

# *Saving Face*

Recognizing & Managing the Stigma  
of Mental Illness in Asian Americans



## Facilitator's Guide

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# **Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans**

## **Study and Facilitator's Guide**

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# **Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans**

## **Facilitator's Guide**

### **Description of the Asian-American community**

Asian Americans are the third largest racial minority group in the U.S. with a 2006 population of 13.1 million. In percentage, Asian and Pacific Islander Americans are the fastest growing racial minority group in the United States. They comprise 43 distinct ethnic groups and speak over 100 languages and dialects, many of which may not be widely spoken outside their own immediate communities. Forty percent of Asian Americans have limited English proficiency, which means that no one in the household over the age of 14 speaks English very well.

### **Overview of mental illness and needs in the Asian-American community**

Asian Americans have mental health disorders at rates that are similar to or greater than those of Caucasians.

- Depression rates among Asian Americans are between 15 and 20%, figures similar to those of Caucasians.
- API females aged 65 and over historically have had and continue to have the highest suicide rates of any racial group, a trend that has persisted since 1990.
- Although there has been a slight decline in recent years, Asian-American women aged 15-24 have the highest suicide rates of all racial groups for that age group.
- Suicide rates among males aged 65 and over have declined for all groups except APIs.
- Death and suicidal ideation rates for elderly Asian Americans seeking primary care are higher than for any other racial group.

### **Overview of mental health stigma**

In 2001, the *Supplement to the Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity* called stigma the most pervasive problem preventing members of all racial and ethnic minority groups from seeking behavioral health care for mental disorders including substance use. Stigma is a particularly critical problem among members of Asian-American ethnic groups, whose knowledge, attitudes, and

beliefs about mental illness are rooted in the teachings of Confucianism, Buddhism, Taoism, and animism, and whose myriad of languages and dialects often are not spoken outside their immediate communities. Stigma often is very subtle in its presentation.

Stigma is a complex phenomenon related to loss of status and disrupted identity. It is associated with labeling, negative stereotypes in the media, language, distorted expectations, and simple lack of knowledge, misunderstanding, or lack of awareness of mental illness. It can focus on visible or invisible attributes, and be perpetuated through conscious or unconscious processes. It can emerge across systems, within a family, or in a community, or in biases that inadvertently emerge among service providers and are reinforced through anger, fear, or prejudice. At the work site it can be initiated by subtle or not so subtle communications from administrators or colleagues. For community members or patients who are members of the non-dominant culture and coping with health or mental health concerns, the cumulative impact of being labeled in multiple ways perceived as negative can be unexpected, far reaching and debilitating.

Several characteristics are associated with the stigma of mental illness in Asian Americans. They are:

- There is a negative cultural connotation associated with mental illness. Culture shapes the expression, recognition, and social acceptance of psychiatric illness and problems. For traditionally identified Asian Americans, the influence of the teachings and philosophies of a Confucian, collectivist tradition discourage open display of emotions in order to maintain social and familial harmony or to avoid exposure of personal weakness. Saving face, the ability to preserve the public appearance of the patient and family for the sake of community propriety, is extremely important to most Asian-American groups. Patients may not be able or willing to discuss their moods or psychological states because of fears of social stigma and shame. In many Asian cultures, mental illness is stigmatizing; it reflects poorly on family lineage and can, for example, influence others' beliefs about the suitability of an individual or his/her immediate relatives for marriage or employment. It is more acceptable to use idioms of distress that are somatic rather than psychological (Kramer et al, 2002; Tseng, 1975; Kleinman, 1977; Nguyen, 1982; Gaw, 1993; Chun et al, 1996).
- Stigma is heightened by immigration and acculturation experiences. Traditional Asian- American cultures greatly value family cohesion within well-structured roles. For many Asians who immigrate to the United States, the stress of relocation increases as they encounter American society, with its emphasis on individual independence from the nuclear or extended family. Differences and changes in values, and language, as well as economic, social, professional and legal status are among the many stressors both voluntary and involuntary migrants experience as they acculturate. These

stressors can contribute to mental illness, substance use, and other conditions that may be a focus of clinical attention, such as problems with domestic relations or acculturation. Due to the stigma attached to mental illness, Asian Americans often are ashamed and reluctant to seek help and treatment for their emotional difficulties. Further, possible experiences of discrimination and prejudice in combination with these stressors may already cause the person to feel marginalized; acknowledging mental illness may make the person feel even more devalued.

- Stigma is not just a patient issue. Many traditional Asian-American patients, particularly the Chinese, view physicians, including primary care providers, as experts whom they hold in high esteem, and they expect them to be able to solve all problems. However, Mark et al (1998) found that 79% of US-trained and 53% of Asian-trained PCPs working in a Chinese-American community health center, all of whom were of Asian origin, thought that Asian patients with mental health problems should be referred to mental health providers. On further probing, much of their resistance resulted from their own stigma and misconceptions about mental illness.

