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Working with Culture: Psychiatric and Mental Health Care Providers' Perspectives on Practice with Asian American Families

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Working with Culture:
Psychiatric and Mental Health Care Providers' Perspectives on Practice with Asian American Families

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Dedication

To my mother and father

Mijung

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In many ways, I am very blessed person because so many wonderful people touched my life and shared the journey with me. I believe that you know who you are if you are reading this. Words cannot thank you enough, but I will try.

I would like to acknowledge and thank many people who helped me throughout this project. It has been both a blessing and a privilege to have them in my corner. They made the five years I have spent here at UCSF one of the most intellectually and personally enriching experiences of my life.

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To the school of fish: Anne, Garret, and Steve, gorgeous fishes in the ocean of interpretation. Sometimes I wonder what kind of fish you are. Great ones!!!

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Finally, to my family in Korea, What can I say? I love you.

The chapter 2 of this dissertation is a reprint of the material as it appears in Journal of Family Nursing. The co-author, Dr. Catherine Chesla, directed and supervised the research that forms the basis for the dissertation.

Working with Culture:
Psychiatric and Mental Health Care Providers' Perspectives on Practice with Asian American Families

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The purposes of this hermeneutic phenomenological study were to 1) understand Asian American families' everyday caregiving practices for a person with mental illness and 2) understand how mental health care providers provide care for AA patients and families. AA was defined as immigrants from Korea, China, and Japan and their descendents.

The specific aims were to 1) examine patterns of family caregiving practices for mentally ill family members among AA families as observed by mental health care providers and, 2) provide a systematic articulation of Confucianism as manifested in the AA family caregiving practices and describe how Confucianism is modified as families acculturate to the United States, 3) identify the particular difficulties perceived by mental health care providers and some strategies they use to cope with these difficulties, 4) examine patterns of practice among mental health professionals providing care for AA patients and families.

Participants were comprised of twenty providers who had treated mentally ill AA patients and families in the past 5 years in the San Francisco Bay Area. Data were collected through face-to-face, in-depth interviews. In addition, field notes and memos were also included in the analysis.

Study findings are consistent with the current knowledge of strong family supports in the AA population, but AA family caregiving practices must be understood as complex interactional, cultural processes. Strong Confucian emphases are still present in AA families, particularly regarding caregiving and communication among family members.

Narratives from practitioners illustrate the clinical reality of cultural competency and describe their practices when caring for mentally ill AA patients and their families. Such detailed illustrations provide insight for novice practitioners or those who have limited opportunity to work with this population. The findings of this study support some current guidelines while challenging others.

Catherine A Chesla

Catherine A. Chesla RN, DNSc, FAAN

TABLE OF CONTENTS

CHAPTER 1: BACKGROUND AND RATIONALE OF THE STUDY

CHAPTER 2: REVISITING CONFUCIANISM AS A CONCEPTUAL FRAMEWORK FOR ASIAN FAMILY STUDY

CHAPTER 3: METHODOLOGY

CHAPTER 4 STUDY RESULT FOR PURPOSE 1: TWO SIDES OF A COIN: ASIAN AMERICAN FAMILY CAREGIVING

CHAPTER 5 STUDY RESULT FOR PURPOSE 2: PROVIDING CULTURALLY COMPETENT MENTAL HEALTH CARE

CHAPTER 6 DISCUSSIONS

List of Tables

CHAPTER 1

BACKGROUND AND RATIONALE OF THE STUDY

I. INTRODUCTION

The impact of mental illness on the family and the community is well established (Donnelly, 2001). Living with a person with a mental illness causes personal, social, and economic burdens on individuals and communities (van Wijngaarden, Schene, & Koeter, 2004). Living with a person with mental illness is sometimes detrimental to a caregiver's own health (E. E. Lee & Farran, 2004). Yet the caregiving experiences of families with a mentally ill member have rarely been documented in the literature and thus this category of caregiver has essentially been ignored (Noh & Avison, 1996). Furthermore, existing research on families rarely focuses on cultural or ethnic minority families including Asian Americans (AA hereafter) families (Noh & Kaspar, 2003).

Whereas the burden of mental illness on the family is apparent across cultures and ethnicities, mental illness may be more burdensome to immigrant and minority families because of social and economic strains that result from immigration and discrimination(Chun, Organista, & Martin, 2003). Immigrant individuals and families experience added stress from the process of acculturation that may influence and shape the experience with a mentally ill family member. AA families face many difficulties including some unique to them because of their cultural backgrounds. The strong emphasis on filial responsibility and family cohesion and harmony over individual happiness shape family caregiving practices among modern AAs.

Because of the tendency to stigmatize people with mental illness and families among the AA population, treatment of the illness is frequently delayed and ultimately results in poor prognoses of the AA patients with mental illness. Delayed treatment and poor prognosis increase the difficulties and the burdens on AA families of persons with mental illness. Marginalization from the existing mental health care system and poor community resources have been identified as major issues for the delayed treatment and health disparity among AAs. As a result AAs often assume 24-hour caregiving responsibility for their mentally ill family member (Koh & Koh, 1993).

The research project presented here had two arms. One arm concerned mental health care providers' perspectives on AA families and their caregiving practices, and the other arm was concerned with mental health care professionals' practice and practice philosophy while caring for AA patients and families. In chapter 2, limitations of current family theories for explaining multicultural families are presented. Confucianism is presented as a possible theory of relevance to AA families and their processes. In the next chapter, the historical and philosophical development of interpretive phenomenology is presented as well as study methods. There are two study result chapters. The first result chapter discusses AA family caregiving for a mentally ill member. The second result chapter discusses mental health care providers' practice. In the final chapter, implications for research, policy and education are presented.

In this study, AA was defined as immigrants from Korea, China, and Japan and their descendents. Mental illness was defined as diagnosis of chronic severe psychiatric disorders, such as major depression, bipolar disorder, and Schizophrenic disorders.

II. PURPOSES AND SPECIFIC AIMS

The purposes of this study were to 1) understand Asian American families' everyday caregiving practices for a person with a mental illness and 2) understand how mental health care providers develop and provide care for AA patients and families. Specific aims were to 1) examine patterns of family caregiving practices for mentally ill family members among AA families as mental health observed, 2) provide a systematic articulation of Confucianism as manifested in the AA family caregiving practices and describe how Confucianism is modified as families acculturate to the United States, 3) identify the particular difficulties perceived by mental health care providers and some strategies they use to cope with these difficulties, 4) examine patterns of practice among mental health professional providing care for AA patient and family.

III. BACKGROUND AND RATIONALES

A. Demographic facts

Asian Americans (AAs hereafter) are the fastest growing ethnic minorities in the United States (H. Chen, Kramer, Chen, & Chung, 2005). The number of AAs in the United States has grown rapidly to 10.2 million, representing 3.7% of the population in 2000 as compared with fewer than 1 million in 1960s (U.S. Census Bureau, 2000). The number of AA is expected to reach 37.5 million by 2050 (S. M. Lee, 1998). Approximately 71% of AAs are foreign born, with Asian immigrants accounting for 2.6% of the total US population. Limited English speaking proficiency is widespread in this group (Kramer, Kwong, Lee, & Chung, 2002).

For mental health care providers who are practicing or planning to practice along West and East Coasts of the Unites States and in metropolitan area where substantial number of AA reside, it is inevitable to encounter AAs as one of the major patient groups (Lu, Du, Gaw, & Lin, 2002). Thus, it is important to understand this population better to provide reliable assessment and treatment for them.

The AAs are a heterogeneous group that consists of at least 43 different ethnic groups who have their origins in unique countries with different languages, religions, health and illness models, and health seeking patterns (S. M. Lee, 1998). Although many of these subgroups share an important cultural heritage, there are also great diversities among them. There are inter- and intra-group differences in socioeconomic status, educational achievements, immigration patterns, traumatic experiences, family dynamics, and degree and process of acculturation. However, few studies recognize the uniqueness of specific AA ethnic groups (Uba, 1994). Joining these unique ethnic groups into one category blurs important differences of which professionals should be aware and may contribute to a homogenized view of AAs (Kim, Yang, Atkinson, Wolfe, & Hong, 2001). Also, the conclusions drawn from analyses using AAs as a single ethnic category may differ from those drawn from a specific ethnic group (Takeuchi & Kramer, 2002). For example, East

Asian Americans comprise at least 42 % of AAs (U.S. Census Bureau, 2000). East Asian countries share a long history with a constant exchange of culture and similar family values. EAAs also share similar immigration histories.

B. Epidemiology of Asian American mental health

Many scholars point out that there is a paucity of epidemiological data regarding mental health status of AAs due to the lack of a large scale study on this population in the United States (Takeuchi & Kramer, 2002). There are two national level mental health surveys in the U.S.: The Epidemiological Catchment Area (ECA) study (Eaton & Kessler, 1985) and the National Comorbidity Study (NCS) (Kessler, 1994). Despite the fact that the NCS can provide more recent data, it is impossible to estimate prevalence properly due to its small AA sample (Sue & Chu, 2003). The ECA study is also critiqued for its inadequate sampling of Asians (Chun, Eastman, & Wang, 1998). Nonetheless, Zhang and Snowden (1999) reported that, in the ECA study, there was no significant difference in the lifetime prevalence rate in schizophrenia, major depressions, dysthymia, obsessive-compulsive disorder or atypical bipolar disorder between AAs and Whites. But, AAs were less likely than Whites to have manic episode, panic, somatization and schizophreniform disorders.

Besides these two national level studies, the Chinese American Psychiatric Epidemiological Study (CAPES) (Takeuchi et al., 1998) was conducted between 1993 and 1994. A total of 1,747 foreign and American born Chinese residents in L.A. County participated in the study. In their report, Takeuchi and his colleagues (1998) reported that the lifetime rate of major depressive episode was 6.9%; 3.4% of the respondents had had an episode in the past 12 months. Approximately 5.2% of the respondents experienced dysthymia in their lifetime; 0.9% had experienced it within 12 months of the interview.

Despite the lack of epidemiological data about the AA population, the literature confirms that EAAs are under great stress and vulnerability. In many studies, AAs consistently report higher depressive symptomatology than their White counterpart, regardless of age.

The stress of immigrant life with its attendant anxiety, conflict, discrimination and alienation may be contributing to poor mental health in this vulnerable population. Noh and Kasper (2003) found that perceived discrimination affects an individual's mental health. They also found that participants with active, problem-focused coping styles were more effective in reducing the impact on depression of perceived discrimination, while frequent use of passive, emotion-focused coping had debilitating mental health effects. Study also shows that discrimination not only negatively affects individual but also collective self esteem (Oh, 2001). In a recent study, Spencer and Chen (2004) stated that discrimination also negatively affects mental health service utilization.

There are many factors correlated with severity of depressive symptomatology among AA population, such as length of stay in the U.S. and acculturation level. The length of residence in the United States is the most powerful predictor for acculturation level and AA mental health in many studies (Hurh & Kim, 1990; Koh & Koh, 1993; Noh & Avison, 1996; Sue, 1994). In these studies, length of residence is generally considered an indirect indicator of acculturation; the longer one stays in United States, the more socio-culturally adapted one becomes to the host society, gaining a larger social support system and better language proficiency, which leads to better mental health status.

In terms of acculturation, researchers confirmed that (a) the more acculturated participants are, the more likely they are to have positive attitudes towards mental health services (Tata & Leong, 1994), (b) highly acculturated participants prefer friends and peers as help sources whereas lower acculturated participants preferred religious leaders and community elders (Solberg, Choi, Ritsman, & Jolly, 1994), (c) highly acculturated participants showed more similarity to European Americans on the Brief Symptom Inventory than did lower acculturated participants (Iwamasa & Kooreman, 1995), and (d) as acculturation levels increased, so too did perceived locus of control (S. E. Park & Harirson, 1995).

Schizophrenia is one of the most prevalent diagnoses among AAs who are hospitalized in psychiatric inpatient units. However, the exact prevalence among AA population is unknown. Overall lifetime prevalence of schizophrenia in Korea and Taiwan is slightly lower than that of the United States, ranging from 0.27 to 0.47 (Gee & Ishii, 1997; C. K. Lee, Kwak, Yamamoto, & Rhee, 1990). Unfortunately, few studies have examined AA with schizophrenia. Bae & Brekke (2002) interviewed 223 individuals with schizophrenia from different ethnic groups. In this study, the Korean Americans were the least acculturated but their symptom levels and clinical status were highly comparable with those of other ethnic groups. This finding conflicted with several projects that have found a relation between acculturation and mental health. The expectations regarding the relationship between acculturation and the symptom and clinical status require further study.

C. Asian Families with a mentally ill member

Gee and Ishii (1997) stressed that is it important for a provider to understand patients' relationships with their families while caring for AA patients. They also pointed out that the treatment of an AA with schizophrenia must involve consideration of the family's attitude toward mental illness and its concern for its reputation in society. In Asian traditions, the family is generally regarded as the basic unit of the society (Lin & Cheung, 1999). A family member's illness is considered a threat to the homeostasis of the family, which often leads to the mobilization of the family's resources. Help seeking typically is a joint family venture rather than a personal decision. An AA patient's first mental health visit often is initiated by a family member and often is preceded by phone calls from one or more family members.

Family members continue to provide social, emotional and practical support for the patient. For example, in Bae and Brekke's study (2002), the percentage of Korean Americans who lived with family (95%) was significantly higher compared to their Caucasian (9.5%), African American (15%), or Latino (42.9%) counterparts. In Shin and Lukens' study (2002), 77% of participants were living with family and the rest of the participants had close and regular interaction with their family. AAs also maintain more familial contact when not living with the family compared to the other ethnic subgroups in this study.

Studies showed that the reluctance in seeking help from outside the family, and the stigmatization of mentally ill people and their family makes it difficult for AAs to seek help from the community when a family member has mental illness (McCollaum & Lester, 1997; Pang, 1998). Chin (1992), in his case study, illustrated extreme reluctance to seek western psychiatric treatment options among Korean American families. Because of the tendency to stigmatize people with mental illness and beliefs that mind-body are not separated depression or other mental complaints are less accepted socially than the physical ones such as back pain, headaches, indigestion, and chest pain (Barry & Grilo, 2002; Cho & Kim, 1998; Pang, 1998). Many AA may get their mental health needs met in ways other than psychiatric/mental health setting, such as general, internal medicine or traditional alternative health care setting. However, the mental health cares through other venues are not sufficiently explored at present time.

