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Model Minority at Risk: Expressed Needs of Mental Health by Asian American Young Adults

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Abstract

The objective of this study is to obtain and discuss in-depth information on mental health problems, including the status, barriers, and potential solutions in 1.5 and 2nd generation Asian American young adults. As a part of the Health Needs Assessment project, the researchers conducted two focus groups with 17 young adults (mainly 1.5 or 2nd generation) from eight Asian American communities (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese) in Montgomery County, Maryland. We developed a moderator's guide with open-ended questions and used it to collect qualitative data. Using a software, we organized and identified emergent themes by major categories. Participants reported a several common sources of stress that affect the mental health of Asian American young adults including: pressure to meet parental expectations of high academic achievement and live up to the “model minority” stereotype; difficulty of balancing two different cultures and communicating with parents; family obligations based on the strong family values; and discrimination or isolation due to racial or cultural background. Young Asian Americans tend not to seek professional help for their mental

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health problems; instead they use personal support networks—close friends, significant others, and religious community. Participants suggested that Asian cultural norms that do not consider mental problems important, and associated stigma of seeking professional care might undermine their mental health help seeking behavior. Our findings support a need for delivering culturally appropriate programs to raise awareness of mental health and cultural training for health providers to deliver culturally appropriate care.

Keywords

Mental health; Asian American; Young adults; Immigrant health; 1.5 generation; 2nd generation

Introduction

Mental health is an extremely important, but commonly overlooked health topic in Asian American (hereafter, AA) youths. The 2005 Centers for Disease Control and Prevention's '10 Leading Causes of Death' [1] highlights significant mental health disparities among racial/ethnic groups. Among females 15–24 years old, Asian Americans and Pacific Islanders (AAPIs) have the highest rate of suicide deaths (14.1%) compared to other racial/ethnic groups (White 9.3%, Black 3.3%, and Hispanic 7.4%) [1]. AAPI males in the same age range have the second highest rate of suicide deaths (12.7%) compared to other racial/ethnic group males in the same age range (White 17.5%, Black 6.7%, and Hispanic 10%) [1]. Although the recent Virginia Tech shooting incident serves as a reminder of the tragic consequences of untreated mental health problems in youth, these statistics point to the large numbers of youths whose lives are severely impaired by mental health problems but do not come to the attention of the public.

Despite alarming suicide rates and other indicators of mental health problems such as depression, this issue continues to be ignored in AAs in general, and particularly in AA youths. Traditional Asian culture suggests that mental health problems exist because one cannot control oneself, and therefore it is considered shameful to reveal that one has mental health problem or to seek help. Consequently, AAs oftentimes hide the problem because they fear the associated stigma. AA youths may experience additional challenges that stem from their position as 1.5 or 2nd generation immigrants (we define 2nd generation as people who were born in the U.S., 1.5 generation as immigrants who came to the US before age 16, and 1st generation as immigrants who came to the U.S. when they were 16+ years old) [Kim D, 2008, Personal communication]. Since the level of acculturation differs from that of their parents' generation or their non-immigrant friends at school, it often creates stressful situations for them in daily life. However, the difficulties of this generation are rarely recognized and addressed. Considering the significance of untreated mental health concerns for AA and their potentially negative impact on the larger society (e.g., Virginia Tech shooting), it is critical to identify factors affecting mental well-being and mental health care utilization in this group.

In a survey of 1,130 Korean American students aged from 18–29, authors reported negative mental health outcomes associated with the dual pressure of cultivating one's Korean background and values while minimizing one's Korean background in order to adapt to the more individualistic culture of America [2]. In the Patterns of Youth Mental Health Care in Public Service Systems Survey of 1,715 youths age 6–17, parents expressed that American culture and prejudice/racial discrimination were contributing to the problem behaviors of their children [3]. Another study of 217 Korean American students (age 13– 18) in Los Angeles reported that ethnic identity (a sense of belonging and positive attachments to one's ethnic groups) was a significant predictor of internalizing and externalizing problems, and

perceived discrimination had a stronger positive relationship with adolescents' externalizing problems [4].