The stigma of having a mental illness is one of the most significant obstacles preventing Asian Americans from seeking help. Religious and cultural beliefs associate mental illness with guilt and shame that affect the patient and the whole family. Patients with mental illness symptoms fear being rejected by siblings and relatives, as well as by members of their community. Denial and concealment of mental illness, with the purpose of protecting the family reputation, are common. Overcoming stigma is difficult and challenging. Clinically, a biological explanation of mental illness may help to dispel part of the stigma of guilt and shame, particularly when the patient and family understand that mental illness is related to biological neurotransmitter imbalances. Close cooperation among social services, health clinics, primary care providers, and mental health providers is very important in providing psychoeducation about the benefits of early evaluation and treatment of mental illness in Asian-American communities. Referral to support groups where the family can get support and information from others who experience similar stress and struggle to cope with mental illness is very helpful to lessen the feelings of being an outcast.

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### **Helpful Readings**

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- Fogel J & Ford DE (2005) Stigma beliefs of Asian Americans with depression in an internet sample. *Can J Psychiatry*. 50 (8). 470-478
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- Yang LH (2007): Application of mental illness stigma theory to Chinese societies: synthesis and new directions. *Singapore Med J*; 48(11). 977-985

### **Purpose of the DVD**

The overarching goal of *Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans* is to demonstrate a culturally competent approach to addressing the stigma of mental illness in Asian-American patients. The DVD is comprised of three interviews of Asian-American simulated patients, from three major sub-ethnic groups of Asian Americans living in the United States, and ethnically matched real clinicians in therapy sessions. The objectives of these scenarios are to demonstrate how Asian-American patients present their stigma, and how skilled therapists manage it. The vignettes include:

- A young, well-educated bicultural professional Indian-American woman with Bipolar Disorder.
- A 54-year old Vietnamese-American man with PTSD and depression.

- The parents of an 8-year-old Filipino-American second grader with Attention Deficit Hyperactivity Disorder (ADHD) who was suspended from school for having a knife in his backpack and could not return without psychiatric evaluation.

In these vignettes the viewer will see patients at various stages in the treatment process. The Filipino-American case shows parts of multiple sessions, enabling the viewer to observe how issues are revealed and managed over time.

### **Learning Objectives**

- To demonstrate how Asian American patients present their stigma of mental illness.
- To demonstrate how skilled therapists manage the stigma.
- To demonstrate how the DSM-IV-TR Outline for Cultural Formulation can be used to organize the patient's sociocultural issues and make them part of the differential diagnosis and treatment plan.
  - This third objective is included primarily for teaching clinicians who will be seeing patients.

### **Potential uses and target audience**

*Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans* originally was conceptualized as a continuing education program for physicians and others needing to meet continuing education requirements in cultural competence, especially those in mental health and primary care. However, as it developed and, more importantly, as we have shown it to various groups and at meetings around the country, it has become clear that there are many audiences for this DVD. They include psychiatry residents, medical students, social work students and practicing social workers, clinical and counseling psychologists, nurses and others working in the health care field, broadly defined. With appropriate facilitation, some of the vignettes also can be used with lay people. For example, the Filipino-American vignette could be shown at a Parent Teacher organization meeting, and the Indian-American one might be very helpful for college or graduate students with similar backgrounds to help them see and accept their own stigma of mental illness.

### **Helpful hints for facilitators**

The DVD consists of a brief introduction by the narrator, Francis Lu, MD, that sets the context for the interviews that follow. It then is divided into three separate vignettes, each with an introduction and a brief concluding commentary. The vignettes vary in length from 15 to 20 minutes. The interviews can be shown either individually for a one-hour class or several can be shown during a longer session. We strongly recommend allowing time for discussion.

The most important task of a facilitator is to maximize the learning experience for members of the group. With a DVD of this type, the facilitator's role will vary from coordinating the activity and moderating the discussion to running a structured didactic session. Whatever method and style is used, questions are included with each vignette that can be used to frame the discussion and maximize the learning experience. Their use is not required although we feel that they will help to enhance the learning experience.

Prior to viewing the DVD, the facilitator should talk a little bit about the culture and history of the patient's country of origin or ancestry. Each vignette is introduced by Dr. Lu, who points out some of the issues that viewers should look for as they watch the DVD. Facilitators should feel free to add to this list as they see fit. After the film has concluded, the facilitator should open the discussion with a lead question and then continue with other questions making certain to give everyone who wants to speak the opportunity to do so. At the conclusion of the discussion, the facilitator should reiterate the key points and briefly summarize the discussion as well as play Dr. Lu's brief concluding commentary.

The amount of time for discussion after playing each of the three vignettes may vary depending on how much time is available for teaching. The program could be shown and discussed in one session if this is all the time that is available. For cross-cultural courses, if there is available time, case-based material could be introduced for further exploration of both the concepts and the cultures. This material can come from many sources ranging from patient vignettes of the learners and faculty to published cases illustrating the use of the DSM-IV-TR Outline for Cultural Formulation.

