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U.S. Mental Health Policy: Addressing the Neglect of Asian Americans

Gordon C. Nagayama Hall and Alicia H. Yee
University of Oregon

Although Asian Americans are proportionally the fastest-growing ethnic group in the United States, federal mental health policies have neglected their special needs. U.S. federal mental health policy has shifted in the past 50 years from an emphasis on increasing accessibility to treatment to improving the quality of care and focusing on the brain as the basis of mental illness. However, the mental health needs of Asian Americans have been a relatively low priority. Myths about Asian Americans that have led to the general neglect of their mental health needs are that they: (a) are a small group; (b) are a successful group and do not experience problems; and (c) do not experience mental health disparities. Nevertheless, Asian Americans are a significant proportion of the population which experiences acculturative stress and discrimination that are often associated with psychopathology. However, Asian Americans who experience psychopathology are less likely than other groups to use mental health services. Political efforts must be made to get Asian Americans into positions of leadership and power in which they can make decisions about mental health policy priorities.

Keywords: Asian Americans, mental health policy, acculturative stress, discrimination, ethnic identity

Currently at 15.5 million persons, Asian Americans are proportionally the fastest-growing ethnic group in the U.S. (U.S. Bureau of the Census, May, 2010). Yet, the mental health needs of this group have been largely neglected. In this article, we will consider U.S. mental health policies that have contributed to a general neglect of people of color, as well as beliefs and attitudes specific to the neglect of Asian Americans' mental health needs.

Gordon C. Nagayama Hall, Department of Psychology and Center on Diversity and Community, University of Oregon; Alicia H. Yee, Department of Psychology, University of Oregon.

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Correspondence concerning this article should be addressed to Gordon C. Nagayama Hall, Department of Psychology and Center on Diversity and Community, University of Oregon, Eugene, OR 97403-1227. E-mail: gnhall@uoregon.edu

U.S. Mental Health Policy

The Community Mental Health Movement

During the 1960s and 1970s, the civil rights movement brought the unique needs, including mental health needs, of people of color to national awareness (Newby, 2010). The community mental health movement, which began in 1963 during the Kennedy administration with the passing of the Community Mental Health Centers (CMHC) Act, was an effort to make mental health services accessible to a broader range of people including Asian Americans and other people of color. The focus of this public policy was to target those most in need of clinical services, regardless of their ability to pay. The goal was to increase access to treatment by establishing community mental health centers (Kiesler, 1992) and to build 2,000 new community mental health centers by 1980 in catchment areas of between 75,000 and 200,000 people (Stockdill, 2005). Funds were provided to the National Institute of Mental Health (NIMH) to provide a national leadership role with respect to this new CMHC policy.

Before the CMHC Act, mental health care was the main responsibility of individual states and was primarily administered via the use of state hospitals. The new CMHC act emphasized deinstitutionalization and increasing outpatient care in local communities. Community mental health centers were required to provide inpatient services, outpatient services, partial hospitalization, emergency services, and consultation and education services (Stockdill, 2005). Diagnostic services, rehabilitative services, pre- and aftercare services, training, and research and evaluation were also considered desirable. The CMHC Act was successful in that more people, including Asian Americans and other people of color, began to utilize mental health services (Kiesler, 1992; Stockdill, 2005). Moreover, the need for inpatient services and the need for detention in the criminal justice system were reduced (Stockdill, 2005). Although these efforts were a well-intentioned first step, Asian Americans and other people of color fared worse in the community mental health system than White Americans in terms of underutilization and premature termination (S. Sue, 1977). Thus, there was more work to be accomplished to ensure that Asian Americans received much-needed mental health services.

The mid-1960s also was a time of rapid growth within the Asian American population. President Kennedy had proposed the Immigration Act in 1965, which removed both the immigration quotas based on national origin and race-based criteria for immigrants (Deaux, 2006). Whereas most of the Asian American population before 1965 was U.S.-born, most Asians in the U.S. since 1965 have been immigrants and born in Asia (Espiritu, 2008).