Previous studies have demonstrated the relationship between perceived discrimination and depressive symptoms [5] and substance use [6] among Filipino Americans, and perceived discrimination was also associated with poor mental health [7] and decreased use of mental health services [8] among Chinese Americans. Discrimination may lead to sadness which impacts worldview, discrimination may-decrease feelings of control and impact self esteem, and/or discrimination may lead to internalizing negative stereotypes [9]. In a study of 2,047 participants using the National Latino and Asian American Study, authors found that self-reported racial discrimination was associated with greater odds of having any DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) disorder, depressive disorder, or anxiety disorder within the past 12 months, controlling for sociodemographic characteristics, acculturative stress, family cohesion, poverty, self-rated health, chronic physical condition, and social desirability. Physical health attenuated but did not eliminate effect of discrimination on mental disorders, and social desirability did not play a role in explaining the association [9].

A national survey reported that AA children aged 18 and younger were less likely than Whites, Blacks, and Hispanics to receive mental health care [10]. In a recent study of 2,095 AAs aged 18 years and older, rates of mental health-related service use, subjective satisfaction, and perceived helpfulness varied by birthplace and by generation [11]. Nearly half of AAs have difficulty accessing mental health services because they do not speak English or cannot find services that meet their language needs [12]. Approximately 70 AA providers are available to every 100,000 AAs in the United States, compared to 173 White providers per 100,000 Whites [12]. No reliable information is available regarding the Asian language capabilities of mental health providers in the United States. One study found that only 17% of AAs experiencing mental health problems sought care [12]. Among AAs, the severity of disturbance tends to be high, perhaps because AAs tend to delay seeking treatment until symptoms reach crisis proportions. Shame and stigma are believed to figure prominently in the lower utilization rates of mental health services in AA communities [13].

Most previous studies reviewed above used a survey design to collect information. Although surveys explore the breadth of the issues and provide an overall trend, they lack in-depth information. Moreover, most studies examined this matter in one or a few subgroups of Asian Americans that have larger population. Therefore, findings from underrepresented groups are rarely presented. Our study tried to fill this gap by investigating the problem with focus groups in eight different Asian American groups including four underrepresented groups (underrepresented group is defined as people who originated from the Asian countries other than the major six Asian subgroups that are included in the Census (Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese)).

This study was a part of the Health Needs Assessment project carried out in 2007 by The University of Maryland School of Public Health research team in collaboration with Center for Asian Health of Temple University, Johns Hopkins School of Public Health, and Asian American community leaders in Montgomery County, Maryland. Through this project, we visited 13 AA communities (Asian Indian, Burmese, Cambodian, Chinese, Filipino, Indonesian, Japanese, Korean, Nepali, Pakistani, Taiwanese, Thai, and Vietnamese), and held 19 focus groups with 174 participants who were age 18 and above. It was during these focus groups that we learned that mental health was one of the most important health concerns for community participants, especially adolescents and young adults who are 1.5 or 2nd generations (12 communities out of 13 communities brought up mental health as one of the top health concerns in their communities). In response to the importance of mental health

issues to the community, our research team performed two separate focus groups to specifically discuss mental health concerns. Since our Internal Review Board (IRB) approval for the initial focus groups was only for adults (18 years old and older), we were not able to include adolescents in these mental health focus groups. Nevertheless, we recruited young adults (18– 30 years old) to discuss their current mental health-related experiences as well as those of adolescent period.

Methods

Sample

We used a convenience sampling strategy to recruit young adults from diverse Asian American communities including hard-to-reach populations. We conducted two focus groups with 17 participants (5 males and 12 females) from eight Asian American communities (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese) in Montgomery County, Maryland. Eligibility criteria were young adults between 18 and 30 years old who lived in Montgomery County for more than six months (Table 1). Recruiting young adult participants from diverse communities was very challenging. Young adults from underrepresented communities were especially difficult to reach. Student workers with existing ties to their respective Asian communities participated in our main Needs Assessment Project and they played a key role in recruiting young adults from diverse backgrounds. Different from the adult population, young adults (especially males) were less likely to be motivated to participate in focus groups. As incentives, we offered a $20 USD value gift and provided dinner for all participants.

Data Collection

We chose to conduct focus groups as our data collection method because it is a highly effective method that uses planned discussion in a non-threatening environment to obtain detailed information that would be less accessible without the interaction found in a group [14, 15]. Human subjects' protection for collecting these data met with approval from the University of Maryland Internal Review Board (IRB).

