ASIAN AMERICAN SOCIAL NETWORK FORMATION, HELP-SEEKING BEHAVIORS, AND INTERACTIONS WITH THE HEALTHCARE SYSTEM

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ABSTRACT

The duty of healthcare providers is to go beyond the principles of beneficence and non-maleficence to create a more equitable health system in which a patient's health outcomes are not determined by their race, ethnicity, language skills, or social or cultural capital. One step in creating this equitable health system is addressing the unique health challenges faced by a rapidly growing part of America – Asian Americans. As of the 2018 census, there are approximately 23 million Asian alone-or-in-combination residents in the United States. This thesis will examine how Asian Americans form social networks, the impact that social networks have on health behaviors and outcomes, help-seeking behaviors, and barriers and challenges faced when interacting with the healthcare system. I will then offer possible solutions for healthcare systems and individual providers on how they can improve interactions with Asian patients, provide culturally responsive care, and address individual and systemic barriers.

I would like to dedicate this thesis to my family and friends who have supported me throughout my entire academic journey and always encouraged me to follow my passions. Thank you to my classmates and faculty memebers in the Center for Bioethics, Urban Health, and Policy for stimulating my intellectual curiosity, engaging in thought-provoking discussions, and reminding me why I decided to go into primary care. Thank you especially to my parents and grandparents, whose immigration journeys were the inspiration behind this thesis. I look forward to a lifelong career of challenging and improving the healthcare system to deliver justice and health equity to Asian patients across the country.

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CHAPTER 1: ASIAN IMMIGRATION TO THE UNITED STATES AND BREAKING THE MONOLITH

To better understand Asian Americans, we must study the context in which they are embedded, beginning with their immigration to the United States. First, I will define "Asian American" as any individual who can trace their roots to the Asian continent or Pacific Islands (Varma, 2004). This includes but is not limited to Chinese, Filipinos, Asian Indians, Vietnamese, Koreans, Japanese, Cambodians, Hawaiians, Guamanians, and Samoans. Filipinos were the first group of Asians to come to the U.S. in the mid-18th century, followed by Chinese, Japanese, and Koreans (Varma, 2004). Early Asian immigrants arrived as laborers to work in sugarcane plantations in Hawaii and in agriculture and in building railroads on the West Coast; they came in search of better working conditions and more opportunities to earn higher wages (Varma, 2004; Yoo et al., 2014).

From the late 1800s to the early 1900s, various discriminatory immigration laws such as the Chinese Exclusion Act of 1882 and the Immigration Act of 1924 were created to deter the arrival of Asians (Yoo et al., 2014). However, the Immigration Acts in 1952, 1965, and 1990 signaled a shift in immigration attitudes and policies. The earlier of these policies came in the wake of the end of World War II and the end of wars in some Asian countries, leading to an influx of immigrants seeking family reunification, refugees, and individuals looking to fill skilled employment positions. For example, the Immigration and Nationality Act of 1965 admitted professionals and workers, allowed families to be reunited, and provided refugee status for those leaving the Vietnam War, which changed

the composition of Asian American communities (Yoo et al., 2014). These acts led to an increase in the migration of graduate students, scientists, engineers, and artists, typically from India, China, Japan, and Korea. Since many of these groups were coming to the U.S. to finish graduate education or to fill skilled labor positions, they could more easily obtain permanent residence in the U.S. and then bring their extended family from their homeland. Some subgroups however, such as those from Vietnam, Cambodia, and Laos, typically entered the U.S. as refugees due to war, instability, and safety concerns in their home country.

The differences in the contexts in which these groups came to America have precipitated disparate educational and economic achievements among groups. For example, Asian Indians, Chinese, Japanese, Koreans are more likely to have at least a high school education compared to Cambodians, Laotians, and the Hmong (Varma, 2004). In addition, illiteracy rates are highest among Southeast Asians, which might explain some adverse health outcomes for those groups (Lee et al., 2010; Yoo et al., 2014).

Present day Asian Americans live in larger family households than other groups in the labor force (Varma, 2004). More than half of them live in six metropolitan areas: Los Angeles, San Francisco, New York, Honolulu, Baltimore/Washington D.C., and Chicago. The largest subgroups, in order, are Chinese, Filipino, Asian Indian, Korean, Vietnamese, and Japanese (Lee et al., 2010; Yoo et al., 2014). The next largest groups are Bangladeshi, Cambodian, Hmong, Laotian, Taiwanese, and Thai (Yoo et al., 2014). Subgroups which have more recently arrived in the U.S. are Bhutanese, Burmese, Nepalese, and Mongolian (Yoo et al., 2014).

CHAPTER 2: SOCIAL NETWORKS & THE IMPORTANCE OF SOCIAL SUPPORT

Social Network Formation

Social networks are made up of family, friends, neighbors, coworkers, participants in religious congregations and organizational activities, etc. (Park, Jang, Chiriboga, & Chung, 2019; Gage, 2013; Schafer & Vargas, 2016; Fuller, Ajrouch, & Antonucci, 2020). Your social network is the web of all your social connections and relationships. One framework that breaks down the different components of your social network is the social convoy model (Park, Jang, Chiriboga, & Chung, 2019; Fuller, Ajrouch, & Antonucci, 2020). According to this model, your relationships with others are grouped together by subjective closeness and vary by three main components: structure, function, and quality. This model involves placing individuals into three concentric circles representing three levels of closeness: close, closer, and closest. Structure includes size of the convoy, composition, contact frequency, and geographic proximity to the person. Function, or type, includes how you are connected (e.g., significant other, friend), aid provided, affirmation exchanges, and how you interact with that individual. Quality is whether the relationship positively or negatively affects your life. Prior models emphasized quantity of relationships and were more one-dimensional in categorizing relationships (family, friends, coworkers, etc.). This model is useful because it acknowledges how the characteristics of every individual in a network – personal (e.g., age, gender) and situational (e.g., norms, values, beliefs) – can shape those three components and the convoy as a whole.

The social convoy model provides us with a framework to analyze an already existing social network. There are two other elements we should examine when studying social networks: network acquisition and maintenance, i.e., how do individuals form networks and how do they maintain their relationships. The acquisition of family members is apparent, but the quality of those relationships can vary. The acquisition of other individuals is more complicated. Initial encounters can be circumstantial, such as neighbors and coworkers, or deliberate, such as members of similar organizations or religious congregations. For example, your initial interaction with a coworker occurs because of your shared workplace but what is the impetus for furthering the relationship and bringing that person into your social network?