Unfortunately, efforts to undo civil rights era policies were initiated in the 1970s and enacted in the 1980s by conservative legal activists (Daum & Ishiwata, 2010). For example, the Supreme Court ruled in the Regents of the University of California v. Bakke (1978) that a separate admissions process to medical school for ethnic minority students was illegal as a method of addressing historical discrimination (although race could still be taken into account in the admissions process). The Omnibus Budget Reconciliation Act of 1981 repealed the 1963 CMCH Act (Kiesler, 1992; Stockdill, 2005). Many community mental health centers were subsequently closed, resulting in persons needing mental health services no longer receiving them. A sense of community responsibility gave way to a heightened sense of individualism, in which individuals were expected to fend for themselves (Etzioni, 2007). The individualist argument, which reflected both amnesia and insensitivity to continuing societal inequities, was that the playing field had suddenly become equal for people of color. Special attention to or programs for particular cultural groups, such as people of color, became regarded as violations of fairness (Daum & Ishiwata, 2010; Vasquez & Jones, 2007).

The Quality of Care Movement

Since the 1980s, United States mental health care policy has generally shifted its focus from increasing access to care to improving the quality of treatment (Kiesler, 1992). This represented a shift from a need-based public policy to one that focused on the quality of services for those who had the ability to pay for them and on containing costs of such services. Not surprisingly, the 1980s saw a rise in private mental health care services, which excluded those who were unable to afford them (Kiesler, 1992). As such, more mental health care began to take place within the context of a managed care model for those with private insurance coverage (Kiesler, 2000). In the past two decades, notable mental health policies, including the Mental Health Parity Act of 1996 and the Wellstone-Domenici Parity Act of 2008, have required equal coverage for mental and physical health. Although these acts were intended to increase mental health care availability, this coverage was limited to those who already had health insurance and did not expand access to those who were not insured. Currently, the greater focus on quality of care ensures quality services for the relatively privileged dominant group, but fails to consider the underserved mental health needs of diverse populations including Asian Americans.

The change in focus on quality of care was the impetus for the empirically supported treatments (EST) movement (Chambless & Hollon, 1998; Rosner, 2005). This movement emphasized scientific standards for evaluating outcomes and short-term treatments, which were

compatible with managed care demands for cost effectiveness. The NIMH, which had once guided public policy on expanding access to care via the development of community mental health centers, squarely placed itself in the quality of care camp by funding randomized clinical trials to evaluate EST outcomes.

Although quality mental health care potentially benefits everyone, the primary focus of the EST and evidence-based practice (EBP) movements has been on White Americans. There have not been provisions in mental health policy to determine the cultural relevance of ESTs and EBPs or to develop alternative culturally competent treatments for communities of color. Nearly a quarter century after Stanley Sue's (1977) report of poor outcomes for persons of color in the mental health system, the United States Surgeon General came to the same conclusion (U.S. Department of Health & Human Services, 2001). The quantity and quality of mental health services for Asian Americans and other people of color were disparate from those received by White Americans. Unfortunately, the development of national standards for culturally and linguistically appropriate services in health care (Office of Minority Health, 2001) and a call by the Institute of Medicine (2001) for patient-centered care based on patient values, which presumably include culture, have had minimal impact on the development of EBPs for culturally diverse populations.

Due to the relative lack of attention to the mental health needs of persons of color over the past three decades, ESTs and EBPs have not been specifically developed to address the ethnocultural contexts of ethnic minority communities. ESTs and EBPs have primarily been developed in White American communities with the assumption that their treatment effects will generalize to other ethnic groups (Hall, 2001). Rather than developing methods that are responsive to the needs of communities of color, the emphasis in the EST and EBP movements has been on disseminating unmodified treatments. Invariably, White Americans are the default group and it is assumed that any positive effects of ESTs and EBPs will generalize to other ethnic groups regardless of how this will occur or of the cultural relevance of these ESTs and EBPs.

