5 Cross-Cultural Considerations with Asian Indian American Clients: A Perspective on Psychological Assessment

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According to the US Census Bureau (2010), Asian Indian Americans constitute the third largest Asian group in the USA with a population of 3.2 million (Hoeffel, Rastogi, Kim, & Shahid, 2010). In this chapter, we will use the term Asian Indian American to refer to those who are of family descent originating from the Indian subcontinent, currently living in the USA and have either been born or have become naturalized citizens of this country.

According to Chandrasekhar (1982), the earliest records of people arriving from the Indian subcontinent to the USA can be dated back to the late 1800s. Immigrants came in as Asian laborers but were not received well by the locals, as the USA was then considered a land for European Americans (Takaki, 1989). The Barred Zone Act in 1917 and later the Exclusion Act in 1924 were exclusionary policies prohibiting Indian immigrants from entering the USA, resulting in a decrease in this population (Chandrasekhar, 1982; Ninian, 2012). However, since the establishment of the US Immigration Act of 1965, an increase in the numbers of professional Asian Indian Americans and their families has been observed. These individuals were well-educated and middle-class urban professionals who sought to advance their career aspirations or seek higher education as graduate students (Farver, Narang, & Bhadha, 2002; Ninian, 2012; Ramisetty-Mikler, 1993). Currently, a large proportion of Asian Indian Americans consist of doctors, lawyers, engineers, scientists, academicians, and aspiring graduates in universities. Career advancement has always been a motivating factor to immigrate to the USA for many Indian professionals since the 1960s and continues to be a critical reason for the increase in population of Asian Indian Americans in the "land of opportunities" (Ramisetty-Mikler, 1993).

Considering the recent expanse of Asian Indian Americans as the third largest Asian community in the USA, this chapter focuses on informing practice within a multicultural context in relation to providing culturally sensitive psychological services to individuals of Asian Indian American heritage. A systematic search of articles published in peer-reviewed journals was conducted via PsycINFO, ERIC, and Proquest Databases during the previous three decades (1979–2012). Descriptors used to conduct this search included "Asian Indian Cultural Beliefs and Practices," "Asian Indian Attitudes towards Mental Health," "Asian Indian Americans cultural beliefs," "Asian Indian Americans and Religion," "Asian Indian Americans and Counseling issues," "Asian Indian Americans and psychological testing," and "Asian Indians and developmental issues." In addition, the references within the selected articles were searched for additional relevant sources. Based on the results of our literature search, broad areas

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covered in this chapter include a review of the Asian Indian American cultural context and issues related to acculturation; attitudes towards mental health, disability, and help-seeking behaviors; and guidelines to inform practice when working with Asian Indian Americans.

Cultural Context and Understanding the Asian Indian American

To understand the ethnic identity of Asian Indian Americans, it is important to consider the cultural diversity within this minority group. India consists of multiple religions, languages, states, as well as different customs and traditional practices pertaining to each state. Eight main religions, which include Hinduism, Islam, Christianity, Sikhism, Judaism, Buddhism, Jainism, and Zoroastrianism, are found in India. Hinduism is the most widely practiced religion in India. In addition, India consists of 28 states, 7 union territories, and 22 languages with their own written scripts and 26 spoken dialects (Lai & Surood, 2008; Pattanayak, 1990). Despite the presence of many languages, it is common practice for professional, working-class Indians to be fluent in English (Pattanayak, 1990). In lieu of this diversity, it would not be surprising to find a similar diaspora of languages, religions, regional cultural variations, and differing traditional values and attitudes among Asian Indian Americans in the USA.

Issues Related to Ethnic Identity Formation and Acculturation

In addition to cultural variations, it is also important to consider that immigration of Asian Indian Americans is a relatively recent phenomenon that has picked up pace since the 1960s. Hence, understanding an individual's cultural background and its impact on his or her attitudes and behaviors should be taken in light of intergenerational influences and the level of acculturation attained among Asian Indian Americans. Acculturation is a group level phenomenon and is defined as the process of change that occurs within ethnic minority individuals when they adapt to the values, attitudes, and belief systems of the dominant culture (Berry, Kim, Power, Young, & Bujaki, 1989). Specifically, it is the extent to which these individuals retain the ethnic values, customs, beliefs, and traditions of their natal culture and the degree to which they identify with the host culture (Dasgupta, 1998; Farver, Narang, & Bhadha, 2002).

According to Berry's two dimensional acculturation model (1989), ethnic group members can adapt to the dominant culture in four different ways. Individuals can solely identify with the dominant culture while rejecting their natal culture through the process of assimilation. Alternatively, they can solely identify with their natal culture while severing ties with the dominant culture through the process of separation. They can also reject values and belief systems of the natal culture as well as the dominant culture via the process of marginalization or they can develop bicultural ethnic identities by maintaining characteristics from both cultural groups via the process of integration.