### **DSM-IV-TR Outline for Cultural Formulation**

The Surgeon General's report, *Mental Health: Culture, Race and Ethnicity* documented widespread mental health disparities for racial and ethnic minority groups and challenged the mental health professions to reduce those disparities through culturally competent clinical care, training, and research. The DSM-IV-TR Outline for Cultural Formulation (OCF) provides "a systematic method of considering and incorporating sociocultural issues into the clinical formulation" (Lu, 2006). It is a comprehensive and inclusive diagnostic tool for the assessment and treatment of mind/body illness across cultural boundaries and diagnostic categories. It provides a structured methodology for teaching cultural competence and diversity skills to

professionals across disciplines that include, but are not limited to, medicine, psychiatry, psychology, social work, and nursing. Despite understandable gaps in a clinician's knowledge about and exposure to diverse cultural groups, the OCF provides a multidimensional process to *contextualize* individual expressions of suffering (idioms of distress) and thus avoid misdiagnosing culturally sanctioned behaviors as psychopathological symptoms (i.e., differential diagnosis) as well as help with the treatment plan.

The five components of the OCF are:

- Cultural identity of the individual
- Cultural explanations of the individual's illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment for differential diagnosis and treatment planning

Facilitators can learn more about the OCF from the references provided below. In addition, the DSM-IV-TR text of the OCF and questions to stimulate discussion can be found in the Appendix of this guide. The Appendix can be copied as a handout for learners as they watch and discuss the DVD.

Published cases can be found in the journal *Culture, Medicine, and Psychiatry*; the book *Cultural Assessment in Clinical Psychiatry*, authored by the Group for the Advancement of Psychiatry and published in 2002 by the American Psychiatric Press, Inc (APPI).; and the book *The Clinical Manual of Cultural Psychiatry*, edited by Russell Lim and published by (APPI) in 2006.

Approximately 17 cases have been published in *Culture, Medicine, and Psychiatry* since 1996; some of the excellent teaching cases appear in the following issues:

- Shin-byung (Divine Illness) in a Korean woman, December, 2000.
- Adjustment Disorder: Intergenerational Conflict in a Chinese Immigrant Family, December, 2002
- Reformulation of Diagnosis with Attention to Cultural Dynamics: Case of a Japanese Woman Hospitalized in Melbourne, Australia, June, 2003
- Clinical Case Study: The American Indian Veteran and Posttraumatic Stress Disorder: A Tele-health Assessment and Formulation, June, 2004

**Helpful readings:**

Group for the Advancement of Psychiatry (2002): Cultural Assessment in Clinical Psychiatry. Washington D.C., American Psychiatric Publishing.

Lim RF (2006): Clinical Manual of Cultural Psychiatry. Washington D.C., American Psychiatric Publishing

Lu FG (2006): DSM-IV Outline for Cultural Formulation: Bringing Culture into the Clinical Encounter. FOCUS. IV (1). 9-10

Lu FG, Lim R, & Mezzich JE (1995): Issues in the assessment and diagnosis of culturally diverse individuals. In J Oldham & M Riba (Eds) Review of Psychiatry. Washington, D.C., American Psychiatric Press, 14. 477-510

**Helpful DVD:**

Koskoff H (2002): The Culture of Emotions, Boston: Fanlight Productions. This is a 58-minute DVD with 23 multicultural experts commenting on the DSM-IV-TR Outline for Cultural Formulation.

## #1 Indian-American Case: Bindu Patel

**Sudha Prathikanti, MD**

### **Overview**

This vignette depicts Bindu Patel, a second-generation Indian American woman in her early 30s who has recently been diagnosed with Bipolar Disorder. Despite her ostensibly "westernized" dress and speech, Ms. Patel comes from a fairly traditional Indian family, and this cultural background poses some specific challenges to her in accepting and treating her mental illness. The vignette illustrates various culturally responsive approaches to diminish stigma, improve therapeutic rapport, and encourage appropriate interventions to achieve and sustain mental health.

### **Cultural Background**

According to data from the 2000 Census, approximately 1.7 million people of Indian origin live in the United States, representing a growth rate of 106% over the previous decade. People of Indian background first arrived in the United States in the mid 1800s and were mostly Sikh farmers settling in California. However, in the face of intense hostility from European-American communities who enacted laws forbidding Indians to own land, intermarry with whites, or to become U.S. citizens, this first wave of Indian immigrants had mostly returned to India by the turn of the 20<sup>th</sup> century. Between 1917 and 1965, federal immigration laws aimed against Asians made it very difficult for people of Indian background to settle in the United States. However, the U.S. Immigration and Naturalization Act of 1965 finally ended ethnic discrimination in immigration policy by stipulating that legal entry into the U.S. would be based on the potential skills of an immigrant, rather than on his or her ethnic origin. During the 1960s, the U.S. became involved in the Vietnam conflict and required a large number of physicians, engineers, and other technical specialists. Thus, the second wave of Indian immigrants who entered the U.S. in the late 1960s and early 1970s were composed of young, well-educated, English-speaking physicians, scientists, and engineers. This second wave of Indian immigrants generally achieved financial success and relative acceptance by members of the dominant American culture, and they were sometimes perceived as members of a "model minority." In the late 1980s, after passage of the Family Reunification Act, this second wave of Indian immigrants sponsored entry of extended family members from India to the U.S. These extended family members constituted the "third wave" of Indian immigrants, and typically were not as well-educated, professional, or fluent in English as their predecessors. While the growth in the Indian-American population has created an increased demand for mental health services within this

community, the marked ethnic, linguistic, socioeconomic, and generational differences among Indian Americans require great sensitivity and responsiveness on the part of mental health care providers.

