

Asian American Providers' Experiences of Working With Asian Americans Diagnosed With Serious Mental Illnesses

Mihoko Maru¹, Uma Chandrika Millner², Jasin Wong³, Jennifer Chen⁴, and Yu-Mui Wan⁵

¹ Department of Psychiatry, Boston Medical Center, Boston, Massachusetts, United States

² Department of Psychology and Applied Therapies, Lesley University

³ Department of Special Education, National Tsing Hua University

⁴ Sargent College of Health and Rehabilitation Sciences, Boston University

⁵ Boston, Massachusetts, United States

Despite cultural adaptations of evidence-based practices and increased cultural competency programs, Asian American communities chronically underutilize mental health services and have significantly high early treatment dropout rates. Often these communities delay accessing treatment unless there is a diagnosis of serious mental illness in the family. While Asian communities have been known to prefer providers of similar ethnicities, ethnic concordance has been presented as a singular solution to address the underutilization of mental health services among these communities. However, little is known about the experiences of Asian American providers working with Asian Americans diagnosed with serious mental illnesses and their families within mental health system in the United States. The purpose of this qualitative study was to explore the experiences and perspectives of Asian American providers working with these communities. Sixteen providers from diverse Asian backgrounds working at two community mental health centers in the East and West Coasts of the United States participated in two sets of focus groups conducted by Asian American researchers. Framework analysis methodology revealed challenges experienced by providers related to client engagement, managing boundaries, communication, and organizational challenges. In addition, providers described strategies used that focused on recovery and rehabilitation, cultural responsiveness, family engagement, and organizational supports. These results have important implications.

What is the public significance of this article?

Asian American providers who work with Asian American clients living with serious mental illnesses encounter various clinical and organizational challenges such as engaging clients in treatment, managing boundaries, and communicating. Asian American providers use culturally informed strategies like focusing on collectivistic values, wellness and functioning, and available resources, to work with their clients. Asian American providers need systems-level changes that can provide them with adequate resources and stronger workplace supports.

Keywords: Asian Americans, serious mental illness, cultural responsiveness, ethnic concordance, client engagement

Asian American communities underutilize available mental health services and have high treatment dropout rates (G. Kim et al., 2011; S. Y. Lee et al., 2015; Xu et al., 2011). Underutilization of mental health services among Asian Americans has been attributed to several factors such as limited English proficiency, low perceived need for mental health services, lack of information, underreporting, among others (e.g., Augsberger et al., 2015; Kang et al., 2010; Park

et al., 2013; Yang et al., 2020). In addition, Asian Americans have a demonstrated preference for informal supports to address their psychological issues (Leung et al., 2012). Increased efforts to culturally adapt evidence-based practices over the past decades have not demonstrated the desired improvements to the already low rates of mental health service utilization among Asian Americans (S. Sue et al., 2012; Yang et al., 2020). A major contributing factor to these

This article was published Online First May 6, 2024.

Mihoko Maru  <https://orcid.org/0000-0003-3190-4670>

Uma Chandrika Millner  <https://orcid.org/0000-0002-7290-3431>

This article was supported by Gayle Berg Research Foundation Award, Sargent College of Rehabilitation Sciences, Boston University, Boston, MA, awarded to Uma Chandrika Millner. The authors declare that they have no conflict of interest.

Mihoko Maru played a lead role in methodology, project administration, writing—original draft, and writing—review and editing, a supporting role in formal analysis, and an equal role in investigation. Uma Chandrika Millner

played a lead role in conceptualization, formal analysis, funding acquisition, investigation, methodology, project administration, and supervision and an equal role in writing—original draft and writing—review and editing. Jasin Wong played a supporting role in formal analysis. Jennifer Chen played a supporting role in formal analysis. Yu-Mui Wan played a supporting role in formal analysis and writing—review and editing.

Correspondence concerning this article should be addressed to Mihoko Maru, Department of Psychiatry, Boston Medical Center, 850 Harrison Avenue, 9th Floor, Boston, MA 02118, United States. Email: mmaru@bu.edu

disparities involves the limited availability of culturally competent providers equipped to work with Asian American communities. Despite the clear preference for ethnic concordance with their providers, there remains a shortage of diverse Asian American mental health care providers in the United States (Jang et al., 2021; M. Lee et al., 2021). Historically, mental health professionals in the United States have been overwhelmingly White, comprising 86% in the 2015 census bureau data (American Psychological Association, 2018; U.S. Department of Labor, 2022). In addition, Asian American communities living in the United States have considerable diversity and heterogeneity, both between and within ethnic groups (Chu & Sue, 2011). Combined with such diversity and the shortage of Asian providers, finding client-provider ethnic concordance can be challenging.

While mental health systems have integrated culturally sensitive services and diversified their workforce by employing Asian American providers, research on provider-client ethnic match alone has shown mixed results on psychotherapy processes and treatment retention (Hall et al., 2016; Presley & Day, 2019; Zane & Ku, 2014). Such data indicate that institution-level changes may be occurring at a superficial level and, therefore, are insufficient in addressing a much larger issue. Mental health care systems in the United States are constructed on and embedded within larger systems of structural racism reflected in policies and practices that deem White Eurocentric individualistic ideology as superior to Asian collectivistic ways of being (Millner et al., 2021). The pervasive model minority stereotype that focuses on the success of Asian Americans in achieving the American Dream places external pressure on these communities holds individuals personally accountable for psychological issues and masks institutional forms of discrimination (S. B. Kim & Lee, 2022). For these reasons, Asian American communities mistrust formal mental health systems where they often experience racism including language-based discrimination. Such mistrust and discriminatory experiences are associated with preference for and greater use of informal networks of friends and family (Spencer & Chen, 2004). In fact, family involvement is central to psychological outcomes and service access and not typically integrated into dominant theoretical conceptualizations in psychology (S. B. Kim & Lee, 2022). In many cases, Asian Americans utilize formal services as the last resort and when psychological conditions become severe or chronic (M. Lee et al., 2021).

Hiring Asian American providers serves as a singular solution to the very complex issue of strengthening the structural competencies of mental health institutions. While cultural racism prevalent within mental health systems contribute to challenges related to access and utilization of culturally competent mental health care among Asian American communities, we speculate that practicing within such systems can be equally challenging for Asian American providers who must adapt to work situations characterized by cultural dissonance. First, when working within Eurocentric mental health systems, these providers may encounter difficulties with countertransference, overidentifying with clients, clashes in cultural values or communication styles, racial animosity, differences in acculturation and racial identity statuses (D. W. Sue et al., 2019). Second, they often have to balance their Eurocentric learning of psychotherapeutic techniques and processes with Asian American cultural constructions of mental health and recovery, including languages and expressions used to describe mental distress and identifying cultural-bound syndromes. Third, for bilingual or multilingual providers,

different values or identities may be expressed that evoke different cognitive states (Kokaliari et al., 2013). Fourth, providers play the role of cultural brokers providing education and support to their clients and families and utilize their knowledge of Asian cultures and immigrant experiences to contextualize their services (Park et al., 2011). Fifth, working with intraethnic counseling dyads may generate various transference and countertransference reactions (Comas-Díaz & Jacobsen, 1991). Finally, Asian American providers are likely to work with Asian individuals and families whose mental health needs are severe and require considerable support navigating systems of care. Combined with their own personal experiences of systemic oppression and racial trauma, these challenges may lead to burnout and other significant psychological conditions (Miu & Moore, 2021). Yet providers of color receive little systemic resources such as training and support for their success and are presumed to be culturally effective by virtue of their ethnic or racial identity.