The Decades of the Brain

Following the shift from access to quality of care, another national mental health policy has resulted in Asian Americans and other culturally diverse groups being further marginalized. In 1989, Congress passed a resolution by President George H. W. Bush that proclaimed the 1990s to be the "Decade of the Brain" (NIMH, 1999). Part of the impetus for this focus on the biological basis of mental disorders came from special interest groups whose goal was to destigmatize mental disorders and to conceptualize them as diseases that were not the fault of the person experiencing them (Miller, 2010). A second impetus for this biological focus was the NIMH, after 22 years of being an independent bureau, rejoined the National Institutes of Health (NIH) in 1999 (NIMH, 1999). This meant that the NIMH began competing for funds with other NIH institutes, almost all of which addressed disorders as biologically based (e.g., National Cancer Institute; National Heart, Lung, and Blood Institute; National Institute of Neurological Disorders and Stroke). Within this context, biological science is more valued than psychological science, and an emphasis on psychological or behavioral approaches has placed the NIMH and other similar institutes, such as the National Institute of Drug Abuse, at a political disadvantage within the NIH (Miller, 2010).

The emphasis on the brain and the biological bases of behavior continued at the NIMH during the 2000s and into the current decade. As part of President George W. Bush's New Freedom Commission on Mental Health, NIMH Director Thomas Insel (2003) indicated that mental illnesses are "brain illnesses." Although former Surgeon General David Satcher (2003) acknowledged on the Commission the role of culture in the diagnosis and treatment of mental disorders, he also referred to the connection between mental disorders and changes in the brain.

At first glance, destigmatizing mental illness by regarding it as a biological disease may seem beneficial to Asian Americans. For instance, Asian Americans who report greater stigma associated with psychological disorders than White Americans (Masuda et al., 2009) may be less inclined to do so if mental disorders are viewed as biologically based and similar to

other medical conditions. Moreover, Asian Americans tend to view psychological disorders as having a biological basis (Mallinckrodt, Shigeoka, & Suzuki, 2005). However, the meaning of psychological disorders cannot be reduced solely to biological explanations (Miller, 2010). For example, a biological account cannot fully explain emotion, which is a critical component of psychopathology and is a psychological construct (Miller, 2010). Brain activity may occur during emotional states, but the brain activity is not equivalent to the emotional states or to psychological disorders. A biological account can even less fully explain cultural and sociocultural influences (e.g., immigration stress, war trauma, discrimination). There is no brain activity or specific genes that correspond with culture. Culture is complex and does not reside in individuals; it is expressed in the interaction of individuals and their social worlds (López & Guarnaccia, 2000). Although a biological account of psychological disorders may be useful in reducing the stigma of psychological disorders for Asian Americans, it can discount the cultural influences on psychological disorders that are important for Asian Americans such as the relative level of acculturation, a known moderator of psychological health (Hwang & Ting, 2008). Moreover, a biological approach to psychological disorders could be used as a rationale not to study cultural differences in mental health outcomes for Asian Americans or other ethnically diverse groups, because this assumption would presume that human biological processes are culturally universal. As with the quality of care movement, the focus on the brain as the basis of psychopathology is based on the assumption that studies of White Americans and their concurrent findings can be generalized to other ethnic groups.

Health Care Reform

Perhaps the most promising development for Asian Americans since the CMHC Act of 1963 with respect to mental health policy is the Patient Protection and Affordable Care Act, also known as the health care reform law, signed by President Obama on March 23, 2010 (NIH Record, October 1, 2010). This act provided health insurance to many who were previously uninsured and allowed a greater number of people the ability to pay for existing health care services including mental health care services (consistent with the provisions of the Mental Health Parity Act of 1996 and the Wellstone-Domenici Parity Act of 2008). The health care reform law also resulted in the establishment of the National Institute on Minority Health and Health Disparities (NIMHD) at the NIH. The mission of the NIMHD is to promote minority health and ultimately eliminate health disparities for ethnic minority groups. This mission is accomplished in part by conducting and supporting basic clinical, social sciences, and behavioral research on health disparities. There is a clear emphasis on research on the societal, cultural, and environmental dimensions of health.