Current data regarding treatment delay among AA patients with mental illness suggest that they do not reach the service systems until very late in the help-seeking process, when their condition was extremely severe and all other resources have been exhausted (Lin & Cheung, 1999). Lin, Inui & Kleinman (1982) found that AA patients with schizophrenia typically were contained within the family and the community and generally did not reach the mental health system until three years after the initial onset of their psychotic symptoms. This delay was significantly longer than for their White and Black counterparts.

Since the 1960s, research on the consequences of an individuals' mental illness on family members has revealed that the illness is distressing both to the ill person and to the person's family (Rungreangkulkij & Gilliss, 2000). Over time, the research paradigm has shifted from viewing families as the source of pathology to the venue for significant interaction (Garace, 1998). Recently researcher have started looking at family caregivers as an 'invisible healthcare system', which constitutes the core care provided in the community

(Ohaeri, 2003).

Family burden, expressed emotion, stress and coping, and family resilience are the most common aspects studied in research on families caring for a person with severe mental illness. Because of the effects of mental illness, people who live with severe psychiatric disorders often feel isolated and different from others (Pickens, 1999). It has been established that the family of a person with schizophrenia undoubtedly experiences the personal distress and that the burden does exist within such families (M. Park, 1999). When people learn that their relative has developed serious mental illness, they experience hopelessness, anger, despair and anxiety (M. Park, 1999; Spaniol, Zipple, & Lockwood, 1992). Many studies showed that the level of family burden was correlated with number of interrelated variables: 1) patient-caregiver relationship characteristics, such as the amount of time spent together and level of engagement in caregiving activity 2) patient characteristics such as symptoms and disabilities, and 3) caregiver characteristics like coping and social support (Harvey, Burns, Fahy, Manley, & Tattan, 2001; Ostman & Hansson, 2004).

Studies show that the more severe a patient's symptoms are the greater the caregiver's distress (Boye et al., 2001). Magliano and colleagues (2000) showed that the level of family burden decreased in relation to an improvement of the patient's social functioning. Some researchers suggested that the patient's diagnosis affects family caregiver burden (Jeon, Brodaty, & Chesterson, 2005). In studies of family caregivers of a person with depression (van Wijngaarden et al., 2004), factors relating to interpersonal relationships are more decisive in causing caregiving burden and less relevant to some caring aspects, such as ADL supervision that is rare among depression patients and more common among schizophrenia patients. However, it is consistent, regardless of the diagnosis, that family caregivers who have less social support and less effective coping strategies experience more burden from the family member's mental illness (Magliano et al., 2000; van Wijngaarden et al., 2004).

Families with a mentally ill member express a significantly greater need for services, yet services available for them are limited (Martens & Addington, 2001). Despite increasing awareness about the importance of family to AA patients, research on family caregivers and family caregiving practice are scarce. Little is known about specific burdens that AA families face, how they cope with such burdens and what are some unique characteristics of AA family resiliencies.

The caregiving experiences of families with mentally ill members have rarely been mentioned in the care-giving literature, and thus, this category of care-giver has essentially been ignored (Chesla, 1988; Lefley & Pedersen, 1996). Related to caregiving experiences, it is note worthy that even though caring for a mental ill family member is burdensome, people also expressed positive experiences such as spiritual growth.

D. Health care professionals and family caregivers

Problems arising between health care system and family are not unique to the AA community. Caregivers encounter many problems communicating with professionals (Muhlbauer, 2002). However, AA and other minority patients and families face unique challenges in accessing mental health care services. This is due to the lack of English proficiency, poor health care coverage and poor information about the health care services. Individuals with limited English proficiency often experience difficulties in obtaining basic information regarding health and access to health care owing to the lack of translated materials and the lack of trained medical interpreters or bilingual providers. In Bae & Brekke's study (2002), 93% of the Korean American participants who are diagnosed with schizophrenia did not speak English or preferred to be interviewed in Korean.

While the language gap is most urgent problem, equally important is the provider's ability to understand how language is used to express concerns and what assumptions are brought to the provider-patient exchange(Lefley & Pedersen, 1996; Leong & Lau, 2001; Perttula, Lowe, & Quon, 1999). Especially when many of AAs show lack of English fluency, (for example 93% KAs in Chicago), bilingualism and biculturalism among health care professional are increasingly (A. M. Chen, 1996; Perttula et al., 1999).

Provider's sensitivity to patient and their family needs to be stressed. For example, Asian family members typically assume that it is natural or even their responsibility to be with the patient when the patient talks to the clinician. However, clinicians unfamiliar with the cultural assumptions might regard it as a manifestation of the patient's pathological dependency or the family's over-involvement. Attempts at confronting such behavior may lead to confusion and a sense of humiliation and my result in premature termination (Lin & Cheung, 1999).

Many studies explored and advocated for ethnic or culturally specific mental health services (Chow, 2002; Uba, 1994). These services have been strikingly successful in terms of increasing utilization, shortening the delay between onset of symptoms and contact with the mental health system, and lowering rate of premature termination (Lin & Cheung, 1999). However, considering the extreme diversity among the AA population, it would be impractical and even unrealistic to attempt to provide mental health service specifically designed for each ethnic subgroup (Lu et al., 2002). Also because of the extreme varieties in terms of immigration history, experience and acculturation level among EA populations, the ethnic match between patient and provider does not necessarily lead to cultural fit between them.

The importance of developing clinical skills in working with culturally dissimilar clients has been emphasized in many mental health related disciplines, such as nursing, social work, psychology and psychiatry, yet the issues of training remains problematic in most fields (Lu et al., 2002; Sloand, Groves, & Brager, 2004; Sue & Morishima, 1982). Thus, it is essential to understand how providers develop strategies and care approaches to ethnically and culturally diverse client populations.

Research suggests that families' perspectives are different from providers' treatment priorities and outcome priorities. In Fisher, Shunway & Owen's study (2002), each set consists of a patient, one of the patient's family member and one of the patient's health care provider who were asked to rank seven outcomes and nine services in order of importance and rate the relative importance of each. In general, the priority for each stakeholder was drastically different; no more than a third of the pairs agreed on outcome priorities, and no more than half agreed on service priorities. Interestingly, within-set agreement was lower than agreement by type of stakeholder. Such perspective differences may cause misunderstanding, tension and frustration between each stakeholder. Lenert et al (2000) found that there were systematic differences in values for health outcomes between patients and health care providers with regard to states with adverse effects of antipsychotic drugs. Family members of patients in general had values that were more similar to those of patients than were those of health professionals. The results emphasize the importance of participation by patients (or family member proxies) in clinical decision-making and guideline development.

Because priorities, treatment goals and treatment choices are closely related to a person's belief on health and illness, the cultural difference of provider and patients and family will deepen the gap between them. Differences in perspectives hinder achieving mutual treatment goals, establishing treatment plans and at times lead to premature exit from the treatment. Even though researchers and practitioners have addressed the potential negative outcome of perspective differences, there are few studies about how providers and families cope with such differences and stay in treatment. This is particularly important because AAs have reported experiencing difficulties in navigating a complex mental health system and health providers who have drastically different perspective on mental illness and treatment from their own.

IV. CONCLUSION

Considering the increasing number of multicultural families in the U.S. and current state of family research and theories that have limited power to explain those families, it is urgent to develop culturally specific family theories. In addition, as numbers of multicultural clients in health care settings increase, it is also urgent to understand how health care providers grapple with the issues of culture and cultural competency. This interpretive phenomenological research project addresses both issues by investigating AA family caregiving practices and current psychiatric health care status in every day living from the perspectives of psychiatric/mental health care providers.

CHAPTER 2

REVISITING CONFUCIANISM AS A CONCEPTUAL FRAMEWORK FOR ASIAN FAMILY STUDY

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Revisiting Confucianism as a Conceptual Framework for Asian Family Study

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Confucianism is the central philosophic background for much of the culture in East Asia (EA), particularly for understanding family and social context. The purpose of this article is to examine more fully Confucianism as a conceptual framework for understanding EA family processes and health practices. Confucianism stresses the traditional boundaries of ethical responsibility and the ideal of good human life as a whole. Embedded within Confucian values are five principal relationships, through which each person defines a sense of identity, duty, and responsibility. Current studies of EA families that consider Confucianism as a theoretical base focus almost exclusively on filial piety and collectivism. Focusing only on these two aspects prevents scholars from exploring more complex interpretations of EA family life. A broader inclusion of multiple concepts from Confucianism can provide guidance in exploring the complex and multidimensional aspects of EA family life and allow for broader articulation of family processes.

Keywords: *Confucianism; Asian American*

The Asian American population in North America is rapidly growing. About 4% of the total U.S. population (11.9 million) is Asian American (U.S. Census Bureau, 2000). This population is projected to reach 20.2 million, comprising 8% of the U.S. population, by the year 2020 (Kurasaki, Okazaki, & Sue, 2002). The percentage of Asian Canadians increased 27% since the 1996 census. As of 2001, Canadians of Asian origin make up almost 10% of Canada's total population (Statistics Canada, 2001).

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Despite this growing population, little has been studied about socialization patterns of immigrants and ethnically diverse populations and their impact on health. In 1992, the American Academy of Nursing urged nurses to develop a knowledge base about diverse families to draw meaningful conclusions about how families function in response to health and illness (American Academy of Nursing Expert Panel on Culturally Competent Nursing Care, 1992). However, there has been limited information available to guide nursing practice with diverse families and, in particular, with Asian families (Willgerodt & Killien, 2004).

The purpose of this article is to examine Confucianism as a conceptual framework for understanding East Asian[1] (EA) family processes and health practices in the family context. We will start with a brief history of Confucianism to illustrate how Confucian values are institutionalized and systematically reinforced in EA countries. The major aspects of Confucian tradition that have shaped and influenced EA family life will be discussed: the five virtues, the five basic human relationships, and how the virtues are prescribed within these human relationships. The implications of the proposed concepts in family research will follow.

Studying Culturally Diverse Families

In nursing and other related health science fields, Confucianism[2] is relatively unknown, although interest is growing (Chan, Cheung, Mok, Cheung, & Tong, 2006; Wong, Pang, Wang, & Zhang, 2003). Interest has increased because family and nursing scholars have recognized that existing family theories and theoretical frameworks were developed primarily for European American families and, thus, may have limited power to explain family processes in different ethnicities. Strong family and social ties observed in EA families appear to buffer members from difficult consequences of life and health crises (Bae & Kung, 2000; Yee, Huang, & Lew, 1998). On the other hand, strong family ties add a layer of complexity to EA life. Despite the critical role of families in EA and their descendants, there is a scarcity of research on family processes unique to this population and a parallel scarcity of theorizing about these processes.

Theorizing is a "process of developing ideas that allow us to understand and explain our data" (Bengston, Acock, Allen, Dilworth-Anderson, & Klein, 2005, p. 4). In a recent text on family theories, the following concerns are raised about improving theory in family knowledge development. First, the purpose of theory is to attempt to explain in broader, more abstract and more inclusive terms what has been observed in empirical study. Second, when theorizing is considered as a process, rather than a product, family theorists and researchers can employ it most productively in a contingent, partial, and personally informed process of articulating the lives and concerns of those studied. Third, explicit theorizing is more productive of knowledge than is research and knowledge generation that is atheoretical or relies on implicit, unexamined, or unexplicated theories.

In addition, three approaches to theorizing are acknowledged: (a) the scientific-method approach to theory development, (b) theory as empowerment, and (c) development of theory as narrative (Bengston et al., 2005). The first and most familiar approach to theorizing is to develop theory as an explanation of ordinary or "natural" events with the aim of describing, explaining, predicting, and controlling ordinary events or processes. Typically, such theorizing is deductive and rational–empirical, but it need not be. A good example is when existing theories, modeled on northern European family life, are employed in the study of diverse families. This approach, although adding to the body of knowledge about diverse families, has inherent limits particularly with families from cultures that have fundamentally different notions of family structures and relationships. For example, research that explored Asian American parenting styles with a framework modeled on European American middle-class families suggested that Asian mothers were controlling, restrictive, and protective (Chiu, 1987). This representation of Asian mothering discounted cultural parenting concerns and framed parenting practices negatively in relation to accepted norms of the majority culture.

A second form of theorizing is emancipatory and relies on a critical approach to knowledge development. The aim of such theorizing is to evaluate and challenge power structures and processes that marginalize and disempower social groups and individuals.

A final approach to theorizing is to generate narrative understandings of families. This approach aligns with interpretive knowledge development and relies on narratives to both understand family life and to articulate those lives in richly detailed explanations. Use of existing theory in narrative theorizing is varied, from those methods that assume that natural events must be encountered without the "bias" of previous conceptualizations (Colaizzi, 1973), to those that use existing concepts and theories to "sensitize" their theorizing (Charmaz, 2000; Strauss & Corbin, 1990), to those that fully engage with extant conceptualizations, considering them preunderstandings that allow for framing and correcting ideas about the families under study (Benner, 1994).

In our work, we attempt to develop narrative theories of ethnically diverse families. The interpretive tradition within which we work engages with and attempts to correct extant concepts and theories. Our purpose in describing Confucian concepts is to articulate an existing, ethnically specific, historically grounded perspective on EA family life. We assume that these concepts provide continually relevant background meanings for EA populations and thus are important to explicate for ourselves and for others who are trying to understand the health practices of EA families. The Confucian concepts presented form, at most, a conceptual framework for understanding EA family life. In addition, these concepts are constantly being challenged and modified in the course of living in North American cultures and contexts. Therefore, we see it as an important task to articulate Confucian concepts so that their extended power or influence in family health and relational practices can be recognized.

Why Confucianism? Why Now?

Confucianism is considered by many to be a form of religion, a branch of ethics, or a school of philosophy. Regardless of how one categorizes Confucianism, it seems impossible for anyone to deny the depth and the pervasiveness of the influence of Confucianism to EAs. It holds strong influence in every aspect of EA life and is constantly adapted and modified by EAs. Buddhism and Taoism are also known to have great influence on EA culture. However, Confucianism has been most influential in shaping the behavior patterns and structures of the family and community (Park & Cho, 1995).

For centuries, the values of Confucianism have pervaded the consciousness of EAs. Confucianism posits the family as the fundamental unit of society, incorporating the economic functions of production and consumption as well as the social functions of education and socialization, guided by moral and ethical principles (K.-K. Lee, 1989). Family cohesion and community are taken as the foundation for sustaining the human community and the state. Confucianism is also understood as a code of ethics that prescribes behavior (Tien & Olsen, 2003). Confucian values can be observed in EA social relations, such as intergenerational relationships within the family and other social interpersonal relationships (Park & Cho, 1995). Thus, understanding Confucianism and its influence on the family can be crucial to understanding EA family processes in health.

