Behavioral Health Service Delivery with Asian Americans

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People of Asian ancestry are the largest ethnic group worldwide and the fastest growing ethnic group in the USA. The Asian American population grew from 11.9 million in 2000 to 20.4 million in 2015 and are the largest group of new immigrants to the USA since 2010 (Lopez, Ruiz, & Patten, 2017). At 5.7% of the US population (U.S. Census Bureau, 2017), Asian Americans may be perceived by some to be a small group. However, the number of Asian Americans in the USA exceeds the combined populations of the country's three largest cities (New York, Los Angeles, Chicago). This number also exceeds the number of Americans who suffer from major depression (Hall & Yee, 2012). Yet, Asian Americans are a relatively invisible group in behavioral health service delivery.

The invisibility of Asian Americans is associated with stereotypes about them (Huang & Hall, in press). Model minority stereotypes promote the perception that Asian Americans are self-sufficient and do not need help. Perpetual foreigner stereotypes make Asian Americans feel unimportant because they are not perceived to be Americans. Because of this invisibility, many perceive Asian Americans as a group that does not merit special attention. Yet, there are issues unique to Asian Americans that affect the delivery and effectiveness of behavioral health services.

In this chapter, we begin by discussing how federal behavioral health policies have failed to benefit Asian Americans. We then discuss the persistent underutilization of behavioral health services by Asian Americans. We follow with a review of efforts to make behavioral health services more culturally relevant to Asian Americans. Cultural relevance includes the use of alternative services outside of behavioral health services settings. We conclude with a discussion of future directions for research and behavioral health service delivery.

Federal Behavioral Health Policies

Behavioral health services became widely accessible in the USA during the 1960s with the passage of the Community Mental Health Centers (CMHC) Act in 1963 (Hall & Yee, 2012). This coincided with a large increase in the Asian American population; the Immigration Act of 1965 removed many restrictions on Asian immigration (Deaux, 2006). Unfortunately, the Reagan administration repealed the CMHC Act in 1981 (Stockdill, 2005). As a result, many community mental health centers were closed. However, the existing community mental health centers were not adequately meeting the needs of Asian Americans. Asian Americans have utilized

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L. T. Benuto et al. (eds.), *Handbook of Cultural Factors in Behavioral Health*,
https://doi.org/10.1007/978-3-030-32229-8_10

behavioral health services at lower rates than any other ethnic group over the past four decades (SAMSHA, 2015; S. Sue, 1977). More on Asian Americans' underutilization of behavioral health services will be discussed later in this chapter.

Since the 1980s, behavioral health care policy in the USA shifted from a focus on access to care, to improving the quality of care (Kiesler, 1992). This policy shift was the impetus for the evidence-based treatments (EBTs) movement (Rosner, 2005). However, EBTs were designed by and for European Americans, not people of color (Hall, 2001). The randomized clinical trials to establish the validity of new EBTs did not include Asian Americans or other groups of color.

The 1990s became the "Decade of the Brain" under the George H. W. Bush administration (NIMH, 1999). The biological basis of mental disorders was prioritized in research funding. The 2000s and 2010s have continued to be decades of the brain (Miller, 2010). National Institute of Mental Health (NIMH) Director Thomas Insel (2003) proclaimed that mental illnesses are "brain illnesses." Although the focus on the brain has provided innovative ways to learn more about behavior, this focus on the brain has shifted public attention and resources away from behavioral health services.

Members of the NIMH National Advisory Mental Health Council recently estimated that 85% of the NIMH budget is devoted to basic research, such as neuroimaging (Lewis-Fernández, Rotheram-Borus, et al., 2016). Only 15% is devoted to clinical research, including work on behavioral health interventions. The basic research that is funded typically takes many years until it is translated into behavioral health interventions that address public health needs (Lewis-Fernández et al., 2016). In some cases, basic research does not ever lead to behavioral health interventions. Similar to the research on EBTs, Asian Americans are rarely represented in basic research. Thus, basic research may divert attention and funding from clinical research that directly addresses the behavioral health needs of diverse communities.