One theory is that people prefer individuals who have common sources of homophily (Centola & van de Rijt, 2015). Value homophily is based on similar attitudes, beliefs, and behaviors. Status homophily is based on nominal characteristics like class, gender, and age. Once an individual becomes part of your network, how do you maintain that relationship? One theory established by Lin is that relationships are maintained through the exchange of social capital or resources (Schafer & Vargas, 2016). Each individual offers social capital, or resources, which can include time, money, and information. Members of a relationship or convoy have access to those resources as a result of partaking in the convoy. Issues can arise though when there is an imbalance between what you take and what you can offer in a convoy, which Lin described as return deficits and capital deficits, respectively. One study found that over time, people with low socioeconomic status (SES) maintained a smaller share of their resource-providing close ties over time (Schafer & Vargas, 2016). This can have a domino effect as individuals

who already lack social capital have little opportunity to form long-lasting connections with individuals who possess more resources. Without this exchange of resources and capital, it can be difficult for low-SES individuals to advance.

Asian American Social Network Formation

Social networks are not static: once a network is formed, it continuously evolves as the characteristics of the individuals within the network change. Relationships have temporal components as well – typically they become more significant with the passage of time. When Asian individuals immigrate to the US, they may experience a "broken convoy" effect, meaning the networks they grew and nurtured in their home countries are disrupted when they move (Park, Jang, Chiriboga, & Chung, 2019). They are then forced to create a new network in the context of cultural and language barriers. Some studies show that friend-related networks are more vulnerable to the broken convoy effect than family-oriented networks (Park, Jang, Chiriboga, & Chung, 2019). Immigrants may have to rely more on their family for support, which can uniquely impact family dynamics and have multi-generational consequences.

Based on value and status homophily, Asian immigrants will typically seek out other Asians from the same background because of their shared culture and language (Weng, "Leadership", 2016; Weng, "Moving", 2016). In immigrant communities, networks usually consist of immigrants from similar backgrounds because of their shared norms about needs and help-seeking (Weng, "Leadership", 2016). Asians who settle in areas that are already heavily populated by other Asian Americans like New York City and California may have an easier time forming a support network since previous

immigrants have slowly built up a network and resources that newcomers can access (Weng, “Moving”, 2016). The disadvantage of moving to an area that already has a large Asian population is that there may be preexisting notions or stereotypes of Asians, which may work for or against immigrants. Settling in an area with no precedent may be beneficial because immigrants “may have more freedom to define their position” (Weng, “Moving”, 2016). However, there would be no support structures already in place so they may have a harder time forming a support network.

Importance of Social Support

Social support is information, time, resources, or any type of help provided by someone in your social network; it also implies mutual obligation (Kim, Sherman, & Taylor, 2008). Perceived social support can be categorized in to four areas: tangible assistance (material or monetary aid); appraisal (having someone to talk to about problems); self-esteem (both positive judgement of self from others and positive self-comparison to others); and belonging (people you can spend time and do things with) (Liao, Rounds, & Klein, 2005). Social support is important because it has proven to be effective in helping people cope with and adjust to difficult and stressful events (Kim, Sherman, & Taylor, 2008; Sangalang & Gee, 2012; Pinquart & Sörensen, 2005; Weng, “Leadership”, 2016). Research shows that high levels of social support are associated with better health and well-being, faster recovery from illness, healthier coping strategies in the face of adversity, reduced psychological distress, and overall better adjustment to stressful events (Kim, Sherman, & Taylor, 2008; Weng, “Moving”, 2016).

Relationships among individuals must always be examined by the context in which they are embedded. Once a connection or network is formed, it continuously adapts based on individual characteristics and relationship structures. Social support is an act or behavior that is inherently influenced by the context of the relationship of the individuals engaging in the behavior. Whether someone will actively and intentionally seek help is determined by the relationship between the support seeker and the support provider, their shared assumptions about relationships, and their attitudes and beliefs toward help-seeking (Kim, Sherman, & Taylor, 2008). Therefore, how social support is practiced "should be viewed within the context of culturally specific patterns of social relationships; people from different cultural backgrounds may utilize and be affected by support from close others differently even if they possess equally supportive social networks" (Kim, Sherman, & Taylor, 2008).

Social support is especially important for racial minority groups and immigrants. Due to the broken convoy effect, immigrants may have to endure general social needs in addition to stressors from the immigration process itself including migratory, financial, and acculturation stress (Weng, "Leadership", 2016; Weng, "Moving", 2016). Studies show that refugees experience extensive trauma and lack of support systems and may therefore need additional support (Weng, "Moving", 2016). Among non-dominant racial groups, social support was found to buffer stress from discriminatory experiences (Weng, "Moving", 2016). In addition, informal support networks are a significant, if not the sole, source of support among immigrant groups and help newcomers' adjustment process (Weng, "Leadership", 2016; Weng, "Moving", 2016). While social support has proven to

be useful in mitigating life stressors, there is no one way of utilizing social support. Furthermore, culture plays a large role in how individuals access social spport.

CHAPTER 3: ASIAN AMERICAN HELP-SEEKING ATTITUDES, APPROACHES, AND BEHAVIORS

As previously established, social support is essential to immigrant and refugee adjustment, overall well-being, good health outcomes, and day-to-day life. However, social support is inherently complicated because it is made up of individuals who are embedded in social and cultural contexts that influence how they seek and provide help. In this section I will address two dichotomies I found regarding Asians' and Asian Americans' use of social support: informal vs. formal support and explicit vs. implicit support. I will also address barriers to help-seeking encountered by Asian Americans.

Informal vs. Formal Support

Formal support comes from trained professionals, like social workers, case managers, lawyers, health care professionals, and government entities. Informal support comes from an individual's social convoys, community leaders, religious organizations, and others. There are multiple reasons why Asians and Asian Americans tend to utilize informal support and seek out formal support only when informal sources have been exhausted. One framework is continuum of care, in which formal services is viewed as a last resort source of assistance: "the framework posits that when individuals need help, they initially turn to their family members, other informal supports, and then finally formal support. In applying the frameworks, research suggests that, in their attempt to resolve problems, Asian Americans tend to first turn to their family for help, then to the rest of their informal support network" (Weng, "Moving", 2016).