Broadly speaking, this minority group can be divided into first-generation and second-generation Asian Indian Americans. First generation Asian Indian Americans are those who moved to the USA in the mid 1960s in the pursuit of a better life, personally and professionally (Das & Kemp, 1997). This group of Asian Indian Americans generally have a strong affinity for traditional Indian roots and often attempt to recreate the same cultural milieu in a foreign land (Dasgupta, 1998; Farver, Xu, Bhadha, Narang & Lieber, 2007). In fact, first generation Asian Indian Americans are sometimes more "Indian" than the residents in India, as they struggle to retain the same sense of culture and tradition they had left with many decades ago despite changes that may have occurred since their departure from India (Farver, Narang, & Bhadha, 2002; Patel, Power, & Bhavnagri, 1996). In accordance to Berry's model (1989), this group of Asian Indian Americans would usually fall under the preferred acculturative mode of separation. In contrast,

second-generation Asian Indian Americans are usually born on American soil and are socialized into two cultures. They are acculturated to both the traditional Indian culture of the family and the wider dominant culture of the American society (Das & Kemp, 1997; Farver et al., 2007). With reference to Berry's model, most members of this group attempt to develop a bicultural ethnic identity by integrating characteristics from both cultures.

The literature on acculturation suggests that higher levels of acculturative stress are associated with minority groups adhering either to the marginalization or the separation acculturation mode (Berry et al., 1989). Furthermore, a difference in the degree of acculturation not only has an impact on the difference in the development and maintenance of ethnic identity across the two generations but also contributes to a host of stressors that may be qualitatively different across both generation groups (Farver, Narang, & Bhadha, 2002). With Asian Indian American families, variations in attitudes and behaviors across the two generations may be observed in differences in perspectives towards gender roles, marriage, family structure and roles, child rearing practices, adherence to religious customs, social interactions and pro-social behaviors, and mental health issues (Ibrahim, Ohnishi, & Sandhu, 1997; Ramisetty-Mikler, 1993).

In addition to the stressors experienced by many Asian Indian Americans adapting to the values, attitudes, behavior, and belief systems of the dominant culture, another area of concern includes the acceptance of this minority population by other cultural groups in the USA. Asian Indian Americans who have different accents and sometimes lack fluency in the English language may experience problems with communication. In addition, their style of dressing (e.g., use of Indian attire), skin color, physical appearance, formal social behaviors, and mannerisms may result in other cultural groups perceiving them as being different or strange. Negative outcomes of such social situations may result in developing stereotypical perceptions of other cultural groups and feelings of isolation which could be considered as a potential source of adjustment stress (Sodowsky & Carey, 1987).

Issues Related to Family Structure, Role Expectations, and Child Rearing Practices

For Asian Indian Americans, family is the fundamental unit in one's society as well as a source of emotional and social support. First-generation Asian Indian Americans generally view the family structure as being formal and hierarchical with each member having a designated role. In traditional family units, the father is usually considered the head of the family, sole bread winner, enforcer of family rules, and decision maker whose authority should not be questioned. The mother is typically viewed as being nurturing and serving as the primary caretaker of the children's day-to-day needs. Children's compliance to parental demands and reverence for elders are considered essential family values. It is not uncommon for older generations to expect their children to care for them in their old age. It is also not uncommon to find married sons living with their families and parents in the same physical space. Furthermore, it is not unusual for traditional family units to place high expectations on their sons, as they would traditionally be responsible with carrying the family name for future generations (Ramisetty-Mikler, 1993).

In most Asian Indian American families, major decisions regarding education, occupation, scholastic and extracurricular activities, marriage, and social behaviors align with the approval of the elders or heads of the family. Attitudes, behaviors, and decisions that are in conflict with family values and rules are viewed in an extremely negative light. In such situations, guilt, shame, and moral obligation towards the family are instrumental in redirecting and governing behaviors and attitudes that conform to familial values and needs. Asian Indian American families usually follow an authoritarian parenting style and family needs are always placed before the needs of the individual members (Inman, Howard, Beaumont, & Walker, 2007; Ramisetty-Mikler, 1993). Professional achievement, academic success, and education are given paramount importance. Failure to achieve these goals could be considered a source of stress for many Asian

Indian American families (Ramisetty-Mikler, 1993; Rao, McHale, & Pearson, 2003). However, despite the rigidity in family structure, a few changes are being observed in family role expectations over the last few decades. For instance, immigrant families allow their children to enjoy more freedom and independence (Sinha, 1985) and immigrant mothers have become more authoritative in their parenting style (Ramisetty-Mikler, 1993).