The research team created a moderator's guide which we used in both focus groups. We first came up with a list of topics and questions we thought were important. Then, we prioritized them based on the order of significance and flow of discussion. Our final moderator's guide included: (1) whether mental health was a concern in young adults in their community; (2) if so, what type of mental health issues were considered as problems; (3) possible sources of stress that affect mental health; (4) whether people with problems seek professional help; (5) if not, what are potential barriers for receiving professional help such as counseling or treatment; and (6) suggestions on possible development of prevention/education program.

We conducted focus groups in June, 2007 and July, 2007. Each focus group lasted approximately 2 h. Both focus groups were moderated by a person with extensive experience in conducting focus groups in diverse population such as White, Hispanic, Asian, youth, and women. There was a note taker who was trained to take careful and systematic notes. Data were collected in the evenings to accommodate participants' work schedules and at places where participants felt comfortable. Focus groups were conducted in English since all participants spoke English fluently. Participants were either 1.5 or 2nd generation.

We received a signed informed consent form from each participant before the focus group. We assure them that their participation was voluntary, their identity would not be revealed, and that the whole session was going to be recorded. We also distributed a short survey to collect demographic information such as age, gender, zip code, religion, education, employment status, marital status, family income, and health insurance status. At the end of

the focus groups, we provided them with a blank paper asking them to write anything that they wanted to say, but they did/could not say publicly, in case they wanted to share private or sensitive information.

Data Analysis

The entire focus group sessions were transcribed immediately after each focus group and compared with notes as needed to assure completeness of data. The research team met after each focus group and reviewed each procedure. After everything was transcribed, transcripts of the focus groups were analyzed by coding emergent themes. These emergent themes were organized by major categories that were identified during the analysis: prevalence of mental health problems among Asian American youths in their communities, definition/perception of mental health, potential sources of stress that affect mental health, mental health help seeking behavior, and recommendations for future program development. We used Max QDA 2007, a qualitative data software, to code the focus group conversation and organize the data for analysis. Once the drafts were written, everyone in research team reviewed and commented on the report. We circulated them to participants of focus groups for their feedback.

Results

Participants actively participated in focus groups and raised mental health as an important health concern among their peers in their community. The biggest challenge associated with mental health was that it is oftentimes taboo to openly discuss in many Asian cultures, and thus people tend to hide, neglect, or deny symptoms rather than seek help. The most common conditions mentioned were stress, anxiety, and depression. Many participants perceived that being “1.5 or 2nd generation immigrants” was a strong contributor to stress in their lives.

Existence of Mental Health Problem in One's Peers in the Community

Throughout the focus groups, we asked various aspects of mental health related issues in Asian American young adults. However, we did not provide a specific definition of mental health to our participants. Rather, we left it up to the participants to define mental health as what they perceive it to be. Consequently, a broad range of topics including stress, anxiety, depression or depressive symptoms, and mental diseases, were brought up by them and thus we included these in the definition of mental health.

Participants expressed that they do not often hear about mental health problems from their peers. However, they also mentioned that it is very likely that their peers do not want to show it or talk about it, even if they have problems. Therefore, they presume that what they feel as prevalence of the problem may be an underestimate of actual problems. In many Asian cultures, it is a taboo to openly discuss mental health related problems, and oftentimes people tend to hide, neglect, or deny symptoms rather than seek help. As one respondent puts it:

> …Asian American males have some kind of mental disorders or depression but they just don't show it as much, because I know my family has…depression but they don't like to talk about it.

Definition/Perception of Mental Health

According to focus group participants, mental health is seen as something that an individual should have control over in Asian culture. For that reason, the occurrence of mental health problems are seen as individual's fault and are something that one may be ashamed of.

Therefore, it is also widely perceived that one should deal with mental health problems oneself rather than seeking outside care.

> When I think [about] mental health, I divide it into two categories: 1) where it's a hormonal imbalance or something that you can see[a] psychiatrist for so you can get medication for it, and 2) emotional issues and things I can't necessarily be treated with medication… the former has more of a physical aspect… where it would be easier for Asian Americans to receive help whereas the latter is a way that I think a lot people, including our parents, but us view as something that we should deal with in private.

