Guidelines for the Assessment and Treatment of Asian Clients

In the 2000 U.S. Census, “Asian” and “Native Hawaiian and other Pacific Islander” were considered two distinct races (Grieco & Cassidy, 2001; for definitions of these races, see Box 2.1 in Chapter 2). Clinicians, however, should be aware that the current literature concerning the assessment, diagnosis, and treatment of clients from culturally diverse groups generally makes no distinction between Asians and Native Hawaiians and other Pacific Islanders. Instead, the generic term Asian is used to designate three major subgroups in the U.S. population (Chung, Kim, & Abreu, 2004; Iwamasa, 2003; Kim, Brenner, Liang, & Asay, 2003; Sodowsky, Kwan, & Pannu, 1995; Mollica, 1989; Mollica & Lavelle, 1988; Sue & Sue, 1987, 2003): Asian Americans (Japanese, Chinese, Filipinos, Asian Indians, and Koreans), Asian Pacific Islanders (Hawaiians, Samoans, and Guamanians), and Southeast Asian refugees (Vietnamese, Cambodians, and Laotians). The literature includes guidelines for mental health professionals working with clients from each of these three subgroups, with specific attention to the special needs of Southeast Asian refugees (Iwamasa, 2003; Okazaki, 2000; Paniagua, 2001a; Sue & Sue, 2003). In this chapter, I use the generic term Asian in summarizing the guidelines recommended in the literature for the culturally sensitive assessment, diagnosis, and treatment of clients from all these subgroups. I also include a summary of guidelines intended specifically for therapists working with Southeast Asian refugees.

Approximately 10.3 million individuals (or 3.6% of the population of the United States) identified themselves as Asian only (i.e., not in combination with other races) in the 2000 U.S. Census. In the same year, 398,835 persons, or 0.1% of the U.S. population, self-identified as only Native Hawaiian or other Pacific Islander. Approximately 1.6 million individuals
reported being Asian in combination with one or more other races (Grieco & Cassidy, 2001; U.S. Bureau of the Census, 2000). In this group, the most common combinations were Asian and White (868,395), Asian and Native Hawaiian and other Pacific Islander (138,802), Asian and Black or African American (106,782), and Asian, White, and Native Hawaiian and other Pacific Islander (89,611) (Grieco & Cassidy, 2001). In total, approximately 1.1 million of the Asians residing in the United States included White among the racial categories they chose to describe themselves (Grieco & Cassidy, 2001; U.S. Bureau of the Census, 2000).

These findings suggest that although the majority of Asians residing in the United States do not consider themselves either biracial or multiracial, clinicians serving the Asian population should be aware that some clients from this race may identify themselves as members of additional races as well (e.g., Asian and Black or African American). As noted in Chapter 2, in the assessment, diagnosis, and treatment of mental disorders among Asian clients (as with clients from any of the four cultural groups discussed in this volume), therapists should take into account the cultural variables associated with all of the races/ethnicities included in their clients’ self-designations. This recommendation may also be applied to Native Hawaiian and other Pacific Islander clients, but the 2000 census shows very little biracial or multiracial self-identification among individuals in this group, so it may not be a significant issue for clinicians. For example, only 475,579 individuals reported in the 2000 census that they were Hawaiian and other Pacific Islander in combination with any other races; of these, 112,964 reported that they were also White, 29,876 said that they were also Asian, and 89,811 reported being also Black or African American (see Grieco & Cassidy, 2001, p. 9).

Among Asians, the most numerous groups in the 2000 U.S. Census were those of Chinese heritage (2.4 million, an increase of about 2 million since the 1990 U.S. Census; see Kim, McLeod, & Shantzis, 1992), followed by persons of Filipino (1.8 million, or about 1 million more from 1990 census), Asian Indian (1.7 million), Vietnamese (1.2 million), and Korean (1.1 million) heritages. Individuals of Japanese heritage made up the smallest Asian subgroup in the 2000 census (approximately 796,700, only about 80,700 more than in the 1990 census; see Kim et al., 1992). Among Pacific Islanders, the most numerous groups were Native Hawaiians (140,652), Samoans (91,029), and Guamanians (58,240).

Socioeconomic Status

In 2000, the median annual income for the Asian and Pacific Islander populations was $53,635, somewhat higher than the median income for the entire U.S. population (i.e., $42,228; U.S. Bureau of the Census, 2000). Among Asians and Pacific Islanders, the median annual income per household
was $22,951, compared with $12,158 for Hispanics and $24,951 for Whites (U.S. Bureau of the Census, 2001, 2002b). Approximately 1.3 million of those who self-designated as Asian only (i.e., not in combination with other races), or 12.6% of this racial group, were living below the poverty level (Bishaw & Iceland, 2003), in comparison with 12.4% of the total U.S. population, 9.1% of Whites, 22.6% of Hispanics, and 24.9% of African Americans. The number of persons self-identified as Hawaiian and other Pacific Islander only (not in combination with other races) who were living below the poverty level in 2000 was 64,558 (Bishaw & Iceland, 2003), or 17.7% of people from this race—a higher percentage than that found in the total U.S. population (12.4%), the Asian population (12.6%), or the White (9.1%) population (see Bishaw & Iceland, 2003, p. 8).