Although flexibility in family role expectations has recently been observed, differential rates of acculturation across first-generation and second-generation family members may result in an increased risk for familial conflict. This usually occurs when second-generation adolescents or young adults have acculturated more rapidly with their host culture in the USA when compared to their first-generation parents. Common areas of familial conflict and family related stress are observed when second-generation adolescents or young adults desire more independence with decisions related to dating, career choices, and marriage (Farver, Narang, & Bhadha, 2002; Inman et al., 2007). In fact, research has indicated that less disparity in acculturation between generations in a family are associated with positive outcomes such as ethnic identity achievement, high self-esteem, lower familial conflict, and higher GPAs among Asian Indian American adolescents (Farver et al., 2007).

Issues Related to Gender Roles and Expectations

Educational level, social class, economic stability, and levels of acculturation are important factors that affect attitudes and behaviors towards gender roles and expectations among Asian Indian Americans. Gender identity may range from patriarchal to egalitarian. First-generation Asian Indian Americans often define gender roles as clearly demarcated and rigid in their definition. This group usually perceives men as being the bread winners and financial providers for the family while women manage the domestic domains of the home (Ibrahim et al., 1997). The eldest male member of the family is considered to be the head of the family and is responsible for taking all the major family decisions (Das & Kemp, 1997). First-generation Asian Indian American women usually tend to be more passive (Chowdhury, 2005; Prakash, 2003; Shaikh & Hatcher, 2004) and economically more dependent than their male counterparts as they are considered to be lower in status and power when compared to the male members of the family (Jejeebhoy & Sathar, 2001; Rani & Bonu, 2003). In fact, women in traditional Asian Indian American families are typically expected to place their family needs before their own (Arnold, Choe, & Roy, 1998; Narayan, Patel, Schafft, Rademacher, & Koch-Schulte, 2000).

An extremely traditional outlook towards gender roles entails males being viewed as more desirable compared to females as they are perceived to provide economic stability to the family. In addition, women are considered liabilities, in conservative, less educated, middle and lower class Indian families, as the Hindu custom of dowry for the female child may still be prevalent in some conservative Indian families (Das & Kemp, 1997). Furthermore, it is not uncommon for gender inequality to prevail within traditional Indian families (Choudhury, 2006), with both genders being discriminated against in different ways, thus threatening the security and well-being of family life (Choudhury & Carson, 2006).

In terms of gender role expression in psychological settings, women in traditional Indian families are perceived as more socially and emotionally dependent on other family members and therefore may be more comfortable with openly expressing their grievances in an emotional manner (Hussain & Cochrane, 2003). In contrast, men are expected to be aloof, tough, independent and non-expressive with their emotions. Therefore, it is more likely that men would avoid disclosing problems of an emotional nature (Agarwal, 1998; Kai, 1999; Mathuranath, George, Cherian, Matthew, & Sarma, 2005; Sudha, Suchindran, Mutran, Rajan, & Sanna, 2007).

With reference to marital practices and decisions in this area, a majority of the marriages among first-generation Asian Indian Americans are arranged and divorce rates are low. It is common practice for first-generation Asian Indian Americans to marry within their ethnic group, social caste, economic class, and religious denomination. Furthermore, it is expected that parents select potential mates for their children, especially daughters. This practice has usually led to the restriction or total prohibition of dating and/or expression of any form of sexuality for daughters of Asian Indian American families. For traditional Indian couples that have recently moved to the USA, new stressors may develop, especially if the husband is trying to establish a career and the wife is left alone at home with minimum contact with the outside world. This is a particularly important issue as extended Indian families in India often live together, and women tend to obtain a lot of support from other females in their families (Wasan, Neufeld, & Jayaram, 2009). Although this issue may be transitory in nature, it could have the potential to result in emotional distress, physical illness, and marital conflicts (Das & Kemp, 1997).

Despite the conservative perception in gender identity and roles amongst first-generation Asian Indian Americans, more flexible and egalitarian gender roles are observed across second-generation Asian Indian Americans. In recent years, arranged marriages are not necessarily the norm though marrying within the same culture and caste are still considered important (Khanna, McDowell, Perumbilly, & Titus, 2009). Marital decisions are made based on factors such as equality in educational levels, social class, and economic independence across both genders. In fact, dual income family providers are preferred over single income families among second-generation Asian Indian Americans as this typically ensures better economic stability and a higher quality of life. Furthermore, women are encouraged to participate in family decision making and more freedom in choice of career, dating practices, and marriage partners are observed in families that have assimilated to mainstream American culture (Das & Kemp, 1997).