At present, there is piecemeal knowledge of the experiences of Asian American mental health providers who work with Asian American individuals, including provider-client relationships and the therapeutic process. Little is known about the cultural competence of providers of color and how they navigate systems of care. We may presume that services provided by Asian American providers are nuanced, complex, and context-dependent warranting the need for in-depth examinations of the experiences of Asian American providers. Such research would allow us to (a) fill existing knowledge gaps of clinical and organizational challenges of providing mental health services to Asian American clients, (b) help identify strategies to enhance Asian American clients' service utilization and engagement, and (c) improve systemic and organizational support for Asian American providers.

The Present Study

This study is part of a larger study that involved a systematic qualitative needs assessment of Asian American families where individuals have been diagnosed with serious mental illnesses. The overarching goal of this project was to develop a culturally sensitive family psychoeducation intervention for Asian American individuals living with serious mental illnesses. The original study was large and yielded a large volume of findings collected from three primary stakeholder groups of Asian American individuals, their families, and providers. The present study utilized a subset of the data collected specifically from Asian American mental health service providers only where providers were directly asked questions regarding their experiences, whereas other stakeholder groups were not asked questions specific to their perceptions of and experiences with their providers. Therefore, the study investigated the following question: What are the experiences of Asian American mental health providers who serve the Asian Americans living with serious mental illnesses and their families?

Method

Participants

Sixteen Asian American mental health providers were recruited through two community mental health centers that provide services to diverse Asian communities. These two programs were located in the Northeast and the Pacific Northwest of the United States. The site in the Northeast involved a culturally specific Asian mental health

program within a large general hospital setting. Participants recruited through this site were not all employees of the program. In contrast, the site in the Pacific Northwest was an independent community service center specifically serving the Asian community, and all participants from this site were employees of that institution. Participant demographics are provided in Table 1. Providers served various Asian American communities through these sites including immigrants, refugees, and American-born individuals from various Asian nationalities and ethnicities including Indian, Bengali, Cambodian, Chinese, Filipino, Korean, Mien, Pacific Islander, and Vietnamese.

Table 1
Provider Demographics (N = 16)

Demographic variable	N	%
Age, <i>M</i> ± <i>SD</i>	38.33 ± 8.05	
Gender		
Male	3	18.8
Female	13	81.3
Ethnicity		
Cambodian	1	6.3
Chinese	4	31.2
Japanese	2	12.5
Korean	1	6.3
Mien-Yuimien (Yao-Mien)	1	6.3
Pakistani	1	6.3
Taiwanese	1	6.3
Vietnamese	2	18.8
Mixed: Chinese and Taiwanese	1	6.3
Mixed: Chinese and Vietnamese	1	6.3
Mixed: Chinese and Malaysian	1	6.3
Percentage of practice conducted in a language other than English (%), <i>M</i> ± <i>SD</i>	58.64 ± 28.99	
Highest level of education completed		
Master's level (MA, MSW, MEd, MFT)	10	62.5
PhD	4	25.0
PsyD	2	12.5
Time spent working with Asian American adults with severe mental illness and their families (years), <i>M</i> ± <i>SD</i>	10.17 ± 7.21	
Reported sites of practice ^a		
Community mental health	15	93.8
Hospital	3	18.8
Private practice	3	18.8
College counseling	1	6.3
School	1	6.3
Consultant	1	6.3
Theoretical orientation/perspective ^a		
Behavioral/dialectical behavioral	11	73.3
Humanistic–existential	3	18.8
Psychodynamic/psychoanalytic	9	56.3
Eclectic/integrative	8	50.0
Cognitive behavioral	12	75.0
Interpersonal	6	37.5
Systems	8	50.0
Multicultural	11	68.8
Other	3	18.8
Modality of practice ^a		
Group	9	56.3
Families	10	62.5
Couples	5	31.3
Case management	10	62.5
Other (parenting workshops)	1	6.3
Do you have any personal or family experience of mental illness? [Yes]	7	43.8

^a Each category is a valid percent.

Instruments

The instruments used in this study included a brief demographic questionnaire and a semistructured questionnaire protocol developed for this study. The demographic questionnaire was designed to obtain information regarding the age, Asian ethnicities, languages spoken, educational background, years in practice, and so forth. The semistructured questionnaire protocol included open-ended exploratory questions that included questions regarding provider experiences, challenges encountered, successful strategies, and sources of knowledge, and so forth when working with Asian communities.

Procedure

Investigators and Consultants

The research team constituted multiple members present during different phases of the research. The initial stages of the design and development of the research included a primary investigator (PI; second author), a psychologist with extensive experience working with Asian American communities. There were four consultants in the study including an Asian American psychologist and researcher, previously the director of an Asian community-based mental health program and three White European American psychologists and researchers who were experts in the fields of psychiatric rehabilitation and family interventions. The data collection process involved two research assistants one of whom was an Asian American doctoral student in social work and the other a white European American research staff with experience of mental health systems as a person with a diagnosis. Prior to commencement of data collection, the primary investigator developed the semistructured questionnaire protocol based on their prior research and clinical experience with Asian American communities. Study site liaisons and four established experts in Asian American mental health, psychiatric rehabilitation, serious mental illnesses, and family interventions shared their feedback on the questions, final wording, flow, relevance, and clarity of the questions in the protocol. Protocols were amended accordingly.

Data Collection

All procedures were reviewed and approved by university and state institutional review boards. We first contacted and established relationships with the directors of two Asian American community-based mental health programs located in two urban locations in the Northeast and Northwest of the United States. These individuals were our partners in the research process. They advised the development of flyers and the development of the questionnaire protocol and arranged for all data collection. Our partners shared flyers at their programs and with their networks. For the site in the Pacific Northwest, we scheduled two 2-hr focus group sessions (one on each subsequent day) to coincide with their lunch hours. For the Northeast site, providers participated in two 2-hr focus group sessions after work hours with each session scheduled 1 week apart. We collaborated with our study partners to provide meals and took time to socialize and connect with study participants prior to data collection.

All providers first completed written consent forms and the demographic questionnaire. They were provided copies of the

questionnaire protocols. Focus groups were considered a culturally sensitive and empowering qualitative methodological tool to collect in-depth and diverse array of information within a short period of time. Focus groups rely on the synergistic effect of key stakeholders, particularly those familiar with each other, to respond to their experiences, fill in gaps, and arrive at shared understandings in real time (Krueger & Casey, 2015; Massey, 2011). Utilizing the protocol, we queried focus group participants about their experiences as Asian American providers providing services for Asian American individuals and their family members. The first 2-hr focus group meeting was an open-ended discussion on provider perspectives. In the second 2-hr focus group, we made a brief presentation on evidence-based practices on family interventions for individuals with serious mental illnesses as a jumping off point for further discussion. The PI facilitated the focus groups while the research assistants prepared seating charts, took minutes, and noted nonverbal responses.