Cultural Variables That May Affect Assessment and Treatment

Prejudice, Racism, and Discrimination

Asians living in the United States have historically experienced prejudice, racism, and discrimination (Sue & Sue, 2003; Yamamoto, 1986). This was particularly true during the period from the 1850s through World War II, when many Chinese immigrants came to the United States to work in gold mines and to build railroads. Other Asians (Japanese, Filipinos, Koreans) followed the Chinese. Many people considered the Asian immigrant men who served as a source of cheap labor during that period “sneaky and sinister,” and laws were passed to prohibit them from owning American land or bringing their wives with them. Discrimination was also apparent in the housing, employment, and educational opportunities available to these immigrants (Yamamoto, 1986). As Yamamoto (1986) has observed, despite significant improvement in the lives of Asians in the United States, “prejudice, racism, and discrimination still persist” against members of this group (p. 92). Mental health professionals who work with Asian clients should be sensitive to the history of racism and discrimination that Asians have experienced in the United States, taking care to avoid any verbal or nonverbal behaviors that Asian clients might interpret as signs of prejudice.

Familism

As is true of all the other cultural groups discussed in this book, Asians tend to place great emphasis on family relationships (Ho, 1992; Sue & Sue, 2003). Among Asians, the family unit, and not the individual, comes first. The kind of individualism associated with Anglo-American
society is not rewarded in Asian culture; rather, like Hispanics, Asians tend
to view individualism from the standpoint of the individual’s peculiarities.
Like Hispanics and African Americans, Asians also place great emphasis
on the extended family. Among Asians, each family member’s role is clear
and unchanging; unlike in African American families, “role flexibility”
within the family is not rewarded. As in Hispanic families, in Asian families
the father is the dominant figure, and his authority is paramount.

**Role of Children and Wives**

Traditional Asians believe that children’s primary duty is to be good
and to respect their parents. Parents are expected to determine the course
of their children’s lives, without consulting the children about their own
desires and ambitions, and any failure on a child’s part to comply with
parents’ expectations is seen as a threat to the parents’ authority. Asian
women are expected to marry, to be obedient helpers to their husbands, to
have children, and to respect the authority of their husbands and fathers.
These strong cultural expectations may explain why Asian women and
children appear less autonomous and assertive, and more conforming,
dependent, inhibited, and obedient to authority, than Anglo women and
children (Ho, 1992; Sue & Sue, 2003). Therapists who work with Asian
clients need to be aware that these are appropriate (or normal) behavior pat-
terns among Asians. A culturally sensitive therapist will avoid suggesting to
an Asian family that children and adolescents need to establish their inde-
pendence from the authority of their parents. Such a therapist will also
avoid discussing the “lack” of assertive behaviors and autonomy in an
Asian woman during the process of family therapy.

**Suppression of Problems Outside the Family**

In general, Asians do not encourage family members to express any
family problems to people outside the family (Sue & Sue, 2003). All prob-
lems (including physical and mental problems) are to be shared only among
family members, just as all rewards received and successes achieved by
individual family members are shared by the entire family. *Shame* and *guilt*
are two mechanisms that Asian families use to enforce norms within the
family (Dana, 1993b). These mechanisms play a crucial role in preventing
Asians from reporting or admitting their problems in public—that is, to
anyone outside the family.

If an Asian does not behave as expected within and outside the family,
he or she may lose the confidence and support of family members, which
could lead him or her to develop a strong sense of shame and guilt. This sense
of shame and guilt may lead to considerable anxiety and depression around
the fear that family support may be withdrawn. Several Asian scholars have suggested that Asians’ desire to avoid this sense of shame and guilt may explain the strong self-control and self-discipline often reported among persons in this cultural group (e.g., Ho, 1992; Sue & Sue, 2003). Thus an important guideline for therapists working with Asian clients is to explore with them this sense of shame and guilt in order to understand how difficult is for these clients to talk about their problems in public. A therapist should not expect that an Asian client will report about his or her emotional problems as soon as the therapist says, “Tell me about your problems” (in contrast to many African American and Hispanic clients, who tend to respond quickly to this invitation the first time they interact with a therapist).