Potential Sources of Stress that Affect Mental Health

There were four major themes that emerged from our focus groups regarding potential sources of stress that affect mental health of participants (as a young adult or as an adolescent based on their past experience).

1. Parental pressure to succeed: Participants agreed that AA parents expect their children to succeed academically and to strive for certain career paths, and to fulfill expectations. Asian American stereotype of being smart and accomplished -the model minority myth- sustained by non AA, may have placed additional pressure on AA youths. In Asian culture, being accepted as a ‘good’ son or daughter oftentimes revolves around academic success and achievement of high status jobs. Many participants related this stress to the selection of their field of study.

   > Let's say I wanted to be an English major since I was little, but they push me to go to medical school, thinking about income and future. Once we start going to college, that's what stresses us, basically. I think it's a bigger issue than we think it is because with all these stereotypes of what Asian Americans are… so there's a pressure from people outside your ethnicity for you to be smart or something…And their parents at home are like, study harder, that's how you do better. And there might be issues because they don't know how to deal with it, or I think the stereotypes and discrimination also play into the health issue as well.

2. Difficulty of balancing two different cultures and communicating with parents: Asian American young adults are expected to respect the culture and values of their home country in the family and household environment while they grew up in the American culture at school or with friends/colleagues. Some acculturate easily, yet others have difficulties. One parent who participated in the main Health Needs Assessment focus group said, “They [Thai adolescent children] are trying to get a balance between their American activities and their Thai activities.” Other participants also mentioned that there is a difficulty in communicating with their parents due to the difference in culture or generation gap and language barrier. One focus group participant said,

   > Our parents dealt with different kinds of stresses than we do now, and the stress we go through now, they might see as a non-issue. I think communication within an Asian family is not very expressive, I mean I know[in] my family we don't express our feelings… so growing up in a household like that, I had a lot of friends, but if somebody kept to themselves a lot, they might not know how to express themselves…” Sometimes I can't express a normal thing to my parents because of the language barrier too, because I'm starting to lose a little bit of my native language, but so, generally speaking, growing up in an Asian household might sort of hinder you from having expressive skills.

3. Family obligations based on the strong family values: Participants discussed how Asian cultural values often expect sons and daughters to take care of their parents as they get older, and this has been raised as a big pressure for young adults. Additionally, even with relatively younger parents, Asian American young adults are still providing care as a translator/interpreter or driver when their parents have difficulties navigating through the American systems due to language and transportation barriers.

   I feel in our community sometimes that we almost have the obligation of taking care of our parents when they are older, taking them in, you know, I see a lot of people here, like friends from high school and American friends, they don't have that on their shoulders…So, not only am I working for myself currently, but I have to think about ten years from now, am I able to take care of my parents, am I able to support my parents? So that stress comes in. We have like a big weight on our shoulders to take care of our parents, just I know that my parents depend on me for a lot of things, like looking at the mail, translating for them or helping my other family out, it's like sort of stressful on me too. I guess that's why depression can fall on us because we think about all the time on top of everything else that we have to do for ourselves.

4. Discrimination or isolation due to racial or cultural background: Participants felt that discrimination based on racial or cultural backgrounds is a significant source of stress, particularly during high school.

   Well I guess for me, hearing those things [discriminator remarks], you like brush it away but then you also have inner anger that builds up, makes you stressed later on, even though you try to ignore it [discriminatory remark].

Current Mental Health Help Seeking Behavior

According to participants, most Asian American young adults do not seek professional help for their mental health problem. Rather, they depend on religion or other trusted sources such as friends or significant other.

> I'm not, a depressed person but if I was I would not even think about professional counseling, it's not even in my set of available things to do. You know, I would think of like, friends, or sleep or something, but I wouldn't even think of professional counseling.

Deterrents of Mental Health Help Seeking Behavior

Participants discussed that there are mainly six different deterrents that prevent them from seeking help related with their mental health problems.

1. Stigma associated with mental health: Participants reported that in Asian culture there is a negative perception of people seeking counseling, and that even if the counseling occurs, they were worried about their parents may be in denial of accepting the fact that their children seeking mental health counseling.

