parents, siblings, children etc?
G. Past and current job
H. Social supports
   I. Stressors
   J. Levels of functioning
3. Mental status examination

Appearance:
Attitude:
Speech:
Motor:
Mood:
Affect:
Thought contents:
Cognition and intellectual resources:
Insight/Judgment:

4. Multi-axial diagnoses

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:
5. Culturally sensitive disclosure of diagnosis

   A. Elicit the patient’s illness beliefs
   B. Accept multiple explanatory models
   C. Clarify the meanings of diagnostic labels
   D. Sensitive and flexible use of terminology
   E. Disclose in stages

6. A customized approach to treatment negotiation

   A. Explore the patient’s understanding and preferences for treatment
   B. Discuss the pros and cons of treatment options
   C. Negotiate and finalize treatment plan
   D. Discuss potential side effects from treatment and possible remedies
Disclosure of Diagnosis

Of the recent Chinese immigrants who met criteria for MDD in a clinic-based survey, a large majority (21/29, 72%) either did not know of the term MDD (you yu zheng) or did not consider it a diagnosable medical illness.
Communicating the diagnosis of MDD to less acculturated Chinese patients

- Process-based approach
- Involve family - understand illness narrative, family dynamics, collaborate on treatment issues
Communicating the diagnosis of MDD to less acculturated Chinese patients

- Culturally sensitive use of Western psychiatric terms
  - *Jing shen bing* - ‘psychiatric disorder’ is synonymous with craziness (refer to violent psychotic disorder and mental retardation)
  - *Xinli wenti* - ‘psychological problem’ is less dramatic and refer to problems such as depression and anxiety
  - Help understand depressive feelings as part of larger context of life struggles (not label it as ‘crazy’ or *jing shen bing*)
Communicating the diagnosis of MDD to less acculturated Chinese patients

- Translation of disorder is important to avoid stigmatized connotations
  1) MDD = zhong xing you yu zheng
      = ‘severe depressive disorder’
  2) ‘Depressive disorder’ = you yu zheng
     or yi yu zheng
  3) ‘depression’ = you yu
  4) avoid mental health jargon
Treatment negotiation of MDD

● Background from HPI
  o “What kind of treatment do you think you should receive?”
  o “What are the most important results you hope to receive from the treatment?”
● Start by providing rationale for treatments - aimed to alleviate suffering and reduce functional impairment
● Discuss available treatment options - provide rational, pros/cons, side effects
Treatment negotiation of MDD

- Explore patient’s understanding, preference for medication treatment, counseling - clarify worries, misconceptions
- Medication - Chinese immigrants may consider treatment for the insane or question usefulness of medication for solving psychosocial problems.
- More familiar with ‘talk therapy’ or counseling (xin li fu dao) “心理辅导”
  - refers to psychological guidance or coaching instead of psychotherapy
Treatment negotiation of MDD to less acculturated Chinese patients

- Incorporate concepts from Traditional Chinese Medicine into Western models
  - i.e. explain “monoamine hypothesis” as an issue of imbalance that disturb the “flow” of one’s life and emotional state (xinqing)
  - antidepressant’s role is to restore the balance of the system, to tonify, and to strengthen energy of the brain (bu nao)
Summary

- Mental health disparities exist among Asian Americans
  - Limited data on a very diverse population
  - Rates of mental health disorders varies by socioeconomic factors (i.e. age, gender, marital status, US born vs. not, English proficiency)
  - Perceived stigma & racism/discrimination impact on health
  - Mental health underutilization
- Diversity of Asian American population
- Incorporate patient’s explanatory model in HPI
- Be aware of using certain translated words in Chinese in explaining diagnosis that might reduce or increase stigma
Bridging the gap: Policy implications

- Need for more research given diverse Asian American population
- Need to target specific demographic group - i.e. mood disorder among young immigrant Chinese women
- Incorporate idea of cultural competency at a clinical level and not just system level
  - As part of medical training curriculum
  - Increase interpreter's awareness of avoiding using certain stigmatizing mental health terms
- Find ways to increase mental health utilization
  - Address language barrier, discrimination, stigma
  - Integrate primary care and mental health services
  - Increase culturally appropriate mental health services
More resources:

Resident’s Video Series

Center of Excellence for Cultural Competence:
http://nyculturalcompetence.org/resources/
THANK YOU!

Guest speaker: Dr. Su Yeon Lee

Dr. Catapano, Dr. Khin Khin, Dr. Griffith, Dr. Norris
Dr. Green, fellow residents
References


References