Historical Background

To fully appreciate the importance of Confucianism and why it is still relevant to EA, it is useful to briefly review how it influenced social structures and was systematically reinforced. Confucian philosophy is primarily a set of ethical ideas oriented toward practice. It stresses the traditional boundaries of ethical responsibility and *dao,* the ideal of the good human life (Cua, 2000). It also may be characterized as an ethics of virtue (Cua, 2000). The core of Confucianism lies in the teachings of Confucius (558-479 Before Common Era, or BCE) contained in the Analects *(Lun yu*; Confucius, 2003), along with the brilliant contributions of Mencius (372?-289 BCE) contained in the *Mencius* (Mencius, 2004). Later, *Daxue* (Great Learning; see http://www.human.toyogakuen-u.ac.jp/%7Eacmuller/contao/greatlearning.htm) and *Zhong yong* (Doctrine of the Mean; Legge, 1998) were added, and they are considered the most important among the Confucian canon.

Confucianism is not merely a Chinese philosophy. As with other great ancient philosophies, such as Buddhism and Daoism, Confucianism was introduced to EA countries and deeply influenced the formation of every aspect of life. Confucianism was the philosophic ground of much of the culture in East and Southeast Asia (Neville, 2000).

Confucianism was established by the teaching of Confucius, which is the Latinized term for K’ung Fu-Tzu (sometimes transcribed as K’ung Tzu). Confucius lived during the “Spring and Autumn Period” (722-481 BCE) in China. During his time, the country experienced many internal conflicts and attacks from outside the region (Billington, 1997). The traditional ritual system was undergoing disintegration, and society was witnessing deep moral decline, social chaos, and general destruction during the wars between the states (Ni, 2002). However, the “Spring and Autumn Period” was also China’s most glorious period in philosophy. Many of the greatest minds of China, such as Confucius, Lao Zi, Mo Zi, Zhuan Zi, Mencius, Xun Zi, and Han Fei Zi, were born during this time.

Confucius spent his life in learning, teaching, editing ancient classics, and offering political services. Confucius believed that his teachings were already inscribed in the ancient traditions, such as rituals, history, music, and poetry. For example, he researched the ancient traditions and composed *Li Ji* (Book of Rite). His own teachings were recorded by his disciples and collected in the book of *Analects* (Billington, 1997). Confucius took up public service as a way of implementing his ideals and practicing his philosophy. His version of utopia was humane and simple, as shown in the following:

> When the perfect order prevails, the world is like a home shared by all. Virtuous and worthy men are elected to public office, and capable men hold posts of gainful employment in society; peace and trust among all men are the maxims of living. All men love and respect their own parents and children, as well as the parents and children of others. There is caring of the old; there are

> jobs for adults; there are nourishment and education for the children. There is a means of support for the widows and the widowers; for all who find themselves alone in the world; and for the disabled. Every man and woman has an appropriate role to play in the family and society. A sense of sharing displaces the effects of selfishness and materialism. Intrigues and conniving for ill gain are unknown. Villains such as thieves and robbers do not exist. The door to every home need never be locked and bolted by day or night. These are the characteristics of an ideal world, the commonwealth state. (Xu, An, & Lao, 1999, p. 128)

It is difficult to describe Confucius' philosophy in a brief or abstract form. Even *Analects* has no specific logical order. All of the lines in the *Analects* are interrelated, and each Confucian text is generally interrelated. Neville (2000), however, articulated the core of Confucius's ideas into three points. The first was Confucius's interpretation of his time. Confucius analyzed pervasive social chaos as the evil of his day resulting from an operative failure of the good. Confucius argued that the inculcation of propriety and ritualized habits of life were necessary to allow people of varying stations and conditions to live fulfilling lives. Second, he believed that high civilization was made possible by ritual. Fundamentally, civilization was required for people to live harmoniously with themselves, their fellows, and the world. Rituals and conventional social habits existed to guide humans so that the ideal status of nature, social institutions, and humans themselves would flourish in harmony. Third, the most important element of human wisdom was competence at ritual and the habit of practicing ritual in all circumstances. Benevolence was also considered a requirement. Confucius believed that the most certain route to goodness was through education and self-cultivation. The broadening of the mind enabled a person to show loving kindness toward others, observe proprieties, and express righteousness in his or her dealings (Billington, 1997). The long tradition of EAs emphasizing education began with Confucius.

Mencius, Confucius' student, focused on benevolence or "human heartedness" as a natural quality of being human. He stressed that "human nature is good." Mencius's philosophy is described as "idealist Confucianism" because of his optimistic view of human nature and his emphasis on the spiritual dimension in Confucian virtues (Billington, 1997). The most important contribution of Mencius is his addition of a metaphysical rationale to Confucius' ethics (Cua, 2000), which paved the way for neo-Confucianism a thousand years later.

The Confucian view of government, especially the notion that the right to govern is not sustained by heavenly decree but by the ability to make its citizens happy and secure, was thought to be harmful by some of the emperors or kings who believed in a strong and absolute enforcement of the authority. It was during the Han dynasty (206 BCE–184 Common Era, or CE) that Confucianism became an officially recognized state ideology of China (Ni, 2002).

Between the third and eighth centuries CE, a process of synthesis known as neo-Confucianism occurred and brought about a modification of Confucianism (Yao, 2000). Early neo-Confucians focused their attention on texts, such as the *Mencius, Daxue,* and *Zhongyong,* and began to evolve a version of Confucianism that was supported by a comprehensive and complex metaphysical system. Under the influence of Taoism and Buddhism, Confucian thinkers tried to explain the linkage between human beings and the universe in a more metaphysical way than earlier teachers (Billington, 1997; Xi, 2000). These changes helped to transform the earlier Confucian concern with self-cultivation and steady moral improvement to a more dramatic quest for spiritual enlightenment.

The infusion of Confucian values into society varied with each EA culture, and tracing the specific influences is beyond the scope of this brief review. However, an example demonstrates how these values were structurally promoted within the general public through education, social, and institutional pressure. Korea, which was perhaps the most Confucian country in Asia (Kalton, 2000), had public practices for rewarding filial piety. For thousands of years, people who cared for parents or parents-in-law were rewarded with monetary compensation and were given a statue in a public place. The statue listed the person's name, family background, and his or her deeds so that others could read and learn by their example. Occasionally, the government printed a book filled with such filial cases. On the other hand, people who did not care for their family were frequently imprisoned or punished with public humiliation.

This brief history gives a glimpse of the pervasiveness and power of Confucianism in EA countries, with specific application in Korea. We will now outline some key concepts of Confucianism that deserve attention in examining EA families in health.

Five Virtues

In Confucianism, there are five basic virtues that one has to pursue: *ren* (benevolence), *yi* (integrity, uprightness), *li* (rite and propriety), *chi* (moral understanding), and *shin* (trust). There are also dependent virtues, such as filial piety, loyalty, respectfulness, and integrity (Cua, 2000). The basic virtues are considered fundamental in leading or guiding action; they are cardinal and the most comprehensive.

Ren 仁

Ren is commonly translated as benevolence, altruism, humanity, or being human-hearted (Zhang, 2002). The Chinese character represents the figure of two people, as *ren* is thought to be possible only when one human being is in relationship with another; one cannot be *ren* by oneself. *Ren* also means a quality that is required to be a human being (Ni, 2002). *Ren* refers to the affectionate concern for the well-being of persons in one's community (Billington, 1997; Cua, 2000). Confucius said that *ren* requires that we "do not impose upon others what you yourself do not want," and ultimately, *ren* requires that we "love the people" (Confucius, 1983). *Ren,* however, is different from a general humanitarian love for the general public. It starts from one's own home and family. Love of one's parents is the first of the *ren.* The second is the love for one's siblings. Thus, *ren* starts from very specific and close relationships. In this way, *ren* differs from humanitarianism or humanism. For example, Mencius harshly criticized Mo Zi, who claimed that one should treat everyone equally, stating that one who cannot differentiate one's own parents from others is no different than an animal (Mencius, 2004).

Yi 義

Yi is translated as the sense of rightness. This is a notion that when one acts, one's intention and the action should be righteous. Human beings should be able to recognize when nonrighteous things or situations fall outside the scope of *li,* or proper social conduct (Cua, 2000). *Yi* and *ren* are the most important basic virtues of early Confucianism. They are paired concepts because each is viewed as a condition of the other, rather than each as standing alone. Because *ren* is about the humane heart, it can be used as a basis for favoring those who are closer to oneself over strangers. Loving others is only possible by restraint of the self. For example, it is natural for a teacher to love her own child more than a student. However, if the teacher shows her love for her child over other students, she would not be a good teacher or a good parent. For Confucians, the restraining of desire that comes from human nature is achieved by self-cultivation. Through cultivation, one can reach a state that is always on the side of the right (Mencius) and is devoted to principle but not in an inflexible way (Confucius). Even though *ren* is a natural human quality, it can only be achieved and fully embodied through cultivation. Especially for those who are in position of being superior, *yi* is not separate from *ren.* Thus, *ren* and *yi* are usually referred to as a pair, rather than each virtue standing alone.

Li received more attention and was more reinforced by rulers than *yi,* who used *li* to systematically reinforce their ideologies and existing political regimes, emphasizing, for example, the inheriting right of the first son and his family over other siblings. On the other hand, rebels used *yi* as the basis to demand justice from a corrupt king or, more rarely, as grounds for a revolution that ultimately resulted in regime change, as follows:

> Hence, how can we say that the son is filial, if he obeys whatever his father said? How can a subject be considered loyal if he follows whatever his king orders. Those who examine what they are expected to follow, that is what filiation and loyalty means. (Mencius, 2004, p. 129)

Li 禮

> Look not at what deviates from *li*; listen not to what deviates from *li*; speak not what deviates from *li,* make no movement that deviates from *li.* (Confucius, 2003, p. 112)

Li defines the boundaries of proper behavior, provides opportunities for satisfying desires of moral agents within these boundaries, and encourages the development of a noble character that embodies cultural refinement and communal concerns (Ni, 2002). *Li* is a broader concept than etiquette. It encompasses not only proper behavior in the social sense but also ritual propriety, social order, effective modes of action, modes of education, and self-cultivation. *Li* also represents the possibility of immortality through family ritual, as one is remembered and honored with ritual ceremony after one's death. Ancestral rites celebrate individual ancestors for three generations. Even after three generations, one is remembered alongside other ancestors.

As *ren* is possible only in relation to other living people, *li* is possible only in the context of relationships and social structures. An individual should know one's own social position and conduct oneself accordingly. Confucius (2003) said that "the ruler rules, the minister ministers, the father fathers and the son sons" (p. 114). Because *li* involves one's unique position in the social web, one needs to establish one's position in relation to others. Within the extended family, one's position in the family tree is important. Traditionally, those who are on the same family line share the same designated character in their name to indicate their position in the genogram. In social relationships, age is the critical factor in establishing relative orientation. Older persons have different social expectations about how to behave and what to expect from their younger counterparts, and vice versa. Thus, it is still common among EAs to ask about age, especially when one encounters strangers. There are rather sophisticated ways to ask about age, such as inquiring about a class year. Orienting oneself in the context of a specific social web is an important social activity among EAs.

As discussed earlier, Confucius's analysis of his time was that ritual and conventional forms of social behavior had failed to keep the peace. He believed that the purposes of ritual and conventional social habits were to orient people so that social institutions and everyday relationships could flourish in harmony (Neville, 2000). These unspoken social rules and codes were possible to learn only through embodied learning and self-cultivation.

Many have criticized the Confucian emphasis on *li,* or proper behavior, as having a limiting and negative effect on behavioral expression. This criticism may involve a misunderstanding of Confucian ideas. The authority of the older is neither absolute nor isolated. Expectations for proper behavior are accompanied by expectations for guiding the young and being a good role model for the young. Confucian teachers criticize the notion of *li* without *ren* or *yi.* Confucius emphasized the embodiment of virtue by self-cultivation over superficial etiquette or shallow acts focused on petty details. Even though the basic human relationship is always viewed as rather hierarchical in Confucianism, one's duties toward others are well distributed and fair.

Chih 知

Chih refers not to the "knowing about" but rather to the ability to recognize and differentiate between good and "not-good" (Zhang, 2002). Such ability is not only a cognitive process but also an intuitive process developed through a continuous process of self-cultivation. Chinese philosophers were not concerned with how knowledge was acquired but rather with what knowledge should be acquired and what ought to be the object of knowledge and research (Zhang, 2002). *Chih* is acquired through long self-cultivation. It was when he was 40 years old that Confucius finally claimed that he acquired the state of *chih*. He harshly criticized his contemporaries as follows:

> What I dislike about your knowledgeable ones is the effort they put into their argumentation. If those knowledgeable persons would only do as Yu did to the water then there would be nothing to dislike in their knowledge. In dealing with the water Yu found it the easiest passage. If the knowledgeable persons would find the path of greatest simplicity their knowledge would also be great. (Mencius, 2004, p. 4)

Shin 信

The Chinese character of *shin* refers to trust. However, as one of the five virtues, it is interpreted as the state of mind that is without deception or lies (Zhang, 2002). This is a character that is important when relating to others.

In one's social life, if one is to have a meaningful relationship with others, one should be trustworthy, without cheating or lying. Also, if a person treats others with shallow friendship or pretentious etiquette, the person is not trustworthy nor *li.*

Five Relationships

Embedded within Confucian values are five principal relationships through which each person defines a sense of identity, duty, and responsibility. The five principal relationships are ruler and subject (government and citizen), parent and child, husband and wife, older sibling and younger sibling, and friend and friend. Confucius taught that peace and harmony could be achieved if every person knew his or her proper place in society and upheld the responsibilities of that place. Through the definition of the five basic relationships, Confucianism provides a simple guide for ordering family and society:

> Justice and righteousness should mark the relations between sovereign and subject. There should be proper rapport between father and son. There should be separation of function between husband and wife. The younger should give precedence to the elder. Faith and trust should reign over relationships between friends. (Confucius, 1983, p. 60)

Confucius taught that if everyone upheld these five basic responsibilities and relationships, social and political order would prevail. In the following section, we will discuss each relationship more deeply. These relationships are prescriptive rather than descriptive. To say that someone is a ruler implies a certain attitude that one is to have toward the ruler and the ruler toward the ruled. Hence, each of the relationships is characterized by two sets of expectations expressing virtues to be displayed by each member (Zhang, 2002). Unfortunately, as time went by, the system developed into a rigid justification of social hierarchy, neglecting the responsibilities incumbent on the superior in each relationship.