Reflection Framework

While reflexivity is typically applied in the data analysis stage of qualitative research (Macbeth, 2001), we integrated it throughout the research process. First, the primary investigator met with the three consultants and each addition research staff member prior to their involvement in the study where they explored positionality, presumptions, and limitations. Expectations and presumptions were discussed prior to the focus groups, and we debriefed after their completion. During data collection, we integrated a reflection framework modeled after the approach typically utilized by the clinical team of our Northeast site (Nghiem et al., 2008). This step allowed study participants to engage in a metacognitive process that consolidated discussion and highlighted important ideas. We invited one focus group participant at each focus group to volunteer as a silent participant observer until the last quarter of each group session. At this point, this participant shared their observations, experiences, comments on group dynamics, and remaining thoughts (Finch et al., 2014). After the completion of the participant observer's reflection, all group members engaged in a postreflection dialogue to verify, clarify, or provide additional insights. The information shared during this reflection period served as verification and clarity on important findings during data analysis. Finally, data analysts met in small groups to discuss their expectations and biases on Asian mental health to prevent any undue influence.

Data Analysis

All focus groups were audio-recorded and transcribed verbatim which were then analyzed using the framework analysis approach (FA; Krueger & Casey, 2015) as recommended by Rabiee (2004). FA is the most used approach to focus group data analysis (Wiggins, 2004) since focus groups tend to yield a large volume of data that is often complex. FA provides a set of steps to analyze the data with the intent to understand the underlying themes and relationships with clear connection to the purpose of the study and is especially beneficial for novice researchers (Rabiee, 2004). These steps include familiarization with the data, identifying a thematic framework, indexing through sorting the quotes and making comparisons, charting through mapping quotes under identified themes, and

mapping and interpretation which examines the relationships and links between the data. This last step includes attention to the patterns via the meaning of words, context, specificity and consistency of responses, and big ideas (Rabiee, 2004). Since we were examining the experiences of Asian American providers constructed from the "ground up" and all data analysts were Asian American, we were informed by the principles of grounded theory methodology (Glaser & Strauss, 1967), in particular, Charmaz's (2006) constructivist approach which emphasizes the relativity of the researcher's experience and situations and reflexivity.

Data Analysts. The data analysis process initially included two Asian American psychologists (PI and senior data analyst) with prior experience and expertise in qualitative research who established the initial coding system. Data were further analyzed by the PI and two Asian American doctoral students in occupational therapy with limited qualitative research experience. The PI trained the students by first orienting them to the project including design, data, and data collection and then providing instructions and readings on qualitative analyses. The PI provided feedback on samples of initial coding and supported their coding efforts throughout data analysis. The senior data analyst conducted the final review and auditing to ensure validity, clarity, and adherence to the data.

To organize our data and manage multiple data analysts, we uploaded de-identified transcripts into NVivo, a qualitative data analysis software package. First, two transcripts were reviewed independently by the PI and the senior data analyst who familiarized themselves with the data and developed an initial list of codes. We then jointly classified and organized data according to key themes, concepts, and emergent categories to develop the initial thematic framework organized around the research question. Second, two junior data analysts and the PI participated in similar familiarizing and further development of the thematic framework. They also participated in indexing, charting, and mapping and interpretation (Rabiee, 2004). They reviewed each transcript independently documenting additional codes, amending codes, hypothesizing the relationships between codes, and identifying potential categories while recording any potential sources of bias (reflexivity). This three member data analysis team met frequently for consensus meetings to discuss coding and systematically and iteratively categorize data into meaningful units. This approach was followed until all data were classified and final categorization of data was determined alongside representative statements. Finally, the senior data analyst reviewed these results and original transcripts to ensure adequate and accurate representation of data. Results were presented for member checking at our Pacific Northwest data collection site to solicit feedback on the family intervention developed for the larger study. The meeting included all the site clinical teams including our focus group participants. Identified themes and categories received informal supported.

Results

The results of this qualitative study clustered into two major sections of (a) challenges experienced by Asian American providers and (b) strategies utilized by Asian American providers in response to these challenges. Each section includes themes and categories with exemplary quotes from participants in this study. Provider descriptions are shared alongside quotes with their assigned study

identity (ID) numbers. After describing the provider, the first time, ID numbers are used for subsequent quotes.

Challenges Experienced by Asian American Mental Health Providers

Asian providers described experiencing a myriad of challenges when providing mental health services to Asian American individuals and their families. These challenges related to engaging clients, managing boundaries, communication challenges, and organizational challenges that impede providers' ability to deliver optimal services. Themes, categories, and illustrative examples are provided in Table 2.

Challenges Related to Engaging Clients in Mental Health Services

Providers discussed extensive challenges experienced while engaging Asian American individuals and their families in mental health services, including those related to helping clients take prescribed psychiatric medications and participating in supportive services. Results from this theme of challenges to engagement clustered into three categories.

Cultural Incongruence Between Services and Client Values. One of the challenges of engaging Asian American clients and families in mental health treatment was due to cultural incongruence or mismatch between Asian cultural experiences, expectations, and values and the culture of mental health services. One such mismatch of expectations was described by a 54-year-old

Chinese American female psychologist who stated, "A lot of folks are thinking about the medical model—you go in, you tell the doctor your problem, you get a pill or a shot, or they fix the broken bone, and it's very concrete" [Participant No. 104]. Other reasons included concerns about privacy or a tendency to minimize concerns. For example, a 56-year-old Japanese American psychologist described the reluctance of clients to disclose their mental health concerns,

Asians tend to minimize what they've been going through when they come to see the therapist. And then if I ask more, then they're like "Yeah, actually, I was going to kill myself." But then he said "I'm okay, I'm doing fine"—still, quite minimizing. [Participant No. 402]

Providers speculated that reasons for minimizing may be related to cultural norms and difficulty describing their problems and concerns. For example, a 50-year-old Cambodian American social worker stated, "When I sit with them longer, they tell me a lot of things, they're not fine. I have learned that [they are] not able to articulate their needs and problems." [Participant No. 101]. A similar sentiment was echoed by a 29-year-old Chinese American marriage and family therapist who stated,

What I find interesting is that they acknowledge that it is a problem. That something is wrong with the person, their child, their husband, their daughter, or whatever. But it's not a "sickness." There's a term for it like "weak brain" or you're "possessed." But taking medication, seeing a doctor, especially counseling. It's a very foreign concept to them. [Participant No. 107]

Here, providers added that clients indicated preference for cultural treatments. For example, Participant No. 108 described, "Sometimes my client would just stop taking [medications] ... They go for

Table 2

Themes and Categories of Study Results for Challenges Experienced by Asian American Providers