   I think it has a negative perception that people going for counseling. They think that you're crazy or you know, just…

   I had a friend who, he never wanted to tell his mom that he had ADD (Attention Deficit Disorder) because it would go on his track record, his mom would not be able to deal with it.

   There is still just that stigma about going to see a psychiatrist, whether it's from your parents or not.

2. Lack of awareness of mental health issues in the community: Many AAs are not aware of the importance of mental well-being. This may partly be due to a cultural influence: some of mental conditions have not been identified in their culture and there are no careers related to psychological counseling. Some AAs may not be aware of the seriousness of the mental problems they experience, or do not recognize that appropriate and timely counseling or treatment may significantly help them.

   Back home that job doesn't even exist seeing a therapist or… So, plus people don't wanna pay money to talk to somebody, they want free counseling. So with that mentality coming to this country knowing that there are professional psychologists and therapists that you can go to… it's just that mindset is not there.

3. Avoid worrying their parents with their problems: Most participants mentioned that they tend not to talk with their family regarding their mental health problem in order to prevent their families from worrying.

   I would normally turn to close friends, or my significant other, like a boyfriend and that's probably my trusted source. I don't like to go to my family with my stress because I think they have too much stress on their own. So, I like to stay away from them.

4. Lack of mental health professionals who can offer linguistically and culturally appropriate care: Many Asian Americans do not feel comfortable speaking to a mental health care professional who does not understand their culture or language.

   I think it'd be good if there were Asian American counselors on campus.

   One of my friends has weekly appointments with them, feel completely safe going to them, but then again, some of it is, they're adopted, they're Asian but they're adopted, so I don't know if they count.

5. Parents' lack of knowledge of mental health issues: parents have different thresholds for what level of a mental health concern is appropriate to warrant seeing a psychiatrist or psychologist, or other mental health professional. Parents may not appreciate the stresses that their children experience now, since they have dealt with different kinds of stress than their children do today. Parents may be unaware that their children are having any difficulties related with mental health due to lack of communication with the children or inability to identify signs of mental health distress.

   Well because I think they have a different threshold for what they think, at what level it's appropriate to see a professional psychiatrist or psychologist because I think for my parents, going to a professional therapist of the sort would be a weakness in an individual, their inability to deal with personal problems and having to rely on someone else for personal issues.

   I think that our parents dealt with different kinds of stresses than we do now, and the stress we go through now, they might see as a non-issue.

6. Costs associated with mental health care: there was a mixed evidence concerning this deterrent. Some participants mentioned that they do not want to pay money to just to talk to somebody. Free services may make treatment more accessible in this case. However, other participants also mentioned that even if it was free, they may not attend therapy due to the stigma.

   People don't wanna pay money to talk to somebody, they want free counseling.

Recommendations for future program development

We asked participants about possible recommendations for future program development. We were able to hear many good recommendations that are specifically tailored for the purpose of serving people of the age group and ethnic backgrounds.

1. Provide awareness education programs.
2. Increase number of linguistically and culturally competent mental heath professionals. Hire more Asian American counselors on campus because Asian American young adults may find them to be more relatable and understanding of the stress they are undergoing.
3. Create a directory of Asian American mental health professionals in the community.
4. Educate parents.

   There's a lot of commercials teaching parents how to talk to their kids and stuff, those are never directed at Asian American parents, Asian American parents wouldn't pay attention to those commercials, I mean language barriers included but like just in general, they don't want to watch that type of thing, so maybe to include them a little more in the media.
5. Involve the school system, community-based organizations (CBOs) or faith-based organizations (FBOs) to disseminate information and implement programs. The group suggested that announcements of any health or mental health programs should be through schools and cultural/faith-based organizations in the community. Having convenient and accessible help may have an effect on an individual's health-seeking behavior. If individuals perceive the help to be too far away or too troublesome to obtain, they may be reluctant to seek it.

   I don't think we have sort of the desire to go and talk to just random people about our personal issues, even if we were made anonymous. We're very private culturally, we have that stigma, so I don't even think that it would have mass appeal, even if it did exist.
6. Develop mental health education programs that can appeal to youth populations.
   a. Combine a sport event component with mental health education to attract more interest.
   b. Provide confidential hotlines.
   c. Provide an online support group or forum where Asian American youth can anonymously post their thoughts or read other postings.
   d. Communicate anonymously with a counselor through instant messenger.
7. The group cautioned that initiating any in-person counseling or support group needed to be a gradual process because of the culture's inclination to be private about personal problems.