> The father is to be compassionate, the son filial, the elder brother kind and the younger brother respectful, the husband just and the wife obedient, the older person gracious and the young compliant, the ruler benevolent and the minister loyal. These ten are called human norms. (Xu et al., 1999, p. 126)

Government and Citizen 君臣有義

The relationship between the ruler and citizen is ideal if it is embedded with a sense of *yi* or a sense of integrity. Ideal rulers or superiors are to be fair and just. Among the most common criticisms of Confucianism is that it promotes dictatorship or corruption. However, it is interesting to note that instead of the basic virtue of *ren,* the most important aspect of the government is fairness. Although the father is supreme within the family, he is subservient to leaders. All people have the responsibility of honoring and obeying their rulers. However, the ruler also has responsibilities to his people. He is supposed to protect his people, ensure their welfare, and, above all, set good examples for them through his own actions. Confucius thought that if a ruler were honest, his people would follow him in honest behavior: "But if the ruler was corrupt, how could he expect anything different from his subjects?" (Confucius, 1983, p. 120).

The ruler also had a responsibility to follow the laws of heaven. If the ruler failed in his obligations, natural and economic chaos might follow, and the people would have to overthrow the ruler.

Parents and Children 父子有親

There should be closeness between parents and children. In all familial relations, respect of parents and grandparents has supreme value. However, the guidance and discipline that parents give to their children should be based on emotional closeness and love. Near total obedience is given to parents by the rest of the family. Ideally, quarrelling, loud talking, smoking, and drinking alcohol are not permitted in their presence. In turn, the elders are supposed to treat the younger generation with affection. They are allowed to be strict but not cruel.

Husband and Wife 夫婦有別

The value that governs the husband–wife relationship is based on a principle of mutuality. The underlying spirit is not dominance but division of labor. It is also important to note that a value of duty looms in Confucian family ethics. If children are involved, the role of the mother should take precedence over the role of wife.

Older and Younger Siblings 長幼有序

Between siblings, older siblings are expected to be a role model for their younger siblings. And in turn, younger ones are to respect to the older ones. The oldest among siblings usually acts as the surrogate of parents in their absence. When resources are limited, the oldest son is typically supported in his education, whereas the other siblings are expected to support the family and the oldest. In return, the oldest is expected to support and to be a representative of the whole family.

Between Friends *朋友有信*

Precedence of the old over the young governs more than sibling relationships; this order is not limited to the family relations but applied to all social networks. A distinctive feature of Confucian ethics is to accept seniority as a value in setting up social hierarchies. However, age alone does not automatically give one status. Obedience in relationships in Confucianism is also contingent on the senior members observing their duty to be benevolent and caring.

Among the five basic human relationships, three are family relationships. This confirms a strong representation of the notion that family is the base of society. In Confucianism, both community and society are a mere extension of the family. Thus, the ideal social relationship is the one that demonstrates qualities that parallel those found in family life. A person who does not do well within family relationships cannot do well in society: "Let the ruler be ruler, the subject be subject, the father be father, and the son be son" (Confucius, 1983, p. 114).

We want to emphasize that the five relationships as expounded by Mencius all involve mutual respect and reciprocity between two parties. All these relationships were seen as mutual exchanges. There was never a demand for absolute obedience for son to father, minister to ruler, or wife to husband (Zhang, 2002).

Relevance to Current Theories

As discussed earlier, this article aims to sensitize family researchers and clinicians to culturally grounded family relationships. To illustrate how Confucian notions can shed light on current family study, we will briefly discuss emotional overinvolvement in expressed emotion (EE). Conceptually, EE refers to an aspect of the family environment that has been a reliable predictor of relapse in psychiatric and nonpsychiatric illnesses (Butzlaff & Hooley, 1998). The original concept of EE included a set of positive and negative emotions. However, three major negative concepts—criticism, hostility, and emotional overinvolvement—have been the focus of research. In the literature, Asian families are often found to have a high level of emotional overinvolvement (Slote & De Vos, 1998). When family members blame themselves for everything instead of the patient, this indicates emotional overinvolvement. They feel that everything is their fault and become overinvolved with the ill member (Lopez et al., 2004).

Jenkins and Karno (1992) and Cheng (2002) have noted that what counts as emotional overinvolvement is a matter of cultural definition. We notice that EE is based on Western individualism: the notion that individuals are the irreducible base of society and are agents detached from others. However, Confucianism views a person as a part of a family with interdependent responsibilities and expectations. In the Confucian tradition, the family is the irreducible unit rather than the individual, and members are expected to be involved with other family member's lives. For example, parents' value as human beings is judged by how well they perform as parents. Parents' performance is judged to be good if their children grow up to be good citizens. Thus, when a child is ill or considered as a bad citizen, EA parents are expected to feel responsible and even blamed for their failure as parents. Confucianism thus provides some background explanation for why EAs may demonstrate emotional overinvolvement at rates that are high compared to non-Asian families. If a high level of involvement is expected in EA culture, then a low level of family involvement may have an adverse affect on an ill family member.

Confucianism in Changing Families

As a result of immigration and acculturation, many EA families face significant challenges to their beliefs and practices. The ways in which Confucian values shape family relationships in this context are unclear and deserve investigation. Exploration of how Confucian precepts are maintained, adapted, and modified by EAs and their descendent family members after immigration to North America may be central to understanding their health beliefs and practices. The following are some pressing questions related to health that we propose for exploration in immigrant EA families.

First, compared to other virtues, filial piety is relatively well researched because of its relevance in family caregiving, particularly with elderly parents (K. C. Kim, Kim, & Hurh, 1991; Sung, 1990, 1995). However, we believe that filial piety is poorly conceptualized and portrays complex EA family life too simply. These conceptual problems stem from the misunderstanding that filial piety is a concept that stands alone. Filial piety is a core tenet of Confucian parent–child relationships, but the virtue is limited to the parent–child relationship. Thus, its implication is relatively limited. Understanding other social relationships, sibling relations, or the marital relationship requires the use of other concepts.

Second, among family subsystems, husband–wife relationships have received the least attention from health researchers. Traditionally, there were strict role divisions and power imbalances between husband and wife. The husband had primary responsibility to financially support the family and the authority to make decisions about important family matters. The wife was responsible for managing the home and caring for the children (Hurh & Kim, 1990). Many scholars have observed challenges to traditional power hierarchies and gender-role conflicts in couples (M. Kim, Han, Kim, & Duong, 2002; M. J. Kim, Cho, Cheon-Klessig, Gerace, & Camilleri, 2002). Studies show that EA women have emotional conflicts about their place in Western society, trying to reconcile the roles of the traditional Asian female with that of the American working woman. When families experience juvenile delinquency or intergenerational conflicts, wives typically feel responsible and are blamed. Because child care is assumed to be the women's primary responsibility in traditional EA culture, women feel frustrated by not being able to guide their children properly (Hurh, & Kim, 1990; Nah, 1993).

Stress from changing traditional gender roles negatively affects men as well as women. Once in the United States, immigrants who had been white-collar workers in their country of origin are forced to engage in small businesses or manual labor. Status inconsistencies arise from taking positions of lower prestige, educational requirements, or pay than those held prior to immigration (Hurh & Kim, 1990; Min, 1990). These inconsistencies, coupled with Confucius precepts that devalue physical labor and emphasize male provider roles, generate considerable stress for Asian male immigrants. Increased explorations of the processes by which couples adapt together to these acculturative stresses are warranted.

In the Confucian tradition, the parent–child relationships take precedence over the husband–wife relationship. However, it is questionable that such hierarchies of relationships continue without modification as the EA family acculturates, and thus several questions warrant further investigation. As parent–child relationships change after immigration, which tenets are easily modified and which are more resistant to change? How are children allowed to participate in family decision making regarding their health? As the EA child ages developmentally, how do immigrant parents influence the decisions regarding the offspring's health?

Last, the relationships between the extended EA family system and community deserve investigation. Many studies have investigated how extended families function as support systems (Chee & Levkoff, 2001; J. H. Kim & Theis, 2000; Y. R. Lee & Sung, 1998). More EA families live in proximity to extended families as compared with non-Asian families. However, their adaptations when extended family support is not available have not been examined. Would EA families turn to the community and, if so, to what extent? How do EA families' expectation toward social institutions, including government and health care systems, influence their illness experiences and expectations of health care providers?

Conclusion

In this article, Confucianism was discussed as a possible conceptual framework for exploring relations in East Asian American families. We attempted to problematize current discourse of diversity and multiculturalism by offering an alternative set of concepts to European-focused family theories. Drawing on ethnically specific and historically grounded theoretical perspectives, such as Confucianism, was suggested as one possible direction for theorizing family health beliefs and practices in ethnically diverse families. Understanding culturally specific family processes will help to further our understanding and ability to address the issues of health disparity within the East Asian American population.

To explore the applicability of Confucianism in modern EA families, studies are needed to explore how families negotiate, redefine, and perhaps reject Confucian values. Studies are also needed to explore the commonalities and differences in how subgroups of EA immigrants negotiate between the culture of origin and the American culture. Qualitative research and comparative research are necessary to this process. More studies are needed to understand families that do not fit the traditional family notion, such as single-parent families and families with gay members.

Notes

1. We want to acknowledge that *Asian* is an extremely broad term. Asia consists of more than 30 countries and islands, each with a unique history and culture. Thus, we will limit this articulation of Confucian concepts to East Asians, including people from Korea, China, and Japan and their descendants. EA countries share many cultural properties similar to each other, and yet many cultural aspects remain unique. The similarities originated from geographical proximity, close international relationships, and paths of new knowledge via trading routes.

2. We acknowledge that the Confucianism presented here is neither a religion, school of philosophy, nor branch of ethics. There are many scholarly discussions about Confucian religion,

epistemology, and ethics. However, such discussions are not within the scope of this article. Here Confucianism refers the basic values and background understanding among people from EA countries.

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CHAPTER 3:

METHODOLOGY

I. INTRODUCTION

Working with mentally ill patients for 14 years both in Korea and the United States gave me an opportunity to observe not only the patients' struggles, but also that of the families of these patients. I came to strongly believe that mental illness is not an individual experience but rather a communal one experienced by all family members. My dissatisfaction with the general mental health service system, policy and state of the science that focused mainly on the individual grew as I witnessed the lack of attention given to family members of mentally ill patients. After I began studying the family as a unit, my passion for family study grew stronger. My interest in family caring practices in the context of ethnic uniqueness also increased. As I studied more, I realized that many studies did not represent the experiences of the clients I saw and their families, or were sometimes irrelevant to them. There are many inherent limitations in he use of quantitative methods while studying the families. These limitations seem to stem from the very nature of the knowledge that these methods present to us.

The purpose of this paper is to present research methods for this hermeneutic phenomenological study. To do so, I will start with 1) addressing methodological issues of studying the experiences of non European American families, 2) the appropriateness of hermeneutic phenomenology in studying Asian American experiences with a mentally ill family member and 3) a brief historical and philosophical background of hermeneutic phenomenology.

II. METHODOLOGICAL ISSUES IN STUDYING NON WESTERN FAMILIES

Despite the socio-cultural changes or differences between disciplines, family is currently accepted as a "group of persons united by the ties of marriage, blood, or adoption and interacting with each other in their respective social positions" (The Encyclopedia Americana, 1987). By definition, family is a collection of individual members. The Cartesian tradition of rationalism, atomism, and methodological individualism underlies this definition. With an understanding of the underpinning Cartesian notions, we can rephrase the definition above as such: family is a group of people made up of individuals each with an inner, private space of understanding. Under the Cartesian definition, each family member is viewed as independent from one another, and can only be understood independently. Such individualistic views of the family limit the units of analysis in family research on the individual level. The interactions between the members are measured quantitatively, because a qualitative difference is considered not to be measurable, or too subjective to study and therefore not scientific. Using the Cartesian view of the family, even when one agrees that the family is a cultural and a social institution, one has to agree to consider the family as comprised of individual members, independent entities, with little or no shared social understandings and meanings.

Non-Western cultures share drastically different ontological positions toward family from that of Western society. Thus, theoretical and methodological issues are raised when studying none-Western families. For example, in the Asian culture, family is not a group of individuals. Family is rather an origin where each individual develops and grows. When discussing family in Asia, one should consider the notion that it refers to not only the immediate nuclear family but also the genealogy of the whole family trees. Often the notion of family even includes the past generations that are already deceased and the future generations that are not yet born. The conceptual and ontological differences are reflected in how we think about the family, how we orient ourselves in relation to family, and what our pressing concerns are when it comes to family, and probably ourselves. Such conceptual differences are also reflected in how Asians interact with each other, what are considered appropriate family processes and what are pathological. Thus, applying family theories that are developed based on the Western family have limited power in explaining the Asian family phenomenon. In addition, the methodological premise of individualism in natural science is not an appropriate match in theorizing Asian families. Thus, to understand Asian families, new methodological approaches are necessary.

III. METHODOLOGICAL ISSUES OF STUDYING LIVED EXPERIENCES

Under Cartesian ontology, one's experience is not accessible to others because it is viewed as a subjective and private mental activity. Because private inner experience is not accessible to others, personal experience is not considered to reside in the realm of science. Scientific truth has nothing to do with one's personal experience. By science, I mean normal science that Kuhn defined (Kuhn, 1996). Gadamer states that the purpose of philosophical hermeneutics is

> To seek the experience of truth that transcends the domain of scientific method wherever that experience is to be found, and inquire into its legitimacy. Hence the human sciences are connected to modes of experience that lie outside of science: with the experiences of philosophy, of art, and of history itself. These are all modes of experience in which a truth is communicated that cannot be verified by the methodological means proper to science (Truth and Method (hereafter TM) xxii).

Despite the apparent differences among many quantitative research approaches, most studies use methodological individualism. Even structural approaches focus on the pattern of relationships between individuals. In a previous chapter, I tried to articulate how the family and the individual are not, in everyday life, independent of each other as the Western Cartesian view claimed. Rational empirical approaches do not accept the notion that the person is thrown into a particular historical and cultural world. By ignoring that we are born into certain webs of relationships and of social and cultural meaning, and by normalizing and predicting human behavior, empirical knowledge fails to formulate a relevant representation of the very thing it claims to be about.