Issues Related to Indian Customs, Values, and Belief Systems

When understanding Asian Indian Americans, whether first or second generation, it is important to consider the cultural values and belief systems that have been instilled within the family unit. Literature suggests that first-generation Asian Indian American immigrants continue to emphasize specific values and goals to their second-generation children—values that were instilled during their own upbringing (Inman et al., 2007). A few of the values that hold importance to Asian Indian Americans involve family interdependence, a strong sense of duty (or Dharma) towards the family, and protection of family honor. Individuality is encouraged within the confines and boundaries set by the family. Therefore, Asian Indian Americans are considered to be more allocentric in their predisposition as opposed to the egocentrism that is more common in Western cultures (Ibrahim et al., 1997; Das & Kemp, 1997). Asian Indian Americans believe in maintaining harmony in social interactions and therefore may be nonconfrontational and view silence as a virtue. Respect for the elderly and older individuals of the family (e.g., parents, older siblings etc.) are given much importance as Asian Indian Americans are taught to believe that “older means wiser” and one has much to learn from the advice given by the elderly because of wisdom the elderly have collected over the years. This respect is also extended to the larger community where sensitivity towards the social climate and formality in social interactions is emphasized (Das & Kemp, 1997).

In terms of intimate interpersonal relationships, modesty in sexual expression and affection in public settings is expected. Furthermore, emphasis is placed on Karma, or the law of cause and effect, especially among first-generation Asian Indian Americans who practice Hinduism, Jainism, or Buddhism. Karma posits that the type and quality of health and life one experiences in the present life is the direct result of one’s deeds and actions in one’s past lives. In the same vein, one’s current behaviors can affect one’s future lives (Lai & Surood, 2008). Hence, Karma is

about retribution for one's past and future actions. Therefore, in the face of challenges, Asian Indian Americans are expected to be patient and endure this retribution to break the cycle of negativity, as this would ensure a better existence for their future lives. Attitudes and behaviors that are considered essential in character development and conform to the idea of Karma, include humility in one's actions, moderation in behavior, discipline and obedience, and a high regard for learning. Attitudes and behaviors that are in conflict with these values may be a source of stress for many Asian Indian Americans as they may fear "losing face" with their larger ethnic community (Das & Kemp, 1997; Ibrahim et al., 1997).

Attitudes Towards Mental Illness, Disability, and Help-Seeking Behaviors

Literature suggests that mental illness or disability among traditional Asian Indian Americans is considered an inherited defect borne of supernatural causes such as spirit possession or retribution for one's Karma or sins committed in past lives (Leung, Cheung, & Tsui, 2012; Parashar, Chan, & Leierer, 2008; Ramisetty-Mikler, 1993). In particular, traditional Asian Indian Americans hold higher superstitious causal beliefs towards mental illness rather than factoring in a biological or environmental basis to mental illness when compared to Western cultural groups (Soorkia, Rosemary, & Swami, 2011).

Keeping awareness of mental health challenges within the family is perceived as a necessary measure to avoid social stigma, maintain family honor, and reduce the chance of being rejected by the larger ethnic community as a whole (Leung et al., 2012; Parashar et al., 2008). Particularly, nondisclosure of psychiatric conditions such as depression and schizophrenia and disabilities such as intellectual disability are prevalent among Asian Indian Americans, because these are considered as least preferred disability types and are associated with the highest levels of stigmatization (Parashar et al., 2008). In fact, traditional Asian Indian American families are reticent about accessing psychological services, as this could potentially endanger the chances of marriage for other family members. Disclosure of a psychiatric illness or disability in the family may be suggestive of a genetic predisposition to mental illness or disability that could be passed on to future generations (Das & Kemp, 1997).

Furthermore, mental illnesses are often perceived as a character weakness rather than a treatable illness among traditional Asian Indian Americans. Therefore, traditional Asian Indian American families would prefer to turn to spiritual healers, occult practices and rituals, and complementary alternative medicine (CAM) such as Ayurveda (herbal medicines) or homeopathic remedies as a cure for these conditions (Ramisetty-Mikler, 1993). Of note, the use of CAM is much higher in Asian Indian American women and the elderly than Asian Indian American men (Misra, Balagopal, & Klatt, 2010). This could be due to the fact that the former two groups, particularly women and senior citizens that are new immigrants, tend to be domesticated, home-bound and have less contact with influences outside their home (Mathuranath et al., 2005; Sudha et al., 2007). Hence, they are more likely to seek support from their extended family, which would usually encourage the use of CAM and other traditional healing methods. Additionally, factors that result in a strong adherence to traditional Indian cultural values may contribute to the rejection of counseling or psychotherapeutic services (Soorkia et al., 2011). The first factor involves a preference towards sharing personal and intimate information with members of the family rather than a counselor, as seeking counseling could be perceived as a shameful practice by traditional Asian Indian American families (Das & Kemp, 1997; Soorkia et al., 2011). A second factor that may inhibit the need to seek mental health services includes the desire to maintain high standards of social and personal morality. In accordance with traditional Indian cultural values, excesses in any behavior or habit such as substance abuse or domestic violence are considered to be borne of poor emotional self-control. Therefore, disclosure of such sensitive information may suggest