Informal support networks may provide greater assistance than formal organizations because of language barriers, shared immigration and life experiences, cultural sensitivity, shared norms about needs and help-seeking, and increased flexibility regarding how and when support is provided (Weng, "Leadership", 2016). In addition, informal networks are based on interpersonal relationships so the individuals involved should be more invested in the outcomes of each other; informal networks are thought to be more stable than funding sources or formal sources for this reason (Weng, "Leadership", 2016). The support provided by members of the same racial group has a multi-generational effect: "ethnic social support serves as a protective factor from the pressure to negate their native culture among youth as well as enhance educational and occupational advancement of the second generation" (Weng, "Moving", 2016). In addition, cultural attitudes towards formal support may prevent Asians from utilizing them. For example, in one study of ethnic minority caregivers, Asian American caregivers were found to provide more care than White caregivers, to have stronger filial obligations and beliefs than White caregivers, and to use less formal support than non-Hispanic White caregivers (Pinquart & Sörensen, 2005).

Explicit vs. Implicit Support

Explicit social support is defined as specific and intentional recruitment and use of social networks in response to specific stressful events that involves the elicitation of advice, instrumental aid, or emotional comfort (Kim, Sherman, & Taylor, 2008). Implicit social support is defined as the emotional comfort one can obtain from social networks *without* disclosing or discussing one's problems; implicit support can take the form of

reminding oneself of close others or being in the company of close others (Kim, Sherman, & Taylor, 2008). There is general consensus that social support is beneficial but the ways in which people gain those benefits can vary culturally.

Some studies show that while the Western model of social support focuses on explicit support, people from Asian cultural backgrounds may more frequently utilize implicit support (Kim, Sherman, & Taylor, 2008; Weng, "Leadership", 2016; Weng, "Moving", 2016). One explanation for this is that implicit support does not disturb relationships and prioritizes group dynamics over individual needs. In individualistic cultures, such as in the United States, the self is seen as independent, meaning people are expected to make their own decisions and relationships are freely chosen and entail relatively few obligations – there is an "every person for themselves" mindset (Kim, Sherman, & Taylor, 2008). Meanwhile in collectivistic cultures, like in many Asian countries, the self is seen as interdependent, meaning people are connected and bound to others, group goals are primary, individual/personal beliefs, needs, and goals are secondary, and relationships are not voluntary but "given" (Kim, Sherman, & Taylor, 2008). Attitudes toward help-seeking therefore are shaped by culture:

> People from individualistic cultures may ask for social support with relatively little caution because they share the cultural assumption that individuals should proactively pursue their well-being and that others have the freedom to choose to help according to their own volition. In contrast, people from collectivistic cultures may be relatively more cautious about bringing personal problems to the attention of others for the purpose of enlisting their help because they share the cultural assumption that individuals should not burden their social networks and that others share the same sense of social obligation (Kim, Sherman, & Taylor, 2008).

Some studies show that Asians and Asian Americans report using explicit social support to help cope with stress less than European Americans (Liao, Rounds, & Klein, 2005; Akutsu & Chu, 2006; Kim, Sherman, & Taylor, 2008; Pinquart & Sörensen, 2005). In addition to actual use of explicit social support, some research shows that Asian Americans also view explicit support seekers less favorably than European Americans (Liao, Rounds, & Klein, 2005; Kim, Sherman, & Taylor, 2008). If Asians view explicit support and help seekers negatively, they are less likely to engage in those behaviors themselves.

As previously stated, culture informs individuals' help-seeking attitudes and behaviors; Asia is comprised of dozens of countries and when people migrate from those countries, they bring all of that diversity and culture with them. While this diversity cannot be overlooked, researchers have found commonalities among Asian Americans regarding social support seeking. Studies of individuals of Chinese, Japanese, Korean, Indian, Filipino, and Vietnamese cultural backgrounds show that all of these groups use social coping strategies significantly less compared with European Americans – the tendency to not seek explicit social support is shared across different Asian and Asian American subgroups (Liao, Rounds, & Klein, 2005; Kim, Sherman, & Taylor, 2008). Furthermore, the differences in support seeking appear to be associated with culture and not ethnic minority status in the United States, meaning that these patterns are unique to Asians and Asian Americans compared to other ethnic minorities in the United States such as Latinx and Black individuals (Liao, Rounds, & Klein, 2005; Kim, Sherman, & Taylor, 2008; Pinquart & Sörensen, 2005). Moreover, culture affects perceptions of mental and physical illness, which consequently impacts whether someone will seek out

professional help from a healthcare provider. This topic will be further explored in later sections.

According to Kim, Sherman, and Taylor, there are three possible reasons for cultural differences in social support seeking in Asians and Asian Americans (A&AAs) compared to European Americans: (1) A&AAs do not have to ask for social support because they have more unsolicited social support available to them than do European Americans; (2) A&AAs have a stronger belief than European Americans that a personal problem should be solved independently because each person should be responsible for their own problems; and (3) A&AAs are more concerned about the potentially negative relational consequences of support seeking, such as disrupting group harmony or receiving criticism from others (Kim, Sherman, & Taylor, 2008).

A study by Liao, Rounds, and Klein further explores why Asian Americans do not utilize explicit social support when experiencing distress. This study sampled college students of Chinese, Korean, Taiwanese, Filipino, Indian, Japanese, Vietnamese, Thai, Cambodian, Singaporean, and bi- or multi-racial Asian cultural backgrounds and compared their health seeking behavior and attitudes to those of White students. This study evaluates Cramer's help-seeking model, which states that help-seeking behavior is a function of four psychological variables: attitude toward seeking counseling, available social support, distress level, and self-concealment (Liao, Rounds, & Klein, 2005). Based on this model, Cramer posited that students would seek counseling (a formal and explicit form of support), when their distress levels are high and if their attitudes toward counseling are positive. Culture plays a significant role in attitudes toward help-seeking and those attitudes inform behaviors. The authors identified the following values across

the Asian subgroups: conformity to norms, family recognition through achievement, emotional self-control, collectivism, humility, and filial piety. These values lead to cultural conflict between the dominant individualistic culture and their Asian culture that discourages them from seeking help. For example, the authors found that self-concealment, "the conscious concealment of personal information (thoughts, feelings, actions, or events) that is personal and negative, was one of the main differences between Asian and White students' help-seeking behaviors.

