Barriers to Mental Health Services for Asian Indians in America

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Introduction

Indians from India have been referred to in the literature as Asian, East, or South Indians to distinguish from other South Asians, West Indians, and North American Indians. While more recently data are being collected on the various subgroups of Asian Americans, the U.S. Census Bureau had routinely grouped all Asians and Pacific Islanders together although this term overlooks major national and racial differences and cultural variations among this very heterogeneous group (Segal, 1998). Table 1 provides several notable statistics for Asian and Asian Indians in the U.S. in 2004 (U.S. Census Bureau, 2007).

Table 1. Statistics on Asians and Asian Indians in the U.S. in 2004

Total Asian population	12,097,281
Total Asian Indian population	2,245,239
Citizenship status, percentage	
Asian, native	32.6
Asian Indian, native	26.7
Asian, foreign born, naturalized	36.9
Asian Indian, foreign born, naturalized	32.0
Asian, foreign born, not a citizen	30.5
Asian Indian, foreign born, not a citizen	41.3
Non-English at home, English spoken "very well"	
Asian	39.7
Asian Indian	55.9
Education achievement - Bachelor's degree or more	
Asian	27.0
Asian Indian	67.9
Occupation – Professional, management	
Asian	45.8
Asian Indian	60.6
Median household income	
Asian	$56,161
Asian Indian	$68,771
Poverty rate	
Asian	11.8
Asian Indian	9.7

An important factor that should be considered in understanding differences between early immigration to the U.S. (pre-1985) and more recent waves in Asian Indians is the enactment of the Family Reunification Act. While earlier waves of Asian Indian immigrants consisted primarily of highly educated males who later married and brought over Indian wives who were less educated and confined to the home, and then highly educated males who married highly educated Indian women, the Family Reunification Act brought dependents that were less educated (Conrad & Pacquiao, 2005; Das, 2002; Segal, 1998; Sodowsky & Carey, 1987).

Primary Cultural Values

1. **Allocentricism -** Traditional Asian Indian values are common to the values held by most Asian cultures. Asians are allocentric (group-oriented) rather than idiocentric (self-oriented). There is an expectation that the individual should make sacrifices for the family, as with investing money in one family member's education and arranged marriages between families (Segal, 1998).
2. **Holistic view -** Asian Indians tend to have a holistic understanding of the mind and body. Psychological distress and disorders are often explained as either a violation of some moral or religious principle or spirit possessions. Physical illness and mental difficulties are often considered God's will or past karma, and are associated with a fatalistic attitude. It is not uncommon to believe that behavioral abnormalities may be a result of someone having cast a spell on the individual. These factors may add to the delay in seeking professional help (Conrad & Pacquiao, 2005).
3. **Religion and Fatalism –** About 80% of India's population is Hindu. Regardless of religion, most Indians believe in fatalism and animism. Psychological distress and disorders are often explained in a religious framework, in terms of either spirit possessions or violation of some moral or religious principle (Conrad & Pacquiao, 2005).
4. **Family -** Family is very important. There are clearly defined roles for every Hindu relationship, such as husband and wife, parent and child, elderly and young, in-laws and the bride, and teacher and the student. These relationships are defined by hierarchy, with much reverence for elders and males. Families are also the primary sources of emotional, social, and financial support. The traditional Indian family is strictly hierarchical, patriarchal, and patrilineal. Interdependence is fostered, self-identity is inhibited, and a conservative orientation is rewarded. The traditional Indian family does not reward competitiveness, achievement orientation, or self-orientation within the family. Independence and self-identity is not rewarded. This is increasingly in conflict with Indians achieving occupational and educational successes (Segal, 1998).
5. **Gender roles -** In traditional Indian culture, males are more valued than females. As Indian society is patriarchal, men are regarded as the head of the household, the decision makers, and primary wage earners. Women are expected to be subordinate to men and dependent on men throughout their lives – first on their fathers, then on their husbands, and finally on their eldest sons. While women are increasingly attaining higher education, this is more often encouraged because it increases their attractiveness to successful bachelors. Thus, while more Asian Indian American women are attaining higher education and securing higher paying careers, the traditional role of a wife as subservient to her husband and as the primary caretaker for the children is still practiced and expected of women (e.g., Segal, 1998).
6. **Parenting practices -** Infants are often overindulged while young children are raised in an authoritarian atmosphere in which autonomy is not tolerated. Adolescence is generally not recognized as a distinct phase. Rather, during this time, parents use shame, guilt, and a sense of moral obligation as the primary mechanisms for control. Parents and families tend to have high standards for their children. Children who display average performance or fail may view themselves as a failure and experience low self-esteem. Unfortunately, these children likely will not receive intervention because seeking help from professionals and others external to the family is considered a sign of disgrace and weakness. (e.g., Segal, 1998).
7. **Boundaries -** Like other Asians, Asian Indians prefer to keep concerns within the boundary of the family network. Reliance on family members is often met with reluctance to trust non-family members, particularly when the subject is taboo. Family secrets are not to be shared with outsiders. Many first-generation Asian Indian immigrants may avoid direct eye contact with authority figures and elders as a sign of respect. Women generally avoid direct eye contact with men (Conrad & Pacquiao, 2005; Segal, 1998).
8. **Relationships -** Many Asian Indian youth do not date until they are in college or leave the home. This may place them at a disadvantage as they are unfamiliar with the rules of dating and makes them vulnerable to abuse by potential partners. Also, as sex is taboo, as well as sex education, many Asian