Section	Theme	Category	Illustrative example
Challenges experienced by Asian American mental health providers	Challenges related to engaging clients in mental health services	Cultural incongruence between services and client values	"The [client/family] try to get the answer right away. And, for us, it takes a long time." [Participant No. 101]
		Cultural mistrust among clients	"There's a trust issue that Western medicine will not do anything to help." [Participant No. 109]
		Client's awareness of their mental illness	"I think the key issue is about insight—different insight levels of the client, themselves, and those of their families." [Participant No. 105]
	Challenges related to managing boundaries	Personal involvement with clients	"I just give that extra 10% ... I find that a lot of us are a little bit more involved, compared to what we have been taught." [Participant No. 400]
		Challenges with family involvement	"What the client needs, and that means [what] the family needs." [Participant No. 107]
	Challenges related to communication	Provider's linguistic competence	"Language becomes an issue. The [other] therapist's [inserted] Mandarin was a lot more fluent than mine, and because of that skill, she was able to explain more." [Participant No. 400]
		Translating mental health or clinical concepts	"Psychology is like a foreign language and its application is challenging in providing mental health services." [Participant No. 403]
	Challenges related to organizational issues	Limited access to resources	"It's just very time-consuming, and then it's not cost-efficient." [Participant No. 105]
		Interactions with non-Asian colleagues	"We almost took on this role, sometimes, of educating him, and needing to warn him about how things work." [Participant No. 402]

culturally appropriate medication, like, acupuncture and stuff, because there are no side effects of it.” Another cultural challenge in engaging clients identified by providers included the tension between being collaborative and holding the “expert” role. This was reflected in a statement by a 37-year-old Chinese American psychologist who stated,

I’m the expert. I have enough authority and enough experience to say, “You think you’re supposed to listen to me, that’s kind of true. But at the same time, I still need you to help me.” And that’s like a completely foreign thing [to clients]. [Participant No. 400]

As providers described challenges with client engagement, Participant No. 104 powerfully summarized the tensions inherent in diverse cultural constructions of self-identity and how one views themselves in the context of interpersonal relationships, such as family,

I thought it was very interesting that we were talking about the client as “the whole family,” not just the one person ... in the “We,” that’s more Eastern and that’s the identity that I was thinking about—therefore, it’s really hard to do family therapy sometimes when you’re saying, “This person is causing this to happen.” Well, if it’s the “we,” how do you say that “We are at fault for what we’re doing?” And that’s more difficult to address. In the Western culture, someone can say, “Well, this is my role,” and can point the finger easily. But when there’s no finger to point because we are a collective, it’s a little bit harder to address and identify parts that need to change.

Cultural Mistrust Among Clients. Providers described cultural mistrust as a factor preventing Asian Americans from engaging with services. Cultural mistrust was sometimes attributed to Western systems as described by, a 37-year-old Korean American male social worker, “[Clients] don’t want to share it with anybody else, even though they have similar problems. In my families, it’s hard to trust anybody, especially immigrant families. Who can you trust to talk about your problem” [Participant No. 110]. At other times, mistrust was attributed to fear of being looked down by the provider, especially in the context of gender and social class differences. This concern was best articulated in a statement by a 40-year-old Vietnamese American female psychologist,

[Client] was a young Vietnamese man but he was older than me probably by ten years, diagnosed with schizophrenia, and he was suicidal and homicidal. But he wouldn’t tell me any of those things. He kept saying to me “You’re a Miss. I can’t talk to a lady. I can’t tell you my bad, dirty thoughts, because you’re a lady.” It went on for six months, and I couldn’t get through to him. He kept saying, “Oh, you’re such a clean person.” But one day, I don’t know what happened, he [came] in and said, “I want to kill my roommate.” And that started the process—they hospitalized him. And when he came out, he thanked me, and said, “I know you were trying to help, but I couldn’t do it yet. I didn’t want you to look down on me.” [Participant No. 401]

Client’s Awareness of Their Mental Illness. Clients’ challenges with awareness or understanding of their mental health situation were another contributing factor of their low engagement in services. Providers attributed challenges with client awareness to certain diagnoses and even diverse age groups. This is exemplified in a statement by a 29-year-old Taiwanese American female social worker who said, “I have a lot of young clients who have schizophrenia, but they’re in denial of having any of these symptoms, like hearing voices. They just don’t think that they have an illness.” [Participant No. 111]

Challenges Related to Managing Boundaries

The establishment of professional boundaries is considered crucial to the therapeutic process and context and upheld as a necessary component of the professional standards of conduct (Gelso & Hayes, 1998). In this theme, providers shared challenges around managing their professional boundaries in their work with their Asian American clients. Results in this theme clustered within two categories.

Personal Involvement With Clients. In this category, providers described their challenges managing their boundaries, as required by their profession, due to greater involvement with their clients, as exemplified in this statement,

I am so much more involved with my clients, than the majority of my other ethnic group colleagues. I find that a lot of us are a little bit more involved, compared to what we have been taught, compared to our other colleagues. [Participant No. 400]

Another provider, a 39-year-old South Asian American female psychologist, described the experience as related to the tension between their training and their cultural values.

The idea of confusion of roles comes through a lot. We talked about having tea, food in the room. [From a Western framework]—well, okay, that’s about “dependency.” What does independence mean for Asian patients? Is there independence? Is it about dependency? And I was like, “Oh, those seem like two polar opposites. How can I make sense of that?” And then [other provider] talked about “interdependency,” and I was like, “Oh, that’s a nice way of capturing it.” [Participant No. 404]

Some providers discussed concerns about acute situations that evoked difficulty managing boundaries with their clients. Providers discussed that Asian clients and families often do not know how to get the assistance that they need, requiring greater involvement of their providers.

I think that’s hard, too, because a lot of our patients are monolingual, and, to even pick up the phone and call 911. Literally I have said to a mom, because the girl couldn’t wake up and I don’t know if she overdosed, but I’d say, “Call 911.” And she was like, “how?” [*emphasis added*]. So, even if she could call, literally call 911, and then say what? So, you do it for her. [Participant No. 401]

Providers also stated that maintaining strict boundaries may be difficult in contexts where providers are tempted to intervene when their clients’ experience discrimination. This was best described by a 43-year-old Vietnamese American female psychologist who stated,

Sometimes they tell me stories, and I see that as a microaggression. Inside, I have this countertransference that they’re being naive, and I want to be protective. I have to remind myself that it’s not my therapy, it’s their therapy [Participant No. 403].

Providers also described challenges occurring from the need for greater self-disclosure. This is exemplified in a statement by Participant No. 401, “for Asian clients they’re like, ‘Well, I tell you everything, why can’t you tell me?’” In fact, these challenges with personal involvement were further described as consistent with cultural values and unique to working with Asian communities later by the same provider,

We’re so involved with our patients! Like, we’re a family member [*deleted*]. I know therapists worry about their patients, but I think I do at

a deeper level. Like, I worry like a mother, like a sister, like a daughter [*deleted*] and I get mad about that because [non-Asian therapists] just walk away, 9:00 to 5:00 and they're done! [They] don't think about it! [Participant No. 401]

Challenges With Family Involvement. Providers also stated that managing boundaries can be challenging due to significant family involvement in client's therapy. Participant No. 402 attributed this experience to, "I think they sort of see the therapist as a part of the family, and once they trust us." Providers also described managing multiple generations and cultural experiences, "[The family] in itself can be a mix, and it shows that diversity [*inserted*] with acculturation and with every generation" [Participant No. 403]. Family involvement also raised concerns about confidentiality, an important boundary in counseling, as described by a 46-year-old Taiwanese American female social worker, "some families are extremely involved, and even become controlling over the treatment... Where are the boundary lines—where to set appropriate limits?" [Participant No. 105]. In this context, providers expressed their concerns about the presence of trauma in Asian families as exemplified in a statement by Participant No. 104,

Sometimes the [families] have their own trauma, and because of their own trauma, they can't be a strong support to our clients with mental illness. You know, we're working with a really fragile population, all the way around, all [emphasis added] the family members. So, it's not just the identified client.