Neuroscience research, however, is not necessarily at odds with behavioral health services. Neuroscience can assist in determining the relevance and effectiveness of behavioral health interventions and in personalizing treatments. This will be discussed later in this chapter. However, the tools of neuroscience have yet to be harnessed for this purpose (Gabrieli, Ghosh, & Whitfield-Gabrieli, 2015).

Underutilization of Treatment

The federal policies described above have failed to impact one of the most enduring health disparities—underutilization of behavioral health services by Asian Americans. Stanley Sue first documented this in 1977 in a landmark study of over 13,000 clients in 17 community mental health centers in the Seattle, WA area. Asian Americans were underrepresented in service utilization relative to their representation in the local population more than any other ethnic group. Four decades later, this pattern has not changed. National data indicate that in every adult age group, Asian Americans are the ethnic group that is least likely to use behavioral health services (SAMHSA, 2015).

Why does this pattern of underutilization exist? Perhaps Asian Americans are more mentally healthy than other groups. There is evidence from national epidemiological surveys that Asian Americans have lower rates of psychopathology than other ethnic groups (Miranda, McGuire, Williams, & Wang, 2008). These lower rates of psychopathology might be reflected in lower rates of behavioral health service use. However, the measures of psychopathology utilized in these epidemiological surveys did not assess culture-specific forms of psychopathology. For example, somatic rather than emotional expression of distress is common among people of Asian ancestry (Ryder et al., 2008).

In addition, psychopathology prevalence differs between generation groups (i.e., immigrant generation vs. children of immigrants [second generation] vs. third-generation). Thus, nativity impacts mental health. Second generation (US-born) Asian Americans have higher lifetime psychopathology rates than immigrant Asian

Americans (Hong, Walton, Tamaki, & Sabin, 2014). These include higher rates of anxiety disorders, depression, and substance use disorders, than immigrant Asian Americans (Hong et al., 2014). Gender also impacts mental health. US-born Asian American women have significantly higher rates of any anxiety disorder, depression, and substance use disorders than immigrant Asian American women (Hong et al., 2014). This immigrant health paradox suggests that living in the USA may have iatrogenic effects.

When Asian Americans experience psychological distress, behavioral health service utilization disparities exist. In an epidemiological study, 54% of European Americans who had a diagnosable mental disorder sought behavioral health services (Wang et al., 2005). In contrast, a comparable epidemiological study indicated that only 28% of Asian Americans with diagnosable mental disorders sought behavioral health services (Meyer, Zane, Cho, & Takeuchi, 2009). An additional 16% of Asian Americans with diagnosable mental disorders sought help in primary care services and 11% used alternative services, such as healers or religious advisors. Behavioral health services are the treatment of choice for European Americans with mental disorders. However, Asian Americans are nearly equally likely to seek help for mental disorders from other providers (Meyer et al., 2009). A review of studies indicates that being able to recognize a mental disorder is insufficient to promote behavioral health service utilization among Asian Americans (Na, Ryder, & Kirmayer, 2016).

Given that nearly three out of four Asian American adults were born in Asia (U.S. Census Bureau, 2017), it might be expected that acculturation is associated with behavioral health service use. Mainstream behavioral health services would be expected to be more appealing to acculturated Asian Americans. However, in a meta-analysis, acculturation was weakly associated with behavioral health service use among Asian Americans (Smith & Trimble, 2016). Thus, regardless of acculturation level, few Asian Americans use behavioral health services.

Asian Americans may be less likely than European Americans to seek behavioral health services because they perceive them as less beneficial than European Americans do (Kim & Zane, 2016). Asian Americans may also view mainstream behavioral health services that require self-disclosure as foreign, as it is not common in Asian cultures to self-disclose (J. Chen & Danish, 2010). In contrast, problem-solving for many Asian Americans may involve indirect coping, such as accepting a situation and enduring a problem while being nonreactive (Hall, Hong, Zane, & Meyer, 2011). Moreover, the focus on interdependence in many Asian American cultures is largely absent from mainstream behavioral health services. Thus, for many Asian Americans, existing behavioral health services are not viewed as culturally relevant.