**Indirect Versus Direct Forms of Communication**

Asians often respond to the verbal communications of others by being quiet and passive; they may go to a great deal of effort to avoid offending others, sometimes answering all questions affirmatively to be polite even when they do not understand the questions, and they tend to avoid eye contact (Chung, 1992; Root, Ho, & Sue, 1986). Therapists who work with Asian clients should be aware that this indirect form of verbal communication is appropriate for individuals from this cultural group. This communication pattern is very different from the usual Western style of communication, in which both the speaker (e.g., the client) and the listener (e.g., the therapist) must look expressive and active, and the participants generally do not answer questions that they do not understand.

Two forms of indirect communication that may create problems during the assessment and treatment of Asian clients are silence and lack of eye contact. Therapists should be aware that among Asians silence is a sign of respect and politeness; it also signals an individual’s desire to continue speaking after making a point during a conversation (Sue & Sue, 2003). In Western cultures, eye contact during direct verbal communication is understood to imply attention and respect toward others. Among Asians, however, eye contact is considered a sign of lack of respect and attention, particularly to authority figures (e.g., parents) and older people. A therapist who does not understand the meanings that Asians ascribe to silence and eye contact during conversation may feel uncomfortable when speaking with an Asian client and may change the entire content of the conversation on the assumption that the client is not interested in or is not attending to what the therapist is saying. This error may prevent an Asian client from either elaborating on a prior point or demonstrating attention and respect toward the therapist in the way he or she considers appropriate (i.e., through silence and avoiding eye contact).
The First Session

Displaying Expertise and Authority

Many Asian clients come to their first therapy session expecting that the therapist will tell them what is wrong and how to resolve their problems (Sue & Sue, 2003). In addition, many Asian clients see therapists as authority figures. Thus, to ensure that an Asian client will return for therapy, the therapist should demonstrate both expertise and authority during the first session. These qualities correspond to one of the two dimensions of therapist credibility that have been identified as important among Asian and Pacific Islander clients, namely, ascribed credibility (Sue & Zane, 1987), which “derives from the position or role that is assigned by others in society. In Asian culture, characteristics that often go with higher ascribed status include older age, male sex, and higher expertise or authority” (Okazaki, 2000, p. 178). Kim (1985) suggests that a therapist can enhance his or her ascribed credibility with an Asian client by demonstrating expertise and authority during the first session in several ways:

1. The therapist can casually mention prior experiences with other clients who have problems similar to the present client’s. For example, the therapist might say, “In my experience with many similar cases . . .” (to show expertise), or “In my professional judgment . . .” (to show authority).
2. The therapist can display his or her diplomas and licenses as well as relevant books.
3. The therapist can use his or her professional title when introducing him- or herself to the client (e.g., “I am Dr. Jones” or “I am Professor Smith”).
4. The therapist can suggest to the client some possible reasons or explanations for the client’s problem.
5. The therapist can give the client the impression that a solution (cure) to the problem is possible.
6. Throughout the session, the therapist can emphasize concrete and tangible goals and avoid comments that suggest the client will need to be in therapy for a long period of time (many Asian clients believe that only an inexperienced “doctor” needs a lot of time to understand and resolve a problem).

Maintaining Formalism and Conversational Distance

In general, Asian clients tend feel that their role in therapy is to be passive, respectful, and obedient in the presence of the authority, the therapist (Yamamoto, 1986). Thus these clients expect formality in the therapist-client relationship. The therapist should not expect an Asian client to be very friendly during the first meeting; rather, this initial contact is generally formal. The therapist should avoid making jokes during this session.
Among Asians, the nature of the relationship between the participants in a conversation often determines the physical distance maintained between them. The basic guideline for therapists to remember concerning conversational distance with an Asian client is to allow the client to define the distance with which he or she is comfortable during the process of assessment and treatment. For example, the therapist can sit down first, allowing the client to determine the distance between them. If the client and therapist have not yet built a trusting relationship, the client is not likely to sit very close to the therapist (Chung, 1992).

Waiting Until the Client Is Ready to Discuss Emotional Problems

In a traditional Asian family, an individual member’s emotional problems are seen as bringing shame on the entire family, thus family members are strongly discouraged from reporting such problems to anyone outside the family. This phenomenon probably explains why current epidemiological data indicate that Asian clients have a very low prevalence of emotional disorders in comparison with members of other cultural groups (Sue & Sue, 2003). In the first session with an Asian client, the therapist must show (both verbally and nonverbally) that he or she will wait until the client is ready to discuss his or her mental problems. This waiting period could include more than one session, and the therapist should be sure the client understands this possibility.