Indian youth learn about sex education through school or others. Divorce is taboo and is believed to be objectionable, especially for women who are expected to be self-sacrificing. Thus, women are often blamed for the termination of a marriage. A divorced woman if often isolated and rarely remarries due to the stigma. Also, conjugal violence among Asian Indians in the U.S. is becoming more apparent, although rarely discussed, especially among highly educated Asian Indian immigrants. More battered shelters for Asian Indian women are being established nationwide (e.g., "Manavi" was established in 1985 in NJ). Spousal violence is present even among professional Indian Americans (Segal, 1998).

Presentation of Common Mental Disorders

1. **Somatization -** Mental health problems are often manifested as psychosomatic ailments (e.g., headaches, backaches, weaknesses, and dizziness). The services of a health care professional are much more acceptable than services of mental health professionals (Segal, 1998).
2. **Stress-related -** Within a culture that is overwhelmingly successful by educational and occupation standards, common sources of stress for Asian Indian males have been associated with lack of success in their careers, jobs, and education. Women were reported to be more likely to experience stress related to hierarchy, their family relationships, and postpartum depression. Younger Asian Indians were more likely to report stress related to their inability to meet their family's high expectations regarding achievement in marriage, gender roles, academics, and occupation (Segal, 1998).
3. **Suicide -** Suicide in South Asian countries is now considered a major health problem. Asian Indian patients are more likely to be secretive about their plans for suicide, and are more likely to make veiled threats. Survivors of suicide attempts are generally socially stigmatized and tend to feel very embarrassed. Most families of suicide attempters have preferred not to hospitalize their family member for the fear of social stigma and tainting the family's reputation (Chandarana & Pellizzari, 2001).
4. **Elderly -** Aging Asian Indian parents consist of a large group residing the U.S. These parents often reside with their eldest sons, but will routinely travel between residences of their children. While they are often regarded as an integral part of the family, most find that they are too dependent on their children financially for their transportation and entertainment. Many elderly women may take on household responsibilities and help with the childrearing of their grandchildren. However, elderly parents are increasingly feeling isolated. With limited access to transportation, financial resources, limited understanding of the American culture, and no familiar activities to occupy them many remain at home with their children or grandchildren (Segal, 1998).
5. **Denial -** There tends to be a certain amount of denial of some mental health issues, such as alcoholism and domestic violence (Das & Kemp, 1997).

Barriers to Seeking Mental Health Services

Table 2. Barriers for Asian Indians in Seeking Mental Health Services

Cultural	Seeking help from external or mainstream resources is considered shameful and loathsome. Suffering of any kind produces hope, which is essential to life. With such stigma associated with mental illness and seeking professional help outside of the extended family, most individuals do not present to physicians and clinicians until their symptoms are severe (Segal, 1998). Most Asian Indians are loathe to use formal human service agencies. Family and religion are considered the primary sources of strength. In times of crisis or illness, Asian Indians use their families, as well as their extended network of relatives, friends, and community elders. Seeking help from others outside the family may even be viewed as self-serving

and a disregard for the family, due to the stigma associated with mental illnesses (Segal, 1998).