## **Clinical Background**

Bipolar Disorder, formerly known as Manic-Depressive Illness, is a serious psychiatric disorder that causes cyclical shifts in a person's mood, energy, and ability to function. Epidemiological data show that among all ethnic groups, including people of Indian origin, Bipolar Disorder occurs in about 1% of the population age 18 and older. Bipolar Disorder typically develops in late adolescence or in early adulthood, although it may occasionally present earlier or later in life. Studies suggest that genetic, neurobiological, environmental, and psychosocial factors all contribute to the development of Bipolar Disorder. A person with Bipolar Disorder experiences dramatic mood swings that range from overly "high" or irritable to extremely low and depressed, but also has periods of normal mood in between. Mixed states characterized by rapidly alternating moods is also possible. The episodes of mania and depression are accompanied by severe and characteristic changes in energy and behavior. Sleep, energy, concentration, rate of speech, and amount of motor activity can all be profoundly altered during an acute manic or depressive episode. For example, during a depressive episode, an individual may report low energy and increased fatigue, losing all interest in social activity or previously pleasurable pursuits. In contrast, a manic episode is typically characterized by excessive energy and an increase in disinhibited or intrusive social behavior including possible hypersexual or hyper-religious activity.

Most people with Bipolar Disorder can achieve substantial stabilization of their mood swings and related symptoms with proper treatment. A strategy that combines mood-stabilizing medication with psychotherapy is optimal for managing the disorder over time. During severe mood episodes where symptoms potentially cause risk of harm to self or others, hospitalization may at times be necessary to treat Bipolar Disorder.

## **DISCUSSION QUESTIONS**

### **Cultural Identity**

- Pay close attention to the demographics and cultural identity of Indian-American patients, assessing which wave of migration led to their residence in the U.S. and which generation of immigrants they represent.
- Even for many second-generation Indian-Americans who may appear quite westernized, the extended family and community often play a major role in negotiating developmental milestones.

- Assess gender, sexual orientation, SES, religious/spiritual beliefs among other cultural identity variables.

### **Cultural Explanations of Illness**

- How does Bindu describe her idioms of distress, the explanatory model for her distress, and the treatment pathways both offered by family and taken by her?
- What approach does Dr. Prathikanti use to ask about Bindu's mental health and her current functioning?
- In what ways does the stigma of mental illness potentially affect Bindu as well as her extended family? How was this history elicited?
- The diagnosis of mental illness may bring shame to the whole family, rather than only to the individual with the diagnosis. Stigma may adversely affect the social status and marriage prospects not only of the person with mental illness, but also their siblings or extended family members.
- Among some first-generation Indian Americans, mental illness may be perceived as a somewhat reversible condition that can be "cured" by undertaking the responsibilities of marriage.
- Explanatory models of mental illness which emphasize biological etiologies may be better received than those emphasizing psychosocial etiologies, since the latter may be perceived as wrongfully blaming the family and community.
- Although Bindu did not receive helpful advice from an elder she sought out in the community, taking guidance from elders is a culturally sanctioned treatment option that should be supported when it is helpful to the patient in coming to terms with mental illness and in negotiating the stigma surrounding such a diagnosis.

### **Cultural Stressors and Supports**

- What are the cultural stressors and supports?
- Dr. Prathikanti makes it a point to inquire about the extent to which Bindu has disclosed information about her Bipolar Disorder diagnosis to various members of her family and community. How does Bindu respond to Dr. Prathikanti's acknowledgment of the impact of family and community in her life?

- In what ways does the “acculturation gap” that may exist between first and second-generation South Asians manifest in Bindu’s life as she deals with developmental issues of young adulthood as well as a diagnosis of Bipolar Disorder?

### **Cultural Elements of the Relationship Between Clinician and Patient**

- Compare the cultural identity of the patient with that of the clinician.
- How would one describe the relationship between Dr. Prathikanti and her patient, Ms. Bindu Patel?
- What approaches does Dr. Prathikanti use to strengthen the therapeutic relationship with Bindu, who is reluctant to acknowledge that she has Bipolar Disorder? To what extent is Dr. Prathikanti successful?

### **Overall Cultural Assessment**

#### **Differential Diagnosis**

The diagnosis of Bipolar Disorder was made based on the symptoms presented. No Culture-Bound Syndromes were seen.

#### **Treatment Plan**

- How did Dr. Prathikanti discuss treatment options with Bindu? What were some of Bindu’s concerns about treatment? How did Dr. Prathikanti attempt to address those concerns?
- Dr. Prathikanti is careful to present psychotherapy as a means to address first specific here-and-now life decisions, rather than to probe initially for early childhood experiences or events that might affect the patient’s personality and coping style. How does Bindu respond to this emphasis?
- Psychotherapy may be viewed with suspicion and skepticism because of the perception that it may disrespect the wisdom of elders, and wrongfully blame parents for the misdeeds of their children. In this context, cognitive-behavioral or supportive psychotherapy may be more accepted than exploratory-psychodynamic approaches.