Efforts to Make Behavioral Health Services Culturally Relevant for Asian Americans

The underutilization of behavioral health services by Asian Americans and other groups of color has prompted researchers and clinicians to explore how to make these services culturally relevant. Some efforts have focused on the therapists and others have focused on therapy. Therapist foci have included ethnic matching of therapists and clients, and therapist cultural competence. The major focus in therapy has been on culturally adapted interventions.

Ethnic Matching

Seeing a therapist that looks like oneself may be a proxy for cultural competence. A client may assume that a therapist of the same ethnicity shares knowledge about their cultural background. Such assumptions may be less likely when there is not an ethnic match between client and therapist. Of course, ethnic similarity is not equivalent to cultural similarity. A therapist and client of the same ethnicity may differ on many

characteristics, including acculturation, education, and socioeconomic status. Nevertheless, for many clients, knowing that therapists of their own ethnicity are available may attract them to seek and remain in treatment.

Following his work in Seattle, Stanley Sue, Fujino, Hu, Takeuchi, and Zane (1991) investigated the effects of culturally responsive behavioral health services in Los Angeles County. Cultural responsiveness involved ethnic and language matching of therapists and clients. Ethnic matching was associated with participating in more treatment sessions for clients of all ethnicities. However, for Asian Americans and Mexican Americans, ethnic match was associated with more treatment sessions only for those whose primary language was not English. Thus, language match accounted for the effects of ethnic match.

A meta-analysis indicates that in subsequent studies, the effects of ethnic match on treatment retention have shown a moderate effect for Asian Americans and weaker effects for other ethnic groups (Smith & Trimble, 2016). Similar to the results of the S. Sue et al. (1991) study, language match accounted for the effects of ethnic match. Thus, having a therapist who speaks the same language is particularly important for Asian Americans.

Although ethnic and language matching may prevent therapy attrition for Asian Americans, the effects of such matching on treatment outcomes (e.g., symptom reduction) are weak (Cabral & Smith, 2011). Thus, the primary benefits of ethnic matching may be when clients first enter treatment. Nevertheless, these initial benefits may be important in increasing Asian Americans' utilization of behavioral health services.

What is the availability of Asian American therapists? Some may assume that Asian Americans are overrepresented in psychology similar to their overrepresentation in other science fields (National Science Foundation, 2013). However, such an assumption may be based on the model minority stereotype. Recent data indicate that Asian Americans are 4% of the US psychology workforce (American Psychological Association [APA], 2017a). Thus, Asian Americans are somewhat underrepresented in psychology relative to their representation of 5.7% of the US population (U.S. Census Bureau, 2016). The difference between the representation of Asian Americans in psychology and in the USA may seem insignificant. However, Asian Americans are the fastest growing ethnic group in the USA. Thus, more Asian American psychologists who are multilingual need to be trained to adequately address current and future public health needs.

There may be pipeline barriers to increasing the representation of Asian Americans in psychology. From 2007 to 2008, only 7% of first-time doctoral students were Asian Americans (APA, 2009). Now, 10 years later, the percentage of Asian Americans in graduate school for psychology only rose 1%, to 8% (APA, 2017b). And at graduation, about 5% of clinical psychology doctorates awarded went to Asian Americans (APA, 2010). The supply of Asian Americans who are potential psychologists may be even more limited at the beginning of the pipeline. In a sample of eighth and tenth grade Asian Americans in the Midwest, less than 3% chose psychologist as a career goal (Howard et al., 2011). The most common goals were artist and fashion designer among Asian American females and computer careers among Asian American males. Asian Americans aspired to careers with prestige and high salaries. Asian American youth may not perceive a career as a psychologist as conferring either.

Families may influence the attractiveness of psychology as a career. Family support for choosing a science-oriented or a helping career influenced whether Asian American college students would choose these careers (Hui & Lent, 2018). However, there is a limited number of Asian Americans who use or are familiar with behavioral health services. Thus, support for a child's career as a psychologist may be limited in many Asian American families. Greater education about psychology as a career, such as high school psychology classes, may be needed for psychology to be considered a viable career for many Asian Americans.