Understanding the Expression of Mental Problems in Somatic Terms

Asians tend to express psychological disorders in somatic terms (Ho, 1992; Hughes, 1993; Sue & Sue, 2003). This phenomenon is associated with the shame, humiliation, and guilt that can result when an individual makes such problems public (Hughes, 1993). Given the choice of talking about physical symptoms (e.g., chest pains, headaches, and fatigue) or talking about psychiatric symptoms (e.g., hallucinations, delusions), an Asian client would probably select the former, because reporting physical complaints is often more acceptable to Asians (i.e., results in less shame, humiliation, and guilt) than reporting emotional or psychiatric problems (Sue & Sue, 2003).

Thus when an Asian client consults with a therapist for the first time, he or she may spend a great deal of time talking about physical complaints such as headaches, back pain, weight loss, and fatigue. The therapist can handle an Asian client’s somatization of psychological or psychiatric disorders during the first session in two ways (Ho, 1992; Sue & Sue, 2003). First, the therapist should always acknowledge these somatic complaints. The therapist should also tell the client that he or she wants to arrange for the client to be
clinically assessed for potential physical disorders (particularly by an Asian physician) before the therapist concludes that the client is exhibiting some form of somatization disorder (e.g., conversion disorder, hypochondriasis, somatoform pain disorder). Second, the therapist should introduce statements that allow the client to move gradually from verbalizations of somatic complaints to verbalizations involving mental health problems. For example, the therapist could say, “I will consult with a physician about your headaches. Perhaps you are having headaches because you do not know what to do to handle some conflicts in your life. Would you like to talk about any such conflicts?” The therapist should avoid making any statements that indicate he or she does not believe that the client “really” has a physical (medical) problem, such as “You don’t have headaches. You simply want to avoid to talk about your mental problems.”

**Understanding the First Session as a Crisis**

Because many Asians believe that mental illness brings shame and humiliation to their entire families, they tend to wait many years (often 5 to 10 years) before seeking professional help for mental problems (Fujii, Fukushima, & Yamamoto, 1993; Gaw, 1993b). Thus by the time an Asian client is brought to the attention of a clinician, his or her condition is often chronic and severe, and the family is in a state of crisis. For this reason, the therapist should always consider the first session with an Asian client as a potential crisis point. Because of this possibility, the clinician should be prepared to display two emergency responses: (a) immediate assessment of suicide attempts and suicidal thoughts, and (b) immediate attention to the present problem and its treatment (including the availability of family support, the possibility of brief inpatient treatment, and consultation with social agencies involved with Asian communities). If the client needs brief psychotherapy, inpatient treatment, and/or medication, the therapist should inform the client’s family of this before the termination of the first session.

As Yamamoto (1986) notes, treating the first session as a crisis is particularly important with elderly Asians referred to outpatient mental health clinics, because of the high frequency of suicidal behavior (approximately 27 in 100,000) among elderly Asians living in the United States. In contrast, the frequency of suicidal behavior is extremely low among elderly Asians living in Asian countries.

**Avoiding Any Discussion of Hospitalization**

Although it is appropriate for the therapist to consider the first meeting with an Asian client as a potential crisis situation, it is also important that he or she avoid making any comments regarding the hospitalization of the
client during the first meeting. Many Asian clients consider psychiatric hospitalization to be a last resort, and instead are likely to expect to hear about alternatives to hospitalization (e.g., outpatient treatment and the delivery of treatments by family members at home) during the first session with a therapist. If the therapist determines during the first session that hospitalization of an Asian client is necessary (e.g., because the client is a danger to him- or herself or others), he or she should follow these guidelines (Fujii et al., 1993; Kinzie & Leung, 1993):

1. The therapist must consult with the client’s family members, who must approve the hospitalization.
2. The therapist must provide the client and his or her family members with a detailed description of the anticipated length of the hospital stay, recommended tests, and treatment modality.
3. The therapist should inform the client’s family members about the hospital’s visiting hours and the reasons family members are not encouraged to go to the hospital with the client (e.g., for clinical or administrative reasons).
4. The therapist should inform the client’s family members that they may bring ethnic foods to their hospitalized relative to replace or supplement the Western-style foods offered in the hospital to all inpatients.
5. During the entire period of hospitalization, the therapist should never tell the client about his or her diagnosis. The therapist should share this information only with the client’s family members, because many Asians believe that if a person who is ill knows “the truth about the illness, he or she might lose hope and deteriorate more quickly” (Fujii et al., 1993, p. 337).