## Helpful Readings

Bhatia S (2007): *American Karma: Race, Culture, and Identity in the Indian Diaspora* (Qualitative Studies in Psychology). New York, NYU Press

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Rangaswamy P (2000): *Namaste America: Indian Immigrants in an American Metropolis*. State College, PA, Pennsylvania State University Press

Sheth P (2001): *Indians in America: One Stream, Two Waves, Three Generations*. New Delhi, India, Rawat Publications

Shukla S (2003): *India Abroad: Diasporic Cultures of Postwar America and England*. Princeton, NJ, Princeton University Press

## #2 Vietnamese-American Case: Hoa Tran

Hendry Ton, MD, MS

### Overview

This vignette depicts a 54-year old Vietnamese man who presents at an initial psychiatrist's visit complaining of headaches and problems sleeping. As the interview progresses, we find that he has been suffering from years of untreated depression and Post-Traumatic Stress Disorder but has been reticent to tell others due to mental health stigma. The vignette illustrates various culturally responsive approaches to diminish stigma, improve therapeutic rapport, and encourage shared decision-making. Mr. Tran's English proficiency on the DVD may be higher than in clinical encounters with similar patients.

### Cultural Background

While the patient is a Vietnamese man, this section will attempt to overview the history of the major Southeast Asian cultural groups that have resettled in the United States. Southeast Asia is home to over 40 different ethnic groups. While each is unique, most have varying degrees of influence from China and India. Southeast Asia became a focus of the Western world when France colonized Cambodia, Laos, and Vietnam in 1858 in what was referred to as "French Indochina." France's rule lasted nearly a century until 1954. Upon France's withdrawal, Vietnam was divided into a communist north and a democratic south. Shortly thereafter, communist and capitalist nations began to view Southeast Asia as an ideological battleground. Conflict spread throughout Indochina. America became directly involved in the Vietnam War, but also was present in the conflicts in the surrounding countries of Laos and Cambodia. The communist North Vietnam captured South Vietnam in 1975, which prompted an initial mass exodus of 130,000 refugees mainly from formerly affluent or military people. Mr. Tran was part of this wave of immigration. In the 1970s and 80s, several more "waves" of refugees came from Vietnam. As a group, the "boat people" as they were called, were poorer and had less formal education. This influx also included prisoners of war, Amerasians, and ethnic Chinese living in Vietnam. Conflicts in Laos and Cambodia also led to the displacement of many thousands of Laotians, Hmong, Mien, and Khmer people as well. According to the 2001 U.S. Census, there are over one million Vietnamese Americans, 170,000 Khmer Americans, 160,000 Laotian Americans, and 170,000 Hmong Americans living in the United States.

## **Clinical Background**

Major Depressive Disorder (MDD) is one of the most common mental illnesses, with a lifetime risk of about 10% in men and 20- 25% in women. MDD is characterized by persistent and pervasive feelings of depressed mood and/or lack of interest for at least two weeks. Accompanying symptoms include sleep disturbance, changes in appetite and weight, problems with memory and concentration, and feelings of hopelessness. Those with severe MDD may also experience suicidal thinking. In Asian Americans, somatic complaints may be a prominent idiom of distress. The rates of depressive disorders in Asians and Pacific Islanders are considerably lower (7%), though many experts believe that the disorder is under-diagnosed and under-treated due to mental health stigma. In the Southeast Asian population, related to the experiences described above, depressive disorders can be as high as 20% in primary care clinics and 50% in mental health clinics.

Post-Traumatic Stress Disorder (PTSD) occurs as a result of experiencing or witnessing a highly traumatic event. Individuals with PTSD may suffer from recurrent intrusive memories, flashbacks, and nightmares of the trauma. Social, emotional, and psychological avoidance of the trauma is common and may manifest as detachment, social withdrawal, and emotional blunting. Patients commonly experience hyper-arousal symptoms characterized by sleep difficulty, hyper-vigilance, and irritability. The prevalence of PTSD is between 1-14%. For certain populations such as torture victims, the rates can be as high as 90%. Some studies indicate that Southeast Asians, many of whom experienced numerous traumatic events from war to re-education camps from the 1950s to 1980s, are at greater risk for PTSD, with rates as high as 70% in mental health clinics.

Treatment of both PTSD and MDD involve use of antidepressant medications and/or psychotherapy. However, adherence to treatment may become problematic for Southeast Asians. For example, a study involving a clinic specializing in refugee mental health at Oregon Health Sciences University showed that of the Southeast Asian patients, who reported adherence to medications, 53% had undetectable levels and only 16% had therapeutic levels.

## **Discussion Questions**

### **Opening questions**

- What thoughts and reactions came up for the viewers as they watched the vignette?
- How emotions or feelings came up for the viewers as watched the vignette?