that the help-seeker is weak and has failed to maintain high standards of moral conduct. This perception could in turn affect the help-seeker's psychological well-being (Das & Kemp, 1997). A third factor that contributes to the underutilization of mental health services among Asian Indian Americans is the perception that counseling and psychotherapy are services required by individuals with severe psychological disorders and mental illness. The practice of seeking professional help to solve everyday problems does not exist, simply because it is usually taken care of by elders in the immediate and extended families. A fourth factor that results in the rejection of psychological services, particularly among Asian Indian American males, is the notion of maintaining a masculine exterior by denying vulnerabilities and concealing emotional and physical fragility that would not be possible within a counseling setting (Soorkia et al., 2011). Finally, as the mental health profession is dominated by Caucasian Americans, cultural mistrust towards this culture group is an important factor that can result in the underutilization of mental health services and negative attitudes towards psychological help-seeking behaviors among Asian Indian Americans (Soorkia et al., 2011).

Another notion prevalent among Asian Indian Americans is the preference for physical pathology over psychological distress, as physical symptoms to illness are perceived as a healthcare concern and therefore are considered treatable. Hence, it is not uncommon for Asian Indian Americans Americans to somatize psychological distress as it is viewed as culturally acceptable and less stigmatizing (Gilbert, 2002; Gilbert, Gilbert, & Sanghera, 2004). For instance, depression, the most common referral among Asian Indian Americans in Western countries (i.e., Canada, the USA, and the UK) and in India, is primarily presented with physical manifestations such as generalized aches (Bhugra & Mastrogianni, 2004; Bhui, Bhugra, & Goldberg, 2000; Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001; Mukherji, 1995; Rait & Burns, 1997), loss of energy, sleep disorders, reduced libido (Wasan et al., 2009), and gastric pains (Ecks, 2004, 2005). Given the high rate of somatization of mental illness, it is therefore not surprising that research has found that Asian Indian Americans endorse the use of medications to treat mental illness that are associated with physical distress, as they believe that it would produce quicker and more satisfactory results. In addition, medication is viewed as more accessible, quicker, and affordable option than psychological treatments (Varghese, 2007).

Guidelines for Practice with Asian Indian Americans

The role of culture in clients' help-seeking attitudes cannot be stressed enough. Like many other Asian ethnicities, Asian Indian Americans who adhere strongly to traditional Indian values of family privacy and nonpublic expression of feelings are less likely to seek help from non-family members, particularly for mental health problems, which as discussed are considered a sign of weakness and which bring shame to the family (Khanna et al., 2009; Leung et al., 2012; Uba, 1994). Also, the underutilization of mental health services among Asian Indian Americans might occur because individual needs are met via other alternatives, such as through consulting with medical physicians, religious or spiritual leaders, herbal doctors or friends and family (Leung et al., 2012). Hence, mental health professionals should be aware of these beliefs, and be able to identify and acknowledge them when they arise so that they are able to work with, within and around these restrictions. Considering these findings, reframing mental health services to promote help-seeking behaviors and attitudes among Asian Indian Americans is required to better manage psychological issues (Leung et al., 2012).

Research suggests that anxiety and depression are prevalent among Asian Indian American because of stressors related to unemployment (Leung et al., 2012), immigration status (Khanna et al., 2009), familial and relationship conflicts associated with the acculturation gap between first-generation and second-generation Asian Indian Americans (Das & Kemp, 1997; Farver, Narang, & Bhadha, 2002), and adjustment issues

with the dominant culture in the USA (Ramisetty-Mikler, 1993). The following guidelines are offered as a framework to make psychological services more accessible to Asian Indian Americans to meet their mental health needs. It is important to consider that most suggestions presented in this section should be implemented simultaneously rather than sequentially to better address the needs of the Asian Indian American clientele when providing culturally sensitive psychological services.