Asian Indian women are reluctant to seek professional help for stress or psychological difficulties. Help is usually not sought until the problem may seem unmanageable to the individual and their family. Thus, suicide attempts and major depression is not uncommon as presenting problems.

As Asian Indians tend to exhibit physical symptoms (e.g., headaches, backaches, weakness, and dizziness) rather than report mental health problems, families usually seek health care professionals who are much more acceptable than mental health care professionals. Although South Asians may be more likely to visit their general practitioners than Whites, they are less likely to have their psychological difficulties identified. This may be an indication that the DSM is not as appropriate with this minority group, especially due to the emphasis on the medical presentation of disorders, and misunderstanding in symptoms that may result in misdiagnosis, under-diagnosis, or over-diagnosis (Barry & Grillo, 2002; Das & Kemp, 1997; Segal, 1998).

Myth of the model minority - With the fluency of English, economic and educational successes, voluntary immigration to the U.S. primarily for economic reasons, and traditionally strong family ties, Asian Indians are considered the "model minority." However, this perpetuates the notion that Asian Indians are immune to discrimination or adjustment upon immigration. With the underutilization of mental health services, and limited interaction with the dominant American culture, this perpetuates the "model minority" status (Das & Kemp, 1997; Sue, 1994).

Socioeconomic

While the majority of Asian Indians are well-educated, are employed as professionals, and have a moderately high median household income compared to other Asians, those living below the poverty line should not be overlooked. Further, many may have limited disposable income and poor health insurance.

Although the unemployment rate for new Asian Indian immigrants is more than double that of immigrants who entered the U.S. before 1980, many are often not aware of emergency assistance and external sources of support. Most Asian Indians who have failed to improve their economic condition often suffer depression, psychosomatic problems, marital conflict, alcohol abuse, and even suicide (Segal, 1998).

Aging Asian Indian parents consist of a large group residing the U.S. These parents often reside with their eldest sons, but will routinely travel between residences of their children. While they are often regarded as an integral part of the family, most find that they are too dependent on their children financially for their transportation and entertainment. Many elderly women may take on household responsibilities and help with the childrearing of their grandchildren. However, elderly parents are increasingly feeling isolated. With limited access to transportation, financial resources, limited understanding of the American culture, and no familiar activities to occupy them many remain at home with their children or grandchildren (Segal, 1998).

Psychotherapeutic

When professional help is sought, Asian Indians tend to hold the expectation that the therapist will serve as a benefactor or guru and provide them with specific advice, rather

than assisting the client to understand their role in the presenting problem (Jayakar, 1994).

As psychotherapy in the West is routinely conducted behind closed doors, this may be particularly threatening for a young Asian Indian patient with a male therapist. This may induce significant anxiety in the client such that it may lead to therapeutic failure. It may be more helpful to incorporate the family unit in treatment (Steiner & Bansil, 1989).

It is not uncommon for Asian Indian clients to invite their therapists to their home or to attend social functions. The therapist's stance of maintaining a professional distance from the client and their family may be viewed as a rejection, and result in a lack of trust of the professional and the mental health system (Steiner & Bansil, 1989).

Asian Americans tend to have higher premature termination rates and fewer sessions for therapy. Contributing factors may include language barriers, staff and therapists who are not culturally sensitive, and different expectations about the therapeutic approach (nondirective, long-term, group therapy; Leong & Lau, 2001).