**Considering Alternative Care Services**

It is a good tactic for the therapist to assume that an Asian client’s presenting problem is a chronic problem developed over a long period. Even in severe clinical cases, however, many Asian families may not agree to allow the hospitalization of their relatives. Therefore, prior to the first session with an Asian client, it is important that the therapist determine the availability of alternative care services. For example, the therapist might consider discussing with the client and his or her family the possibility that the client could be cared for at home with some professional assistance; many Asian families would see this as a more acceptable course of action than hospitalization. The therapist should have available a list of the local community mental health services agencies specifically devoted to treating Asians (see Box 5.1 for some examples of such agencies). These alternatives could facilitate the assessment and treatment of Asian clients whose
families refuse to allow hospitalization and may help these clients to avoid the stigma of mental illness that results from hospitalization or inpatient treatment (Yamamoto, 1986, p. 117).

**Box 5.1** Examples of Agencies Offering Alternative Services for Asian Clients

- Asian Community Service Center (Los Angeles)
- Pacific/Asian Preventive Program (San Diego)
- Richmond Area Multi-Service Center (San Francisco)
- Asian Counseling and Referral Service (Seattle)
- Asian American Drug Abuse Program (Los Angeles)
- Center for Southeast Asian Refugee Resettlement (San Francisco)
- Asian Counseling and Treatment Center (Los Angeles)
- Korean American Mental Health Service Center (Los Angeles)
- Operation Samahan (San Diego)

**Providing Concrete and Tangible Advice**

Asian clients often want therapists to deal with their immediate concerns by providing concrete and tangible advice in the first session (Root et al., 1986; Sue & Sue, 2003). The therapist should be careful to avoid prolonged verbal exchange with the client during the first session and should also avoid making any suggestions that appear ambiguous. For example, the statement “Mr. Sue, you need to change your behavior in a positive way if you want your wife to stay with you” tells the client nothing about exactly what he has to do. In addition, the therapist should avoid discussing solutions to problems that involve long-range goals. For example, the following statement is both ambiguous and implies a long-term goal: “Let’s talk about what you need to do to change your behavior in the next 6 months. What do you think you should do to improve your relationship with your wife?” A better statement with an Asian client would be as follows: “During the next 5 days, write on a piece of paper the number of times you and your wife hold hands, eat, and take short walks together. When you return for therapy next week, we will talk about what you have written.” This statement is concrete (i.e., it tells the client exactly what to do, both to improve the relationship and to provide the therapist with information), and it suggests a short-term goal (i.e., the client will bring the results of the assignment in for discussion the following week).
Understanding That Psychotherapy Is Not Expected

An Asian client is not likely to expect the therapist to conduct psychotherapy to deal with the client’s problem in the first session; rather, the client will expect that this session will be spent on what the therapist wants to know about the client in general. In some cases, therapists may need to have several sessions with Asian clients before they can initiate psychotherapy. However, if the therapist determines that the client is in an emergency situation or crisis, he or she must consider recommending inpatient treatment and/or medication.

As noted above, in Asian cultures individuals are discouraged from discussing problems (particularly mental problems) with anyone outside of their families. Thus the therapist cannot expect that during the first session an Asian client will share his or her feelings or emotional problems (Sue & Sue, 2003). The best approach the therapist can take in the first session is to let the client know that the therapist is available to listen when the client is ready to talk, and that the therapist understands that it may take several sessions before the client is able to discuss emotional problems openly.

Considering the Client’s Organic Explanation of Emotional Problems

Because Asian clients tend to express their emotional problems in somatic terms, as discussed above (Sue & Sue, 2003), these clients generally place a great deal of emphasis on organic variables as explanations for their emotional problems. For this reason, Asian clients often expect to receive medication (to deal with these “organic” problems) during their first contact with a therapist. A practical guideline for the therapist in this regard is to accept the client’s interpretation of the origin of his or her mental problems as an example of the client’s belief system. This tactic can greatly enhance the therapist-client relationship in future sessions. If the therapist does not recommend medication during the first session, he or she should explain why in concrete terms. For example, the statement “I don’t think you need medication” does not offer the client enough information; he or she still needs to know why the therapist is not prescribing medication. A better approach would be for the therapist to say, “To improve communication between you and your wife, I would like to recommend a technique based on learning how to solve problems. Medication is another alternative, and I might consider that later, after I have consulted with your physician regarding the medications you are currently taking to prevent complications that can arise from the combination of two or more medications.”
Avoiding Trying to Collect Too Much Information

In general, mental health practitioners are trained to conduct a thorough clinical interview (i.e., to get as much information as possible) during the first meeting with a client. This approach is not recommended with Asian clients, however (Gaw, 1993b), because of these clients' reluctance to discuss personal matters with persons outside their families. In the first session, the therapist should avoid asking questions about specific and sensitive issues (e.g., “How is your sexual relationship with your wife?”) and instead ask more general questions (e.g., “How is the relationship between you and your wife?”). By emphasizing general questions in the first session, the therapist can enhance the therapist-client relationship and prepare the way for asking the client about more intimate matters in subsequent sessions.