Kuhn (1996) once wrote that research paradigms are loosely connected sets of philosophical beliefs, methods, and exemplars in problem solving that establish boundaries for research, govern the conduct of inquiry and establish criteria for judging results. He further claimed that when researchers are challenged by questions that cannot be addressed with the familiar boundaries for their paradigm, such questions are frequently devalued or dismissed.

Many social scientists focus their efforts on observable and measurable outcomes. This approach has produced strong and useful theories capable of explaining many of human behaviors. Unfortunately, measuring actions and observable outcomes of social interaction provides an undersocialized view of meaningful social interaction (Granovetter, 1985). Habermas claimed that everyday experience is already symbolically structured and inaccessible to mere observation.

Gadamer (2004) said that we must seek the experience of truth that transcends the domain of scientific method wherever that experience is to be found, and inquire into its legitimacy. Hence the human sciences are connected to modes of experience that lie outside of science: with the experiences of philosophy, of art, and of history itself. These are all modes of experience in which a truth is communicated that cannot be verified by the methodological means inherent in accepted scientific procedures. Thus, to provide more complex, nuanced and valid explanation of social interaction, one must have reliable methodologies of interpretation.

IV. HERMENEUTIC PHENOMENOLOGY AS KEY TO UNDERSTANDING CULTURE AND FAMILY

A. Why is this method appropriate for the study of family caregiving practices? (Purpose 1)

Families share the cultural meanings. Members share experiences that are uniquely shaped by family history and understandings of the world shared within families. These shared experiences are, most of the time, difficult and rarely fully articulated. A family is different from an individual or any other group. Family holds and hands over cultural traditions to a person. The family is the place where some of the most fundamental aspects of human life are implanted in a person. As a holder of culture, the family is an ontologically different entity from the individual. Thus, study methods appropriate to individuals may not be appropriate to families. In addition, if one wants to study culture, tradition, or the changes of cultural practice, the family should be the key place to observe them.

Family caregiving practices that members negotiate and practice without specific prescription happen in everyday life. Narrative accounts from a family member with a mentally ill member and from practitioners who care for them will allow us to describe and understand how family caregiving is actually practiced (Chesla & Chun, 2005).

In addition, hermeneutic phenomenology is an appropriate method for articulating cultural beliefs and practices. The cultural meanings are shared by members in the form of cultural habits, practices and customs, for which there is no written or precise account. The vague yet prescriptive nature of cultural meaning makes it difficult to study culture by employing a theoretical grid, particularly one that may not be culturally appropriate. Lee & Landreth (2003) identified filial piety as a major contributing factor for AA family caregiving . Filial piety was the only concept that got attention even though there are other concepts that may influence family and social life. Hermeneutic phenomenology allows various aspects of family life to show up as they are lived. Thus various cultural properties can be presented and analyzed in terms of the ethnic group members' own perspectives. Theoretical constructs, such as acculturation and Confucianism, serve as sensitizing constructs for the analysis of these texts.

B. Why is this method appropriate for the study of practitioners' caregiving practices? (Purpose 2)

Providers' perspectives on AA families are particularly helpful to understand the complexity of the family caregiving practices. Providers contact multiple families for long periods of time and thus have practical knowledge of a breath of complex family caregiving practices in AA families. In addition, providers are often detached from and engaged in the family caregiving at the same time. Such flexible modes of engagement with the families allow providers unique perspectives on family caregiving practices among AA families. Providers also have contact with families from multiple ethnic groups, thus enabling them to provide accounts of intra- and inter-group differences among different ethnic groups. Such unique positionality of health care providers has been rarely explored in health care research. In addition, providers' accounts may provide crucial insights when it comes to highly stigmatized illness or rare illness. This is particularly relevant to this study because it is well documented that mental illnesses bring extreme stigma not only to patients but also to families. Such severe stigmas often hinder AA families from participating in research projects. As a consequence, there is a scarcity of empirical data on this population, making it impossible to understand ethnically specific family processes and to develop culturally specific treatments for them.

In studying providers' perspectives, I argue that its ontological stance and methodological properties make the hermeneutical phenomenology a suitable methodology for studying perspectives of practitioners. In addition, the kind of knowledge that I try to understand in this study is ontologically different from that which we seek in normal science. Thus, such knowledge requires different epistemological approaches. To better ground these arguments, I will further examine the nature of phenomena this research project dealt with. Firstly, family caregiving, its processes, and providers' practices are situated. By situated, I mean that they are culturally and historically grounded. Secondly, family caregiving, as well as providers' practices, are everyday engaged practical activities (Chesla, 1995). Thirdly, the knowledge that I tried to gather is a kind of knowledge that developed and resided within the practice of mental health providers. Fourthly, I am trying to gather that knowledge via their narratives of practice with specific patients and families. Finally, I also try to gather such knowledge via providers' reflections on practice philosophies including overall assessments of their learning over time, and their assessment of what they don't know. Such narrative accounts, unlike questionnaires, allow providers to fully express their concerns (Chesla, 1995).

V. BRIEF HISTORY OF HERMENEUTIC PHENOMENOLOGY

Among many branches of phenomenological tradition, hermeneutical phenomenology stems from Martin Heidegger's philosophy, followed by many other philosophers such as Hans-Georg Gadamer, Hannah Arendt, Paul Ricoeur, Herbert Dreyfus and Charles Taylor, etc. For a long time, hermeneutics and phenomenology were considered independent disciplines. It was Heidegger who critiqued transcendental phenomenology and developed a new ontological tradition of phenomenology. Many philosophers contributed to the tradition that generated the possibility for Heidegger's position including Kierkegaard's thesis (Kierkegaard, 1954).

A. Hermeneutics – Schleiermacher and Dilthey

Hermeneutics was originally the theory and method of interpreting the Bible and other difficult texts. However, modern hermeneutics is generally understood as the study of understanding, especially the task of understanding texts (Palmer, 1969). Palmer (1969) emphasized that hermeneutics achieves its most authentic dimensions when it moves away from being techniques for text explication and attempts to see the hermeneutical problem within the horizon of the general account of interpretation itself, and of being human, which is grounded in interpretation.

Friedrich Daniel Ernst Schleiermacher (1768-1834) can be considered to be the founder of modern hermenutics. Until Schleiermacher, hermeneutics was divided into two branches, one dealt with Greek and Latin classical texts and the other dealt with the Bible. Each branch required particular applications and operational rules (Ricoeur, 1981). Shleiermacher tried to frame general hermeneutics as the art of understanding (Palmer, 1969). For him, understanding as an art is the re-experiencing of the mental process of the text's author (Palmer, 1969). This position stays within the tradition of the private subject. He stated that there are two interacting moments: grammatical interpretation dealing with the linguistic issues, and psychological interpretation focusing on the subjective and individual contribution of the author. Ideal interpretation, for Schleiermacher, is a holistic activity. Any given piece of text needs to be interpreted in light of the whole text to which it belongs, and both need to be interpreted in light of the broader language in which they are written, their larger historical context, a broader pre-existing genre, the author's whole corpus, and the author's overall psychology. Such holism is in essence, circular, and leads to his notion of the hermeneutic circle, which will be discussed in detail later in this chapter.

Wilhelm Dilthey (1833–1911) extended hermeneutics as interpretation of text to interpretation of all human acts and products, such as history, and to interpretation of a human life (Innwood, 2000). Dilthey believed that the reductionist and mechanistic perspective of the natural sciences was not an appropriate methodology for human science (Palmer, 1969). Dilthey despised the traditional notion of knowing as a strictly cognitive act. He proposed that knowledge about human beings should incorporate feeling, will and, most importantly, the historical context of the human life. He drew the line sharply between natural science and human science. "Understanding" was identified as the key word for human science and "explaining" for natural science.

The sciences explain nature; the human studies understand expression of life.

Behind life, thinking cannot go (Dilthey, 1957)

Dilthey proposed that there is a systematic relation between life, expression and understanding (Dilthey, 1957) . Dilthey thought that by investigating this relationship, human science could be an independent discipline with outside validity. Gadamer (2004) provides his version of Dilthey's historicalism in his book *Truth and Method*.

> …There was no such thing as a universal subject, only historical individuals. The ideality of meaning was not to be located in a transcendental subject, but emerged from the historical reality of life. It is life itself that unfolds and forms itself in intelligible unities, and it is in terms of the single individual that these unities are understood (Gadamer, Truth and Method, P218).

B. Phenomenology – Brentano and Husserl

The tradition of phenomenology is extraordinarily diverse in its interests, interpretation of the central issues of phenomenology and the application of what is understood to be the phenomenological method (Moran, 2000). Phenomenology should be understood as both a philosophical method and a philosophical movement (Laverty, 2003). Moran (2000) points out that phenomenology is best understood as a radical, anti-traditional style of doing philosophy, which emphasizes the attempt to try to describe a phenomenon as it appears to the person who experiences it.

The saga of phenomenology generally starts from Franz Clemens Brentano (1838-

1917), who influenced Edmund Husserl (1859 – 1938), the founder of phenomenology. Brentano's notion of intentionality means a directionality of intention that is a mental activity and emphasizes the mental relationships with the objects. Brentano's view, Heidegger later critiqued, offered only a notion of "pure" intentionality, excluding a tacit or skillful embodied intentionality, or intentionality directed by 'taken for granted' cultural practices and habits. Brentano's notion of intentionality influenced Husserl a great deal. Phenomenology, for Husserl, is a science of the essential structures of pure consciousness with its own distinctive method, namely Husserlian phenomenology. Husserlian phenomenology (transcendental phenomenology), is out of the scope of this paper. However, it is worth mentioning phenomenological reduction, to more effectively distinguish Hermeneutic phenomenology from Husserlian Transcendental Phenomenology. Phenomenological reduction refers to eidetic reduction and transcendental reduction (epoché, bracket). Husserl, a PhD. in Mathematics, believed that we get to the essence by turning our attention away from concrete individuals and focusing on what they have in common, such as in mathematical studies of the essential natures of numbers and shapes.

> I have particular intuition of redness or rather several such intuitions. I stick strictly to the pure immanence; I am careful to perform the phenomenological reduction. I snip away any *further* significance of redness, any way in which it may be viewed as something transcendent, e.g. as the redness of piece of blotting paper on my table, etc. And now I grasp in pure seeing the meaning of the concept of redness in general, redness in specie, the universal seen as identical in this and that. No longer is it the particular as such which is referred to, now this or that red thing, but reds in general….could a deity, an infinite intellect, do more to lay hold of essence of redness than to see it as a universal? (Husserl, 1964, pp. 44-45)

One may also more radically leave the natural attitude altogether, put the objects we are concerned with in brackets and instead reflect on our own consciousness and its structure. By putting aside psychological, cultural, religious, and scientific assumptions, new features of those acts come to the fore. Husserl asserts that we need to bracket certain fundamental structures in order to allow more basic objectifying acts of consciousness to become visible in them. The essential feature of bracketing is to alter or to move away from the assumptions both deeply embedded in our everyday behaviors towards objects and also at work in natural science. Despite my rejection of the possibility of using a complete phenomenological reduction, I have to admit that his insights about our life world and culture are shared by many philosophers after him, including Heidegger.

C. Hermeneutic phenomenology – Martin Heidegger and Hans-Georg Gadamer

i. Martin Heidegger

Martin Heidegger (1889-1976), a direct student of Edmund Husserl, took phenomenology into a very different direction. His influence does not stop with philosophy, but has spread into many other disciplines. Most of the post-modern thinkers admit Heidegger's influence in their intellectual life. Palmer (Palmer, 1969) explains that Dilthey saw hermeneutics in the horizon of his own project of finding an historically oriented theory of methodology for human science, Heidegger used the word "hermeneutics" in the context of his larger quest for fundamental ontology. Charles Taylor has said that Heidegger's importance lies in the fact that he is one of the few contemporary philosophers who have helped to free us from the grip of rationalism (Taylor, 1999). I believe that one of Heidegger's contributions is also his new interpretation of phenomenology and, as a consequence, its hermeneutical turn opened up a possibility of a new methodology. Others' experiences are not only accessible to us, but are an ontological basis of our own being.

In his book *Being and Time* (BT hereafter) (1962/1927), he proposed that phenomenology is "*to let that which shows itself be seen* from *itself in the very way in which it shows itself from itself*" (BT, p58). That is letting things become manifest as what they are, without forcing our own categories on them, and allowing things to show themselves as they do in our everyday experiences in the world. Thus, our experience is constituted by interpreting and encountering what has already been interpreted by us and by others. So, the business of doing phenomenology means, according to Heidegger, doing hermeneutics.

> The methodological meaning of phenomenological description is interpretation. The logos of a phenomenology of Dasein has the character of hermeneuein, through which are made known to Dasein the structure of his own being and the authentic meaning of being given in his understanding of being. Phenomenology of Dasein is hermeneutics

> in the original sense of the word, which designated the business of interpretation (BT, P37).

Hermeneutics for Heidegger, becomes interpretation of being of Dasein (Heidegger, 1962/1927) and becomes ontology of understanding and interpretation (Palmer, 1969). Then Heidegger declared that the goal of his project is a hermeneutics of being a human rather than studying just being as the totality of objects. He distinguished entity and being of entity. He claims that the being of entity is utterly dependent upon us. We first contact entities in terms of their use or availability in relation to our projects or concerns. We arrange and manipulate things according to the project at hand. Heidegger said there are three modes of disclosure of entity; ready-to-hand, present-at-hand, and un-ready-to-hand. He concludes that the essential disclosure of things is only possible through our concerned dealing with them in the world in ready to-hand mode. Heidegger claims that the being of entity and being of human being is ontologically different. It is because only Dasein (a tentative name for being of human being) can distinguish the entity and its significance (Sheehan, 1999). He begins his interpretation of Dasein by pointing out that Being-in-the-world is the basic state of Dasein. The world, for Heidegger, is not either universe or environment. It is the whole in which the human being always finds oneself already immersed, surrounded by its manifest as revealed through an always pre-grasping, encompassing understanding (Palmer, 1969).

