

**PROMOTING CULTURAL COMPETENCE IN COUNSELING ASIAN AMERICAN
CHILDREN AND ADOLESCENTS**

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Asian Americans are commonly perceived as the diligent and high-achieving “model minority.” This positive stereotype has negative consequences for this ethnic minority group because it trivializes their social and mental health problems. This image of success has made many overlook the true nature of the struggles many Asian American families have to face in the United States. Scientific literature suggests that Asian American children experience major adjustment problems in school including loneliness, isolation, withdrawal, rejection, anxiety, low self-esteem, and interpersonal distress. Cultural barriers exist between the Asian and the dominant society and influence Asian Americans’ cognitive appraisal and coping choices when personal and emotional problems arise. These barriers also prevent clinicians from identifying and subsequently providing effective mental health services for Asian American children and their families. In this article, the authors examine the Asian cultural conceptions of mental health and various cultural barriers in an attempt to promote cultural understanding and competence among clinicians working with Asian American children and their families. Recommendations for clinical practice and future research directions are provided. C _ 2009 Wiley Periodicals, Inc.

Asian Americans are identified as one of the fastest growing student populations entering the American educational system. In turn, school psychologists and counselors are increasingly likely to encounter these children who may present with clinical issues that are different from those of the mainstream culture. Asian American children may not benefit to the same degree from established psychological theory and counseling techniques (Hung, 2006). Rooted in Western individualistic understanding of the self, the discipline of psychology inherently creates problems when used to understand Asian Americans with Eastern backgrounds and more collectivistic views of the self (Markus & Kitayama, 1991, 1998). Furthermore, Asian Americans are often portrayed by the general public as a “model minority” and are often perceived to experience fewer, if any, social and psychological problems in their adjustment in the United States (e.g., Sue & Morishima, 1982; Uba, 1994). Asian Americans are seen as being extraordinarily well adjusted, as demonstrated by high educational levels, occupational success, and above average earnings. However, behind the “model minority” facade, studies have demonstrated and

continue to reveal that Asian American students do suffer from a range of mental health problems (Leong & Lau, 2001; Yeh, 2001; Zhou, Pevery, Xin, Huang, & Wang, 2003). These problems are often masked by cultural or familial practices (Sue, Sue, Sue, & Takeuchi, 1995). The purpose of this article is to examine culturally related barriers that could prevent clinicians from effectively identifying mental health problems and subsequently delivering culturally responsive services to Asian American children, adolescents, and their families. One should note that Asian Americans as a group are quite heterogeneous, with more than 20 subgroups, each made unique by linguistic, cultural, and sociodemographic backgrounds and immigration history in the United States (Sue & Morishima, 1982). Erroneous conclusions can be drawn when researchers and mental health providers treat Asian Americans as a single category. However, despite differences in the belief systems and cultural norms or values among different groups of Asian Americans, there are significant similarities among Asian cultures, and most Asian Americans are likely to subscribe to those values. These shared values provide a cursory understanding from which mental health professionals can build their understanding of Asian Americans. With this in mind, this article will focus first on cultural identity and acculturation, followed by a discussion of cultural barriers to seeking help, and their corollary impact on children's school adjustment. Finally, we will discuss the implications for future practice and research.