Cultural Competence

Ethnic matching is not available in many behavioral health service settings. How can the 96% of psychologists who are not Asian American effectively treat Asian American clients? One approach is cultural competence.

Derald Wing Sue, Arredondo, and McDavis (1992) defined cultural competence as having three components: (a) awareness of how one's cultural values and biases impact the client; (b) knowledge of the client's culture; and (c) skills in providing culturally relevant treatment. This model is the basis of professional guidelines for cultural competence. The goal of therapist cultural competence is to produce positive outcomes for clients (S. Sue, Zane, Hall, & Berger, 2009). Indeed, even European American therapists, as long as their ethnic minority clients perceived them to be culturally competent, had a strong working alliance with their clients (Constantine, 2007; Fuertes et al., 2006) and were effective with ethnic minority clients (Hinton et al., 2004, 2005).

In a review of the cultural competence literature, Chu, Leino, Pflum, and Sue (2016) contended that cultural competence is effective because it considers clients' psychosocial contexts, adapts the therapeutic approach to the client, and focuses on therapist qualities. Clients' social contexts include social and environmental factors such as discrimination, poverty, immigration, and inadequate educational resources. Social contexts also include cultural norms. The therapeutic approach may include therapist–client ethnic or language matching. It also may involve incorporating cultural concepts, such as interdependence. Therapist qualities include empathy, self-awareness, and the ability to empower clients. Thus, cultural competence goes beyond simply matching clients and therapists on a demographic basis.

What are the effects of cultural competence on therapy? Therapists' perceptions of their own cultural competence are not associated with their clients' experiences in therapy (Smith & Trimble, 2016). More informative than therapists' perceptions are clients' perceptions of their therapists' cultural competence. Similar to the findings for ethnic/language match, a meta-analysis indicates that clients' perceptions of therapists' cultural competence are associated with longer participation in therapy (Smith & Trimble, 2016). In addition, common factors, such as perceived therapist warmth and empathy, are associated with therapists' perceived cultural competence (Constantine, 2007; Fuertes et al., 2006). However, similar to the findings for ethnic/language match, the effects of clients' perceptions of therapists' cultural competence on treatment outcomes are minimal (Smith & Trimble, 2016).

Cultural Adaptations

Although ethnic/language matching and therapist cultural competence have weak effects on treatment outcomes, cultural adaptations of interventions have been shown in recent meta-analyses to have moderate effects on reducing psychopathology (Hall, Ibaraki, Huang, Marti, & Stice, 2016; Smith & Trimble, 2016). A cultural adaptation has been defined as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Unlike ethnic matching and cultural competence, cultural adaptations focus on the therapy rather than the therapist.

Cultural adaptation models have been developed for Asian American populations. Leong and Lee's (2006) cultural accommodation model is a top-down adaptation of existing behavioral health interventions and involves three steps. The first is the identification of the cultural limitations of theories assumed to be universal. For example, EBTs focus on the individual and typically do not address interdependence. The second step is the identification of such culture-specific psychopathology, such as somatization. The third step is to develop a culturally accommodated intervention and to evaluate if it has incremental validity over the unaccommodated model.

Hwang (2006) also proposed a cultural adaptation framework for Asian Americans. Principles that guide the framework include general guidelines for adapting cognitive-behavioral therapy (CBT) to meet the needs of Chinese American clients, strengthening the client–therapist relationship, and understanding Chinese notions of self and mental illness. The framework incorporates top-down adaptation, as well as bottom-up development of culture-specific interventions. In developing culture-specific interventions, community input is solicited from clinicians, experts, community members, and clients. However, many clinicians may not follow the guidance of conceptual frameworks, such as Leong and Lee's (2006) or Hwang's (2006) models, for cultural adaptation in clinical practice (Smith & Trimble, 2016).