Reframing and Increasing Service Utilization by Customizing Service Delivery Methods

One of the reasons for the stigma and consequent high need for self-concealment of mental illness (Choi & Wynne, 2000) is that new Asian Indian American immigrants may not have been exposed to much information about the causes and interventions for mental health issues and therefore have different understandings of such issues (Choi & Wynne, 2000). Hence, to reduce the stigma associated with mental illness and increase help-seeking behaviors amongst Asian Indian Americans, it might be helpful for mental healthcare providers to promote mental well-being programs rather than curative programs. Mental well-being programs can focus on providing basic information about mental health issues, psychoeducational programs, and personal development counseling to enhance mental wellness (CHAT, 2010; Khanna et al., 2009; NIE Wellness Centre, 2012). Such alternatives may be more agreeable to Asian Indian American clients who are emotionally troubled, but are not ready to seek help for their psychological issues. These alternative could also help these clients learn more about their conditions and provide them with avenues to seek help that are less stigmatizing.

Alternatively, there may be some potential Asian Indian American clients who might recognize the need for help, but might not be ready to reveal their identities in a public venue. Research has suggested that counselors need to remember that like other Asian groups, Asian Indian Americans might be uncomfortable with individual face-to-face counseling in a structured time and place (Arthur, 1997; Fouad, 1991; Hayes & Lin, 1994; Siegel, 1991). Hence, the steps needed to access services could include help seekers to obtain a first consultation via non-face-to-face methods, such as telephone helplines or online chat rooms (Chang, Yeh, & Krumboltz, 2001), both of which provide relative anonymity. More importantly, such anonymous methods of communication allow mental health workers to respect Asian Indian American cultural beliefs about mental illness and cater to their need for self-concealment (Masuda & Boone, 2011). Once sufficient trust and rapport has been built between the therapist and the anonymous client on the phone or on-line, then it would be easier to move these sessions to a therapeutic counseling setting (Alife, 2013; Coman, Burrows, & Evans, 2001; Flynn, Taylor, & Pollard, 1992; Masuda & Boone, 2011; Pregnancy Crisis Service, 2012; Swinson, Fergus, Cox, & Wickwire, 1995).

Using Systems-Based Therapeutic Approaches

It is important to recognize the cultural variations that exist across individuals of this ethnic minority group within the broader context of acculturation (Khanna et al., 2009; Ramisetty-Mikler, 1993) in the USA. Literature on Asian Indian Americans suggest that first-generation and second-generation Asian Indian Americans may hold different perceptions on expected family roles, gender identity roles, and attitudes towards social conventions such as marriage, dating, interactions with other cultural groups and career choices (Das & Kemp, 1997; Dasgupta, 1998; Farver, Narang, & Bhadha, 2002: Khanna et al., 2009). Therefore it would be helpful for mental health professionals to understand the client's acculturation status (Garcia & Zea, 1997) using Berry's two dimensional acculturation model (1989) or Sue's model (1981) on minority identity development (Ramisetty-Mikler, 1993).

Although the literature suggests that first-generation Asian Indian Americans usually follow

the acculturation mode of separation whereas second-generation Asian Indian Americans seem to be more bicultural in their ethic identification (Das & Kemp, 1997; Dasgupta, 1998; Farver, Narang, & Bhadha, 2002), our experience working with Asian Indian American families suggests that mental health professionals should directly ask the client their perceptions on various social and cultural issues. This assists mental health professionals to avoid making any inaccurate assumptions regarding the client's cultural worldview. In addition, direct questioning also aids in acquiring a comprehensive picture of the client's ethnic identity by understanding his/her multiple identifications in terms of age, gender, community, caste, religion, sexual orientation, and socio-economic status (Braun, Fine, Grief, & Devenny, 2010; Ibrahim et al., 1997). Furthermore, to gain a better understanding on the client's acculturation status, we find it most useful to ask the client questions on their perceptions on family and/or marital relationships, gender roles, religious/spiritual practices, cultural traditions, social conventions, and parenting practices (to name a few) to gain a better understanding of their acculturation status.

As most Asian Indian Americans have a culturally collectivistic orientation, it is important to understand the various social influences that may or may not have an impact on the client's attitudes and behaviors (Khanna et al., 2009). Bronfenbrenner's ecological model (1979) provides a comprehensive framework to examine the various social systems (such as the client's immediate and extended family, friends, religious groups, and larger community) and its influences (Ramisetty-Mikler, 1993). As family is the most prominent influence for many Asian Indian American clients, it is essential to understand the client's family structure, gender role expectations, class relationships, intergenerational relations, and expectations of filial duties (Khanna et al., 2009). Maybe more importantly, it is necessary to evaluate how the client's perceptions could be different or similar to the beliefs held by his/her immediate and extended family members. For some clients, the perceptions held by their friends, religious affiliations, and the larger community hold significance. Hence, when working with Asian Indian Americans who hold more traditional Asian Indian values, it is essential for the therapist to take into account these various contextual influences and the impact of both immediate and extended families on clients' decision making process and level of coping. (Leung et al., 2012).