CULTURAL IDENTITY AND ACCULTURATION

Acculturation is one of the most important variables in the development of Asian Americans' cultural identity. Acculturation can be defined as the degree to which immigrant or minority populations identify with the mainstream dominant culture (i.e., White American culture), and the extent to which they have integrated the dominant culture into their lives (Leong & Lee, 2006). Over the years, theoretical models of acculturation have been developed and revised. Early theoretical work in acculturation used a unilinear conceptualization of acculturation (see Miller, 2007, for a review). Unilinear models of acculturation are based on the assumption that, as immigrants and ethnic minorities adjust to and internalize the host culture, the ties to one's culture of origin is weakened (Ryder, Alden, & Paulhus, 2000). Therefore, the only outcome of the unilinear model is assimilation of the host culture (Miller, 2007). The bilinear model proposed by Berry (1979, 1990) conceptualizes each culture as a distinct continuum. Cultural integration is achieved when the individuals are able to maintain features of their indigenous culture as they acquire behaviors and values from the mainstream culture (Berry, 1979; Suinn, Khoo, & Ahuna, 1995). A multidimensional view of acculturation occurring on several different dimensions or domains has also been proposed (Kim & Abreu, 2001; Zane & Mak, 2003). According to Miller (2007), the process of acculturation occurs across two broad domains: behavioral (e.g., language, affiliation, food preference) and cognitive (e.g., values). Miller provides empirical evidence that acculturation and enculturation (adherence to one's culture of origin) occur across multiple dimensions and that adherence or espousal of each dimension is likely driven by distinct underlying processes. Because of the differences in climate, language, work habits, religion, and dress, immigrants frequently experience problems as they come into contact with a new culture (Berry, 1990). Acculturation strategies play an important role in the acculturation process. Scientific literature suggests that a higher level of acculturation led to more recognition of the needs of psychological services, more tolerance of

stigmas associated with mental health issues, and more direct discussion of personal problems with psychologists (Tata and Leong, 1994).

CULTURAL BARRIERS TO SEEKING MENTAL HEALTH SERVICES

Cultural barriers exist between Asian and the dominant society and influence Asian Americans' cognitive appraisal and coping choices when personal and emotional problems arise (Lazarus & Folkman, 1984). These barriers also prevent clinicians from identifying and subsequently providing effective mental health services for Asian American children and their families. *Cognitive Barriers* Culturally informed conceptions of mental illness and well-being of Asian Americans are embodied in the notions of nature, causes, and cures. Culture influences the labeling of illnesses despite their invariant clinical characteristics. Research indicates that the nature of the attributed cause for a problem is related to the intended solution for the problem and the sources of help seen as appropriate (Cheung, Lee, & Chan, 1983). Driven by the popular belief of body–mind holism, some Asian Americans do not make distinctions between psychological and physical illnesses. As a result, Asian Americans seek help from a physician for both physical and psychological problems. In terms of culturally informed conceptions of cure, Asian Americans' beliefs prompt them to adopt avoidance and problem minimization. Studies indicate that Chinese Americans tend to view mental illness as a problem that will be mediated by willpower and the avoidance of morbid thoughts (Arkoff, Thaver, & Elkind, 1966; Root, 1985). These cognitions encompassing traditional Asian notions of nature, cause, and cure of mental illnesses explain Asian Americans' reluctance to initiate counseling services. These beliefs may also lead them to perceive psychological help-seeking behavior as an unnecessary and inappropriate means for solving personal difficulties (Leong & Lau, 2001; Sue & Sue, 1990).

Affective Barriers

Culturally based affective gaps exist even after a problem is cognitively construed as psychological (Leong & Lau, 2001). Asian Americans are reluctant to report problems and to seek professional help because of feelings of shame and the stigma associated with having psychological difficulties (Leong & Lau, 2001; Root, 1985). Because the family name and “face” are so important to Asian Americans, seeking help from mental health professionals is usually the final option for Asian Americans, who often try to first deal with psychological issues independently or by asking for help from friends or family/community members (Maki & Kitano, 2002). Because Asian Americans are composed of a number of distinct subgroups that differ in religion, language, and values, great differences exist within this population (Maki & Kitano, 2002; Sandhu, 1997; Sue, 1994; Sue, Zane, & Young, 1994). Atkinson and his colleagues (Atkinson & Gim, 1989; Atkinson, Lowe, & Matthews, 1995) found no gender and intragroup differences among Chinese American, Japanese American, and Korean American undergraduates in their attitudes toward mental health services. However, Sue and Kirk (1975) found that Chinese American female students used mental health facilities significantly more frequently than did Japanese American female students. Overall, compared to other ethnic groups, Asian Americans are more reticent about disclosing psychological difficulties and show the longest delays in seeking mental health care from professionals. Cultural difference in coping style can be explained by the difference in beliefs about personal control. Rothbaum and colleagues (i.e., Rothbaum, Weisz, & Snyder, 1982; Weisz,