Challenges Related to Communication

In this theme, providers described challenges they often faced in communicating with their Asian American clients. Two categories emerged in this theme that illustrated the significance of language in clinical work with clients.

Provider's Linguistic Competence. As a challenge to fully engaging with their clients, providers described the limits of their linguistic competence even with shared languages. For example, Participant No. 400 described concerns regarding their fluency when they stated, "language becomes an issue—the [other] therapist spoke both Mandarin and Taiwanese [*deleted*]. And her Mandarin was a lot more fluent than mine, and because of that skill, she was able to explain more." Providers described challenges related to being multilingual as articulated by Participant No. 403,

In every family session, it's not unusual that you hear people talking Vietnamese, English, or French ... you get to a certain point, and then there's no other English word, and then you naturally go to French, because that feels more intimate, or there are childhood memories. I'm not always a match with their abilities.

Translating Mental Health or Clinical Concepts. Providers found translating concepts into the client's language made communication difficult. Participant No. 400 stated, "Sometimes it's hard to find the actual words in their language. So, it's almost like, you learn the psychology language as your first language; and then, trying to translate that into the Chinese mental health language." In such situations, providers stated that translations need to include cultural context as exemplified in this quote by Participant No. 104, "Not just an outside interpreter. It has to be somebody who really knows the interpretation and can explain it. The cultural side of the interpretation." The importance of cultural interpretation of unfamiliar mental health concepts, and the limitation of using

a language interpreter, was further emphasized by Participant No. 108,

You cannot really ask someone to translate and then let us do the [counseling] ... I try to offer some booklets that I bring back from Cambodia, but I am never able to use the translation. It has to be culturally translated and that needs to be in person.

Challenges Related to Organizational Issues

Providers also shared their concerns about organization-level challenges they experience in their place of work that impact their work in both clinical and nonclinical contexts. The results from this theme also clustered around two categories.

Limited Access to Resources. Providers described being constrained by limited resources in terms of time, training, and personnel. For example, Participant No. 108 stated the difficulty experienced with dedicating time to their professional development, "To have time to attend training, to learn, to read up on things, it takes a lot of time. Unfortunately, for most of us, that's not the time that we have." In a similar vein, providers discussed their challenges in developing and sustaining programs as exemplified in this quote by Participant No. 105, "I needed to do a lot of reading over the weekend. It's just very time-consuming, and then it's not cost-efficient—only two [clients]. So, we were only able to survive for 8 months, and then I stopped it." These concerns were reinforced by Participant No. 104 who expressed the dilemma around improving services with limited human resource or staff capacity, "Every time all these [services options] came up, I kept thinking, oh, that takes so much energy of the case managers. Oh, that takes so much more time. Oh, these are great things, and we need more staff."

Interactions With Non-Asian Colleagues. Asian providers also discussed the challenges of working alongside their non-Asian peers including the need to inform and educate them on culturally sensitive clinical care. This was exemplified in a statement by Participant No. 402, "We had a male Caucasian individual [on the team] and the rest, of course, were Asian women. We almost took on this role, sometimes, of educating him, and needing to warn him about how things work." Providers also discussed feeling pressured to establish their credibility as skilled professionals as described by Participant No. 403 who stated,

One thing I often do with non-Asian clinicians and colleagues, is to not assume that they are aware that we were trained and supervised in the United States, or we came from programs that are very rigorous. Growing up in the Northeast, I finished [doctoral degree] in [University] which looks more at multicultural issues and because you have to start from there to modify other theories, to teach others, and you have to let people know that you are credible and [that] you actually have a very full training!

Strategies Utilized by Asian American Mental Health Providers

Asian American providers described several strategies that supported their efforts in providing mental health services to Asian American individuals and their families including clinical interventions focused on recovery and rehabilitation and implementing a culturally responsive approach to client engagement. Organization-level strategies were also discussed. Themes, categories, and illustrative examples are provided in Table 3.

Table 3*Themes and Categories of Study Results for Strategies Utilized by Asian American Providers*

Section	Theme	Category	Illustrative example
Strategies utilized by Asian American mental health providers	Strategies focused on recovery and rehabilitation	Provide education	"We would certainly educate them about neurotransmitters, saying that it's only because of the things in your brain is not balanced. That's why you need to take medication." [Participant No. 106]
		Focus on wellness and functioning	"I will look at the functional level of a client—social, school, work. And also, insight and self-management skills." [Participant No. 105]
		Cultivate therapeutic alliance	"I think just validating that [mental illness] is painful, and it's a real struggle, but we'll walk through it as much as we can, is my approach." [Participant No. 401]
	Use a culturally responsive approach to client engagement	Focus on collectivistic values	"I find that family members, or one's own family or culture, somehow gets lost, and actually that's such a solid, deep resource that gets ignored for one or two generations." [Participant No. 403]
		Identify available resources	"In my clinic, there's a lot of different Asian providers. We consult each other, and we've learned through that way." [Participant No. 401]
		Access existing resources and supports	"We have all these people around who are willing to help us and make sure that if [the client] does fall apart, we know what to do next." [Participant No. 400]

Strategies Focused on Recovery and Rehabilitation

In this theme, providers described their focus on recovery and rehabilitation, that is, attention to functioning, knowledge and skill-building, and support that helped them provide services to Asian American clients. Provider responses clustered in two categories.

Provide Education. Providers reported their efforts to educate their clients about their mental illness. Providers explained that the psychoeducation process helps normalize the experience of symptoms, validate the clients' experiences, and inform them about psychotherapy. Participant No. 108 explained, "I've been trying to normalize things—educating clients that, this is common. A lot of people have it ... And also set real expectations. It's not going to happen overnight, but things will change slowly." In addition, Participant No. 105 described her strategy of making relevant content accessible for her Asian American clients,

Whenever possible, we do psychoeducation with clients, and also, family. I have been collecting Chinese materials for MDD, schizophrenia, anxiety. So, I've been reading Chinese newspapers. Whenever I find a good story about mental illness, I clip it, and then I make copies for individual clients, sometimes in a support group, too.

Focus on Wellness and Functioning. Participants described dealing with many of the challenges that they face in their work by focusing on the overall wellness and functioning of their clients such as meaning and purpose and family and community connections. Examples were provided by Participant No. 403 who stated, "somehow, we forget about dreams and wishes of someone who is struggling with a psychiatric illness" and by Participant No. 105, "if, along the way, we can do some hope instilling, [clients] still can lead a meaningful life." Providers identified the goals of their work as including functional outcomes and community inclusion for their

clients. In one example, a 29-year-old Chinese American social worker shared their goals, "for a client to feel like they belong to the community, or kind of close to feeling comfortable interacting with people in a community" [Participant No. 111]. Participant No. 402 shared, "I try to encourage [clients] to focus on what their difficulties are, now. What are you worried about now? Can't sleep or can't make new friends? Let's talk about those things." Finally, a 29-year-old Vietnamese American social worker stated, "For me, it would be self-sufficiency. Being able to do things on their own. We can be there as resources. But being able to function outside, in a job, interacting with other people" [Participant No. 108]. Providers shared their reasons for their preference for functional goals and discussed the limitations of diagnoses, as exemplified in this statement by Participant No. 401,

I think learning about diagnosis can be complicated and complex for the consumer. ... We talk about language. Dealing with schizophrenia, even though it's a word, it doesn't mean anything. ... So, we really have to work around it, talk around it, and explain the symptomologies and functioning because that's what they can understand. How they're not functioning. I think that's all palpable to them because you can say "sleep" or if it's "go to work" and, again, identifying the diagnosis just because they have a problem—I think that's the stigma in itself.