Hall et al. (2019) investigated how practicing therapists in the USA and Japan culturally adapt CBT with clients of Asian ancestry. Unlike the independent cultures in which CBT originated, interdependence is emphasized both among Asian Americans and in Japan. Semi-structured, open-ended interviews revealed that therapists in both countries addressed interdependent conceptualizations of the self. The intrapersonal approach of CBT was adapted to address social roles and norms in family, school, and work settings. For example, a Japanese therapist described how a new member of a sports team needed to adjust to her role on the team:

> The skills needed in our culture are something different from the U.S. We call it the *senpai-kohai* relationship. *Senpai* is the older member and *kohai* is the younger member. The *kohai*, the younger member, has to show respect for the older member in a very strict way like their teachers or older people.

Another cultural adaptation that Hall et al. (2019) identified was therapists addressing clients' indirect communication. For example, clients' seeking therapy may tacitly communicate that they are experiencing distress but they may not directly discuss the distress. Indirect communication may serve to maintain group harmony in interdependent cultural contexts (Hall et al., 2011). For example, a depressed Chinese mother may describe physical symptoms instead of psychological symptoms when talking about her depression to her family, so as not to scare them. The therapists' response to their clients' indirect communication was to become more direct in their communication with their clients, such as directly asking about their client's problems (Hall et al., 2019).

Cultural adaptations extend the reach of evidence-based interventions. However, similar to EBTs, culturally adapted interventions tend to be broadly applied. As Hall et al. (2019) found, therapists in the USA and Japan apply cultural adaptations involving interdependence to clients of Asian ancestry. However, interdependence may not apply to all people of Asian ancestry. Asian Americans may vary on interdependence based on their acculturation level and ethnic identity. Highly acculturated Asian Americans with limited ethnic identity may not benefit from a culturally adapted intervention. In this case, unadapted interventions may be beneficial (Hall & Ibaraki, 2016).

As discussed above, the personal and cultural relevance of behavioral health services may influence their effectiveness for Asian Americans. Social neuroscience may offer a promising method to address how self-relevant an intervention is to the individual client. Neuroscience evidence suggests that the self-relevance of an intervention may predict its effectiveness. A study on the relative effectiveness of smoking cessation campaigns found that the medial prefrontal cortical (mPFC) response predicted the effectiveness of these campaigns (Falk, Berkman, & Lieberman, 2012). mPFC activity is associated with self-related processing, which may indicate that the most effective campaigns were self-relevant. Interestingly, self-reported relevance of the campaigns did not predict effectiveness. Thus, neuromarkers offer a promising way to match effective treatment approaches, such as culturally adapted interventions, with particular clients.

For many Asian Americans, conventional evidence-based cognitive-behavioral interventions that focus on the self may not be perceived as personally or culturally relevant. These

approaches focus on individual cognitions and emotions, which may not be as informative about health for Asian Americans as they are for European Americans, as discussed above. In contrast, many Asian Americans may want to address more pragmatic concerns in therapy, such as family, school, and work issues. For example, Ibaraki and Hall (2014) found that addressing academic concerns in counseling with Asian American college students was associated with participating in a significantly greater number of counseling sessions than when academic concerns were not addressed.

A cognitive-behavioral treatment approach that may have personal and cultural relevance for Asian Americans is Social Problem-Solving Therapy (SPST; Nezu & Nezu, 2016). SPST focuses on stressful problems in the real world. Social problem-solving is the process by which people attempt to cope with these stressful problems by altering the problem situation, their reaction to the problem situation, or both. The problem-focus of SPST has been found to be more self-relevant that a focus on emotions for Chinese American elderly adults, whose culture emphasizes emotional moderation (Chu, Huynh, & Areán, 2012). We are currently evaluating the personal and cultural relevance of SPST based on self-report and neuroimaging with Asian American adults (Huang, Hall, & Berkman, 2019). Personal and cultural relevance of a behavioral health intervention could potentially predict the effectiveness of the intervention.

Alternative Services

Regardless of the effectiveness of efforts to make behavioral health services culturally relevant for Asian Americans, many Asian Americans will never benefit from these services because they will not seek them. As discussed above, the combined percentages of Asian Americans with mental disorders who seek help in primary care settings (16%) or alternative service settings (11%) is nearly equal to the 28% who seek help in behavioral health service settings (Meyer et al., 2009). Moreover, the results of a meta-analysis indicate that Asian cultural values, including emotional self-control, conformity to social norms, and collectivism, are associated with a lower likelihood of having positive attitudes toward seeking psychological help (Sun et al., 2016). Thus, in order to meet many Asian Americans' behavioral health needs, services may need to be delivered in contexts besides traditional ones, such as primary care or ethnic community service agencies.