Furthermore, the collectivistic nature of Asian Indian culture indicates that individuals in this culture often define themselves in relation to the people around them and the social situations they are in (Markus & Kitayama, 1998; Markus, Mullally, & Kitayama, 1997; Yeh & Hwang, 2000). Change can only take place with the help and in the context of the people whom the client interacts most with, i.e., his/her family, community, and social system (Yeh & Hwang, 2000). It may therefore be unrealistic for the therapists to expect their clients to make decisions that are independent of these systems—a concept that may be alien to the Western perspective of therapy. In such situations, the treatment dyad should therefore shift from "therapist-client" to "therapist-family," and the ethics of care should also shift from what's best for the client to what's best for the client in conjunction with the family (Wasan et al., 2009). Hence, it is important for therapists to engage the family in the therapeutic process and involve the family as the client's most important resource outside of therapy. For severely mentally ill clients, particularly those suffering from psychosis, the family may be key informants of the clients' medical history and therefore would play an important role in confirmation of diagnosis and medical management (Wasan et al., 2009). It is therefore recommended that the key focus of therapy is on enhancing the supportive aspects of the family system so as to maximize the family's ability to manage the care of the client. If family issues/stressors are the precipitating and perpetuating factors of the client's problem, then it might be helpful for the therapist to provide family therapy using a systemic approach.

Our experience with clients of Asian Indian American background supports that this minority group shows a strong preference towards psychological services that are more family based.

Therefore, assessment and treatment goals that are in conflict with the client's family and cultural values more often lead to poorer treatment outcomes such as noncompliance with treatment recommendations and/or premature termination of psychological services. Alternatively, treatment recommendations are perceived positively if they aim to facilitate family cooperation to allow flexibility in decision making instead of focusing on individualism that may affect the family structure. Our observations support the findings indicated in the literature on multicultural issues that need to be considered when working with Asian Indian Americans (Ibrahim et al., 1997; Khanna et al., 2009; Leung et al., 2012; Ramisetty-Mikler, 1993).

Using Directive Therapeutic Approaches

To successfully obtain the required information from the Asian Indian American client, therapists need to adopt counseling techniques or communication styles that are respectful and directive. Traditional Asian Indian Americans often assume that health care problems are usually beyond the control of patients, and therefore doctors have the responsibility of playing a very active role in identifying patient problems and providing solutions (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). Contrary to Western forms of psychotherapy, this belief is also applied to therapists and mental health professionals who are expected to play a more active and "expert" role in problem identification and solution generation (Lee & Armstrong, 1995; Wasan et al., 2009). In fact, the literature indicates that client-centered therapy that involves extreme verbalization and self-disclosure of thinking processes and feelings may not meet the needs of this client population as it is in conflict with their cultural values of modesty in thought, action, and humility (Ibrahim et al., 1997; Ramisetty-Mikler, 1993). Instead, approaches that are more cognitively inclined such as psycho-education or collaborative decision making between the client and therapist are perceived as more useful in building a therapeutic alliance, as it allows the therapist to be more active in communication, self-disclosure, and advice giving (Khanna et al., 2009). In addition, the use of narratives (e.g., success and challenges faced by other Asian Indian Americans as examples), direct role playing techniques, and progress monitoring of skills have been considered instrumental in developing a comfortable therapeutic environment (Ramisetty-Mikler, 1993).

Finally, as the Asian Indian American client initially tends to be more passive in the therapeutic process, the communicative context is often saturated with nonverbal messages. In a few situations, the client's words may contradict his/her nonverbal behaviors. Hence under these circumstances, it would be helpful for therapists to be more sensitive to these nonverbal cues during the therapeutic process. Also, learning more about the nonverbal behaviors that are prevalent among Asian Indian American could help therapists gain a better understanding of the client's needs, attitude, and behaviors during the initial stages of therapy (Ibrahim et al., 1997; Khanna et al., 2009).

Allocating Counselors Based on Client Values and Gender Preferences

Considering the strict hierarchical nature of Indian society (Kakar & Kakar, 2009), mental health care providers must be aware that Asian Indian clients view people in terms of their positions/ranks relative to their own. For example, research in the USA has found that Asian American students, including Asian Indian Americans, tend to have greater respect for those whom they perceive as having more authority, knowledge, or expertise than them. Hence, they are more likely to develop positive relationships with "expert" counselors than "non-expert" ones (Shea & Yeh, 2008).