Use a Culturally Responsive Approach to Client Engagement

In this theme, providers described multiple strategies used to engage their Asian clients and families. Responses in this theme clustered around two categories.

Cultivate Therapeutic Alliance. Providers discussed the ways in which they cultivated therapeutic relationships with their clients

such as using their linguistic competence, tailoring the intervention to address client's acculturation experiences, and taking on an expert role. Providers also discussed that their ability to offer clinical care in clients' native language made a significant difference in building relationships, as described by Participant No. 110,

When I did this intake in my language, Korean, I noticed a huge dynamic change on that intake, between the intake specialist and the client. If there's an interpreter [deleted], it's hard to acknowledge their feelings about their story. So, it can go more in detail, its more empathic, more mutual understanding.

Providers also took on the role of the expert to engage their clients through a culturally congruent lens, as explained by Participant No. 400 who stated, "sometimes you do have to put on that, 'I'm the doctor' hat and, I'm here to tell you this, this, and this." Providers also described integrating cultural approaches as exemplified by a 29-year-old Taiwanese marriage and family therapist,

There is something that you can do, if not taking medication and seeing a doctor, especially counseling. It's a very foreign concept to them, so, anything like that [they] just won't go with that. I'll find something else, like, go to the temple, or see a monk, or something, priest, or something like that. [Participant No. 107]

Finally, providers emphasized that building trust with their clients increased engagement. One strategy used was through case management to address their clients' most immediate needs. This was exemplified in a statement by Participant No. 105, "We mainly serve low-income clients. So, their basic needs have to be met, first. Housing, food stamp, medical coupon. If we are helping them getting all their basic needs met, their trust is really built up." Other strategies described by providers included self-disclosure, validating client experience, and building trust. Finally, providers articulated the importance of consistency as is best exemplified in a statement by Participant No. 105,

When [client with schizophrenia] got referred to us, he had no insight at all. Even though he was court-ordered, he still refused to take any medications. But then, our psychiatrist still saw him every other week. Three years later, he agreed to take medications, and now it's no problem talking to him about his diagnosis of schizophrenia, and also, his symptoms—negative and positive symptoms. And he can totally accept it.

Focus on Collectivistic Values. Relationship-building is a central component of mental health services. The providers emphasized relational and community connections by contextualizing them within Asian collectivistic values. In one exemplary quote, Participant No. 400 explained these values and stated the limitations of their training in fostering such values,

It's part of our culture, where we're intimate. I come from Asia. I'm interdependent. We're interdependent on each other. It doesn't mean I lose my independence; it just means that I know that, with my connection with other people, I'm a happier, healthier person. Trying to foster that when we have so many providers, and that for a relationship you have with a person, it sometimes takes a lot more than just what we are trained to do.

Providers also described leveraging case management approaches to foster family and community-based connections that support collectivistic values. For example, Participant No. 403 stated that she included family members as an effective resource, as exemplified in a

quote. Other providers discussed coordinating care with external services and establishing additional support networks as a strategy to increase community connections for clients. Participant No. 401 reported on the effectiveness of home-based care in their statement, "it becomes the whole community helping my [client], and they feel that you're not judging them. Like you're an advocate." This approach is further reinforced by Participant No. 400 when she stated,

They feel the sense of community, when there are so many of us in the picture with them. And because of this, [providers] lose boundaries that we have, and we're willing to share, and we don't even bat an eye when they offer us food. We wouldn't even think about it. So, I feel like they gain that sense of community, and decrease a sense of isolation.

Identify Available Resources

In a final theme, providers described organizational level strategies that help provide services. Their responses clustered around two main categories: (a) use opportunities to learn about Asian cultures and (b) access existing resources and supports.

Find Opportunities to Learn About Asian Cultures. Providers discussed the need to develop their own knowledge about Asian cultures in working with clients from ethnically diverse Asian communities. This experience was illustrated by Participant No. 400 who stated, "working with different cultures is, in the end, just being able to be willing to hear their stories and not over assume things." Providers also discussed the importance of learning from their Asian colleagues about their clients' cultures,

Even though I'm Vietnamese and I know the culture because I was raised in it, but I don't know [clients] experience. ... In my clinic, there's a lot of different Asian providers. We consult each other, and we've learned through that way. I think it's more, we talk about the different cultures and what Asians from different countries or different cities [experience]. So, for me, that's how I learned. [Participant No. 401]

Access Existing Resources and Supports. Providers discussed the benefits of receiving support for their work. In addition to less demands on their time, they found educational materials, supports for families, and integrated and coordinated care to be helpful. Participant No. 105 stated,

I think it would be very helpful if there can be an existing set of curricula that we can just study, get familiar with, and then use it weekly or every other week. That can save us a lot of time and energy.

Providers reported on the benefits of working at an institution with integrated behavioral and health care where they could easily access medical professionals and provide case management services. For example, Participant No. 105 stated, "many family members as caregivers have their own depression, anxiety. ... We try our best to have different case managers taking care of the various family members." The benefits of care being available for the whole family at mental health centers were best described by Participant No. 400 who stated,

We have all these people around who are willing to help us and make sure that if [the client] does fall apart, we know what to do next. We're hoping to decrease the chances of things going really bad. So that's like two intersections there—it's like, language itself sometimes becomes a

barrier. And then also, having enough providers around to do different parts of the work definitely helps. [Participant No. 400]

Discussion

This qualitative study was designed as a systematic qualitative study to explore the experiences of Asian American providers of mental health services to Asian Americans living with serious mental illnesses and their families. This study sought to fill existing knowledge gaps around Asian American mental health services. Study data revealed a predominance of challenges experienced by providers in delivering mental health services to their Asian American clients. Providers also described useful strategies in their work with clients.

Some of the results from the study speak to general experiences of providers working with clients with serious mental illness. Similar to previous research (e.g., A. S. David, 1990), providers discussed client's level of awareness of their diagnosis as a contributing factor to low service engagement. Providers emphasized the importance of psychoeducation, among other approaches to recovery and rehabilitation that benefit populations living with serious mental illnesses. They highlighted the importance of taking a recovery-oriented approach and the need to focus on functioning (i.e., what an individual client can and cannot do) rather than on symptoms and diagnoses (Dixon et al., 2016; Williams et al., 2016). In addition, providers discussed tangible supports through recovery-oriented services and case management as conducive to client engagement with clinical benefits (Lim et al., 2022).

More specifically related to Asian American communities, providers extensively discussed challenges related to engaging their Asian clients associated with underutilization of mental health, lower treatment attendance, and high rates of premature termination (S. Y. Lee et al., 2015; Xu et al., 2011). As highlighted in previous literature, providers attributed these challenges to cultural incongruence between Asian collectivistic cultural experiences, expectations, and values and the individualistic nature of mental health services (S. B. Kim & Lee, 2022). They also highlighted the broader systemic issue of cultural mistrust of Asian American clients for Western mental health systems (Comas-Díaz & Jacobsen, 1991; E. J. R. David, 2010). These issues have been widely documented.