### **Cultural Identity of the Individual**

- What are the roles and values with which Mr. Tran identifies? To what degree are they influenced by his ethnicity, acculturation, and gender among other cultural identity variables?
- Some of the most salient cultural roles that Mr. Tran appears to identify with are that of a Vietnamese-American man struggling to preserve traditional Vietnamese cultural values in the United States. Related to this, he discusses the challenge of being a good father and provider for his family. Additionally, Mr. Tran's traditional concept of how to be an appropriate patient at a doctor's office is also made apparent. All these aspects of Mr. Tran's cultural identity as traditional Vietnamese are influenced by his ethnicity, immigration, and acculturation.

### **Cultural Explanations of the Individual's Illness**

- What idioms of distress did Mr. Tran initially present?
- What approach did Dr. Ton use to ask about Mr. Tran's mental health experiences?
- What were Mr. Tran's beliefs about the cause of his illness (explanatory models)? How was this history elicited?
- How did Dr. Ton explain his own understanding of Mr. Tran's illness? In what ways did it differ from the usual clinical model?
- How does stigma of mental illness appear in the interview?

### **Cultural Factors Related to Psychosocial Environment and Levels of Functioning**

- What are the cultural supports and stressors that Mr. Tran experiences from his family, religion/spirituality and his community?
- From the mainstream community?

## Cultural Elements of the Relationship between the Individual and the Clinician

- Compare the cultural identity of Mr. Tran to that of Dr. Ton.
- How would you describe the relationship between Dr. Ton and Mr. Tran?
- What approaches did Dr. Ton use to improve the therapeutic relationship? To what extent was he successful?
- Dr. Ton disclosed that he had children as well. What is the impact of provider disclosure of personal life for traditional patients from the API community?
- Dr. Ton referred to himself as an expert and frequently related that he had significant experience treating depression and PTSD. How did the consumer respond to this? How did Dr. Ton engage the patient in treatment planning?

## Overall Cultural Assessment

### Diagnosis

- Given Mr. Tran's cultural identity, what is the differential diagnosis?

### Treatment

- How did Dr. Ton discuss treatment options with Mr. Tran?
- What were some of Mr. Tran's concerns about treatment?
- How did Dr. Ton attempt to address those concerns?

### Key Points

- *Form a collaborative understanding of the illness (explanatory model).*
  - Elicit the patient's understanding of symptoms and illness
  - Attempt to reach common ground regarding the character and degree of importance of symptoms and explanation
  - Elicit the patient's expectations of treatment
  - Shape treatment plan to address the patient's idioms of distress.
- *Incorporate cultural strengths and strategies.*
  - Explore culturally sanctioned treatment options and support them appropriately.
  - Support the patient's role in family and society when possible.
  - Identify cultural strengths and build upon them

- *When considering psychiatric medications for Asian Americans due to possible differences in medication response:*
  - Start at a lower dose
  - Titrate to therapeutic dose slowly
  - Monitor closely for side effects
  - Asking the patient to bring in medications facilitates discussion of medication effects and side effects
- *When considering psychotherapy for traditional Vietnamese patients:*
  - Exploratory/psychodynamic insight-oriented therapy may be seen as intrusive, inappropriate, or even dangerous.
  - Supportive/interpersonal approach may be more culturally appropriate.
  - Cognitive behavioral approach is generally accepted well in this community.

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## #3 Filipino-American Case

**Brett Sevilla, MD**

### Overview

Johnny is an 8-year old Filipino-American boy who was referred by his school principal after a steak knife fell out of his backpack in class. He has been suspended from school indefinitely and faces expulsion.

In this case, we see his mother, a 32-year old nurse, and his father, a 33-year old medical technician, both Filipino immigrants, who reluctantly see a child psychiatrist. They complain that the school “threatened” them by not allowing Johnny to return to school until he was “cleared” by a psychiatrist. They state that the knife “must have just fallen into his backpack.” They deny any behavioral problems, insisting there is no need for a full evaluation because “he’s a good boy and he’s not crazy.” They request a letter from the psychiatrist stating that he is “normal” and able to return to school immediately.

### Cultural Background

The Philippines are an archipelago of more than 7,100 islands located across the South China Sea from mainland Asia. Named for King Philip II, the Philippines were ruled as a Spanish colony for almost 300 years until 1898, when control was transferred to the United States for the next 48 years. As a result of centuries of western control, Filipino culture has been strongly influenced by Spanish culture and language, Roman Catholicism, and American education, with many educated Filipinos speaking fluent English in addition to one of over 70 native languages. Yet their English language ability often belies underlying traditional beliefs and may create a false impression of greater acculturation to the United States.

Although the first Filipinos arrived in North America in 1587 aboard Spanish Galleons, permanent Filipino settlement did not begin until 1765. The bulk of Filipino immigrants, however, have arrived in the United States since the early 20<sup>th</sup> Century. As of 2004, more than 2.1 million U.S. residents identified themselves as Filipino, constituting the 3<sup>rd</sup> largest Asian ethnic group in the U.S. The majority of Filipinos are Catholic, though there are significant minorities of Protestants, Muslims, and Buddhists. While the influence of Catholicism mainly accounts for Filipino beliefs in spiritual causes and cures for mental illness, many Filipinos simultaneously maintain beliefs in mystical, personalistic, and naturalistic causes of mental illness, and consult traditional healers before seeking mainstream psychiatric care. Such treatments include: “psychic surgery,” herbal medications, “bonesetting,” magnetic

healing, magical extractions, reflexology, repositioning of organs through massage, and mystical healing rituals.