Although the health care reform act created greater access to services for many persons, including Asian Americans, there was little consideration for how culturally relevant these services may be or how they could become more culturally relevant. Moreover, the focus of the NIMHD is on physical diseases such as cancer, cardiovascular diseases, child health improvement, HIV/AIDS, obesity prevention, and diabetes. This focus is consistent with the NIH-wide focus on physical diseases. Psychological disorders, such as depression, may be relevant to the NIMHD's priorities insofar as they moderate the course of these physical diseases. Nevertheless, mental health issues are at best secondary priorities in the NIMHD.

In summary, U.S. federal mental health policy has shifted in the past 50 years from an emphasis on increasing accessibility to treatment to improving the quality of care and emphasizing the brain as the basis of mental illness. While community mental health centers were established in the 1960s to increase access to mental health care, federal funding for these centers ended during the 1980s. Since then, the quality of care focus in mental health policy has spawned the EST and EBP movements, which have largely overlooked Asian Americans. The Decade of the Brain that began in the 1990s and continued into the 2000s has further marginalized Asian American mental health needs. In 2010, the signing of the Patient Protection and Affordable Care Act has brought some hope for Asian Americans, as it is one of the most promising developments in federal mental health policy since the CMHC Act of 1963. Nevertheless, federal mental health policy has largely ne-

glected Asian Americans. There are additional reasons specific to Asian Americans that have resulted in the neglect of their mental health needs.

Neglect of the Mental Health Needs of Asian Americans

The neglect of people of color that has resulted from the mental health policies discussed above has been particularly acute for Asian Americans. One major reason for this neglect is that those who have had the authority and power to make decisions concerning public policy, research, and mental health priorities and funding have rarely been Asian Americans or other people of color, or have failed to truly understand Asian American mental health needs. The mental health needs of Asian Americans generally are not a priority for politicians or administrators in positions of power to make such decisions. It is also possible that those with such power may have inaccurate or biased beliefs and attitudes about Asian Americans (reviewed below), which have contributed to the general neglect of the mental health needs of Asian Americans.

Myth #1: Asian Americans Are a Small Group

Persons of Asian descent constitute the majority of the world population. Moreover, Asian Americans have become the largest new immigrant group (Pew Research Center, 2012). Yet, some might argue that Asian Americans are too small a group to warrant specific attention regarding public policies and service delivery issues concerning mental illness. Although Asian Americans are the third largest non-White ethnic group in the U.S., at 5% of the U.S. population, their numbers are less than half of those of Latino/a Americans and African Americans. Given the relative small size of the Asian American population, some could contend that proportionately less attention should be devoted to Asian Americans. However, the 15.5 million Asian Americans in the U.S. exceed the combined populations of the three largest U.S. cities—New York, Los Angeles, and Chicago. Moreover, the number of Asian Americans in the U.S. exceeds the 14.8 million Americans who suffer from major depression. Public policymakers would be hard-pressed to justify neglecting the mental health needs of the citizens of New York, Los Angeles, and Chicago, or of all depressed Americans because the relative size of these groups is small. Nevertheless, the neglect of the mental health needs of Asian Americans is on the same scale. However, White Americans make up the vast majority in these three cities, and they also represent the main sufferers of major depression, which makes their needs a priority with regard to mental health policy in the U.S.

Asian Americans in the U.S. are very heterogeneous, including at least 30 different cultural groups (Liu, Murakami, Eap, & Hall, 2009). There are, however, some broad similarities across Asian American groups. For example, various Asian American groups share and adhere to identifiable Asian values, such as collectivism, emotional self-control, and filial piety (Y. Park, Kim, Chiang, & Ju, 2010). Specific challenges faced by Asian American groups are also very similar including issues with language barriers, immigration stress, underutilization of mental health services, and poor outcomes when mental health services are actually used. Nevertheless, the needs of certain Asian American groups can significantly differ as a function of socioeconomic status, education level, language fluency, and pre- and postmigration history (Institute of Medicine, 2009). Thus, Asian Americans are a sizable and heterogeneous group with complex needs that warrant greater attention.