Working With Southeast Asian Refugee Clients

Whereas the guidelines presented above are suggested for use with all Asian clients, the following additional guidelines are strongly recommended for therapists who work with Southeast Asian refugee clients (Cook & Timberlake, 1989; Mollica, 1989; Mollica & Lavelle, 1988). As noted above, these clients have come to the United States with histories of traumatic events unlike those generally reported by other Asian clients (particularly Asian American/Pacific Islander clients). For this reason, the therapist must plan carefully for the first session with a Southeast Asian refugee client. Below, I offer brief discussions of some specific points that therapists should consider when working with clients from this group (Ho, 1992; Mollica & Lavelle 1988).

Avoiding Questions About Traumatic Events

During the first session with a Southeast Asian refugee client, it is extremely important that the therapist avoid making statements or asking questions that deal with traumatic events the client may have experienced. The therapist must be familiar with the fact that the client comes to therapy with a history of trauma that may include torture, the loss of loved ones through killing or disappearance, the witnessing of killings, and/or sexual abuse perpetrated by enemies during wartime. It is extremely difficult for such a client to discuss these kinds of events during his or her first meeting with a therapist. Given the traumatic events that Southeast Asian refugees have experienced, the therapist should not end the first session before assessing the client for suicide attempts, organic brain syndrome (because of the high potential for head injury among these refugees), and depression.
Avoiding Pressing the Client to Say More

A Southeast Asian refugee client may experience considerable stress if the therapist urges the client to talk about his or her problems during the first session. The therapist should not encourage a client from this group to say any more than what he or she volunteers without prompting. For example, the therapist should avoid asking questions such as the following during the first session: “Are you sure that this is the reason you need help?” or “Do you think that some dreams about very bad events in your life are creating problems for you?”

Reducing the Client’s Stress as Quickly as Possible

A Southeast Asian refugee client is likely to expect help from the therapist quickly in terms of lowering the level of stress caused by a lack of resources; many such clients cannot afford housing, food, clothing, and other vital elements for their survival in the United States (Cook & Timberlake, 1989). The therapist should be familiar with the social services agencies (particularly agencies that deal specifically with refugees) operating in the community that can assist the client with his or her needs and thus help to lower the client’s level of stress.

Conducting Psychotherapy

The guidelines summarized below are based on recommendations for psychotherapy with Asians offered by Chung (1992), Ho (1992), Iwamasa (2003), Mollica and Lavelle (1988), Murase (1992), Root et al. (1986), Sue and Sue (2003), and Yamamoto (1986).

Educating Clients in the Terms of Psychotherapy

Because many Asian clients are unfamiliar with terms such as therapy, psychotherapy, verbal therapy, psychodynamic therapy, and behavior therapy and do not understand how various kinds of psychotherapy differ from traditional healing methods, the therapist should begin the psychotherapy process with a brief introduction in which he or she discusses the meanings of relevant terms (Kim, 1993).

Conducting an Assessment of Shame and Humiliation

During the process of psychotherapy with an Asian client, it is important that the therapist conduct an assessment of the persistence of shame and humiliation in the client resulting from the stigma of mental illness.
The therapist should also discuss this issue and the results of the assessment with the client and his or her family members. Conducted after the first meeting (which is often a crisis situation), this assessment should include attention to the following points (Gaw, 1993b), which the therapist may use to infer that the client is having problems talking openly about mental problems because of shame and humiliation resulting from the public admission of such problems:

1. Extreme concern on the part of the client or a family member about the therapist’s qualifications
2. Excessive worry about confidentiality
3. Refusal to submit claims for coverage of treatment to a private insurance company
4. Difficulty in keeping appointments or frequent late arrival for therapy
5. Refusal of family members to support the client’s treatment
6. Insistence on receiving services from an Anglo clinician to avoid Asian therapists
7. Refusal to seek treatment even when a severe mental health problem is evident

**Discussing the Duration of Therapy**

Most Asian clients expect quick solutions to their mental problems. As noted above, however, by the time Asians seek professional help, they often have chronic psychiatric disorders. Therapists should inform their Asian clients that it is unrealistic to expect quick solutions to chronic mental health problems and should provide estimates of the likely duration of treatment (Yamamoto, Silva, Justice, Chang, & Leong, 1993). It is not generally recommended that therapists working with Asian clients undertake long-term treatment that emphasizes the uncovering of underlying conflicts (Murase, 1992). Relatively short treatment periods (i.e., no longer than 2 or 3 months) are recommended; if the therapist believes treatment should be extended for a longer period, he or she must negotiate this decision with the client.