Family plays a central role in the life of a typical Filipino, with mutual interdependence among family members encouraged and reinforced. Families often have a matriarchal structure, and major decisions are often deferred to elders within the extended family network. Respect towards elders and those of higher status (professional or otherwise) are culturally emphasized. Moreover, the value given to smoothness within interpersonal relations is manifested in indirect, non-confrontational communication. As a result, families that disagree with a physician's assessment or recommendations are unlikely to express such disagreement directly, but may fail to adhere to prescribed treatment plans.

The mental illness of a family member is thought to reflect badly upon the entire family and is often considered shameful. Ill family members may be hidden within the home for years to avoid exposure and to protect the patient. Psychiatric treatment is not widely available in the Philippines, and is viewed as being necessary only for the most severely ill with hospitalization being a last and likely permanent resort. Such attitudes, combined with unfamiliarity with modern psychiatric techniques, often result in fear and skepticism toward recommendations for psychiatric treatment.

## **Clinical Background**

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common cause of disruptive behavior in children, as well as one of the most common reasons for referral to a child psychiatrist. While estimates of the prevalence of ADHD from 1.9% to 15.1%, a recent community survey by the Centers for Disease Control and Prevention found that 7.8% of children 4 to 17 years old had ever received a diagnosis of ADHD, with higher rates among boys. Thousands of scientific papers have been published on the condition since the 1930's, yet it continues to be viewed with skepticism by the lay press and public. Broad dissemination of inaccurate or misleading information via the internet or other media often exacerbates the fears of parents of children referred for psychiatric evaluation.

As the name implies, ADHD is characterized by developmentally inappropriate degrees of inattention, hyperactivity, and impulsivity that begin early in childhood. Children are likely to experience impaired functioning academically and interpersonally, with both adults and peers. Although the hyperactivity may remit over time, inattention and impulsivity often persist into adulthood. Treatment with medication and psychosocial strategies has been shown to be effective in the short term, and it has the potential to mitigate negative outcomes during later adolescence and early adulthood.

## **Culturally Competent Clinical Encounter**

Despite the serious nature of the incident, which prompted this referral, these parents seem to be anxiously minimizing its significance. While this may initially appear to represent resistance, denial, or lack of adequate supervision, shame is undoubtedly a major factor in this family's reaction to the referral. They are clearly anxious to leave and have the problem dismissed before others in the community become aware of the incident or the psychiatric referral. Moreover, this family has not followed through with prior recommendations for assessment, and failed to disclose a family history of mental illness to the psychiatrist.

The clinician must recognize the influence of stigma in order to avoid misunderstanding and misinterpreting the family's behavior. Acknowledging and normalizing the embarrassment is an important first step in preventing it from being acted upon through early termination or otherwise not adhering to the treatment plan. Praising the family's courage for coming in acknowledges their strength and concern for their son's well-being, and helps to establish rapport despite the discomfort of the situation. Reassurance regarding confidentiality (within legal limits) may also help open up the discussion. Nevertheless, collateral input is still critical to ensuring that the clinician has an accurate understanding of the situation from multiple perspectives. Though not shown in the DVD, an interview with the child is essential.

The presentation of a diagnosis is a critical juncture in the assessment process. Clinicians should carefully avoid denigrating the family's explanatory models for the patient's symptoms (normal behavior, divine punishment, medical illness, racist teachers, laziness, etc.) when discussing the results of the assessment. Yet even when presented sensitively with appropriate psychoeducation, a psychiatric diagnosis confronts any denial, which may remain, and may trigger a fearful response based on stigmatized beliefs about its implications for the patient and the family. If this occurs and the family's concerns cannot be alleviated in the session, the clinician should communicate that the family is welcome and encouraged to return in the future. Care should be taken to avoid direct criticism of their decision; this would be culturally inappropriate and potentially narcissistically wounding, decreasing the probability of the family's returning at a later date.

Because physicians are typically held in high esteem, families may be reluctant to openly disagree with medical recommendations. Families may politely agree to medications, yet fail to adhere to the regimen. This often results from widely held stigmatized beliefs about the dangers and implications of psychiatric medications. In this particular case, such beliefs were sadly reinforced by the mother's experiences with her chronically mentally ill sister, despite her professional training as a nurse. Clinicians should be alert to the possibility of silent non-adherence, and sensitively explore the family's concerns when it is suspected.

## **Discussion Questions**

- Why might the family have walked out of the session when the diagnosis was presented?
- What factors contributed to the family's reluctance to get treatment for Johnny?
- What strategies can a clinician use to engage this family?
- What potential pitfalls might occur if the clinician is unfamiliar with the Filipino culture?