Related to self-concealment is the concept of "loss of face," which is especially prevalent in East Asian cultures. "Face" represents "a person's social position or prestige gained by performing social roles that are well recognized by others and serves as a mechanism for maintaining group harmony;" per this concept, Asian students may avoid disclosing their problems to others – friends, family, and even health professionals – to prevent loss of face and maintain their social role (Liao, Rounds, & Klein, 2005; Leong & Lau, 2001; Abe-Kim et al., 2007). Multiple studies have also found that acculturation impacts attitudes toward explicit help-seeking. Acculturation is the "process by which the attitude and behaviors of people from one culture are modified over time as a result of contact with a different culture" (Liao, Rounds, & Klein, 2005). According to these studies, individuals who are more acculturated, i.e., adopt the values, norms, and lifestyle of the dominant individualistic culture, may have more favorable attitudes toward explicit support use (Liao, Rounds, & Klein, 2005; Leong & Lau, 2001; Abe-Kim et al., 2007). Asian Americans do not need to relinquish their Asian cultural heritage – if they can simultaneously retain their Asian identities and adapt/embrace the dominant culture, they will have more favorable attitudes toward help-seeking. This acculturation-enculturation

process (the process of adapting to the dominant culture while retaining indigenous cultural orientations) is one possible solution to consider when trying to overcome barriers to seeking formal and/or explicit sources of help (Liao, Rounds, & Klein, 2005; Leong & Lau, 2001).

CHAPTER 4: SOCIAL NETWORKS AND MENTAL HEALTH

Asian Americans have the lowest rates of mental health services utilization among U.S. populations, but this is not due to absence of mental illness (Yoo et al., 2014; Leong & Lau, 2001; Okazaki, 2000; Abe-Kim et al., 2007). Instead, there are many cultural and socioeconomic factors that affect whether Asians and Asian Americans will access mental health resources. Culturally sensitive mental health care is important for Asians and Asian Americans because culture significantly impacts presentation and perception of mental illness in these communities.

Specific Asian populations are at especially high risk of mental illness and should therefore have specific attention paid to them. Refugees and asylum seekers may have higher rates of trauma, anxiety, and depression (Weng, "Moving", 2016). For example, Southeast Asian groups have poorer functioning compared to other East Asian groups, which can be linked to refugee and involuntary minority status, exposure to war time trauma, and socioeconomic disadvantage (Leong & Lau, 2001). Older Asian American women had the highest rate of suicide among older adult women of all racial ethnic groups in 2005 and 2009 (Yoo et al., 2014). The challenges in accessing mental health care can be divided into the following categories: initial contact or reporting; culturally insensitive treatment; and language, physical, and socioeconomic barriers.

Initial Reporting of Mental Illness

Differences in reporting of mental illness between Asian Americans and other Americans may be related to cultural scripts or perception of mental illness, acculturation, familiarity with Western concepts and treatment of mental illness, and baseline epidemiological rates of mental illness (Akutsu & Chu, 2006; Abe-Kim et al., 2007). The illness labeling process is the process by which culture influences the phenomenological experience and identification of illness; culturally informed conceptions shared by Asian groups of the nature, causes, and treatments of mental illness and of well-being affect whether and from whom they will seek help (Leong & Lau, 2001). One of these cultural scripts is the concept of mind-body holism; according to this framework, there is no distinction between psychological and physical disorders, i.e., there is a tendency to somaticize psychological distress and believe that it is brought on by organic factors (Leong & Lau, 2001; Abe-Kim et al., 2007). Consequently, Asian Americans who adhere to this cultural script may seek help from a medical doctor rather than a mental health provider. Alternatively, Asian Americans may attempt to treat the somatic symptoms that accompany mood or anxiety disorders like fatigue, headaches, abdominal pain, and sleep dysregulation with indigenous or home remedies, thus delaying treatment by mental health professionals (Okazaki, 2000).

Another cultural script is the separation of mental illness and negative feelings and emotional difficulties; per this script, behaviors are considered signs of mental illness only if they are upsetting, dangerous, or disruptive to the social group (Leong & Lau, 2001; Perry, 2011; Okazaki, 2000). For example, families may ignore the negative symptoms of schizophrenia such as anhedonia, flat affect, isolation, and depression-like

symptoms. However, if someone exhibits positive symptoms of schizophrenia such as delusions, hallucinations, disorganized speech, and disorganized behavior, then their family may be more likely to seek help because those symptoms could cause disruption and be perceived as more disturbing than the negative symptoms.

In addition, among some Asian Americans, Alzheimer's Disease and other dementias are perceived as forms of mental illness with shame attached that extends beyond the person diagnosed to the entire family (Yoo et al., 2014). As a result of this perception, family members may not seek help for fear of bringing shame by seeking treatment or may seek treatment from inappropriate providers. Stigma and shame are especially salient in the context of collectivist cultures and filial piety, which "serves to foster respect and obligation to individual family members, especially one's parents" (Yoo et al., 2014). In this context, asking for professional help may be perceived as inadequacy to care for the impaired elder by family caregivers (Yoo et al., 2014; Pinquart & Sörensen, 2005). Family caregivers who are unable to care for an impaired elder may suffer shame and loss of face if other members of the Asian American community perceive that the family has not cared adequately for the impaired elder (Yoo et al., 2014; Pinquart & Sörensen, 2005).

Another influence on attitudes toward seeking mental health care is acculturation, or integration into the dominant culture. Research suggests that more highly acculturated Asian Americans hold more positive attitudes toward seeking psychological services (Leong & Lau, 2001). Specifically, the integrationist mode of acculturation, in which individuals simultaneously retain their native cultural identity and move to join the dominant society, is the most promoting of positive attitudes toward seeking mental

health counseling (Leong & Lau, 2001). Furthermore, familiarity with the Western model of mental illness and treatment modalities can affect attitudes toward counseling (Abe-Kim et al., 2007). Asian Americans may be unaware of the reasons to seek mental health care and how to appropriately access services. They may not know what symptoms classify as a mental illness per the Western model of mental illness. They may also lack knowledge of what mental illness treatment looks like and the diversity in options from medications to different types of counseling.