Dasein is not an entity that stands alone. It's always caught up in the world, dealing with things and others. Dasein's Being-in-the-world is only possible because it is Being-with-others (Heidegger, 1962/1927). We encounter others while we engage the project of being. As a thrown and temporal being, we encounter others in history and tradition. Being thrown means the fact that Dasein always finds itself within a given cultural, social and historical realm. Being thrown as a participant in a particular lifeworld makes it possible for us to have a pre-understanding about the world that we live in and about ourselves. Living within traditional and societal norms, which is very vague, yet quite prescriptive, is how Dasein dwells in the world most of the time. It is familiar and rather comfortable. However, one can be exposed to the facticity, the strangeness and foreignness of life (Heidegger, 1962/1927). The breakdown and rupture of the everyday allows what is usually presupposed and accepted to become questionable. Unreflective habits and customs become visible in that which resists, reverses and withdraws from the meaningfulness maintained and reproduced in everydayness. Facticity refuses, resists, and reverses interpretation and meaning. One's meaningful relationship with things and others is only possible in the context of throwness and temporality.

ii. Hans-Georg Gadamer

Hans-Georg Gadamer (1900-2002) is considered to be a founder of philosophical hermeneutics. He was influenced by Heidegger a great deal. His book, *Truth and Method* (2004), is a decisive event in the development of modern hermeneutic phenomenology. Gadamer, like Heidegger, questioned the traditional naturalistic notion of hermeneutics as a methodological basis for human science in contrast to natural science. He asserts that the truth in the human sciences is ontologically different from that of natural science and the Cartesian tradition. He also accepts the Heiddegerian notion of understanding and the notion of a hermeneutical circle. He emphasizes language as the vehicle of communication and of cultural preservation and transmission. He states that hermeneutics is an attempt to open ourselves up to the other. Truth is not reached methodically but dialectically, Gadamer claimed. His philosophy rests heavily on Heidegger's hermeneutics of facticity and historicity, which was influenced by Dilthey. For him, prejudices do not constitute a willful blindness which prevents us from grasping the truth; rather they are the form from which we launch out to attempt to reach understanding (Moran, 2000).

> The self-interpretation of the individual is only a flicker in the closed stream of historical life. For this reason, the prejudgments of the individual are more than merely his judgments; they are the historical reality of being (TM, P261).

Gadamer also states that prejudices (or horizons of understanding) can change depending upon shifts in social constructs and with subjective experience. Gadamer does not restrict his analysis to the understanding of things, but applies the concepts of understanding to the hermeneutical interpretation of a text through the concept of the hermeneutical conversation as bridging "the distance between minds" and between horizons of interpretation and understanding. The goal of the hermeneutical conversation is to come to an understanding. This understanding can only occur if both parties find a common language:

> Hermeneutical conversation, like real conversation, finds a common language, and finding a common language is not, any more than in real conversation, preparing a tool for the purpose of reaching understanding but, rather coincides with the very act of understanding and reaching agreement. (TM 388)

Both for Gadamer and Heidegger, language and practices are not only instruments for communication, but also disclose, participate in and constitute one's lifeworld. Language and practices hold and pass on the tradition. Tradition conceals itself in language and practices. Gadamer continues that experience is not so much something that comes prior to language, but rather experience, itself, occurs in and through language.

II. HERMENEUTIC PHENOMENOLOGY AS A SCIENTIFIC RESEARCH METHOD TO EXPLORE ASIAN AMERICAN LIVED EXPERIENCE WITH A MENTALLY ILL FAMILY MEMBER.

A. Some Definitions

i. Lived Experience

Lived experience is the starting and end point of phenomenological research (Van Manen, 1990, p. 36). For Dilthey, lived experience is a unity that is held together by a common meaning.

> That which in the stream of time forms a unity in the present because it has a unitary meaning is the smallest entity, which we can designate as an experience. Going further, one may call each encompassing unity of parts of life bound together through a common meaning for the course of life an "experience"- even when the several parts are separated form each other by interrupting events (Dilthey, 1989, p. 86).

For Gadamer, experience is a process, and a true experience is the experience of one's own historicality in light of human finitude. Experience is distinct from sameness in that it always connotes change.

> Every experience is taken out of the continuity of life and at the same time related to the whole of one's life. It is not simply that an experience remains vital only as long as it has not been fully integrated into the context of one life, consciousness, and the very

> way it is preserved and dissolved by being worked into the whole life. Consciousness goes far beyond any significance it might be thought to have. Because it is itself within the whole of life, the whole of life is present in it too (TM, P60).

ii. Understanding

In the dictionary, understanding is defined as 1) to perceive the meaning of, comprehend, 2) to be familiar with, have a thorough knowledge of something or 3) capacity to feel something of what another person is experiencing. However, hermeneutical understanding is defined differently and is worth reviewing to fully articulate hermeneutic phenomenology.

For Dilthey, understanding does not mean comprehension or retention of rational concepts. It is the process of understanding the other person's mind. Thereby, it is to open up to his/her lifeworld. In tern, we expand the possibility of understanding our own experience. His view on understanding, however, remains a mental process, as his teacher Scheiermacher, and remains in the realm of epistemology.

Heidegger proposed that understanding is a Dasein's way of being in the world. For him, understanding means that a person grasps one's own possibility for being, in the context of one's lifeworld. Because of our ontological structure mentioned above, Heidegger said that pre-suppositionless interpretation is impossible. Understanding is already interpreting and is embedded in the world, which penetrates the subject and object relationship between the world and us.

Understanding is a fundamental condition of Dasein's being-in-the-world. It makes any interpretation possible. Understanding is only possible because Dasein already has significance and meaning. Through Heidegger's notion of understanding, it moves from the epistemological realm to the ontological realm.

iii. Hermeneutical Circle

For Schleiermacher, the hermeneutical circle refers to the relationship between individual parts and the whole text. The dialectic interaction between the whole and the part, each giving the other meaning, occurs in a circular motion. Dilthey followed

Schleiermacher's definition of the hermeneutic circle. However, he said that it is the meaning that understanding grasps in the essential reciprocal interaction of the whole and the parts. For him, meaning is always historical and contextual. Meaning is grasped in a particular time in history.

It was Heidegger and Gadamer that interpreted the hermeneutical circle as ontological. Heidegger begins by challenging the general notion of questioning. He states that questioning is one form of disclosure. But he analyzed the structure of questioning and revealed that to ask something, we must have some kind of initial understanding of what we are asking about. He claims that our pre-understanding and the mode of access are crucial to the answer of the question. By pre-understanding, he means vague, average understanding (BT.P5). He points out that average understanding makes questioning possible. But, at the same time, this pre-understanding blocks or interferes with answers to the very question. He explained that it is because preconception can distort or conceal the answer completely.

> Further, this vague, average understanding of Being may be so infiltered with traditional theories and opinions about Being that there remain hidden as sources of the way in which it is prevalently understood.(BT, 25)

Any answer to the question that is guided by pre-understanding will shed light and disclose phenomena in a certain way, but will allow one to formulate further questions. So our understanding will be advanced. Any inquiry is provisional, as Heidegger put it, because of the circular relationship between pre-understanding and understanding. For Heidegger, the hermeneutical circle refers to the circular relationship between the inquiry and the disclosure of the truth.

He believed that the rock bottom pre-understanding for human beings is one's particular culture and mood that the culture carries with it. Everyday, ordinary encounters with things, how things reveal themselves in their average everydayness should be the starting point of the inquiry of being a human.

B. Hermeneutic phenomenology in exploring lived experience

Benner and her colleagues defined hermeneutic phenomenology as a practice of interpretation and understanding of human concerns and practices (Benner, Tanner, & Chesla, 1996). They further explained that it attempts to capture everyday skills, habits, and practices by eliciting narratives about the everyday and by observing action in meaningful contexts. The general aim of phenomenological research is to provide an open horizon for phenomenon to emerge as it is understood and then be communicated to others (Johnson, 1997).

III. DATA COLLECTION

A. Study Aim and Design

The purposes of this study were to 1) understand Asian American families' everyday caregiving practices for a person with a mental illness and 2) understand how mental health care providers provide care for AA patients and families. In this study, Asian American was defined as immigrants from Korea, China, and Japan and their descendents. Mental illness was defined as diagnosis of chronic severe psychiatric disorders, such as major depression, bipolar disorder, and Schizophrenic disorders.

The specific aims were to 1) examine patterns of family caregiving practices for mentally ill family members among AA families as mental health care providers observed, 2) provide a systematic articulation of Confucianism as manifested in the AA family caregiving practices and describe how Confucianism is modified as families acculturate to the United States, 3) identify the particular difficulties perceived by mental health care providers in caring for AA families and some strategies they use to cope with these difficulties, 4) examine patterns of practice among mental health professionals providing care for AA patients and families.

The primary source of this hermeneutic phenomenology was the person's experience. It was assumed that those who have provided care for AA families with a mentally ill family member know more about the phenomenon than the researcher (Gadamer, 2004). Data sources were designated theoretically to have a better opportunity to glimpse the lifeworld and experiences of caring for AA families with a mentally ill family member. Persons' experiential descriptions can be gathered in many ways. However, for this proposed study, each person's lived experience was gathered mainly in the narrative mode.

B. Recruitment

Participants consist of mental health providers who have treated mentally ill AA patients and families in the past 5 years in the San Francisco Bay Area. The San Francisco Bay Area is unique in terms of its large Asian American population and the effort to develop a culturally focused mental health system. Thirty percent of residents of the San Francisco Bay Area are Asian Americans (U.S. Census Bureau, 2000). The need for ethnically and culturally focused mental health care delivery eventually led to the development of multiple ethnically and culturally focused inpatient and outpatient services. Participants were recruited by 1) posting flyers at inpatient hospital and outpatient clinics whose major clients are Asian Americans, 2) using the snowball technique, and 3) giving presentations of the study at staff meetings in mental health clinics and in hospitals.

C. Procedures

i. Interviews

The phenomenological study design involved face-to-face interviews and participant observations. Potential provider participants were recruited through flyers and telephoned me to receive further information. Providers recruited through staff meetings where the study was presented individually volunteered. At this time, I scheduled a face-to-face meeting. Each interview lasted approximately 90 minutes. Two participants had an additional interview to clarify the content of the previous interview. The follow up interview lasted no more than 60 minutes. The total time of participation in this study was no more than 180 minutes. All interviews were conducted at a convenient and mutually agreeable location that would afford the participant privacy.

Interviews were open-ended and minimally structured, encouraging the participants to articulate their own experience with their Asian American clients and clients' families. Interviews focused on providers' narratives of their practice of caring for AA patients and families, as well as their practice philosophies and treatment approaches. Providers were asked about their general practice and educational background. To understand providers' perspectives on AA family caregiving practices, providers were asked about 1) unique issues or dilemmas and 2) unique strengths or skills that they have observed in AA patients and their families. To understand providers' practice and practice philosophy, providers were asked to describe specific practice approaches that they have used with AA patients and their families that have been particularly successful as well as those that have not worked particularly well. To gather narratives, providers were encouraged to provide specific incidents to illustrate their answers. I used minimal prompts during the interview and let the story unfold by itself. Providers were prompted only to enhance my understanding of the story and for clarification purposes. Examples of some prompts that I used are: 'Why was this episode of care unique to you?', 'What helped you to be successful with this family?', 'What stood in your way?', and 'If you were to care for this patient and family today, what would you do differently' (See Appendix for Sample Questions).

Interviews were digitally recorded with the consent of each participant. The interview was transcribed by professional transcriptionists. Participants were informed that they could stop or take a break at any point during the interview or choose not to participate in the study at anytime. The research was approved by the Committee of Human Research at the University of California, San Francisco.

ii. Study participants

Participants were diverse in their ethnic/cultural background, practice settings and professional background. Participants consisted of 7 social workers, 5 psychiatrists, 4 registered nurses, 2 psychologists, 1 licensed psychiatric technician and 1 psychiatric resident. Among them, 14 were working in inpatient settings, 5 in outpatient settings and 1 in Psychiatric Emergency Services. The average years of experience were 16.3 years, with experience ranging from one year to 23 years. Only 4 of the participants were White, whereas 16 of them were Asian Americans. Among the Asian American participants, 5 of them were born in America, while 11 were foreign born. All inpatient participants were working at the Asian focused unit, where most patients were Asian Americans or immigrants from Asia. Participants from public outpatient clinics were working at parallel agencies, where the major goal is to serve Asian American clients. In addition, participants from private practices were trained at the Asian focus unit or one of the parallel agencies during their professional training.

Table 1: Participants

Profession / Practice setting	Inpatient	Public outpatient	Private outpatient clinic	Private practice	Psychiatric Emergency Services	
RN	4					4
Psychiatrist	3		1		1	5
Psychologist				2		2
Social worker	2	3	2			7
LPT	1					1
Psychiatric resident	1					1
Total	11	3	3	2	1	

iii. Field notes/Memos

I took field notes and memos as vigorously as I could during and after interviews. These field notes were an important part of the data to serve as the context of the environment, my understanding of the participants, reflections about the interview.

IV. DATA ANALYSIS

A. Interpreting the data

The analysis and interpretation of the data started with the first interview and continued throughout the course of the study. Each transcription was read and reread carefully. The first reading was to understand the interview in terms of its flow and its organization.

During the reading, narratives were identified. Because this project had two purposes, each purpose and related specific aims were investigated separately. Parts of the interview and the whole interview were used to deepen my understanding of each provider's practices. As a new interview was added to the data, it was compared and contrasted with existing interviews.

Many kinds of memos were written. A memo was written for each interview: the location, the general mood and the impression of the interview. Questions such as what was missing in the interview and follow up questions for the next interview was documented. All identified narratives were named and grouped according to their theme and an extensive memo about the narrative was written. In addition to the narrative specific memos, thematic and reflective memos were also written. An expert hermeneutic researcher (Dr. Chesla) assisted the research in the development of an understanding of text and to identifying gaps and blind spots that may hinder or complicate interpretation.

The goal of hermeneutic phenomenology is achieved by showing commonalties and differences in the participants' experiences. Benner and Wrubel (1989) identified five sources of commonalities : 1) by understanding the situation in which the person is historically and currently engaged, 2) by understanding the embodied knowing of the person about the encountered situation 3) by understanding the lived time by which one projects oneself into the future based on one's past, 4) by understanding the concerns with which one is meaningfully oriented towards the situations and finally 5) understanding the common meanings which create possible issues, agreements and disagreement between people.

Plager (1994) pointed out that the fundamental issues in phenomenological data analysis are: forestructure of understanding, interpretation, the hermeneutic circle and mode of involvement. I tried to fully explore Confucianism as my forestructure for the proposed hermeneutical exploration in my theory paper.

The interpretation of hermeneutical phenomenology unfolds with three levels of analysis: the paradigm cases, thematic analysis and exemplars. Paradigm cases are strong instances of particular patterns of concerns, ways of being in the world, or ways of working out a practice (Benner et al., 1996). Even though interpretation begins with the analysis of each case, each case does not stand alone, as it is in a case study methodology. Benner points out that identifying a paradigm case is almost always a shared experience among the research team members. The aim of studying paradigmatic narratives is to understand the situation within the practical lived world of the participant, with all of its constraints, realities, and possibilities (Benner et al., 1996).