Myth #2: Asian Americans Are a Successful Group and Do Not Experience Problems

Census data suggest that, as a group, Asian Americans have completed more education, have greater levels of employment, and report with less poverty than all other U.S. ethnic groups including White Americans (U.S. Bureau of Labor Statistics, 2009). Since the civil rights movement in the 1960s, Asian Americans have been considered a "model minority" that has succeeded without the support, such as affirmative action, given to other groups (Wu, 2008). Current U.S. immigration policies have favored the immigration of Asians with professional skills and advanced degrees (Junn & Masuoka, 2008). This apparent success of Asian

Americans could be assumed to immunize them from problems that other groups may face who are less educated and poorer. Of course, there is much variability across Asian American groups, with some groups having less education, greater unemployment, and higher poverty than others (U.S. Bureau of the Census, 2010). Nevertheless, even Asian Americans who are successful by educational, employment, and income standards, seem to experience stressors associated with their ethnicity.

The 60% of Asian Americans who are immigrants may experience acculturative stress associated with learning and fitting into a new culture, concerns about legal status, and potential guilt for leaving behind loved ones (Gee, Spencer, Chen, Yip, & Takeuchi, 2007). Acculturative stress has consistently been found to be associated with psychopathology among Asian Americans at varying stages of the acculturation process. It is associated with psychological distress, depression, and suicidal ideation among Korean immigrant adolescents (Cho & Haslam, 2010; W. Park, 2009), psychological distress and depression among Asian American college students (Constantine, Okazaki, & Utsey, 2004; Hwang & Ting, 2008), and psychological distress among Asian international students in the U.S. (J. Lee, Koeske, & Sales, 2004; Wilton & Constantine, 2003). It is important to note that experiencing acculturative stress is not indicative of an inherent weakness on the part of immigrants, but involves, in part, problems of the dominant culture in accepting and incorporating immigrants. Also, not all immigrants experience acculturative stress, and even Asian Americans born in the U.S. can experience acculturative stress to the extent that they identify with Asian cultures and experience conflicts with the mainstream culture. Acculturative stress can continue to negatively impact individuals long after the initial immigration process (e.g., experiences with discrimination, loss of ethnic identity), meaning that even seemingly highly acculturated individuals can experience the negative effects of acculturative stress (Hwang & Ting, 2008).

The apparent success of Asian Americans may be interpreted to mean that discrimination against Asian Americans is limited or even nonexistent. However, employment discrimination exists insofar as Asian Americans who earn the same income as White Americans have more education than their White American counterparts (Wu, 2008). This means that Asian Americans are overeducated for the incomes they earn relative to White Americans. Asian Americans also are underrepresented in managerial positions relative to other ethnic groups (Zeng, 2011).

The assumption that Asian Americans have made it in society, do not experience inequities, and experience no discrimination is a denial of their racial reality and is a type of microaggression (D. Sue, Bucceri, Lin, Nadal, & Torino, 2007). Microaggressions are denigrating messages to people of color based on racial or ethnic minority group membership (D. Sue, Capodilupo, et al., 2007). Asian Americans are considered by others to be less American than White or African Americans (Devos & Banaji, 2005). Asian Americans are mistakenly perceived as being from another country or as a nonnative English speaker as frequently as Latino/a Americans are (Cheryan & Monin, 2005). Being the target of ethnic jokes, not being accepted because of one's ethnicity, experiencing difficulties in succeeding associated with one's ethnicity, being treated badly because of one's accent, and worries about immigration are experiences that occur at least twice as frequently for Asian Americans as they do for White Americans (Romero, Carvajal, Volle, & Orduña, 2007). Examples of these data are displayed in Figure 1. A recent example is that ESPN used the headline "Chink in the Armor" to describe a poor performance by New York Knicks basketball player Jeremy Lin, a Taiwanese American (Hsu, 2012). It is doubtful that an ethnic slur would be used in a headline involving an African American or White American basketball player. Moreover, Asian Americans reported experiencing greater levels of discrimination (e.g., unfair treatment or insults based on race or ethnicity) by adults and peers than Puerto Rican or African Americans in a high school in New York City (Greene, Way, & Pahl, 2006).