Rothbaum, & Blackburn, 1984) have classified belief controls into two types: primary and secondary. Primary control (i.e., perception that one can take actions to get desired outcomes) is defined as the belief that individuals can enhance their welfare by influencing external realities, such as other people, life event, and environments. However, when people are unable to change the external reality, they engage in “secondary control” (accepting one’s life situations as they are, instead of managing to change them), such as changing one’s cognition, affect, or behavior to accommodate the existing external reality to account for its impact. Significant cultural differences between Western (American) and Eastern (Japanese and Chinese) individuals have been identified. Weisz et al. (1984) demonstrated the emphasis on primary control in Western cultures and the reliance on secondary control in Japanese culture. Caucasians and Japanese develop distinct psychological characteristics, which are attuned to social practices that emphasize *influence* in the United States and *adjustment* in Japan. This difference is further evidenced in other empirical research (e.g., Spector, Sanchez, Siu, Salgado, & Ma, 2004). The findings from these studies suggest that people with a collective cultural background, such as Asian Americans, may be more likely to use secondary control when facing difficulties, whereas people from an individualist society, such as Caucasians, may favor primary control to directly deal with problems.

Value Orientation Barriers

Asian Americans’ tendency to adopt avoidant coping and wishful thinking may be related to their cultural values and worldviews (Sheu & Sedlacek, 2004). There are five prominent differences in cultural values between Asian and American mainstream society (Moy, 1992; Sue, 1998; Tsai & Uemura, 1988). First of all, Asian cultures place a high value on collectivity, whereas the Western value system emphasizes individualism. In the Asian society, family is the primary source of emotional support. Asian Americans are taught to think of how one’s behavior might affect not only the present family, but the whole family line as well. Allegiance to one’s parents (filial piety) is particularly important, and this obligation is to be maintained even after children are grown and have married. Therefore, interdependency has a higher value than self-reliance, and individual identity is based on and secondary to family identity. Second, Asians tend to adhere to the value of duty and obligation, whereas Western values emphasize personal rights and privileges. In the Asian society, mutual obligation is emphasized in interpersonal relationships. For instance, the employee has a duty to the employer, and the employer is obligated to the employee. Third, the Asian society values hierarchy and status, whereas the Western society values equality and egalitarianism. The Asian family, for instance, is traditionally patriarchal, with communication and authority flowing from top to bottom. Because of the importance of recognizing roles, position, and status, a major part of the Asian child’s social development is dedicated toward learning the proper way to relate to others within the social hierarchy. Furthermore, Asian cultural values emphasize harmonious interdependence, fitting in, and family hierarchies (Uba, 1994). These values prevent individuals from direct confrontation, in which the standard cultural practice is not to “rock the boat.” Fourth, the Asian culture values deference and respect, whereas Western values encourage assertiveness. Asian American children are taught the importance of maintaining harmonious relationships, and the concepts of shame and dignity are used to achieve interpersonal harmony. To preserve such harmony and dignity, Asian Americans tend to use indirect and nonconfrontational styles of communication. Last, the Asian society values self-control and restraint, whereas the Western society

values emotional expressiveness. Asian cultural pressure discourages direct and open expression of emotions, so that emotional maturity is marked by one's ability to suppress emotions. The incongruence between the concepts of Asian values of a relational and interdependent self bound by fluid boundaries, and the Western view of individuation, differentiation, and boundaries (Kagitcibasi, 1997) creates barriers to psychological diagnosis and treatment. The fluid boundaries, family integration, and interdependence that are characteristic of an Asian American will be considered pathological from a Western view of healthy family functioning that advocates clear boundaries and individuation from the family.