The patriarchal nature of Asian Indian American families also impacts Asian Indian American perceptions of gender-related authority. In the Indian Subcontinent, men are usually perceived as having more power and authority than women (Jejeebhoy & Sathar, 2001; Rani & Bonu, 2003).

Hence, more traditional Asian Indian Americans, as well as first-generation Asian Indian Americans, may prefer male therapists since these are perceived to have more authority than their female counterparts (Shea & Yeh, 2008).

Societal beliefs about male–female relationships could also have an impact on the gender of the therapist chosen to work with Asian Indian American clients (Rathod, Kingdon, Phiri, & Gobbi, 2010). For example, there may be objections to female therapists working with male clients or vice-versa, as public knowledge of this could put a strain on marital or familial relationships (Rathod et al., 2010). Therefore having the same gender treatment dyad may be helpful in facilitating the treatment process.

Given these cultural and societal beliefs, it is important for mental healthcare providers, particularly intake personnel, to check with potential clients about gender preferences for their therapist, and to respect and accede to their clients' choices. Doing so could potentially increase commitment to the therapeutic regime while reducing resistance towards building trust, rapport and disclosure during the therapeutic process.

Collaborating with Medical Professionals and Indigenous Healers

Literature suggests that Asian Indian Americans tend to be conservative and reserved with self-disclosure and often somatize their mental health issues (Leung et al., 2012). Therefore, given this high rate of somatization of mental illness amongst Asian Indian Americans (Gilbert, 2002; Gilbert et al., 2004), it is not uncommon for clients of this minority group to first seek assistance from primary health care providers. Considering this finding, it could be prudent for psychologists to collaborate with physicians to develop effective ways to assist Asian Indian Americans to become more accepting of receiving treatment. Treatment options in the form of allopathy and psychotherapy could be helpful in alleviating symptoms of depression and anxiety that are most prevalent in Asian Indian Americans (Leung et al., 2012).

The effectiveness of collaborating with indigenous healers (e.g., astrologers, yoga professionals, experts in Ayurveda etc.) in the therapeutic process has not been researched much in the multicultural literature. However it has been observed that some Asian Indian Americans may recruit alternative therapeutic and medicinal approaches to treat mental health issues (Misra et al., 2010). Therefore, if the Asian Indian American client appears to be more inclined towards seeking indigenous forms of healing, then it would be helpful for the therapist to acknowledge the participation of indigenous healers in the client's therapeutic process (Constantine, Myers, Kindaichi, & Moore, 2004; Khanna et al., 2009). For example, the therapist could collaborate with indigenous healers to create therapeutic formats that would fit within the client's understanding of mental illness or disabilities. However this could only be possible if the therapist and indigenous healer share similar collaborative attitudes and goals with the client. If direct collaboration is not possible, then we recommend that therapists at least other forms of help that the client would be comfortable using while undergoing Western-styled therapy (Highlen, 1996). This form of collaboration could be helpful for traditional Asian Indian Americans, especially if spiritual healing is part of their cultural worldview (Lee & Armstrong, 1995). Furthermore, collaboration of this nature could also aid to empower the client to gain insight into his own problems and create appropriate solutions that are compatible with their own cultural schema.

Conclusion

The immigration of Asian Indian Americans is a relatively recent phenomenon that has picked up pace since the 1960s. Currently, this minority population broadly consists of two generations—first- and second-generation immigrants. In addition, the Asian Indian American community consists of a diaspora of diverse languages, religions, class, education levels, and regional cultural variations. Despite this diversity, there exists

commonly held beliefs, values, attitudes, and behaviors that may be considered when understanding the cultural context of this minority ethnic group. In addition to the cultural context, the degree of acculturation between first-generation and second-generation immigrants should also be considered when evaluating the needs of clientele from this ethnic group.

Stressors within this group could arise from issues related to unemployment, immigration status, familial and relationship conflicts associated with the acculturation gap between first-generation and second-generation Asian Indian Americans, and adjustment issues with the dominant culture in the USA. Furthermore, these stressors have resulted in the high prevalence of mental health issues such as anxiety and depression among Asian Indian Americans.

Despite the presence of mental health issues, psychological services are not being adequately used by Asian Indian Americans. Factors associated with the underutilization of mental health services include a strong adherence to traditional Indian values and practices, and the stigma associated with mental illness and psychological services. Solutions to make psychological services more accessible and acceptable for Asian Indian Americans include reframing mental services by using nonconventional forms of service delivery, collaborating with other professionals, and using system-based approaches to therapy.

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