Culturally Responsive Mental Health Treatment

Even when Asian Americans access mental health services, they have higher rates of premature termination of treatment than non-minority clients (Leong & Lau, 2001; Okazaki, 2000). One reason for this is culturally unresponsive services, i.e., services without language or ethnic match, poor cross-cultural understanding, and discrepancies between patient and provider goals and expectations of care (Abe-Kim et al., 2007). The cultural scripts of shame, stigma, loss of face, somatization of problems etc. can impact how patients interact with mental health providers and the amount and type of information they are willing to disclose (Akutsu & Chu, 2006).

Cultural value orientations influence emotional management and communication styles: Asian individuals may prefer to keep information about family problems within their kinship domain due to collectivist and Asian cultural values because disclosure of personal problems may be viewed as bringing shame to family members and the community (Leong & Lau, 2001). The Western model of psychotherapy usually involves open verbal communication and focuses on the individual, sometimes encouraging

patients to put their individual goals and needs before those of the collective; Asian Americans may feel uncomfortable unveiling information about themselves or subscribing to the advice from therapists (Leong & Lau, 2001; Akutsu & Chu, 2006; Abe-Kim et al., 2007). In addition, some Asian Americans believe it is detrimental to dwell on and analyze depressing or disturbing thoughts and that the situation can be improved by willpower and avoidance of those thoughts; this is incongruous with the Western psychotherapy model, which involves exploration of those thoughts (Leong & Lau, 2001). If Asian Americans believe there is dissonance between the Western treatment model and their own "conception of cure" (credibility of cure or treatment), then they may perceive the Western model as ineffective and terminate treatment prematurely (Leong & Lau, 2001; Akutsu & Chu, 2006; Abe-Kim et al., 2007).

On the provider end, mental health professionals may have biases about Asian Americans and their ability to experience social and psychological problems due to the "model minority" myth (Ngo-Metzger, Legedza, & Phillips, 2004; Leong & Lau, 2001). The model minority myth was created in the 1960s as "a way to prove that all races could be successful if they just worked hard enough, and as an excuse to ignore institutionalized and systemic racism;" as a result of this myth, "Asian Americans have been stereotyped as a group that is more successful than any other ethnic minority group, does not face societal barriers, and therefore does not need help" (Ibaraki, Hall, & Sabin, 2014). Mental health providers may invalidate the experiences of Asian Americans, believe their problems are not significant enough to receive treatment, or prematurely think their problems have resolved and end treatment too quickly.

Another issue is the under- or over-diagnosing of mental illness based on a patient's culturally informed presentation of the illness and inconsistencies with how the provider expects patients to present, i.e., therapist bias in clinical judgment. If clinicians use the Western nosological system to evaluate someone from a different cultural background or if the clinician has a narrow definition of how an illness should manifest, then they misdiagnose patients. As previously discussed, Asian Americans may define, express, and communicate their problems differently than other Americans for many reasons (stigma, loss of face, causal beliefs, somatization of illness, language barriers, etc.) (Leong & Lau, 2001; Abe-Kim et al., 2007). Issues can arise if clinicians overpathologize behaviors or experiences that are normal in that culture or underpathologize based on their preconceived notions of how people from that culture should act (Leong & Lau, 2001). For example, it may be normal in a culture to hear or see a dead relative during bereavement but if clinicians are unaware of this, then they may diagnose them as having a psychotic disorder. Another example is the assumption that Asians are reserved, a feature of the model minority myth, which may lead clinicians to ascribe depressive symptoms, like flat affect and withdrawn behaviors, to the patient's culture.

Language, Physical, and Socioeconomic Barriers

Language barriers are multifaceted – they not only limit the providers that can be utilized but also affect how patients are evaluated (Yoo et al., 2014; Leong & Lau, 2001; Abe-Kim et al., 2007). First, the translation of diagnostic tools to Asian languages is complicated by "issues of conceptual and semantic equivalence;" second, interpretation

of assessment tools is “complicated by findings that the original factor structure of self-report scales often does not generalize” to Asian Americans (Leong & Lau, 2001). Essentially, the assessment and diagnostic tools that we perceive as objective do not have cultural validity and may be more subjective than we initially thought. In these cases, the clinical judgment of a provider is important in bridging the gap between these tools and a patient’s clinical presentation. Furthermore, clinical presentations of Asian Americans whose primary or native language is not English may be misjudged. If they are trying to communicate in English, they may be seen as more disorganized, withdrawn, or disturbed since they cannot communicate freely in their native language; conversely, because speaking in a non-native language requires concentrated effort and increased awareness, they may modify their expression, behaviors, etc. which would change the clinical picture (Yoo et al., 2014; Leong & Lau, 2001).

The physical and socioeconomic barriers faced by Asian Americans in accessing mental health services are similar to those faced by many other minority Americans. It is important we acknowledge they exist, so we do not fall into the trap of aggregating all Asian Americans together, thus masking the challenges of the most vulnerable subgroups. Barriers include lack of awareness or knowledge about available services, inability to access services due to logistical and geographic obstacles (unable to get time off, lack of childcare, no transportation, etc.), lack of insurance coverage, and inability to pay for services (Yoo et al., 2014; Leong & Lau, 2001).

Social Support and Mental Health in Asian Americans

Asian Americans tend to prefer support from informal sources like family and friends over formal support, but there can be conflict between Asian cultural values and help-seeking. For example, elderly Asians, an especially vulnerable population, may not be able to search for providers, schedule an appointment, or may not have Social Security or other pension benefits to pay for services due to language, logistical, and socioeconomic barriers (Yoo et al., 2014; Leong & Lau, 2001). Any assistance in completing or paying for these services would most likely come from family members and elders may be hesitant to disclose their need for help to their family for fear of disturbing group dynamics.

Furthermore, Asian American elders have high rates of depression and suicide risk, compared to all racial ethnic groups; language-cultural barriers, social isolation, lack of support network and resources, financial hardship, and discrimination have been found to be associated with depression and suicide ideation or attempts (Yoo et al., 2014). In elderly populations, participation in religious activity has been shown to buffer the risk of suicide; in Asian American populations as a whole, social support from family has been associated with decreased odds of major depressive disorder (MDD) and general anxiety disorder (GAD) (Yoo et al., 2014; Sangalang & Gee, 2012). On the other hand, social strain from family is associated with increased odds of MDD and GAD (Sangalang & Gee, 2012).