Exemplars are the vignettes which support and capture the meanings in situations and help them to recognize these meanings in different circumstances and to describe qualitative distinctions (Leonard, 1994). A range of exemplars allows one to establish a cultural field of relationships and distinctions (Benner, 1994).

Thematic analysis is the process of the identification and working out of themes in the text (Benner et al., 1996). It is an attempt to articulate the broader understanding that arises from consistent comparisons and readings, side by side, of the different paradigm cases and exemplars.

B. Evaluation of the hermeneutic phenomenological study

The quality of an interpretive account does not rely on a fixed set of criteria such as we find in natural science as reliability and validity. Earlier in this chapter, the ontological difference in the nature of truth in human science from natural science has already been articulated. It has established the primacy of hermeneutics over the scientific method in human understanding.

Yet, the possibility of using validity and reliability for evaluating qualitative research in general is still in the forefront of scientific debate (Koch, 1996; Madison, 1988; Sandelowski, 1986; Van Manen, 1997; Whittemore, Chase, & Mandle, 2001). Yet some scholars insist that new criteria are needed for evaluating qualitative studies other then validity and reliability. However, setting criteria encompassing all methodologies in qualitative research would not only be impossible, but also contradicts its notion of truth. All research is temporal and thrown as researchers and the informants, yet criteria may help researchers to share a common language with each other, hence increasing understanding.

Madison (1988) proposed nine criteria for evaluating hermeneutic accounts; an account 1) is coherent because it presents and unifies a picture including contradiction; 2)is comprehensive in giving a sense of the context and temporality of the participants; 3) is penetrating the central problems which are being examined; 4) is thorough in dealing with all the questions posed in the research; 5) must be appropriate in answering the questions raised by the text itself; 6) is preserving the contextual situation through writing; 7) must agree with what the text says, but show where interpretations were made because previous interpretations were deficient; 8) is suggestive in raising questions for further research; and 9) has potential in uncovering and illuminating future events.

V. LIMITATION

Because of the limitation of time and resources, the recruitment of participants was limited to the San Francisco Bay Area. The cultural diversity in the area is unique compared to other areas of the United States. AA families who live in other areas where there is limited access to multicultural health care systems may develop different family processes and adjustment strategies to their health issues. Unlike the providers who participated in this study, health care providers who rarely encounter AA patients and families may have difficulty in finding institutional and structural support. However, the goal of this study is to address the pressing issues of everyday AA family practices so that providers can appreciate the complexity of AA family life with a mentally ill member in full. In addition, I am trying to illuminate the excellences of providers' practice and practice philosophies that developed through extensive practice and training so that other providers can learn from their experience.

Providers who participated in this study are serving a poor and underserved population, most of whom do not have health insurance or rely on public health care systems, such as the Medicare and MediCal. Thus, their practice setting and their clients may differ from those who have private health insurance.

Because this research project focused on the family caregiving practices among families who reside with, or have at least weekly contact with the person with a mental illness, this study does not address how AA families support and care for a mentally ill member when they do not reside with the ill family member or when they live far away from the patient. This study was not able to address the issues of the families that do not fit in with the traditional structure of the traditional AA family, such as same sex couples, single or mixed families. Considering the important role of family in the AA individual’s life, it is important to study how the notion of family is modified and adjusted as the family structure changes.

CHAPTER 4

STUDY RESULT FOR PURPOSE 1

TWO SIDES OF A COIN: ASIAN AMERICAN FAMILY CAREGIVING

I. INTRODUCTION

Asian Americans (AA) are the fastest growing ethnic minorities in the United States (Chen, Kramer, Chen, & Chung, 2005). The number of AAs in the United States has grown rapidly to 10.2 million, representing 3.7% of the population in 2000 as compared with fewer than 1 million in the 1960s (U.S. Census Bureau, 2000). The number of AAs is expected to double by 2025 and to reach 37.5 million by 2050 (S. M. Lee, 1998). Mental health care providers who are practicing or planning to practice where a substantial number of AAs reside such as the West and East Coasts of the United States and in metropolitan areas, will inevitably encounter AAs as one of the major patient groups (Lu, Du, Gaw, & Lin, 2002). Thus, it is important to understand this population in order to provide reliable assessment and treatment.

AAs are a heterogeneous group comprised of at least 43 different ethnic groups who have their origins in unique countries with different languages, religions, health and illness models, and health seeking patterns (S. M. Lee, 1998). Although many of these subgroups share an important cultural heritage, there is also great diversity among them. There are inter- and intra-group differences in socioeconomic status, immigration patterns, life experiences, family dynamics, and acculturation level. Recent studies emphasize the uniqueness of specific AA ethnic groups. Kim and colleagues (2001) cautioned that joining these unique ethnic groups into a single category blurs important differences that professionals should be aware of and may contribute to a homogenized view of AAs. Also, the conclusions drawn from analyses using AAs as a single ethnic category may differ from those drawn from a specific ethnic group (Takeuchi & Kramer, 2002) .

In this study, Asian American (AA) were defined as 1) immigrants from East Asian countries, such as China, Korea, Taiwan, Hong Kong and Japan, 2) descendents of East Asian immigrants, and 3) children of mixed marriages where one of the parents is East Asian American. As a sub-group, East Asian Americans comprise at least 42 % of AAs (U.S. Census Bureau, 2000). East Asian countries have a long history of exchanging culture and thus, share many common cultural values including family values. In addidition, East Asian Americans share similar immigration histories (Berg & Jaya, 1993).

Understanding AA family caregiving for a mentally ill person is particularly important because a disproportionately high rate of AAs with a mental illness reside with or have regular contact with their families. Unfortunately, there is no sound national database on community-based residential arrangements of persons with severe mental illness and the characteristics of their caregivers (Lefley & Hatfield, 1999); however, the ethnic differences in terms of family caregivers who reside with a mentally ill patient are apparent. For example, in Guarnaccia's study (1998), approximately 32 % of White patients resided with their families, whereas 60 % of African-American patients and 75 % of Hispanic-American patients resided with their families. Even higher percentages are suggested among Asian-American patients (Lin, Miller, Poland, Nuccio, & Yamaguchi, 1991); up to 83% of Korean American patients with schizophrenia reported to reside with family (Shin & Lukens, 2002).

The data discussed in this article are part of an interpretive phenomenological research project. The purpose was to further understand AA family caregiving practices from the perspective of mental health care providers. The specific aim of this paper is to show the complexity of AA family caregiving based on the data from mental health care providers (providers hereafter) working in various practice settings. In addition, we will 1) address limitations of current family theories in explaining multicultural families and 2) discuss ontological and epistemological issues of studying multicultural families from multiple perspectives.

II. PROBLEMATIZING CURRENT FAMILY THEORIES

Interest in a culturally grounded family theory has increased because scholars have recognized that existing family theories and theoretical frameworks were developed primarily for European American (EA) families and, thus may have limited power to explain family processes in different ethnic and cultural groups (Park & Chesla, 2007). Strong family and social ties appear to buffer members from difficult consequences of life and health crises, particularly in AA families (Bae & Kung, 2000; Yee, Huang, & Lew, 1998). On the other hand, strong family ties add a layer of complexity to AA life as caregiving responsibilities may add burden to caregivers. Despite the critical role of families for AAs and their descendants, there is a scarcity of research on family processes unique to this population and a parallel scarcity of theorizing about these processes. Recently, scholars started exploring new possibilities to theorize AA families. For example, Park & Chesla (2007) proposed to explore Confucianism as a conceptual model for AA families. We argued that concepts derived from Confucianism provide continually relevant background meanings for AA populations and thus are important to explicate for those who are trying to understand the health practices of AA families. Additionally, We argued that these concepts are constantly being challenged and modified in the course of living in the context of North American cultures. Therefore, articulating Confucian guiding concepts and their modifications in everyday practices are important theoretical tasks in studying AA families.

AAs generally view the family in a fundamentally different way than Whites. Where as Whites generally consider the individual to be the irreducible unit of society and the family as a group of individuals, AAs generally consider family to be the irreducible unit of society. This does not mean that there is no notion of individuality in AA culture; however, the individual only exists in relation to the family and larger community. Such ontological differences are reflected in current family theories and may be the root cause of the limited implications of majority of family theories to AA families. From an individualistic theoretical perspective, AA family processes have been viewed as over-involved, demonstrating a lack of individuality between members (Cheng, 2002). Taking such a theoretical stand on AA families is particularly problematic if practitioners attempt to use it to guide their practice. Such theoretical perspectives may negatively shape practitioners' approaches to AA families and lead to negative experiences for both practitioners and AA families. Cultural misunderstandings hinder providers from building therapeutic alliances, and cause miscommunication, alienation, and premature withdrawal of the family from the treatment process.

III. ONTOLOGICAL AND EPISTEMOLOGICAL ISSUES OF STUDYING MULTICULTURAL FAMILIES AND STUDYING MULTIPLE PERSPECTIVES

In this study, providers' experience and their perspectives on AA families were investigated. Providers' perspectives on AA families are particularly helpful to understand the complexity of the family caregiving practices. Providers contact multiple families for long periods of time and thus have practical knowledge of a breadth of complex family caregiving practices in AA families. In addition, providers are often detached from and engaged in the family caregiving at the same time. Such flexible modes of engagement with families allow providers unique perspectives on family caregiving practices among AA families. Providers also have contact with families from multiple ethnic groups and are able to provide accounts of intra- and inter-group differences among different ethnic groups. This unique positionality of health care providers has been rarely explored in health care research.

In addition, providers' accounts may provide crucial insights when it comes to highly stigmatized or rare illnesses. This is particularly relevant to this study because it is well documented that mental illnesses bear extreme stigma not only to patients but also to families among AAs (Hom, 1998; Shin & Lukens, 2002). Such severe stigmas often hinder AA families from participating in research projects. As a consequence, there is a scarcity of empirical data on this population, making it difficult to understand ethnically specific family processes and develop culturally specific treatments for them.

Hermeneutic phenomenology guided the design and conduct of this study (Benner, 1994). Chesla (1995) argued that hermeneutical phenomenology is an appropriate methodology to study family process, because it is based on a philosophy that admits shared meanings between family members and that takes serious families' commitment and values. These Heideggerian perspectives form the assumptions that guide the methodology and that specifically guided the design of this project.

First, family caregiving, its processes, and providers' practices are situated. By situated, we mean that they are culturally and historically grounded. As a situated being, we already have a vague understanding of the world in which we are living. Unfortunately, the very understanding limits our understanding, as we cannot understand beyond our horizon of understanding. Thus, our understanding of the world is a constant modification of our existing understanding through our practices in the very world we are trying to understand. By assuming that a human being can be perfectly objective without prejudice, we are denying our own ontological and epistemological possibilities.

Second, family caregiving, as well as providers' practices, are everyday engaged practical activities. Family caregivers and providers do not stop and reflect upon what they are doing during activities. For example, during cooking for a family member, one does not stop and reflect upon what she/he is doing. It is possible to stop and reflect, but it will disrupt the activity. If one has to stop and reflect during the conversation or cooking, it would be impossible to finish any activity. In this study, we tried to understand the activity not the reflection.

Third, the knowledge is developed and resides within practices, in this instance, in the practice of mental health care providers. In this project, we are trying to gather that knowledge via their narratives of practice with specific groups of AA patients and families. We also try to gather such knowledge via providers' reflections on their practice philosophies including overall assessments of their learning over time, and their assessment of what they don't know. Such narrative accounts, unlike questionnaires, allow providers to more fully express their practical understandings, generated during years of experience in working with AA patients and families.

IV. METHODOLOGY AND METHODS

A. Participants

Twenty mental health care providers who have treated mentally ill AA patients and their families during the past 5 years in San Francisco Bay Area were recruited. The San Francisco Bay Area is unique in terms of its ethnic focused mental health system. Compared to other metropolitan areas, thirty percent of residents of the San Francisco Bay Area are AAs (U.S. Census Bureau, 2000). To serve such a diverse population, the San Francisco Bay Area led development of multiple ethnically and culturally focused inpatient and outpatient services. Such models effectively increase consumer satisfaction and decrease a premature drop out rate (Gamst et al., 2003)

Recruitment methods included 1) flyers at an inpatient psychiatric hospital and various outpatient mental health clinics where the majority of clients were AAs, 2) presentations at staff meetings, and 3) a snowball technique. Providers were diverse in their ethnic/cultural background, practice settings and professional background. Participants included 7 social workers, 5 psychiatrists, 4 registered nurses, 2 psychologists, 1 licensed psychiatric technician and 1 psychiatric resident. Among them, 14 were working in inpatient settings, 5 in outpatient settings and 1 in Psychiatric Emergency Services. The average years of experience were 16.3 years, with experience ranging from one year to 23 years.

B. Data collection

The verbatim data were collected through face-to-face, in-depth interviews. All interviews were conducted by Ms. Park. Interviews were open-ended and minimally structured. Interviews focused on providers' narratives of their practice of caring for AA patients and families, as well as their practice philosophies and treatment approaches. Minimal prompts were used during the interview to let the story unfold itself; follow up questions included using narrative and reflective questions. Each interview was digitally recorded and was transcribed by a professional transcriptionist. The research was approved by the Committee of Human Research, University of California, San Francisco.

In addition to face-to-face interviews, field notes and memos made during and after the interviews were also included in the analysis. These field notes were an important part of the data and provided the context of the environment, the interviewer's understanding of the participants, and the reflections about the interview. In this study, software Atlas-Ti was used to organize and manage large amount of data.

C. Data analysis

Plager (1994) pointed out that the fundamental issues in phenomenological data analysis are: forestructure of understanding, interpretation, the hermeneutic circle and mode of involvement. We claim Confucianism as the forestructure for this particular hermeneutical exploration. The analysis of the data began at the time the first narrative was collected and extended through final interpretation and articulation of the research findings. Interpretation within hermeneutic phenomenology comprised of three levels of analysis; paradigm cases, thematic analysis and exemplars. Paradigm cases were strong instances of particular patterns of concerns, ways of being in the world, or ways of working out a practice (Benner, Tanner, & Chesla, 1996). Even though interpretation began with the analysis of each case, each case did not stand alone. Rather parts of the interview and the whole interviews informed each other and deepen the researcher's understanding of the practitioners' experiences. The aim of studying paradigmatic narratives was to understand the situation within the practical lived world of the participant, with all of its constraints, realities, and possibilities (Benner et al., 1996).