Beginning, perhaps start with stress level or how to deal during exam time or career choices, or tie how things like that can…and expose them slowly to the program and then allow them to immerse themselves slowly into and build the bond with the psychologist or therapist and then be able to talk about more deeper issues if they have any, but that could perhaps help.

Discussion

Through in depth focus group discussions, we found that mental health is one of the most important health concerns for 1.5 and 2nd generation AA young adults. Participants discussed their definition or perception of mental health, potential sources of stress that affect their mental health, current mental health help seeking behavior, and deterrents of mental health help seeking behavior. Our findings indicate potential sources of stress are closely related to being 1.5 and 2nd generation, acculturation or/and model minority myth. Asian parents consider academic success as the most important thing in their children, and thus AA youths feel pressure to meet the expectation. Participants also brought up difficulty of balancing two different cultures and communicating with their parents. This stems from difference in degree of acculturation between parents and children. AA youths tend to acculturate faster because of the school environment whereas parents tend to keep their original culture. Therefore, conflict of cultures can arise in the family setting, and this has been raised as a source of stress for our study participants. Similar findings have been reported in studies of Korean American students and Asian American and Pacific Islanders [2, 3]. Our finding of discrimination as a source of stress has also been found in other studies. Authors found perceived discrimination affected depressive symptoms [5], substance use [6], poor mental health [7], decrease in feelings of control and self esteem, and anxiety [9].

Our findings suggest that AA youths are less likely to seek professional help for their mental health problems. This is consistent with findings of other studies [10, 11, 13]. A study indicated that compared to other racial and ethnic groups, AA youths used outpatient service, 24-h care, informal services (self-help, peer counseling, or religious counseling), and any mental health services less than other racial ethnic groups [16]. Study participants mentioned stigma as the biggest deterrent in health seeking behavior. A study in Hispanic children pointed out that stigma reduces mental health patients' access to resources and opportunities which prevents the public from wanting to pay for mental health care [17]. Shame and stigma are believed to figure prominently in the lower utilization rates of mental health services in AA communities [13]. Participants also mentioned that lack of awareness of resources/importance of care and parents' lack of knowledge of mental health needs as major deterrents. Lack of mental health professionals who can offer linguistically and culturally appropriate care was also raised as a main issue. It is consistent with a report which revealed that a large number of AAs have difficulty accessing mental health services because of language [13].

Although we were able to acquire in-depth information for certain topics, our findings should be interpreted in light of several considerations. Given that this was a smaller study within a larger project, the number of participants is small and the participants represent a convenience sample. Additionally, this population is difficult to motivate and the underrepresented groups were especially difficult to reach. Therefore, it may not be possible to generalize findings of the study to larger groups of AAs. Nevertheless, we think this is an important contribution to literature since there is lack of in-depth information of this kind. We included extensive information of various aspects of mental health problems in AA young adults, and tapped into some hard-to-reach groups' opinions. Future studies of a larger scale may add robustness to our findings. Our findings also have important implications for future interventions or program development for this group. Recommendations provided by participants reflect effective and feasible measures that apply culturally responsive solutions and that will actually work for this group.

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Table 1

Characteristics of participants (*n* = 17)

Age range	18–30	Annual household income	
Gender		<$10,000	2
Male	5	$10,000–$19,999	2
Female	12	$20,000–$29,999	0
Education		$30,000–$39,999	1
Less than high school	1	$40,000–$49,999	1
High school graduate	7	$50,000–$59,999	0
Bachelor's degree	9	$60,000–$69,999	3
Master's/doctoral degree	0	$70,000–$79,999	2
Ethnic background		$80,000–$89,999	1
Asian Indian	1	≥$90,000	0
Cambodian	3	Marital status	
Chinese	1	Married	1
Indonesian	6	Single	16
Korean	3	Health insurance	
Taiwanese	1	Yes	13
Thai	1	No	4
Vietnamese	1		