**Avoiding Personalism**

Unlike most Hispanic clients, Asian clients do not expect a high level of personalism in the client-therapist relationship during psychotherapy. Therapists working with Asian clients should be aware that they usually expect the formalism of the first session to continue in subsequent sessions.
Recommended Modalities of Therapy

Medication

As noted above, many Asian clients expect to receive medication as part of therapy. Therapists who prescribe medication for Asian clients need to be aware that the drug dosages recommended for Anglo-Americans are not necessarily applicable for Asian clients because of “differences in body weight and possible ethnic differences in drug metabolism and sensitivities” (Gaw, 1993b, p. 276). If medication is used with Asians, the overall recommendation is to keep doses low because Asians have been shown to have a tendency to respond at much lower doses than non-Asians (Fujii et al., 1993; Kinzie & Leung, 1993). Because many Asian clients use herbal remedies to treat physical and mental problems, the therapist should discuss with the client any potential side effects that may result from the consumption of traditional medicines in combination with psychotropic medication.

Behavioral Approaches

Behavioral approaches (e.g., behavior therapy techniques) are recommended for Asian clients because these approaches are concrete and directive. Also, behavioral approaches do not emphasize the exploration of internal conflicts, which can tend to enhance the “shame” that an Asian client may experience as a result of reporting his or her problems to a therapist.

Family Therapy

The use of family therapy is recommended for Asian clients for two reasons (Berg & Jaya, 1993). First, among Asians the family unit is more important than the individual. Second, because the concept of withholding information among family members is foreign to many Asians (Hughes, 1993; Sue & Sue, 2003), Asian clients generally expect that their family members will be actively involved in their assessment and treatment by mental health professionals. Asian clients expect therapists to share all information regarding treatment issues with all their family members, rather than only with the client. Additional guidelines concerning family therapy with Asian clients include the following (Berg & Jaya, 1993):

1. When the therapist introduces problem-solving techniques to deal with marital problems or conflicts between children and parents, these techniques should emphasize a process of negotiation rather than head-on confrontation. In this process of negotiation, the therapist serves as the mediator, given the clients’ view of the therapist as an expert and a person in a position of authority.
2. To enhance the likelihood of peaceful negotiation, the therapist should see the parties who are in conflict separately before seeing the family members together in therapy sessions.

3. The therapist should keep differences in age and status in mind when addressing family members. For example, the therapist should always address the head of the family by his or her last name and the appropriate title of courtesy (e.g., Mr. Sue, Dr. Sue, Mrs. Sue). During the therapy process an Asian client may ask the therapist to call him or her by first name, but until this happens, the therapist should continue to show proper respect for the client by maintaining the formality of using the client’s last name. As Berg and Jaya (1993) note, many Asian clients believe that the respect they receive from a therapist is more important than what the therapist does to help them to solve their problems.

4. Family therapy must be (a) problem focused, (b) goal oriented, and (3) symptom relieving on a short-term basis (Kim, 1985). Therapy that emphasizes internal conflicts, self-assertion, expression of anger, and acquisition of insights is not recommended for Asian clients (Kim, 1985). Such clients generally expect a therapist to define the goals of family therapy in terms of situational changes requiring external solutions.

5. Family therapy aimed at helping Asian children and adolescents to develop independence from their parents is not recommended. In their social contacts with Anglo-American children, Asian children quickly learn that in the typical mainstream American family, the children are allowed to speak and to question authority and are encouraged to be independent. In family therapy with Asian families, the Western model of sharing power among family members may compete with the vertical, hierarchical structure of traditional Asian families, in which parents (particularly fathers) are in a position of unquestionable authority (Kim, 1985). Thus the therapist must determine whether all Asian family members in therapy share the same values concerning the undisputable leadership and authority of parents before family therapy begins. In this process, the therapist should evaluate the acculturation levels of all family members (see Chapters 2 and 8).

6. Because Asians emphasize the family unit over the individual, the therapist should ask questions concerning family relationships during the process of assessment and treatment (Berg & Jaya, 1993). For example, the following questions do not emphasize the relationships between the client and other family members: “What do you think about your problem?” “If you stop drinking after treatment, how will you feel?” “How does this problem affect you?” Questions aimed at eliciting similar information, however, can be phrased in terms of relationships: “What do you think your father will say is the main problem between you and him?” “If you stop drinking after treatment, what will your family notice you are doing differently?” “How does this problem affect your family?”

7. The therapist should always protect the dignity and self-respect of all members of the family; this includes avoiding embarrassing family
members in front of one another and the therapist. This guideline is often referred to as helping the client “save face” (Berg & Jaya, 1993; Kim, 1993). For example, an Asian father “loses face” during the process of family therapy if the therapist tells him (in the presence of other family members) that he is “wrong” to demand that his son select a profession that is acceptable to his parents. To avoid embarrassing the father, the therapist should reframe the issue in a positive way. For example, the therapist might begin by complimenting the father on his concern for the family: “I understand that you would like your son to have a profession that could help the family’s financial situation. But would you agree that your son would be happier if he selects a profession that is rewarding to him and to the family?” The therapist can thus preserve the dignity and proper role of the father while suggesting an alternative solution to the problem.