Recommendations for Therapy

1. Trying to apply Western values and expectations of behavior on Asian Indians will not result in success. For example, family therapy may not be appropriate due to the hierarchical structure of traditional Asian Indian families. Also, group therapy may not be acceptable to many Asian Indians who do not find it acceptable to share family problems with others. Sharing this information may be viewed as shameful, and stigmatizing for the family (Conrad & Pacquiao, 2005; Juthani, 2001).
2. Treatment of Hindus has to be culturally sensitive and include Hindu beliefs and practices. Clinicians have to be aware that patients are rarely self-referred and the role of the family is crucial.
3. Not incorporating the family during initial assessment and future sessions may be regarded as counterproductive. Juthani (2001) suggests that clinician should listen to the family's identified spokesperson first to learn about the primary presenting problem and reason for the consultation. This initial contact may be very important in order to have the patient's compliance in treatment. Also, coercing the client to talk about their family, especially as contributors to the mental illness is anti-therapeutic (Ananth, 1984).
4. Juthani (2001) also suggests that clinicians should try to maintain control, focus on symptoms, and be interactive. A passive, non-judgmental, and neutral stance may actually induce anxiety in the client and their family.
5. The therapist should not expect automatic compliance. As the therapist and other professionals are viewed as authority figures, Asian Indian clients may not readily share their disagreements and views about their treatment. Rather, these disagreements may be demonstrated through premature termination, noncompliance with protocols, and passive-aggressiveness in sessions (Juthani, 2001).
6. Asian Indians prefer the clinician to play a role that is active, directive, and problem-focused. The client may show very little initiative towards self-directed action (Ananth, 1984).
7. Clinicians must be aware of misunderstanding nonverbal communication of Asian Indians. Asian Indian patients may not express their emotions exuberantly, as it is not culturally acceptable. Thus, an Asian Indian client may rarely make eye contact or smile, may maintain a distance, and often look down (Futa, Hsu, & Hansen, 2001). However, this may vary greatly between first generation and second generation Asian Indians.
8. The DSM may not be as appropriate with this minority due to its emphasis on the biomedical model for mental disorders. This may result in misdiagnosis, under-diagnosis, or over-diagnosis as the

presentation of many mental health problems may be different for Asians as compared to Caucasian Americans (e.g., somatization; major depression, hypochondriasis, Conrad & Pacquiao, 2005).

9. With limited information on Asian Indians in therapy, it is imperative that the therapist does not pigeon-hole the client based on some knowledge or understanding of the culture. The level of acculturation of that individual, as well as the client's views on gender roles, and other areas, are very important in informing treatment (Ibrahim & Ohnishi, 1997).
10. Therapy should be focused on time-limited and problem-focused interventions. Short-term, problem-solving focused, or crisis intervention approaches with limited and practical goals are recommended (Futa et al., 2001; Segal, 1991).
11. Overall, it may be helpful to recruit support from community and religious leaders, and professionals (e.g., doctors) to de-stigmatize the predominant views of the Asian culture toward mental illness and mental health care. Also, providing pamphlets in community centers, religious sites such as temples, and other social settings may help reduce the negative attitude toward seeking help for mental health problems, as well as emotional difficulties in general (e.g., domestic violence). Further, while the majority of Asian Indians may demonstrate fluency in English, translators should be available for those who are not proficient in English (e.g., Chen, Kramer, Chen, & Chung, 2005).
12. More research is warranted in order to understand how Asian Indian families have changed from the traditional family unit. Segal (1998) summarized five issues that were identified by Asian Indian parents and children as causing emotional difficulties in the home (i.e., Control, Communication, Marriage, Prejudice, and Expectations of excellence). Further, with increasing numbers of second- and third-generation Asian Indians in America, acculturated to the mainstream U.S. society, mental health difficulties and utilization of mental health services specific to this growing population need to be examined.
13. While immigration laws and fluency in English have helped Asian Indians to not be perceived as a threat to American society, Asian Indians constitute a "silent minority" (Segal, 1998, p.353). However, as the number of Asian Indian immigrants has grown in U.S., so too has discrimination. While earlier Asian Indian immigrants were overwhelmingly highly educated professionals, over the 1980s, far less educated immigrants have perpetuated the negative perceptions of many Asian Indians as cabbies and motel owners (Segal, 1991). These and other negative perceptions have resulted in acts of violence, particularly following September 11, 2001, when several Asian Indians were targeted as being terrorists. More attention should be paid to how Asian Indians who have faced discrimination and acts of violence have dealt with these stressors.

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