The primary social unit for many Asian Americans is the family but the support provided by family comes with caveats – being so embedded in the family can cause group problems to become individual problems (social strain in the group can lead to

mood disorders in individuals). However, individuals cannot be extracted from their social web so clinicians must adapt their treatment models to make them more accessible and culturally responsive to Asian Americans.

CHAPTER 5: SOCIAL NETWORKS, PHYSICAL HEALTH, AND INTERACTIONS WITH THE HEALTHCARE SYSTEM

Differences in Quality of Care

Differences also exist between how Asian Americans and other Americans interact with health professionals regarding their physical health and with the healthcare system as a whole. Asian Americans' perception of their doctors and quality of care can affect understanding of illness, adherence to treatment, and continuity of care. On the other, how doctors perceive Asian American patients and any biases they hold can affect the type and quality of care they provide.

Multiple studies demonstrate that Asian Americans report lower rates of satisfaction with their medical care, primary care access, and overall quality of patient–physician interactions than do White Americans (Ngo-Metzger, Legedza, & Phillips, 2004; Saha, Arbelaez, & Cooper, 2003; Murray-García et al., 2000). In addition, Asian Americans were less likely than White Americans to report that their doctors talked to them about lifestyle; they were also more likely to report that their regular doctors did not understand their background and values (lower levels of cultural sensitivity) and that their doctors did not listen, spend as much time, or involve them in decisions about care as much as they wanted (Ngo-Metzger, Legedza, & Phillips, 2004; Murray-García et al., 2000). The consequences of Asian Americans being unsatisfied with their care or believing their doctors do not understand them are decreased trust in their medical care and increased risk of changing their doctor, leading to loss of continuity in care (Ngo-Metzger, Legedza, & Phillips, 2004).

The reasons for these differences in quality of care are related to factors like the clinical encounter, physician biases, and patient characteristics such as education, race, ethnicity, and health literacy. According to some studies, the differences in the quality of patient–physician relationships appear to be influenced in part by the physicians' race/ethnicity because minority patients tend to prefer physicians of their own race/ethnicity and rate those physicians as providing better interpersonal care than other-race physicians. In fact, some studies estimate that nearly one-half of Asians have been found to have race-concordant regular physicians (Lee et al., 2010; Saha, Arbelaez, & Cooper, 2003). In addition, patients' language proficiency, acculturation, and socioeconomic status affect physician-patient interactions (Ngo-Metzger, Legedza, & Phillips, 2004; Saha, Arbelaez, & Cooper, 2003). Health literacy, which is informed by all those characteristics, significantly influences quality of patient–physician interactions, satisfaction with health care, and use of health services (Lee et al., 2010; Saha, Arbelaez, & Cooper, 2003).

Physician biases, stereotyping, and heuristics (also known as cognitive shortcuts) can also affect the quality of care provided by doctors. The Institute of Medicine (IOM) Committee suggests that physicians might use stereotyping, defined as "the process by which people use social categories (e.g., race, gender) in acquiring, processing, and recalling information about others" as a cognitive shortcut to make judgments and diagnostic decisions (Ngo-Metzger, Legedza, & Phillips, 2004; Ibaraki, Hall, & Sabin, 2014). In the clinical encounter, physicians may be under time-pressure, resource constraints, and high cognitive demands, thus leading them to rely on stereotyping or heuristics. Asian Americans, partially as a result of the model minority myth, are seen as

having few health problems or negative health habits (Ngo-Metzger, Legedza, & Phillips, 2004). In one survey looking at ethnic groups and perceptions of their health, respondents were more likely to choose Asian Americans as the least likely to suffer from all diseases (stroke, diabetes, alcoholism, obesity, heart disease, and cancer), meaning people tend to view Asian Americans as healthier than other ethnic groups (Ibaraki, Hall, & Sabin, 2014).

This bias may extend to physicians – under pressure, they may utilize heuristics, thus leading to fewer interventions and health counseling for Asian patients. For example, cancer is the leading cause of death for Asian Americans, but one study found that the rate of cancer screening among Asian Americans is lower than in White Americans (Ibaraki, Hall, & Sabin, 2014). The authors believe that stereotypes about Asian American health and their risk factors for developing cancer played a role in lower rates of screening recommendations and counseling by physicians (Ibaraki, Hall, & Sabin, 2014). Health care providers may be unaware of the high rates of other diseases and negative health behaviors in the Asian community like high smoking rates, high prevalence of cardiovascular disease among Japanese and Chinese Americans, high rates of depression and PTSD among Southeast Asians, and high rates of type 2 diabetes among South Asians (Ngo-Metzger, Legedza, & Phillips, 2004; Lagisetty et al., 2016). Furthermore, access to care has been found to be restricted among Vietnamese, Korean, and Chinese Americans, who are more likely to be uninsured than White Americans (Ngo-Metzger, Legedza, & Phillips, 2004). If health care providers rely too much on heuristics and assume that their Asian patients have positive health attitudes and

behaviors, regularly access healthcare, and do not need help, they may miss vital information about them and undertreat them.

Social Support and Physical Health in Asian Americans

The effects of social networks on physical health have mixed findings, similar to the effects observed on mental health. Social cohesion among a group of people, defined by "constructs such as perceived connectedness, solidarity, and shared resources that allow people to act together," can augment health by promoting social integration, buffering stress effects, and facilitating positive behavioral changes; high social cohesion has been associated with improved physical health and lower rates of chronic illnesses like hypertension, myocardial infarction, and stroke (Lagisetty et al., 2016). However, social dynamics can be disrupted in instances when family members, such as children, have to serve as interpreters; this can upset family power dynamics, cause embarrassment, lead to incorrect or incomplete communication if the interpreter does not know medical terminology, and delay care for individuals who do not want or cannot ask for help from family members (Lee et al., 2010).