Providers described the adaptations that they made in working with Asian American clients with serious mental illnesses. First, linguistic competence of clients' native language made a significant difference in client engagement, but providers experienced challenges related to fluency and translating psychological concepts. Providers stated that direct interpretations of psychological terms were not enough and that knowledge and familiarity of the client's cultural contexts were necessary to aid in client understanding. Second, providers described several cultural adaptations in their work such as taking the role of the expert (Hwang, 2006), tailoring services to the acculturation level of their clients, emphasizing Asian collectivistic values, and engaging in more self-disclosure (Chu & Sue, 2011). Third, providers described greater personal involvement with their Asian American clients and families than their non-Asian counterparts. These boundary extensions could be attributed to intraethnic transference (e.g., idealization of the therapist, ambivalence toward therapist) and countertransference reactions (e.g., identification with the client especially in when there are shared discriminatory or oppressive experiences, survivor's guilt; Comas-Díaz & Jacobsen, 1991). These extensions may also fall

into the category of cultural adaptations made within mental health delivery systems that provide little support and guidance on therapeutic relationships between providers and clients who share similar ethnic minority identities. Fourth, Asian American providers described limited time and inadequate personnel to be able to provide culturally appropriate services. They described the need to engage their clients by supporting the clients' most immediate needs (for food, shelter, etc.) and (re)creating relational and community connections by leveraging their available formal resources to simulate collectivistic systems. Such limited availability of resources likely affects their ability to perform the role of cultural brokers to support clients and families (Park et al., 2011). Finally, at the organizational level, providers found themselves having to establish their credibility with their non-Asian peers. While such emergent organizational challenges experienced by Asian American providers need further exploration, these circumstances likely contribute to vulnerability to burnout among these community-based mental health providers where burnout is determined by workload, work relationships, role clarity, fairness, and access to supports (O'Connor et al., 2018). For Asian American providers, having opportunities to continue to learn about the clients' communities and having access to external resources and supports were key ingredients to positive outcomes.

Limitations

Generalizing the findings of this study may be difficult due to the sampling method, data collection techniques, and the qualitative design of the study. While the participants were geographically, linguistically, and ethnically diverse, they were enrolled using convenience sampling at community mental health centers in large cities in the East and West Coasts of the United States. Participants may not be representative of the experiences of all Asian American providers. Study findings need to be triangulated with additional perspectives of individuals with lived experience and their families and through the perspectives of administrators and supervisors. While acknowledging all the benefits, focus group methodology may have resulted in group think or limited the ability of participants to fully express their opinions without judgment from their peers. Finally, study findings are not generalizable to the wider population due to the qualitative nature of this study. This study was nested within a larger study, which limited our ability to fully capture the experiences of Asian American providers. Further research is necessary for broader delineation and confirmation of these findings through individual interviews and data collection from other institutions (e.g., hospitals) or geographical regions (e.g., rural areas). We believe that soliciting client and family experiences of their providers would help to provide additional information on this topic. Overall, we believe further research is needed on the effect of cultural and structural racism on the work experiences of Asian American providers.

Implications

These study findings have important implications for providers in addressing Asian American mental health. First, mental health practitioners working with Asian American clients living with serious mental illnesses ought to provide services that prioritize client engagement through culturally congruent services. Psychological services need to establish trust, integrate Asian cultural

values, provide tangible supports, and situate Asian American clients within White Eurocentric contexts where members of minoritized communities have been systemically disenfranchised and have had their cultural constructions of mental health either misconstrued or considered subsidiary to dominant constructions. Particular attention needs to be dedicated to the centrality of caregivers and families in the recovery process from serious mental illnesses. For non-English speaking clients, providers' linguistic competence should not be presumed or restricted to direct translations. Rather, language used in mental health settings needs to be contextualized within Asian cultural values, experiences, and norms. Second, organizational resources and supports for Asian American providers are key ingredients to providing mental health care to Asian communities. Presumptions of the adequacy of ethnic concordance between provider and client are highly problematic. Asian American providers are often trained within Eurocentric theoretical conceptualizations that assume universality in their applications, work in majority White spaces that either ignore alternative mental health constructions or reinforce their inferiority. These providers need resources, support, training, and systems to combat various forms of cultural racism that they and their clients experience. Mental health care systems can provide supervision and mentoring, establish systems of peer support and additional collaborative processes, nurture the innovative work of Asian American providers, allow for cultural exchange among Asian providers, develop communities of care at work through inclusion and belonging, and reduce workplace discrimination (e.g., questioning the credibility of Asian American providers) and prevent burnout from an already demanding profession. Finally, at the larger systems level, there needs to be greater awareness of systemic barriers and facilitators to providing mental health care to Asian American communities. We need to work toward strengthening the Asian American mental health care workforce, address biases and stereotypes, such as the model minority myth, raise awareness of Asian Americans' mental health needs, and adjust mental health policy priorities to ensure greater access to culturally congruent care (Nagayama Hall & Yee, 2012).

Conclusion

Overall, we consider this study to be important in identifying the experiences of Asian American providers working with Asian American clients living with serious mental illnesses and their families. Providers outlined the challenges and strategies of their work and outlined their need for organizational and institutional support.

