Working with Asians

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Introduction

First, I am a Caucasian, born and raised in New York City. So, it is a bit audacious for me to be writing about working with Asians. However, for the past thirty years I have worked in many Asian countries, assisting them in the development of 12 Step programs and addiction treatment. So, that's the context in which I am writing.

Second, Asians constitute 50% of the world's population. Between the populations of China and India alone, they constitute 40% of the world's population. It would be inappropriate to speak of "Asian culture," and pretend that there is homogeneity. For example, Indonesia alone consists of 13,000 islands, with 200 million people. Thus, it is an error to try to categorize such a vast population in generalized statements.

Third, the largest groups of Asians are Chinese, with 1.3 billion people in China alone. The second largest ethnic group is Filipinos, and the third is Japanese. Asians are the fastest growing "minority" group in America. Therefore, it is a population those of us working in the addiction recovery field need to further understand. Asians now constitute 6% of the US population, and that number is estimated to be 10% by 2050. Many Asians in America today are refugees (80%), coping with issues such as homesickness, loneliness, separated families due to war/conflicts, little contact with their families who remained in Asia, hurtful/painful memories, PTSD, culture and values clashes, and Asian emotional restraint vs. American individuality. These are difficult and complex issues caregivers in America face when working with Asians.

Values and Culture

Significant values and cultural issues face Asians in America, or if you are blessed enough to have an opportunity to work with Asians in Asia, as I have been. Here are just a few of these differences:

1. Most Asian have strong family ties. It is important for caregivers to respect family lines and ancestry by addressing patients as "Mr." or "Mrs.", acknowledging the importance of family roles. There is traditionally great respect for age, status, authority and elders. The family is the basic unit of society. However, in China today, we are experiencing the greatest mass migration in the world's history, with 350 million Chinese moving out of the countryside into the cities, thus "breaking up" the traditional Chinese nuclear family. The societal impact of this migration is enormous, contributing, in many cases, to skyrocketing rates in Asia of substance use and abuse, depression, and other affective disorders

2. "Face" is critical to Asians. To "lose face" is shaming, and one can lose face in many ways. A simple example of "face" is always offering the person "an out," saying, "You could do this, or you could do that. What would you prefer?"
3. Generally, "internal" family issues are not to be shared externally. Hence, a caregiver might experience low levels of emotional expressiveness, even when dealing with highly emotional, perplexing issues. Reserve, restraint, indirectness and subtleness may be part of their communication with the caregiver. On the other hand, there often is low tolerance for ambiguity, preferring precision to indefinite messages from their doctor.
4. "Time" takes on a different meaning in cultures that have been around for millennia. So, when you say to a patient to "come tomorrow" for treatment, that might be too indefinite and misunderstood. "Tomorrow" might be anytime between the next 24 hours or next few weeks.
5. Religion plays a central role in many Asian cultures. For example, of the 200 million Indonesians, virtually 100% are Muslim. Indian cultures will see a mixture of Hindus, Buddhists, Muslims, Sikhs, etc. Confucian thought still plays a strong role for some Chinese groups. Singapore is a multi-ethnic, multi-religious blending of Christian, Muslim, Buddhist, Sikh, Hindu, etc. faiths.
6. Many Asian nations are patriarchal, with males more valued than females. Some roles are ascribed (assigned by others) and other roles are achieved (based on skills, experience, education, status). This is important for caregivers to understand patients "give" counselors status on the basis of our education. Hence, if you are counseling an Asian, use your title, "doctor," and post your degrees on the wall—they just might think we know something.

Ethnic Differences in Mental Health and Treating Asians

To begin, it is important for westerners to be aware of our possible racism and egocentrism, our biases, stereotypes, and our differing world-views. We need to try to "understand" our patients' culture. We need to cultivate appropriate help-giving practices. A word of caution: no matter now many books you read about Asia, it is difficult for westerners to appreciate the subtleties of the culture. Although I have been visiting Asia for nearly 30 years, I am still making cultural mistakes. For example, it is common for me to go for walks with all of the substance abuse patients from the ward at Beijing Medical University where I have been training and working for nearly a decade. On one occasion, as we approached the door to the hospital, I opened the door and held it for the patients to enter the building—a common courtesy westerners might offer. The patients felt angry and insulted by my insensitivity. They lost face. It is proper for them to hold the door for me. After all, I am "the doctor," and my act of "courtesy" was a sign of disrespect for them. I am constantly, and, at times, embarrassingly learning about Asian culture.