One negative consequence of continued exposure to discrimination is psychopathology. Discrimination has consistently been associated with psychopathology for Asian Americans and other groups of color in the U.S. (Hall, 2010). Discrimination was associated with depression in studies of Asian American eighth graders (Romero et al., 2007), Asian American interna-

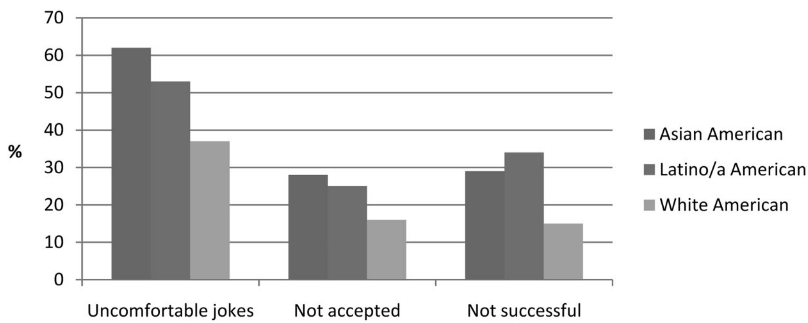

Figure 1. Difficulties associated with ethnicity among eighth graders (Romero et al., 2007).

tional students (Wei, Ku, Russell, Mallinckrodt, & Liao, 2008), Asian American college students (Wei et al., 2010; Yoo, Gee, & Takeuchi, 2009), and Korean American older adults (Jang, Chiriboga, Kim, & Rhew, 2010). Discrimination has also been found to be associated with internalizing and externalizing disorders in Korean American adolescents (Shrake & Rhee, 2004), and with general psychological distress among Asian American college students (Hwang & Goto, 2009). In the U.S. National Latino and Asian American Study (NLAAS), discrimination was more strongly associated with mental disorders than acculturative stress or years in the United States even among immigrants (Gee et al., 2007). These cross-sectional studies cannot determine the causal direction of the discrimination–psychopathology association. However, longitudinal data among Southeast Asian immigrants to Canada indicate that those who experienced discrimination were more likely to become depressed at a future date and that depression did not predict subsequent experiences of discrimination (Beiser, 2009).

Myth #3: Asian Americans Do Not Experience Mental Health Disparities

Despite the disparity between White and Asian Americans in discrimination experiences, which can result in psychopathology, there is other evidence that Asian Americans do not experience mental health disparities relative to White Americans. Data from the Collaborative Psychiatric Epidemiology Survey, which is a nationally representative sample, suggest that Asian Americans, African Americans, Black Caribbeans, and Latino/a Americans (other than those from Puerto Rico), have lower rates of lifetime or past year psychiatric disorders than White Americans (Miranda, McGuire, Williams, & Wang, 2008). Miranda et al. (2008) concluded that a focus on mental health disparities between persons of color and White Americans may not be a public policy priority.

An alternative interpretation of the Collaborative Psychiatric Epidemiology Survey is that the cultures of many persons of color may contain protective factors that prevent them from experiencing the level of psychopathology that White Americans do. Thus, acculturation to the U.S. might be associated with psychopathology for Asian Americans and other groups of color. Indeed, there is evidence from community surveys that Asian American women born in the U.S. experience greater levels of psychopathology than immigrant Asian American women (Takeuchi et al., 2007), and that Asian Americans born in the U.S. experience greater levels of suicide ideation than immigrant Asian Americans (Cheng et al., 2010). However, there is contrary evidence of higher levels of psychopathology among immigrant Asian Americans versus U.S.-born Asian Americans (Jimenez, Alegría, Chen, Chan, & Laderman, 2010), and no between-groups differences in psychopathology (Chentsova-Dutton et al., 2007; Zhang & Ta, 2009). Such inconsistencies may occur because nativity is not always an accurate proxy of acculturation.