## **Cultural Identity**

- Filipino immigrants, middle-class SES, Catholic, English-speaking, parents are health care workers

## **Cultural Explanations of the Illness**

- Idioms of Distress: Parents reluctantly acknowledged problems with concentration and minimized other symptoms due to the stigma of mental illness.
- Explanatory Models: Bad school system, religious explanation
- Treatment Pathway: Church and prayer, spiritual healing in the Philippines, change of school, psychiatrist as last resort

## **Cultural Stressors and Supports**

- Stressors: stopped going to church, fear of schizophrenia
- Supports: Family, Church. (nothing known about extended family).

## **Cultural Elements of the Relationship Between Clinician and Patient**

- Cultural identity of the clinician includes Filipino ethnicity, but he may have been seen as Caucasian by the family.

## **Overall Assessment**

- Differential Diagnosis: ADHD was diagnosed despite the different explanatory models offered by the family.

- Treatment Plan: medication, psychoeducation that is respectful of the parents' culture.

### **Summary Key Points**

- Stigma may present itself to the clinician at any time during the assessment or treatment process.
- It may take the form of affective expression, observable behavior, verbal statements, or avoidance
- Clinicians must alertly look for manifestations of stigma and initiate discussions with families to minimize its negative impact.
- Traditional beliefs should be sensitively and respectfully explored, and agreements about treatment plans should be negotiated
- Adherence should be monitored and addressed without direct criticism.

### **Helpful Readings**

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## Appendix

### THE DSM-IV OUTLINE FOR CULTURAL FORMULATION

#### **A. Cultural Identity of the Individual.**

Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preferences (include multilingualism).

#### **B. Cultural Explanations of the Individual's Illness.**

The following may be identified: the predominant idioms of distress through which symptoms of the need for social support is communicated (e.g., "nerves", possessing spirits. Somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual symptoms in relation to the norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-bound Syndromes...").

#### **C. Cultural Factors Related to Psychosocial Environment and Levels of Functioning.**

Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

#### **D. Cultural Elements of the Relationship Between the Individual and the Clinician.**

Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

#### **E. Overall Cultural Assessment for Diagnosis and Care.**

The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

**Source:** American Psychiatric Association (1994): Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). Washington, D.C., American Psychiatric Press

## SUGGESTED DISCUSSION QUESTIONS

### A. Cultural Identity

1. What are the cultural identity variables that patients may use to self-identify?
2. Within each cultural identity variable, such as ethnicity, to what extent does the term encompass homogeneous vs. heterogeneous phenomena?
3. How does the clinician come to know the individual's cultural identity? To what extent does this require discussion with the individual vs. simply observing the person?
4. How do the several cultural identity variables relate to one another to form more complex forms of cultural identity? For example, what is the degree of involvement with the culture of origin and the host culture?
5. Do Caucasians have a cultural identity?
6. What is the cultural identity of each viewer in the audience?
7. What is the importance and significance of understanding the individual's cultural identity? How might it help the clinician with understanding the other sections of the Outline?

### B. Cultural Explanations of Illness

1. What are the idioms of distress that the patient presents?
2. How can it be determined if a particular phenomenon is related to the individual's culture vs. the individual's psychopathology?
3. When should a cultural consultation be requested?
4. How can stigma of mental illness affect the reporting of symptoms?
5. What are the Culture-Bound Syndromes discussed? Have viewers come across any in their work?
6. What explanations of illness are discussed in the program?
7. What treatment pathways are discussed in the program?
8. What is the significance of understanding the topics in this section? What difference might it make in the differential diagnosis and treatment planning?

### C. Cultural Factors Related to the Psychosocial Environment and Levels of Functioning

1. What are the cultural stressors seen in this section of the program? How might they affect the onset and course of illness?
2. What are the cultural supports seen in this section of the program? How might they affect the onset and course of illness?
3. What supports/stressors are primarily intrapsychic vs. interpersonal vs.

environmental?

4. How would the viewer assess the individual's religion/spirituality?
5. How would the viewer assess the individual's family/kin network?

#### **D. Cultural Elements of the Relationship Between the Individual and the Clinician**

1. How important is it to understand the clinician's own cultural identity?
2. What are the similarities in the cultural identity variables between the patient and clinician? What are the differences?
3. How is relationship (rapport, communication, transference, counter-transference, etc.) affected by similarities in the cultural identity variables between the patient and clinician? By the differences between them?
3. What transference phenomena influenced by culture have viewers experienced?
4. What counter-transference phenomena influenced by culture have viewers experienced?

#### **E. Overall Cultural Assessment for Diagnosis and Care**

1. Discuss how understanding of the four areas above aid in the process of constructing a differential diagnosis that incorporates cultural issues?
2. How can the clinician utilize the "Age, Gender and Cultural Features" sections of the narrative sections of the diagnostic categories in aiding the process of differential diagnosis?
3. How can the clinician utilize the "Other Conditions that May be a Focus of Clinical Attention" in aiding the process of differential diagnosis that include cultural issues?
4. What biological aspects of treatment planning are affected by cultural issues?
5. What psychological aspects of treatment planning are affected by cultural issues?
6. What sociocultural interventions may be useful for individuals and their families?
7. What religious and spiritual interventions may be useful for individuals and their families?