References

- American Psychological Association. (2018). *Demographics of the U.S. psychology workforce: Findings from the 2007-16 American community survey*.
- Augsberger, A., Yeung, A., Dougher, M., & Hahn, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC Health Services Research*, 15(1), Article 542. <https://doi.org/10.1186/s12913-015-1191-7>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage Publications.
- Chu, J. P., & Sue, S. (2011). Asian American mental health: What we know and what we don't know. *Online Readings in Psychology and Culture*, 3(1). <https://doi.org/10.9707/2307-0919.1026>
- Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry*, 61(3), 392-402. <https://doi.org/10.1037/h0079267>
- David, A. S. (1990). Insight and psychosis. *The British Journal of Psychiatry*, 156(6), 798-808. <https://doi.org/10.1192/bjp.156.6.798>
- David, E. J. R. (2010). Cultural mistrust and mental health help-seeking attitudes among Filipino Americans. *Asian American Journal of Psychology*, 1(1), 57-66. <https://doi.org/10.1037/a0018814>
- Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*, 15(1), 13-20. <https://doi.org/10.1002/wps.20306>
- Finch, H., Lewis, J., & Turley, C. (2014). Focus groups. In J. Ritchie, J. Lewis, C. M. Nicholls, & R. Ormston (Eds.), *Qualitative research practice* (2nd ed., pp. 212-242). Sage Publications.
- Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. Wiley.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Publishing Company.
- Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, 47(6), 993-1014. <https://doi.org/10.1016/j.beth.2016.09.005>
- Hwang, W.-C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist*, 61(7), 702-715. <https://doi.org/10.1037/0003-066X.61.7.702>
- Jang, Y., Yoon, H., Kim, M. T., Park, N. S., & Chiriboga, D. A. (2021). Preference for patient-provider ethnic concordance in Asian Americans. *Ethnicity & Health*, 26(3), 448-459. <https://doi.org/10.1080/13557858.2018.1514457>
- Kang, S. Y., Howard, D., Kim, J., Payne, J. S., Wilton, L., Kim, W., & Maramba, D. (2010). English language proficiency and lifetime mental health service utilization in a national representative sample of Asian Americans in the USA. *Journal of Public Health*, 32(3), 431-439. <https://doi.org/10.1093/pubmed/fdq010>
- Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, 45(1), 104-110. <https://doi.org/10.1016/j.jpsychires.2010.04.031>
- Kim, S. B., & Lee, Y. J. (2022). Factors associated with mental health help-seeking among Asian Americans: A systematic review. *Journal of Racial and Ethnic Health Disparities*, 9(4), 1276-1297. <https://doi.org/10.1007/s40615-021-01068-7>
- Kokaliari, E., Catanzarite, G., & Berzoff, J. (2013). It is called a mother tongue for a reason: A qualitative study of therapists' perspectives on bilingual psychotherapy—Treatment implications. *Smith College Studies in Social Work*, 83(1), 97-118. <https://doi.org/10.1080/00377317.2013.747396>
- Krueger, R., & Casey, M. (2015). *Focus groups: A practical guide for applied research*. Sage Publications.
- Lee, M., Bhimla, A., Lu, W., & Ma, G. X. (2021). Correlates of mental health treatment receipt among Asian Americans with perceived mental health problems. *The Journal of Behavioral Health Services & Research*, 48(2), 199-212. <https://doi.org/10.1007/s11414-020-09704-6>
- Lee, S. Y., Martins, S. S., & Lee, H. B. (2015). Mental disorders and mental health service use across Asian American subethnic groups in the United States. *Community Mental Health Journal*, 51(2), 153-160. <https://doi.org/10.1007/s10597-014-9749-0>
- Leung, P., Cheung, M., & Tsui, V. (2012). Help-seeking behaviors among Chinese Americans with depressive symptoms. *Social Work*, 57(1), 61-71. <https://doi.org/10.1093/sw/swr009>
- Lim, C. T., Caan, M. P., Kim, C. H., Chow, C. M., Leff, H. S., & Tepper, M. C. (2022). Care management for serious mental illness: A systematic

- review and meta-analysis. *Psychiatric Services*, 73(2), 180–187. <https://doi.org/10.1176/appi.ps.202000473>
- Macbeth, D. (2001). On “reflexivity” in qualitative research: Two readings, and a third. *Qualitative Inquiry*, 7(1), 35–68. <https://doi.org/10.1177/107780040100700103>
- Massey, O. T. (2011). A proposed model for the analysis and interpretation of focus groups in evaluation research. *Evaluation and Program Planning*, 34(1), 21–28. <https://doi.org/10.1016/j.evalprogplan.2010.06.003>
- Millner, U. C., Maru, M., Ismail, A., & Chakrabarti, U. (2021). Decolonizing mental health practice: Reconstructing an Asian-centric framework through a social justice lens. *Asian American Journal of Psychology*, 12(4), 333–345. <https://doi.org/10.1037/aap0000268>
- Miu, A. S., & Moore, J. R. (2021). Behind the masks: Experiences of mental health practitioners of color during the COVID-19 pandemic. *Academic Psychiatry*, 45(5), 539–544. <https://doi.org/10.1007/s40596-021-01427-w>
- Nagayama Hall, G. C., & Yee, A. (2012). U.S. Mental Health Policy: Addressing the Neglect of Asian Americans. *Asian American Journal of Psychology*, 3(3), 181–193. <https://doi.org/10.1037/a0029950>
- Nghiem, K., Ray, S., Ide, K., Khan, S., & Millner, U. C. (2008). *The relational reflection model: An Asian team approach to complex trauma* [Symposium]. Diversity Challenge organized by the Institute for the Study and Promotion of Race and Culture, Chestnut Hill, MA, United States.
- O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, 53, 74–99. <https://doi.org/10.1016/j.eurpsy.2018.06.003>
- Park, M., Chesla, C. A., Rehm, R. S., & Chun, K. M. (2011). Working with culture: Culturally appropriate mental health care for Asian Americans. *Journal of Advanced Nursing*, 67(11), 2373–2382. <https://doi.org/10.1111/j.1365-2648.2011.05671.x>
- Park, S. Y., Cho, S., Park, Y., Bernstein, K. S., & Shin, J. K. (2013). Factors associated with mental health service utilization among Korean American immigrants. *Community Mental Health Journal*, 49(6), 765–773. <https://doi.org/10.1007/s10597-013-9604-8>
- Presley, S., & Day, S. X. (2019). Counseling dropout, retention, and ethnic/language match for Asian Americans. *Psychological Services*, 16(3), 491–497. <https://doi.org/10.1037/ser0000223>
- Rabiee, F. (2004). Focus-group interview and data analysis. *The Proceedings of the Nutrition Society*, 63(4), 655–660. <https://doi.org/10.1079/PNS2004399>
- Spencer, M. S., & Chen, J. (2004). Effect of discrimination on mental health service utilization among Chinese Americans. *American Journal of Public Health*, 94(5), 809–814. <https://doi.org/10.2105/AJPH.94.5.809>
- Sue, D. W., Sue, D., Neville, H., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.
- Sue, S., Cheng, J. K. Y., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. *American Psychologist*, 67(7), 532–544. <https://doi.org/10.1037/a0028900>
- U.S. Department of Labor. (2022). *Labor force statistics from the current population survey: Household data, annual averages, 11. Employed persons by detailed occupation, sex, race and Hispanic or Latino ethnicity*. U.S. Bureau of Labor Statistics. <https://www.bls.gov/cps/cpsaat11.htm>
- Wiggins, G. S. (2004). The analysis of focus groups in published research articles. *The Canadian Journal of Program Evaluation*, 19(2), 143–164. <https://doi.org/10.3138/cjpe.19.007>
- Williams, V. C., Deane, F. P., Oades, L. G., Crowe, T. P., Ciarrochi, J., & Andresen, R. (2016). Enhancing recovery orientation within mental health services: expanding the utility of values. *The Journal of Mental Health Training, Education and Practice*, 11(1), 23–32. <https://doi.org/10.1108/JMHTEP-09-2015-0042>
- Xu, Y., Okuda, M., Hser, Y. I., Hasin, D., Liu, S. M., Grant, B. F., & Blanco, C. (2011). Twelve-month prevalence of psychiatric disorders and treatment-seeking among Asian Americans/Pacific Islanders in the United States: Results from the national epidemiological survey on alcohol and related conditions. *Canadian Journal of Program Evaluation*, 45(7), 910–918. <https://doi.org/10.1016/j.jpsychires.2010.12.009>
- Yang, K. G., Rodgers, C. R. R., Lee, E., & Lê Cook, B. (2020). Disparities in mental health care utilization and perceived need among Asian Americans: 2012–2016. *Psychiatric Services*, 71(1), 21–27. <https://doi.org/10.1176/appi.ps.201900126>
- Zane, N., & Ku, H. (2014). Effects of ethnic match, gender match, acculturation, cultural identity, and face concern on self-disclosure in counseling for Asian Americans. *Asian American Journal of Psychology*, 5(1), 66–74. <https://doi.org/10.1037/a0036078>

Received January 6, 2023

Revision received January 4, 2024

Accepted January 10, 2024 ■