The relationship of acculturation, rather than nativity, to psychopathology has also been examined in several studies. The results of these

studies are equivocal. Acculturation to the mainstream U.S. has been found to be positively associated with depression and anhedonia among college students, including Asian Americans (David, Okazaki, & Saw, 2009). However, another study suggests that mainstream U.S. acculturation is negatively associated with depression among Asian American college students (Hwang & Ting, 2008). Still other studies suggest that acculturation is not directly associated with psychological distress, depression, or suicidal ideation among Korean immigrant adolescents (Cho & Haslam, 2010), depression among Asian American adults (Chentsova-Dutton et al., 2007), or psychological distress among Korean immigrant adults (Shim & Schwartz, 2008).

A possible explanation of the lower rates of psychopathology among people of color relative to White Americans that is not captured by nativity or acculturation is the protective effect of ethnic identity. The ethnic identity of people of color is generally stronger than that of White Americans (Phinney, Dennis, & Ossorio, 2006). There is also evidence of ethnic identity as a protective factor against psychopathology among people of color in the U.S. (Hall, 2010). Among Asian Americans, ethnic identity was negatively associated with internalizing and externalizing disorders in Korean American adolescents (Shrake & Rhee, 2004), psychological distress and suicide attempts among Asian American adults (Cheng et al., 2010; Yip, Gee, & Takeuchi, 2008), and psychological distress among Filipino American adults (Kiang & Takeuchi, 2009). Moreover, ethnic identity was positively associated with psychological quality of life among Asian American adults (Utsey, Chae, Brown, & Kelly, 2002). However, ethnic identity was not associated with lower rates of negative affect in a sample of Asian American young adults (Kiang, Yip, & Fuligni, 2008). The protective effects of ethnic identity against psychopathology may be most relevant for U.S.-born Asian Americans and for older Asian Americans (Yip et al., 2008).

Yet another reason for apparently low rates of psychopathology among Asian Americans is culture-bound syndromes. Asian Americans may experience psychopathology that does not map onto DSM diagnoses. For example, Zheng et al. (1997) identified a neurasthenia syndrome among Chinese Americans in Los Angeles that was distinct from other DSM disorders.

One area in which there are pronounced ethnic disparities for Asian Americans is in use of mental health services. In the Collaborative Psychiatric Epidemiology Studies, only 9% of Asian Americans had utilized mental health services in the past year versus 18% of the general population (Abe-Kim et al., 2007). Lower mental health service use could be equated with fewer mental health problems and could be viewed as consistent with the lower rates of psychopathology among Asian Americans relative to White Americans (Miranda et al., 2008). Nevertheless, help-seeking disparities also exist among those having psychological disorders. Among those likely to have *DSM–IV* disorders, only 28% of Asian Americans sought specialty mental health services during the past year compared to 54% of the general population (Le Meyer, Zane, Cho, & Takeuchi, 2009). However, these findings are moderated by nativity. Among third-generation Asian Americans, 19% had utilized mental health services in the past year, slightly above the 18% for the general population (Abe-Kim et al., 2007). Moreover, among U.S.-born Asian Americans likely to have *DSM–IV* disorders, 40% sought specialty mental health services during the past year. Thus, mental health service use disparities primarily apply to Asian American immigrants and their children.

One proposed reason for the underutilization of mental health services by Asian Americans and other groups of color is that available services are not culturally competent (S. Sue, Zane, Hall, & Berger, 2009). Culturally responsive mental health services have been found to result in better outcomes for Asian Americans and other persons of color than services that are not culturally responsive (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Cultural responsiveness included ethnic, gender, and language match between clients and therapists.