One aspect of racism of the well intended is to see Asians as a "model minority group," having a bias that Asians are easier to work with than other populations because they might seem more compliant and less conflictual. Issues that caregivers need to consider

when working with Asian Americans are the client's migration history, race and racism they have experienced, class and classism, and the traditional Asian family life cycle.

Also, there are significant ethnic differences when dealing with mental health issues, particularly with first generation Asians living in the West.

1. Asians view mental health issues differently than westerners: their experience of pain, what is labeled as a symptom, how they communicate about their pain or symptoms, their beliefs about its causes, their attitudes towards helpers, doctors, and hospitals, and their expectations about treatment.
2. It is important that western caregivers appreciate the Asian understanding of somatization. Often, patients will initially come to counselors with somatic complaints: headaches, gas, fatigue, restlessness, appetite, sleep disorders. Thus, we need to move slowly when shifting from physical to emotional issues, saying, "I will consult with your doctor regarding your headaches. Sometimes headaches are related to conflicts. Would you like to talk about any conflicts or stress in your life?" We need to avoid saying physical symptoms are psychological. Asians generally believe mental health issues have an organic basis and prefer holistic concepts of treatment, involving the mind and body.
3. There are some personal issues that are more acceptable for which to seek help: financial problems, school/academic issues, career concerns, and parental conflicts. Some mental health problems are viewed as "fire diseases," related to chronic, unresolved anger that leads to bodily imbalance, excessive accumulation of file elements in the body.
4. Caregivers need to understand that the first session of treatment is a "crisis" for the patient. Since emotional or issues related to addiction are "personal," and not to be discussed with strangers, an Asian patient must be significantly impaired to seek help. We need to avoid discussion of hospitalization too soon in the process. It is important to consult with the family to approve hospitalizations. We need to provide detailed descriptions of the proposed length of stay in residential treatment, tests involved, and treatment modalities to be used and speak with the family about visitation hours, food, and practical daily living issues.
5. On the other hand, telling the full truth might act as a nocebo, the loss of hope (the opposite of placebo). Hence, in China, it remains the tradition that if a patient has cancer, the doctor will tell the family but not the patient, lest the patient become depressed and lose hope. Westerners need to understand that psychotherapy is not expected. The "talking cure" is a foreign concept to most traditional Asians. It is important for the counselor to wait until the client feels comfortable and is ready to discuss emotions and always use restraint when gathering information, especially during the intake process. It is helpful to discuss your role, what will happen, and the possible need for there to be some personal disclosure.
6. We need to consider alternative treatment services and avoid discussing long-term care solutions. Lengthy therapy is done by "inexperienced doctors," in their mind. Saying, "Let's talk about what you need to do in the next 6 months," does not work. Instead, we ought to say, "In the next 5 days, write the number of times you

and your wife speak about… At our next session we will talk about what you did together."

7. Provide tangible/concrete advice and be problem-focused, goal-oriented, seeking symptom relief. Caregivers should avoid emphasizing acquisition of insights. For example, saying, "Mr. Li, you need to change your behavior in a positive way" tells the client nothing. When considering medications, saying "I don't think you need medications" does not offer enough information. Instead, say why not. "To improve your communication with your wife, I would like to recommend a technique that has worked very well with the couples I treat. Medications are another alternative that we might consider later. I will consult with your physician regarding medications." Further, when discussing medications, it is important to thoroughly present the possible side effects with the counselors taking an active/directive role, but always done respectfully, and honoring "face."
8. It is important that caregivers understand the role of "will-power" when working with Asians. It is helpful to suggest possible reasons for the client's problems and alternatives that allow the patient to show some personal restraint, control, and will power. Caregivers should give the impression that the problems as solvable, always emphasizing concrete, tangible goals.
9. We should expect to be asked personal questions. "Are you married? Do you have any children How much money do you make?" It is not uncommon for me to be asked by my Chinese patients about the size of my house in America, how many rooms do we have. This is a double bind, for if we tell them the size of our homes, they might lose face, given the tiny apartments by comparison in which most Chinese families live. However, we also need to remember that strict neutrality is seen as indifference.
10. We need to expect some degree of formalism and conversational distance. We should try to avoid making jokes that might be a sign to the patient of unprofessionalism on our part. Prolonged, direct eye contact is disrespectful, particularly when directed at an authority figure.
11. Some degree of therapist's self-disclosure is expected. Patients expect you to give advice, direction and advocacy. The key factors affecting therapy are the installation of hope, fostering trust, and treatment models that make sense to the client.
12. Counselors should allow the client to define the physical distance in the session by our sitting first, and allowing the client to sit where they wish. Further, Asian clients seem to do best with rational, logical, structured approaches to therapy vs. affective and reflective orientations.
13. For Asian Americans, living in the U.S., a counselor might anticipate intergenerational conflicts over culture and the acculturation and assimilation process into being "American." They may speak of the values clashes between themselves and their families, either the parents who reside with them in the U.S. or their families remaining back in Asia.
14. In the first session it is helpful to mention your experience working with similar problems as a means of establishing your credibility, by saying, "In my experience with many similar cases…." Or "In my professional judgment…."