Other studies examine how the composition of social networks can influence health and how social networks and individual characteristics affect sources of health information. A study by Park, Jang, Chiriboga, and Chung, divides social networks into the following four types: diverse (broad range of networks composed of family, friends, and neighbors, and participating in religious and organizational activities); family (maintaining close ties and contacts with family with a relative absence of friends); friends (having close ties and contacts with friends but less with family; and restricted

(involving a limited number of social ties and participation in social activities) (Park, Jang, Chiriboga, & Chung, 2019). This study found that Asian Americans in the most diverse network type reported the fewest risk factors of poor self-rated health, mental distress, and dissatisfaction with life (Park, Jang, Chiriboga, & Chung, 2019). However, this study also noted that certain characteristics transcend networks with regards to health. For example, regardless of social network type, participants with characteristics such as older age, female gender, low educational levels, and shorter stays in the U.S. reported greater ill health (Park, Jang, Chiriboga, & Chung, 2019). This information can help guide the type of interventions we provide and are another reminder that healthcare providers must acknowledge the role that social determinants play in health behaviors, attitudes, and outcomes.

Another study looked at the relationships between social networks, individual characteristics, and health professionals and sources of health information, specifically among Asian Americans. According to the authors, health information is beneficial because it can facilitate positive health behaviors and promote physical and mental health; however, foreign-born immigrants may face challenges in accessing or utilizing health information because of less health information-seeking experience in America, less trust in health information, and less confidence in obtaining health information (Jang, Yoon, & Park, 2018). This study identified three sources of health information: internet; social networks (family, friends, co-workers, neighbors, religious/organization members, etc.); and health professionals (Jang, Yoon, & Park, 2018). The authors then divided participants by characteristics and what types of health information they use: the resource-heavy group (utilizes all sources) was associated with higher levels of

education, English proficiency, and positive self-ratings of health; the resource-scarce group (low engagement across all types of health information sources) was associated with less education, fewer years of residence in the U.S., limited English proficiency, negative self-ratings of health, and being foreign-born; and the family-dominant group (exclusive reliance on their family), which shared many of the same characteristics as the resource-scarce group, but were disproportionately represented by older adults (≥60 years of age) (Jang, Yoon, & Park, 2018). Other notable findings from the study are as follow: foreign-born individuals preferred the Internet over the other sources, possibly because of its easy access, anonymity, and language capacity; the resource-heavy group had the lowest rate of unmet healthcare needs compared to the resource-scarce group, which had the highest rate of unmet healthcare needs; and members of the resource-scarce and family-dominant groups rarely used reliable information sources such as health professionals and health websites (Jang, Yoon, & Park, 2018). This study helps to identify the characteristics that the most vulnerable Asian Americans possess, e.g., foreign-born, fewer years residence in the U.S., limited English proficiency, less education, older, and small number of close ties in their social network. This information can help guide future health interventions, focusing on addressing health inequities among these vulnerable populations. For example, older Asian Americans who rely exclusively on family members for support may need additional health education, formal support from case managers or social workers to ensure access to care, and overall, more counseling and time with health professionals to address any unmet healthcare needs.

Social networks can be beneficial to health when they are diverse and have resources to offer the members within them. Interactions among people facing shared

stressors and experiences may improve health outcomes because there is mutual understanding regarding their experiences, and they are able to share information, offer emotional support and advice, and opportunity for social comparison (such as coping and adjustment mechanisms) (Gage, 2013). However, if an individual's social network is made up exclusively of others who share the same stressors – for example, a group of Asian Americans who have been in the U.S. for less than 10 years with the same level of education and English proficiency – then the benefits reaped from their shared experiences can only take them so far. Diverse networks can broaden the pool of resources available and address the needs of more vulnerable members.

CHAPTER 6: INTERVENTIONS AND RECOMMENDAITONS USING A BIOETHICAL FRAMEWORK

Literature examining social networks and Asian American health outcomes is scarce. The goal of my thesis is to see what role health professionals could play in advocating for Asian Americans' healthcare needs, how they could provide culturally responsive care, and better identify and utilize their patients' social support systems. Studies that interview Asian American community leaders give us the best information on the existing resources and needs because they are embedded within the community. A study by Weng found that currently, leaders discover issues through word of mouth since they are trusted and highly regarded members of the community or by being part of an informal support network (Weng, "Leadership", 2016). Weng notes that formal support and needs assessments are one way to address needs of vulnerable and growing Asian American communities (Weng, "Leadership", 2016). While informal support networks provide a safe space where Asians can practice their cultures and traditions and engage with others of similar backgrounds, they are not adequate enough to address all the needs of the community for many reasons: assistance is provided on a voluntary basis (compared to systematized help from formal organizations); help is usually restricted to members of the network so new immigrants or people outside of the network may not have access; financial and human resources may not be sufficient; and overall, the services and assistance needed may go beyond the capabilities of informal networks (Weng, "Moving", 2016).

Using social justice and agency as my bioethical framework, I will discuss interventions that may be implemented on systematic and individual scales. Social justice in this context means recognizing the diversity among Asian Americans and that more vulnerable populations will need additional help in order to achieve equitable outcomes. Agency is similarly important because while theoretically all Americans have equal rights and freedoms, that is not the reality of the lived experiences of Asian Americans. Agency means acknowledging that individual characteristics, social standing, and circumstances can limit or expand the options available to someone and the capacity to act in a given scenario.

Individual, Cultural, and Systemic Barriers to Accessing Care

Some of the systemic barriers faced by Asian Americans are similar to those faced by other minority communities such as lack of transportation, financial and insurance constraints, language barriers, stigma and shame of seeking services, insufficient knowledge or awareness of available services, inability to navigate the American healthcare system, infrequent referral to formal support, and inadequate help from mainstream or formal services (Yoo et al., 2014; Lee et al., 2010; Weng, "Moving", 2016). Some of these barriers are culturally rooted like stigma and shame surrounding help-seeking, as discussed in previous sections. Other barriers are tied to the systemic disenfranchisement and structural racism Asian Americans have encountered throughout American history.

A culturally specific barrier to care is the gap between Western and traditional/complementary and alternative medicine. For example, in focus groups, Asian

American elders with chronic conditions like heart disease and hypertension reported lack of awareness of preventive care, belief in traditional medicine, and non-adherence to medications associated with lower perceived benefit compared to herbal medications (Yoo et al., 2014).