Cultural values have also been proposed as deterrents to seeking mental health services. However, the association between Asian values and help-seeking has been inconsistent. Adherence to Asian values has been found to be negatively associated with favorable attitudes toward professional help-seeking among Asian American college students (Kim, 2007; Liao, Rounds, & Klein, 2005; Shea & Yeh, 2008;

Wong, Kim, & Tran, 2010). In contrast, Asian values were not associated with help-seeking attitudes among Asian American high school students (Omizo, Kim, & Abel, 2008), and acculturation was not associated with help-seeking attitudes in another study of Asian American college students (Ting & Hwang, 2009). More germane to professional help-seeking than general Asian values is stigma tolerance. Those having strong Asian values may not have favorable attitudes toward professional help because of the stigma associated with seeking such help. Although acculturation was not associated with help-seeking attitudes in the Ting and Hwang (2009) study, stigma tolerance was associated with favorable help-seeking attitudes among Asian American college students. Moreover, the effect of Asian values on help-seeking attitudes may be moderated by other variables. For example, among Asian American college students who adhered to traditional Asian values, a belief that depression resulted in somatic consequences was associated with a greater likelihood of professional help seeking (Wong et al., 2010). Asian Americans who regard psychological disorders as an illness may seek help in primary medical care settings (Le Meyer et al., 2009). Thus, help-seeking attitudes may be influenced by how well the treatment addresses the perceived etiology of psychopathology (Hall & Eap, 2007).

It might be expected that Asian American immigrants would use alternative medicine (e. g., acupuncture, herbal treatments) more than U.S.-born Asian Americans because of its apparent cultural relevance. However, in the NLAAS, U.S.-born Asian Americans were found to make greater use of alternative medicine than Asian American immigrants (Le Meyer et al., 2009). Alternative medicine included services provided by a religious or spiritual advisor, a healer, a doctor of Oriental medicine, a chiropractor, or a spiritualist. Use of alternative medicine services by immigrants accounted in part for their underutilization of mental health services, particularly among those who did not speak English (Le Meyer et al., 2009). Twenty-eight percent of the Asian Americans in the NLAAS sample having a probable *DSM–IV* diagnosis used alternative medicine (Choi & Kim, 2010).

To summarize, Asian Americans constitute a significant proportion of the population that deserves as much attention as other similar-sized groups, such as those who are depressed or the populations of the three largest U.S. cities. Acculturative stress is associated with psychopathology among Asian Americans, as is discrimination, which is even more strongly associated with psychopathology than is acculturative stress. Asian Americans appear to have lower rates of psychopathology than White Americans, which may be the result of the protective effects of ethnic identity. Nevertheless, first- and second-generation Asian Americans likely to have a psychological disorder are less likely to use mental health services than other ethnic groups. Such underutilization may be explained by the lack of cultural relevance of available services and the use of alternative medicine, particularly by those who do not speak English.

These three myths are not the only reasons for the neglect of Asian Americans. For these and other reasons, Asian Americans have not had the political clout to advance group interests. Although Asian American political influence may be increasing, it is not commensurate to the rate of growth of the Asian American population.

Conclusions

Asian Americans have been neglected by U.S. mental health policies. Although the Community Mental Health Centers Act of 1963 made mental health services more accessible to the public, Asian Americans underutilized these services (S. Sue, 1977) and continue to do so today (Le Meyer et al., 2009). Although Asian Americans are a large ethnic group in the U.S. at 15.5 million people and proportionally the fastest growing, their mental health needs have not received proportionate attention.

Many of the public policies that were most friendly to the needs of Asian Americans and other populations of color, such as the Community Mental Health Centers Act, the Civil Rights Act, and the Immigration Act, became law in the 1960s. During a conservative era that began in the late 1970s, many of these advances were undermined. However, the 2010 Patient Protection and Affordable Care Act is cause for optimism and hope for people of color.

There is an urgent need for research and development of mental health services for Asian Americans. Unfortunately, the mental health needs of Asian Americans are unlikely to become a national priority unless those in power are concerned about these needs. Although Asian Americans have many non-Asian allies, those most concerned about the mental health needs of Asian Americans are Asian Americans themselves. This means that political efforts must be made to get Asian Americans into positions of leadership and power in which they can make decisions about mental health policy priorities.

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