Primary care settings may not carry the stigma of mental health care settings. Moreover, as psychological distress is commonly manifested somatically for people of Asian ancestry (Ryder et al., 2008), seeking help in these settings for distress manifested as a physical health disorder (e.g., sleep problems) may carry less stigma than seeking help for a psychological disorder (e.g., depression). Common reported symptoms include sleep problems (i.e., sleeping too little or too much) and pain. Asian Americans who view distress as biologically based may be more likely than those who view distress as interpersonally based to seek help from behavioral health providers (Na et al., 2016).

A medical setting might also provide an opportunity for mental health literacy education (Na et al., 2016). Mental health problems could be presented as a disease, similar to physical illness. Similar to physical illness symptoms, mental illness symptoms warrant professional help. For example, sleep interventions administered in a primary care setting do not carry the stigma of mental health interventions. These interventions address a somatic problem, which may make sleep interventions particularly relevant for many Asian Americans. Moreover, some sleep disorders, including short sleep duration and sleep disordered breathing, are prominent among Asian Americans (Chen et al., 2015). Sleep interventions not only improve sleep duration and quality, but have been demonstrated to reduce depression (Hasler, Buysse, & Germain, 2016). Asian Americans who would not otherwise seek behavioral health services might be attracted to sleep interventions that address both somatic and psychological symptoms of distress. Successful sleep interventions might also make Asian

Americans open to other interventions to reduce psychological distress.

Alternative care settings might also offer opportunities to provide behavioral health services. Movement-based approaches may be appealing to some Asian Americans because of their Asian philosophical roots. For example, *lishi* is a traditional form of a Chinese movement system. *Lishi* promotes breathing, balance, coordination, and alignment. The movements and stances involve images relevant to Asian cultures that were named after animals and objects that are commonly found in traditional Chinese cultures. Results of preliminary work by Nolan Zane and colleagues indicate that Southeast Asians who practiced *lishi* exhibited improved psychological well-being and physical balance relative to a control group. *Lishi* is culturally relevant and its group format encourages social interaction and ethnic identity, which have been shown to be protective factors against depression (Rivas-Drake et al., 2014).

Unfortunately, the research on alternative services for Asian Americans is virtually nonexistent. Nevertheless, it is important to evaluate the effectiveness of alternative services relative to conventional behavioral health services. If the two types of services are on par with respect to reducing mental disorders, perhaps greater attention and resources should be devoted to alternative services as an approach to improving Asian Americans' mental health.

Future Directions

Efforts to extend the reach of behavioral health services to Asian Americans and other people of color have largely failed. In a classic conceptualization, S. Sue and Zane (1987) contended that distal variables, such as client ethnicity and therapy techniques, are less influential on behavioral health service outcomes for people of color than proximal variables that are more culturally relevant to particular individuals. Sue and Zane (1987) observed that most strategies to improve the effectiveness of behavioral health services with people of color focused on distal variables. Over 30 years later, this distal focus continues and may explain why the reach of behavioral health services to Asian Americans remains limited. Asian Americans are a diverse group in terms of national and cultural backgrounds. However, these groups have been combined in most research. The broad category of Asian American is a distal variable. A much more fine-grained approach is necessary.

There are six Asian American ethnic groups that number one million or larger (U.S. Census Bureau, 2016). Most of the psychology literature on Asian Americans focuses on people with Chinese and Korean ancestry (Kiang, Cheah, Huynh, Wang, & Yoshikawa, 2016). Americans of Chinese ancestry are the largest Asian American ethnic group at 4.9 million (U.S. Census Bureau, 2016). However, Asian Indian Americans number 4.1 million, Filipinx Americans number 3.9 million, and Vietnamese Americans number two million, Korean Americans number 1.8 million, and Japanese Americans number 1.4 million. Thus, there is a need for more research on the heterogeneity within the broad category of Asian Americans.