Communication Barriers

To establish interpersonal relationships with persons from different cultures, effective verbal and nonverbal exchanges are necessary (Chan, 1992). Barriers to intercultural communication are not limited to linguistic differences, but also to differences in thought patterns, values, and communication styles. The communication styles of Asian Americans are significantly different from those of Western cultures. The style of Asian communication is highly contextual. Recipients must rely on their knowledge of and appreciation for nonverbal cues and other subtle affect to interpret the conveyed messages. The dominant American culture, however, communicates primarily through words. Direct, precise, and clear information is delivered verbally, and receivers in this communication style can simply take what is said at face value. An elaborate, subtle, and complex form of interpersonal communication is most suitable to the Asian culture because this style enables its people to avoid causing shame or loss of face to themselves and others to maintain harmonious relations. In fact, any form of direct confrontation and verbal assertiveness is considered rude, disrespectful, and in direct opposition to the preferential Asian American way of communication (Chu & Sue, 1984). For example, silence is considered a valuable way to express not only interest but also respect, either from the speaker's or the receiver's perspective. The use of direct eye contact implies hostility and rudeness (Chan, 1992). Barriers in communication styles between Asian and Western cultures can hinder the development of the therapeutic relationship, exacerbate the hesitation to seek psychotherapy, and continue to cause the premature terminations that are often found when working with Asian Americans (Leong & Lee, 2006).

Practical Barriers

Researchers have identified a set of practical barriers that prevent Asian American families from seeking and using professional help (Kung, 2004; Leong and Lau, 2001). First of all, there is a lack of knowledge of the available services among Asian Americans. Second, there is difficulty in the family's ability to access services because of economic and geographic realities, such as work commitments, lack of child care, and lack of transportation. Chan and Leong (1994) report that Asian American children frequently feel that they lack sufficient support from their parents, as many of them work long hours and spend very little time with their children. Third, there is a lack of culturally sensitive mental health professionals (Uba, 1994). Psychologists and counselors may underdiagnose Asian Americans' mental health problems and further delay their access to appropriate help (Yeh, 2001). Zhang and Dixon (2003) reported that multiculturally responsive counselors are rated by Asian students as more knowledgeable, attractive, trustworthy, and capable of helping them with personal and social problems. Fourth, there is

a lack of bilingual mental health professionals who can cater to the linguistic needs of some Asian clients (Chung & Lin, 1994; Takeuchi, Sue, & Yeh, 1995; Ying & Miller, 1992). In addition, Asian Americans experience problems with racial prejudice, discrimination, and decreased availability of social support as a result of immigrating to a new country (Sue, Sue, Sue, & Takeuchi, 1998). A high percentage of Asian households lives below poverty level (Liu, Yu, Chang, & Fernandez, 1990). Many face underemployment or unemployment, social isolation, and racial tension; others have suffered from poor health and psychological problems such as depression and alcoholism (Lee, 1982). In addition, an increase in domestic violence and youth gang activities has also been observed in Asian communities (Liu et al., 1990; Sung, 1987). These are indicators that many Asian American families are in crisis; yet, these problems are often overlooked and not addressed.

IMPACT OF CULTURAL BARRIERS ON CHILDREN'S SCHOOL ADJUSTMENT

It is not surprising, therefore, that these cultural gaps constitute stressors that negatively impact the well-being of many Asian Americans, especially school-age children. In a review of the literature, Aronowitz (1984) found that immigration stress for children is often manifested as behavioral disorders in the school setting, which may also indicate depression. This was confirmed by Zhou, Peverly, Xin, Huang, and Wang (2003), who found that first-generation Chinese American adolescents reported significantly higher levels of depression and social stress than their Mainland Chinese and European American counterparts. In fact, the U.S. Department of Health and Human Services reported that the rate of suicide among Chinese Americans between the ages of 15 and 24 is 36% greater than the national average (Karnow & Yoshihara, 1992). In particular, Liu and colleagues (1990) reported that, for Chinese American adolescents in this age range, the suicide rate is consistently higher for those born abroad (7.1 per 100,000) than for those born in the United States (5.2 per 100,000). Generally, studies on Asian Americans have found that recently immigrated Asian American students report higher levels of depression, social anxiety, loneliness, and isolation than their Caucasian counterparts (James, 1997; Sue et al., 1998). Specifically, Yeh and Inose (2002) found that Asian American junior high and high-school immigrant students listed school, communication, unfamiliar customs and values, as well as interpersonal relationships as the most common areas of cultural adjustment difficulties. Abe and Zane (1990) also found that foreign-born Asian Americans reported greater levels of interpersonal distress than their Caucasian counterparts, even after controlling for such factors as demographic differences, social desirability, self-consciousness, extraversion, and other-directedness (i.e., being attuned to the desires and needs of others). Abe and Zane concluded that, although their sample of Asian Americans had resided in the United States for an average of 10 years, stressors such as language barriers and the loss of social support networks from home might have continued to exert negative effects on their psychological adjustment.

