


Herbert and Gabriel make a valuable contribution to the debate on stretching. 

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Improving the mental health of Asian Americans

Depends on training primary care clinicians and educating the community

Asian Americans suffer a disproportionate burden of disability from mental illness. Yet compared to whites they have less access to mental health services, receive poorer quality mental health care, and are under-represented in mental health research.¹ The September 2002 issue of the *Western Journal of Medicine* (www.ewjm.com) looked at ways of improving the mental health care of this fast growing minority group.

One of the problems in looking at the evidence on the mental health of Asian Americans is that the term "Asian American" includes at least 43 different ethnic groups, which have their origins in countries as diverse as China, Japan, Laos, India, and the Philippines. Therefore, the conclusions drawn from analyses using "Asian American" as a single ethnic category may be very different from those made when specific ethnic groups are examined.

Nevertheless, the available data suggest that the burden of mental health distress is high among Asian Americans. Community studies using mental disorder symptom scales show that Asian Americans have a higher prevalence of symptoms compared to whites.² In a survey of a random sample of Chinese Americans in Los Angeles, using a standard diagnostic interview, 7% reported that they had experienced neurasthenia.³ This syndrome of persistent and distressing fatigue is considered by patients as a medical rather than psychiatric diagnosis, despite its similarity and overlap with mood and anxiety disorders.⁴ The most striking statistic is that among women aged 15-24 and over 65 years, Asian Americans have the highest suicide rate of any racial group in the US.^{1,5}

The theme that dominated the special issue of the *Western Journal of Medicine* is that primary care providers, rather than mental health specialists, are in the best position to reach out to Asian Americans

with mental illnesses and, ultimately, to improve access to specialty mental health care. This is because Asian Americans prefer to seek help from their primary care providers, rather than from mental health specialists.⁶

Some of the reasons for this preference are the



Key strategies of the Bridge Program

Communication with patients

- We discuss mental illness in a way that recognizes patients' commonly held belief in a connection between mind and body
- We explain treatment as a way of restoring balance in the body and brain (using the concept of yin and yang)
- We always ask patients about their use of alternative therapies

Tailoring treatment

- Our experience, and limited evidence, suggests that Asian Americans require lower than standard initial doses of psychotropic medication—this reduces the risk of side effects and improves initial acceptance and engagement with treatment¹³
- We have found that cognitive behavioral therapy and skills training are more effective than insight oriented psychotherapy for immigrant Asians

Liaison with mental health professionals

- We share the care of patients with mental health specialists, especially for complex presentations and when patients do not respond to treatments
- Even after referral, we continue to see patients regularly so that they do not feel abandoned

Community education

- Led jointly by primary care providers and mental health specialists, this is aimed at lowering the stigma of mental illness and encouraging patients to seek treatment

shame and stigma such patients attach to receiving mental health services and the fact that they are more likely to find an Asian bilingual primary care provider than a bilingual mental health professional. In addition, the traditional Asian view of health does not separate body and mind, so patients may not see the value of consulting a mental health specialist. This is particularly true when patients have prominent somatic symptoms as part of their depressive, anxiety, or neurasthenic syndromes.

Unfortunately, when Asian Americans with mental illnesses do present to primary care providers, providers often find it difficult to identify their patients' psychiatric disorders. In one prospective community study, primary care doctors significantly under-recognized psychiatric distress in their Asian American patients compared to Latino patients.⁷ Even Asian American providers themselves recognize the difficulty of diagnosing and treating mental illness in their Asian patients and say that they feel inadequately trained for this task.⁸

There are many barriers to recognizing psychiatric distress in Asian Americans. The stigma of mental illness makes it difficult for patients to discuss their emotions. Doctors in turn find it difficult to ask about mood and feelings, out of fear that they will open up a Pandora's Box and then be unable to manage their patients' concerns. Diagnosis of mental illness can be complex in Asian American patients because they often have highly somatic presentations, and many have a history of multiple medical investigations before a psychiatric diagnosis is even considered.

These barriers can be overcome. Based on research showing that training primary care providers and educating patients can improve the outcomes of depressed patients,⁹ a model for providing primary mental health care to Asian Americans has been developed in New York. The model, known as the Bridge Program, involves training primary care providers in the early detection and management of common mental disorders, educating the Asian community about mental health issues, and giving providers the communication tools to offer culturally responsive care (see box). Early results suggest that the intervention may be improving detection rates of psychiatric disorders,¹⁰ and the model is now being replicated in other US cities with large Asian populations.

The model also grew out of a worldwide recognition that community education led by primary care providers, in partnership with mental health specialists, is the best way to promote mental health knowledge among Asian communities worldwide.¹¹ Such knowledge is urgently needed—Japan, for example, has more suicides each year than the US, despite having less than half the US population.¹²

Last year Surgeon General David Satcher issued a landmark report on the mental health of racial

and ethnic minorities.¹ One clear message of the report is that primary care providers hold the key to improving access and care to Asian American and other minority groups with mental disorders. ♦

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EDITOR'S NOTE

The *Western Journal of Medicine* was forced to close for financial reasons, and the September issue discussed in this editorial was the last for the foreseeable future. Readers can continue to freely access old issues of *WJM* online at www.ewjm.com. The editors are continuing to seek a funding source that might allow a re-launch.