As discussed previously, behavioral health services, including those that are culturally adapted, tend to be broadly applied. However, culturally adapted interventions based on East Asian cultures (e.g., Hwang, 2006; Leong & Lee, 2006) are not necessarily applicable to other Asian cultures. Although the quest for cultural relevance is complex and costly, it is critical to reduce health disparities for Asian Americans, who utilize behavioral health services at a lower rate than any other ethnic group in the USA (SAMHSA, 2015).

A variable that is somewhat more proximal to behavioral health services outcomes than ethnicity is collectivism or interdependence. As discussed previously, collectivism has been found to be associated with a lower likelihood of having positive attitudes toward seeking psychological help (Sun et al., 2016). Interdependence has been identified as a critical issue in cultural adaptations of psychotherapy with people of color, and therapists may adapt behavioral health services to address interdependence (Hall, 2001; Hall

et al., 2019). However, the effects of incorporating interdependence in psychotherapy have not been evaluated. Moreover, interdependence is a broad and relatively distal construct that varies according to cultural context.

Within and across ethnic groups, Asian Americans vary on acculturation. As discussed previously, acculturation was weakly associated with behavioral health service use among Asian Americans (Smith & Trimble, 2016). This may be because of psychometric limitations of acculturation measures. Acculturation also is relatively distal to behavior.

A construct more proximal to behavior for many Asian Americans is face (Leong, Byrne, Hardin, Zhang, & Chong, 2017). Face involves one's prestige and position in society. Loss of face is a loss of prestige and status through violations of collective norms. For example, failing to fulfill the obligations of one's role as a family member (e.g., be a good student) causes face loss for the individual, as well as the whole family. A person concerned about face loss is vigilant about the impact of their behavior on others. Concern about saving face facilitates the functioning of the group among Asians and other interdependent groups (Zane & Yeh, 2002).

Loss of face is more pronounced among Asian Americans than among European Americans (Leong et al., 2017). It is also more pronounced among less acculturated Asian Americans. It is positively associated with depression and social avoidance. Moreover, face concern has been found to inhibit self-disclosure in therapy (Zane & Ku, 2014). Concern about loss of face may be less adaptive in independent contexts in which face concerns tend not to guide behavior.

Recent research suggests that loss of face is not associated with psychopathology among Asian Americans per se. The association of concerns about loss of face and depression and anxiety were mediated by an avoidant coping style (Braje & Hall, 2016). However, concern about loss of face coupled with a direct problem-solving approach was not maladaptive.

The potential benefits of face concern among Asian Americans should not be overlooked. Although loss of face may be indirectly associated with internalizing disorders, it may be a protective factor against externalizing disorders. In a national sample of college-aged men, concern about loss of face was a deterrent against sexually aggressive behavior 1 year later for Asian American men but not for European American men (Hall, DeGarmo, Eap, Teten, & Sue, 2006). Thus, concern about the impact of one's behavior on the group may be a deterrent against aggressive behavior in interdependent cultural contexts.

Future research on Asian Americans could address how face concerns influence usage and impact of behavioral health services. The effect of mental health literacy interventions to reduce the stigma and loss of face associated with seeking help could be evaluated (Choi & Miller, 2014). Addressing face concerns in therapy could also be examined as a method of increasing self-disclosure (Zane & Ku, 2014). In addition, variability among Asian American ethnic groups in the effects of face concerns could be evaluated. For example, Chinese Americans have been found to be more concerned about loss of face than are other Asian American groups (Braje & Hall, 2016).

The fact that Asian Americans are the ethnic group that is least likely to use behavioral health services suggests that they are the group that warrants the most attention. This is one of the most persistent public health disparities. Yet, Asian Americans have been overlooked in behavioral health policies (Hall & Yee, 2012). Asian Americans will need to be prioritized in behavioral health policies, research, and services if mental health disparities are to be reduced. Otherwise, the behavioral health services disparities of the past four decades will continue.

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