IMPLICATIONS FOR PRACTICE AND RESEARCH

Implications for Practice

Providing culturally responsive mental health services to Asian American children, adolescents, and their families is characterized by Leong and Lau (2001, p. 211) as a "dangerous opportunity." The danger lies

in the continued underutilization of mental health services despite high levels of mental health problems among this population. Furthermore, because of culturally inappropriate or culturally insensitive diagnosis and treatments, the Asian Americans who do enter the mental health system terminate services prematurely. The main challenge for mental health professionals is to develop culturally sensitive practice in addressing the urgent mental health needs of Asian Americans. The following are a few suggestions:

1. When counseling Asian American children and adolescents, explore some common difficulties involving parent–child conflicts caused by different levels of acculturation, feelings of guilt, academic stressors, negative self-image, and struggle for interdependence and independence.
2. Seek help from older generations in the community, religious leaders, student organizations, and church groups (Solberg, Choi, Ritsma, & Jolly, 1994). The importance of these leaders organizations cannot be underestimated as they are more attuned to the idiosyncrasies of the population, which may make mental health services more appealing and culturally appropriate for Asian American families.
3. Approach Asian parents with directive counseling styles, structured situations, and concrete solutions to problems because they have a low tolerance for ambiguity. 4. Similarly, provide crisis oriented, brief, and solution-oriented approaches rather than insight and growth-oriented approaches (Berg & Java, 1993). 5. Help Asian American families develop self-advocacy skills by providing knowledge about the U.S. educational, political, and legal systems as well as skills in dealing with these systems and in using American ways of problem solving.
6. Establish cultural validity in clinical diagnosis by becoming knowledgeable in cultural variations in symptom expression. For example, treat Asian Americans' somatic complaints as a sign that a more comprehensive assessment and corollary intervention may be needed (Dhooper, 2003).
7. Do not view the strong value placed on interdependence in Asian American families as enmeshment and pathological dependency (Durvasula & Mylvaganam, 1994). Use the family's care, concern for, and commitment to the individual's well-being as powerful resources.

Implications for Research

The most studied groups in the scientific literature are Chinese and Japanese Americans. These two groups have historically represented the largest Asian groups in the United States, but the characteristics of the population are fast changing. Many Southeast Asians (e.g., Vietnamese, Cambodian, and Lu Mien) who have come to the United States are not only victims of war and torture, but have to deal with dislocation and refugee status (Nishio & Bilmes, 1987; Novas, Cao, & Silva, 2004). It is not difficult to imagine that the mental health issues of refugees and recent immigrants are different from other Asian ethnic groups. There is a need to sort out the complexity of variables within the diversity of the Asian American population (Sue, 1994). There are two critical issues for the future of mental health service delivery for ethnic minorities, including Asian Americans, namely the need for cultural competence and evidence-based practice (Whaley & Davis, 2007). However, there is a lack of empirically supported guidelines on cultural competencies (Arredondo & Toporek, 2004). There is a lack

of research on cultural adaptation and culturally validated outcome measures (Huey & Polo, 2008). External validation of empirically supported treatments requires efficacy (focusing more on internal validity) and effectiveness research (focusing more on external validity) with ethnic minority populations (Whaley & Davis, 2007). Adaptation of empirically supported treatment for use with Asian Americans is likely to lead to more culturally competent services.

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