Furthermore, Asian Americans are the least likely ethnic minority to follow preventive care guidelines for diabetes, due to lack of understanding or awareness of services and cultural values, health beliefs, and practices that influence how they comprehend and manage their diabetes; for example, individuals who view diabetes as an "imbalance of life energy" may only take their medications when they are symptomatic (Yoo et al., 2014; Lee et al., 2010). Cultural values and beliefs may also offer solutions in how we can better manage these conditions. Family involvement has been shown to be highly effective for Asian Americans in helping with dietary management of diabetes during family meals (Yoo et al., 2014). This could be related to collectivist beliefs and strong family ties and obligations. Additionally, routine checkups and regular preventive care has been found to not be a cultural norm for many Asian Americans (Lee et al., 2010). In a study by Lee et. al, participants in most Asian communities reported that in their countries of origin, going to the physician on a regular basis was not the norm; they go to the physician for curative care, not preventive care (Lee et al., 2010).

Culturally Responsive Healthcare and Interventions

One way health professionals can improve health outcomes is through cultural humility and culturally responsive care. Previously, some health professionals were taught they needed to be culturally competent, meaning to have fixed ideas about the

attitudes and behaviors of certain ethnic minorities. However, this can lead to the heuristics and biases previously discussed, which may be counterproductive in trying to improve Asian American health, especially because cultural competence is rooted in the idea that culture is static and that all individuals within a subgroup experience and practice their culture similarly (Carrillo, Green, & Betancourt, 1999; Tervalon & Murray-Garcia, 1998). To prevent stereotyping and homogenization of Asian subgroups, intragroup variability must be emphasized; factors such as religion, acculturation, and socioeconomic status contribute to diversity among subgroups (Ngo-Metzger, Legedza, & Phillips, 2004). Instead, health professionals should commit to cultural humility, which "incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998). One practical way to incorporate this into patient care is the "patient's explanatory model," by which health professionals try to understand the patient's conceptualization of their illness, including the cause, severity, prognosis, treatment, and influence on their life (Carrillo, Green, & Betancourt, 1999). Health providers should also assess patients' personal and social context such as their immigration status (generation, years in the country, context in which they immigrated, etc.), health habits, and health beliefs and practices (Ngo-Metzger, Legedza, & Phillips, 2004).

In addition, the "matching hypothesis, the notion that the effectiveness of social support is determined by whether or not the support provided matches the support needed and desired by a distressed individual," should be taken into consideration when creating

treatment plans for patients (Kim, Sherman, & Taylor, 2008). Studies also suggest that Asian Americans who prefer more implicit and indirect support (such as simply being there without discussing the issue at hand) or who are from collectivistic cultural backgrounds may have greater difficulty with disclosure than people from other cultural backgrounds (Liao, Rounds, & Klein, 2005; Kim, Sherman, & Taylor, 2008). Health providers cannot rely on heuristics to inform their diagnostic evaluation of patients and assume that no disclosure equates to good health; instead, they must engage in shared-decision making and elicit what type of support will best benefit their patients. They must be aware that cultural differences and agency may lead to differences in help-seeking patterns and overall health behaviors.

On a macro-scale, educational programs can be implemented to address cultural barriers to seeking formal help. These programs could target beliefs and attitudes, increase awareness of the existence of stigmatized problems in the community, and provide information on how and when services should be utilized (Weng, "Leadership", 2016). The path to reducing cross-cultural barriers between providers and patients is a two-way street: patients need better understanding of American healthcare cultural norms and providers must improve their interpersonal skills and practice with cultural humility (Saha, Arbelaez, & Cooper, 2003). Other systemic interventions are broader access to care, whether through financial assistance, insurance coverage, or interpreter services. Asian Americans, especially Koreans, Vietnamese, Chinese, Filipino, and non-Indian South Asians are more likely to be uninsured than Whites – Asian Americans "who were uninsured had 40% fewer visits to physicians compared with those with health insurance," and uninsured Asian Americans are also "less likely to have a regular source

of care" (Lee et al., 2010). Furthermore, the context in which Asians immigrate to the U.S. can affect their access to health insurance. For example, Asian Americans who work in home business, restaurants, and childcare may not receive insurance from employers; vulnerable populations such as unemployed or low-income individuals, students, retirees who do not qualify for Medicare, and undocumented migrants likely cannot afford or obtain insurance (Lee et al., 2010). Language and health literacy barriers affect patients' capacity to schedule and arrange appointments (including transportation to visits), explain symptoms, and understand their diagnosis and treatment (Lee et al., 2010; Leong & Lau, 2001). Several studies have shown that culturally and linguistically tailored community interventions related to self-care and informational support improve chronic health condition management (Yoo et al., 2014).

A social justice approach should be taken when implementing interventions for Asian Americans. This approach should consider aspects such as the social and historical contexts in which they migrated from their country of origin, where they migrated to, individual characteristics, cultural embeddedness and acculturation, and agency. Healthcare resources are inequitably allocated, and healthcare systems, providers, and insurance plans are not always held accountable for meeting the needs of diverse and vulnerable patients and communities (Murray-García et al., 2000). It is evident that we are not meeting the health needs of Asian American communities. Some studies show that patients are more likely to seek out informal sources of assistance than consult with medical professionals for advice regarding chronic disease management (Centola & van de Rijt, 2015). Informal support networks and community organizations can provide a solid foundation from which formal support and systematic interventions can be

developed. Utilizing existing programs and community leaders can help "retain the customs and service delivery styles of the countries of origin," while also providing more power to advocate for policy changes, access to political institutions, and public health and education programming (Weng, "Moving", 2016).

As the Asian American population continues to grow and evolve, it is imperative that healthcare providers are aptly suited to address their health needs. This thesis sheds light on the ways Asian Americans form social networks, how they utilize them, and their help-seeking behaviors. In order to meet this population's increasing health needs, we must acknowledge that they may not seek help the way other American subgroups will. Instead, we must create interventions that take into consideration their unique healthcare perspectives and behaviors and meet Asian patients where they are. However, we must be careful not to develop new heuristics and assumptions about Asian patients during this process and continuously recognize that Asian Americans are not a monolith but rather are an extremely diverse group with roots in dozens of countries. As I enter the field of primary care, I am looking forward to serving Asian patients and hope this thesis serves as a framework to addressing the social health and overall wellbeing of my patients.

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