8. If the central issue in family therapy is divorce, the therapist should follow these practical guidelines (Ho, 1987). First, because divorce is not socially acceptable in Asian communities and is seen as a very serious decision, the practitioner should not raise the idea of divorce as a possible solution to the family’s problems; instead, he or she should wait until the clients clearly indicate that it is time to discuss this alternative. Second, because many Asian clients are not familiar with the legal process of divorce, the practitioner should make available to the family members the legal information they need as well as the names, addresses, and telephone numbers of lawyers who have expertise in working with Asian clients. Third, because many Asians feel that divorce brings shame on the entire family, Asian clients who decide to divorce may be faced with the withdrawal of social and economic support by relatives and friends. The practitioner should assist such clients in finding new support systems by encouraging them to meet other Asians who have shared the same experiences. To facilitate this, the therapist might schedule a therapy group made up of Asians who have been divorced.

9. Although it is generally assumed that Asian clients are likely to prefer to involve their entire families in the assessment and treatment of their mental disorders, the therapist must carefully evaluate this issue with each Asian client. An assessment of the client’s level of acculturation is helpful in this regard (for examples of acculturation scales recommended for use with Asians, see Table 8.1 in Chapter 8). As Yamamoto (1986) notes, highly acculturated Asian clients may or may not want family members to be involved in their psychotherapy.

Avoiding Talk Therapy

The use of talk therapy is not recommended with Asian clients, who generally prefer therapy that is more active (i.e., that deals with problems quickly) (Gaw, 1993b). As Tsui (1985) notes, Asian clients “expect tangible evidence of intervention, not abstract discussion” (p. 360). For this reason, therapies that involve self-exploration and psychodynamic interpretations of symptoms are likely to be ineffective with Asian clients.
Group Therapy

Because of the tendency among Asians to avoid sharing their problems with people outside their immediate families, group therapy is not generally recommended for Asian clients, particularly in cases involving sensitive issues, such as sexual dysfunction and infertility (Tsui, 1985). Group therapy may be appropriate for an Asian client, however, if the client has no support system (relatives and close friends) available and needs an alternative support system quickly. For example, as noted above, Asian clients who elect to divorce may lose the support of relatives and close friends as a result; these clients might benefit from sharing their experiences with other Asian clients who have also lost social support because of similar “misbehavior” (see Ho, 1987, p. 63).

Additional Guidelines for Therapists

Working With Southeast Asian Refugee Clients

In addition to the above guidelines, which are applicable to therapy with all Asian clients, three specific guidelines are suggested concerning the process of psychotherapy with Southeast Asian refugee clients. First, despite the important role of the extended family in Asian cultures, the therapist should consider carefully before suggesting the use of family therapy because many members of the client’s family may not be available (e.g., because of death or disappearance).

Second, during the process of psychotherapy the therapist should be ready to assist the client in the pursuit of many different kinds of services (Flaskerud & Anh, 1988). The therapist should provide the client with information on local mental health centers as resources for treatment and education about mental disorders as well as education about American society (including culture and lifestyle). A client who is a refugee is also likely to need information about financial assistance programs, community resources for assistance with food and housing needs, and vocational and language training opportunities in the community. The therapist should also inform the client about culturally relevant assessment and treatment for mental disorders, family-related problems, and adjustment problems.

Third, given that recent reports indicate that approximately 50% of Southeast Asian refugees in the United States may be suffering from post-traumatic stress disorder, or PTSD (Kinzie & Leung, 1993), the psychotherapy process with clients from this population (i.e., after the first session) should include thorough screening for PTSD and discussions of specific stressful events the clients have experienced. Therapists should keep in mind, however, that these clients may not discuss feelings about such traumatic experiences for many months. Clients from this group may not voluntarily reveal the severe traumas they have been through, either
because they simply avoid talking about these events in general or because they do not think that symptoms such as recurrent distressing dreams and irritability (the primary symptoms of PTSD) are related to their presenting problems. In addition, Southeast Asian refugees might not talk about these events because they believe that clinicians do not want to listen “to the terrible stories and the agony endured by the refugees” (Kinzie & Leung, 1993, p. 290).

**Social-Skills Training**

Social-skills training is particularly recommended for Southeast Asian refugee clients who have severe anxiety about the possibility of deportation or who fear that their behaviors may give a bad reputation to other Asians (Yamamoto et al., 1993).