15. When working with children or adolescents, in traditional Asian families, therapy that develops children's independence from parents is not recommended. Instead of saying, "What do you think about your problem" ask, "What do you think your father would say about the problem?" Reframing conflicts is helpful. For example, to a father who comes with his son for treatment, a counselor might say, "I understand you'd like your son to have a profession that would help the family's financial situation. Would you agree that your son would be happier if he selected a profession that is rewarding to him and the family?"
16. Divorce, in most Asian cultures, is still not socially acceptable. Although divorce is on the increase in many Asian nations, there remains a strong social taboo about marriage and divorce. Counselor should wait until the client raises the possibility of separation or divorce, and give legal information if requested by recommending legal counsel, and assist the family in finding new family support systems.
17. When treating Southeast Asian refugees (a growing population in America), we need to avoid questions about traumatic events, torture, and loss of loved ones, abuse or violence. Counselors should avoid pressing the client to say more about highly emotional, traumatic events in their past. It is important to reduce the client's stress as quickly as possible, and to know and recommend the culturally appropriate social services available to them.
18. We should not be surprised if the patient offers us food or a gift. They might communicate important issues through food rather than through words. They do not accept the western idea of "laying your cards on the table" but may reveal more about themselves by what they bring to counseling vs. what they say in counseling. Although westerners are taught in counseling school to not accept gifts from patients, we need to respect the potential loss of face to the client if we decline their gracious gift.

Treatment Phases

In the beginning phase of treatment, the counselor needs to engage the family and patient in the process by the following steps:

- We should make the initial appointment with the family "decision-maker;"
- We need to explain the role of the helper to the patient and their family;
- Counselors might form initial social and cultural connections whenever possible;
- We should be especially aware of shameful words regarding mental health and addiction;
- Counselors need to assess the patient's readiness for change and involve the family members in treatment whenever possible; and,
- We should set mutual goals with the patient and their family members.

After the initial phase of treatment, the following steps should be taken;

- We need to focus primarily on the problems presented, avoiding interpretations;
- We should apply a psycho educational approach as much as possible;

- At times, counselors may need to assume the role of problem-solver, teacher, advocate for the patient and their family, intermediary and interpreter of cultural variants. Although it often runs contrary to our training, we need to convey our expertise, confidence, and use caution in establishing an egalitarian relationship. Remember, treatment is not a democratic process;
- Reframing is helpful wherever possible, stressing positive behaviors, capitalizing on family strengths, community support, and the role of intermediaries and do-betweens;
- We should expect few expressions of strong emotions, and allow the patient time to recover from these expressions, if and when they occur;
- Counselors should not be surprised if the patient and/or their family invites us to dinner or presents us with a gift to show their gratitude. The patient may want to be our friend after treatment. Caregivers should always remember that the loss of face by turning down the gift could be devastating to the therapeutic relationship.
- We need to engage the family decision makers, and extended network of support systems.

Conclusion

The world is flat. Asian Americans are a growing, significant population in the U.S. Many of us may have an opportunity to work internationally, in Asian countries and with Asian populations in America. It is important to remember these suggestions when working with Asians, yet, always acknowledging the significant cultural differences. The worst position we can take as caregivers is to assume that we understand another's culture or even worse, that they need to be like us.

For more information about opportunities to do volunteer work in Asia, contact David Powell at djpowell2@yahoo.com.