Exemplars were smaller narratives, or portions of narratives which support and capture the meanings in situations and supported the identification of qualitative distinctions in practices (Leonard, 1994). The range of exemplars allows one to establish a cultural field of relationships and distinctions (Benner, 1994). Thematic analysis is the process of identification and working out of themes in the text (Benner et al., 1996). It is an attempt to articulate the broader understanding that arises from consistent comparisons and readings, side by side, of the different paradigm cases and exemplars.

V. FINDINGS

Providers' perspectives on strengths and struggles of AA families with a mentally ill member were similar regardless of their practice setting. Providers reported that there was no clear distinction between family strengths and struggles. What was identified as strength became a source of struggle and dilemma to families and patients. For example, the strong family ties and support were the most distinctive and positive characteristics of AA families. At the same time, such a strong emphasis on the family as a unit added burden on patients and their family caregivers. For the sake of discussion, we categorized aspects of AA family caregiving practices into positive and negative aspects. These distinctions are somewhat artificial as families' actions embodied both positive and negative poles. For the sake of articulation and to emphasize situations that bring both the positive or negative aspect of family engagements, we separated these discussions.

A. Positive sides of strong family support

i. Family engagement in treatment

Providers reported that what set AA families apart from families of other ethnic groups was the strong emphasis on family. Providers were impressed by AA families' dedication toward their mentally ill family member, and their demonstration of bonding and support. For patients from other ethnic groups, the families were either not available or showed significantly lower levels of support. For AA patients, the family was still the primary support through their treatment and illness management.

> Provider: I do think that it is more important for my Asian American patients to include family. If I don't have the family's agreement on what the nature of the problem is, and what ought to be done about it, then there is very little chance that the treatment recommendation will happen. So, for a lot of reasons it seems to me that is more important...well more important and more possible…

AA families were often the point of access, forming a bridge between the patient and mental health services. AA patients' contacts with mental health systems were often initiated by families. Families brought patients to a clinic for an evaluation or called the police or 911 after patients became dangerous or acted bizarrely in public. During initial contacts, the collateral information from the family was especially valuable because it helped providers to assess the functional and clinical baseline level of the patient. In Psychiatric Emergency Services, or during the initial assessment phase, the fact that families lived with patients and were available for information made a great difference in providers' approach to diagnosis and treatment planning for patients.

> Provider: Keep in mind that many, many patients I see in PES don't have any family connection. So it's not even a question bringing the family into this. It's not even possible because it's just not there. And it's much more frequently the case with Asians that the family is involved and is concerned. So, first thing is that the family is important because they are there, more than others.

During hospitalization, AA families visited their family members almost daily or as often as they could. AA family visits typically consisted of multiple family members, from multiple generations. Family visitors brought food cooked specially for the patient. Providers explained that in AA culture, foods represented not only nutrients but also love. Families attempted to convey a message to patients that they still loved them, even though they may have done something unacceptable, such as being violent towards a family member. By bringing a home-cooked meal for patients, families demonstrated attachment despite the fact that they hospitalized them in the first place. Providers believed such support fostered hope and a sense of future possibility for the patient.

> Provider: It takes hours to cook it and stuff and, you cut the stuff up and you cook it. So it's like you spend a lot of time preparing it. So it's very special. … You can still be a mom, and make him soup. You can still be in the parental role and show that you care. … They don't say, "I love you," or lots of hugs and kisses like the others in the society. So what they do is bring food to say. … You don't say, "I love you," to somebody, so you do other things to show it… that the family still cares.

Families' efforts to convey love and belonging were not limited to bringing home cooked meals during hospitalization. Providers described other family efforts to make patients' hospitalization as comfortable and as normal as possible. Even though they were hospitalized in a locked unit, families' actions communicated that the patients' they were still connected and attached to their families. For example, during the visiting time, families' main concerns were whether patients were comfortable and maintained an appropriate level of self-care. When patients were too psychotic, depressed or too aged to clean themselves, the family helped the patients with showers or baths. They would walk around inside the unit with patients when ambulation was encouraged. Even though such activities sound mundane, they allowed these families to express caring in the given situation of hospitalization.

Another positive role AA families played during patients' hospitalization was to provide different perspectives on the patients' prognosis. Patients sometimes disclosed symptoms to their families that they tried to hide from providers. In other cases, families reported to providers that patients exhibited symptoms during the visit or that the patients still acted "crazy". Such a discrepancy of symptoms and behaviors was valuable information for providers when evaluating patients' prognoses. Establishing patients' baseline functional and symptom level help providers to determine patients' prognosis and prevent premature discharge.

Another unique family function was support for medication adherence. Throughout the patients' course of illness, families provided patients a significant level of assistance in terms of medication compliance. During inpatient hospitalization, especially when patients refused medication, families assisted and supported the patient in taking prescribed medication. Families often translated the information about medication to patients when they could not speak English. In some cases, providers reported that they adjusted the medication time so that the patients' families could be with the patients during medication administration. Such an approach was particularly helpful when patients were non-English speakers or when patients were paranoid toward the medication or providers.

> Provider: (she) didn't speak English. Every time when I brought her medication in a Dixie cup, she talked to me…I think she was asking something…but you know…I don't speak her language either…So, next time when I was assigned to her, I brought her medication when her children were visiting her. So that they could translate what I had to say to her…. you know…it was much easier for her… She was just asking simple things…like name and what was the medication for…

In this case, the provider used the time to explain the medication not only to the patient but also to the family. He explained that because the family was to take care of the patient after her discharge. It was important for him to make sure that the family also understood the medications.

Families played a significant role in patients' adherence to psychotropic medication in the community. Many times, medication compliance was one of the conditions under which families would take patients back home. In many cases, outpatient care providers relied on families to monitor patients' medication compliance. It was usually the families who reminded patients medication times and checked upon medication supplies.

AA families were involved in patients' treatments in various capacities extending far beyond visiting patients during the hospitalization. Providers reported that AA families often actively participated in the treatment planning and remained the major support system for patients for an extremely long period of time. AA families often provided stable housing for patients, and even provided a job or daily activities after patients' discharge. Furthermore, because families generally took patients back home and continued to care for the patients after discharge, it was only natural for providers to include families during discharge planning. Even in cases where the patients were discharged to a halfway house or a long-term care facility, the home with their families were viewed as the ideal final disposition.

> Provider: We rarely discharge a patient home without the family approval. So we always work with the family until family thinks that the patient is ready to go home.… A lot of time, the patient thinks he can go home, but family would say that " no, no, no not yet." And we listen to them and we trust them, because they are the one who stays with the patient day in and day out. We maybe stay with patient maybe ten days or month. Family may stay with the patient for years. So their evaluation and their concern are very important for us.

AA family support was not limited to the immediate family, but in many cases, extended families were also involved in the care of the mentally ill member. Providers suggested that extended families developed ways of sharing care responsibilities; taking turns watching the mentally ill person, taking turns monitoring medications or taking turns to appointments. There were cases that multiple extended family members lived in the same building, making it much easier to care for the patient.

The AA cultural orientation toward family care constantly interfered with the American health care system, particularly around issues of privacy. There were cases where patients declined to give permission to talk with their families. This caused problems when the patients wanted to go home after discharge. While the families were willing to take the patients back, they had insufficient information about the patients' illnesses and how to care for them. Knowing about the patients' illnesses, treatment courses and medications was crucial for a positive outcome. Often, such conflicts resolved as patients realized that providers needed to talk with their families in order to discharge them home. The issue of privacy was particularly problematic in the psychiatric emergency service or outpatient settings. The inability to collect collateral information regarding the patient and provide the family with the information about the patient's condition, led to treatment failure. The following case is about a young Asian American who presented to Psychiatric Emergency services after attempting suicide by cutting his wrist with a knife at a hotel. The wound was superficial and the patient reported to the provider that he was feeling desperate because he had a significant amount of debt from gambling. The patient reported that as soon as he made a superficial cut, he became scared and did not want to hurt himself any more. The patient was remorseful about his suicide attempt. In addition, the fact that he drove himself to the hospital underscored his will to live. The patient had a reasonable plan to contact school financial services and talk to his sister about his problem. However, he refused to give permission to staff to contact his family while he was in psychiatric emergency services. The provider discharged the patient to the community because he was not suicidal anymore and had a reasonable plan to cope with the psychosocial stressors that led to the admission. Later the provider learned that patient committed suicide a couple of months after his visit to the clinic.

> Provider: What I wish I had done was work harder on getting his agreement to let his mother know, or, at least, to not let him leave without that being done. So, I don't know if that would change anything. Because he might have been admitted to the hospital, won a hearing, and never let anybody notify to his mother. I can say that for the future it's going to make me aware of that constellation of symptoms. I can say that it seems repetitive among young Asian people - actually, young second generation Asian people in their 20s. I don't know exactly what the common factors are and what's the best thing that ought to be done. But I know that I am going to be very cautious about that constellation in the future. ... So as an emergency room psychiatrist, I guess, that's the biggest problem that I face. Now, in all of these cases, we are talking about young

> people in essence, without family, because we didn't have access to the families. We couldn't reach the families. It makes it very important for me to realize how important it is to contact families. Would it make any difference? I don't know. I don't know if it would have kept any of them from killing themselves ultimately. Certainly, I wish I could have tried it.

ii. Giving a place in the world

In AA culture, being a productive and contributing member of society was highly valued and encouraged. Thus, even a mentally ill member was expected to contribute to the family unit to some degree. Patients were allowed to work, even though patients might not be high functioning and mostly come and go without any specific functions. As long as they did not become disruptive to the business, patients were given a role. By cherishing whatever talent the patient might have, regardless how mundane, families incorporated patients into family life. In most cases, patients' participations in family businesses were a way of supporting patients rather than using patients as a source of labor. Such acts seemed an effort to give patients a place in the world.

There were many concrete examples of how parents or older siblings tried to provide a meaningful place in the world to their mentally ill family member. One Korean American mother who took her schizophrenic daughter to work everyday. She had a newspaper stand at the corner of the street and a clothing alteration shop. Since her daughter's first break at the age of 18, her mother brought her to work daily except for during the times she was hospitalized. When the patient was not in a "*good mood*", she would lay down on the small newsstand floor withdrawn all day. When the patient was in a good mood, she would help her mother sell newspapers. However, the mother would tell her friends that her daughter helped her with her business. By framing her daughters activity as 'helping her', she tried communicated that her daughter was still a contributing member of the family and society. The mother's actions were qualitatively different from hiding her daughter's mental illness from her friends because she was very open about it. Most of her friends were aware of the situation.

Another case was a man who was psychotic and autistic, the patient was " *just a very strange, strange young man"* according to the provider. However, the patient was good at math, and was allowed to work in his father's business as a bookkeeper.

> Provider: …It was what he could do. He was basically protected from having to deal with the public. And he was happy with that. He stayed at home. He didn't marry, which is, I suppose that could be a matter of some concern. But mostly they were just glad that he had this skill that he could do. It didn't make that much difference that he heard voices and he dressed funny and all of that stuff. But they could be proud about the fact that he could do the books. And he could be proud of that. I think American families might very well have been really concerned about what other people would think about his peculiar speech and his peculiar appearance and so on. But, they might have over looked the fact that he had a strength that he could use….

Having a place in the world included such things as fulfilling complex family roles and providing practical support including caregiving. For example, an American born Chinese American patient who was in her late 20s was the youngest, but the highest functioning of three children. Even though she had a mental illness, she cared for her mother after the mother had a stroke. Providers thought that her role as a caregiver was stressful to her: She was often hospitalized in an inpatient unit to recuperate and stabilize. In an attempt to give her a break from her caring responsibilities at home, providers occasionally arranged residential treatment instead of discharging the daughter directly to home.. However, it also was clear to the provider that being a caregiver for her mother was a meaningful role for the patient, even though the burden of caring for her mother triggered her depression. When the mother had a second stroke and was sent to a nursing home, patient became extremely depressed and suicidal.

> Provider: We figured she was kind of going through an identity issue because her role was to take care of her mother, and now she didn't know what to do because her mom was in a nursing home…

Having a meaningful place in the world is an existential issue to every human being. AA families' efforts to give a place in the world to persons with a mental illness seemed particularly important because the chance to participate in society is limited for persons with mental illness. Sustaining a meaningful place in the world started from their place in family. The AA families' strong commitment to individual family members was closely related to an individual members' commitment to their family. Patients' family commitments included taking care of other family members, being a good child to parents, a good parent to children, and keeping the family reputation intact. Commitment to family also motivated patients to control their behavior and overcome their illness.

> Provider: …They (AAs with a mental illness) feel socially responsible for their family's reputation as well as their own personal reputation. That may actually be more important to them than their personal reputation so they are more likely to struggle to bring their behavior into acceptable bounds if they are psychotic or refrain from self-destructive behavior. …

Emphasis on being a productive member with good standing encouraged patients to redirect their energy to more practical things when experiencing symptoms. Such redirections may have led them to keep good hygiene, to get a meal regularly and on time, and to maintain a schedule. AA patients were motivated and struggled to reintegrate into the society and be productive as soon as possible.

> Provider: Depression… that might completely stymie an American. I mean, White Americans might be completely caught up in the idea of their depression. When in fact it's not that serious. I think that denial can serve Asian American patients pretty well in this case because they push hard to get through it. And they deny and they go ahead with their lives. And all that is may be a healthier thing to do. So in case of less serious illnesses, it may actually be functional.

B. Negative sides of AA family caregiving

Whereas a high level of involvement was a positive attribute, there were times when such involvement became too much for the patient and family, and eventually added burden to patients and family caregivers.

i. Difficulties in transition to and from professional care

For AA families, the cultural emphasis on caring for the ill family member at home was pervasive and considered to be a fundamental social obligation. Thus, sending an ill family member to a professional care facility was considered a violation of being a good family, abandonment or neglect. Neglecting an ill family member reflected badly on the family and was seen as lapse of character or inhumane. Caring for an aged parent is particularly emphasized for filial children in Confucianism. In literature on filial piety, *The Hsiao Ching* (*The Hsiao Ching*, 1970), the majority of the stories are about how a child or a child-in-law cares for an aged parent during an illness. Additionally, there are many stories about how a family is punished for not caring for their ill parent.

Because of the cultural emphasis on hands-on family caregiving, families were particularly tormented when they had to make a decision about sending patients to a long-term care facility. Providers in an inpatient unit provided narratives of a particular case that demonstrated the family caregivers' ambivalence and struggles when transitioning an aged mother into a long term care facility.

The patient was a Chinese immigrant female in her late 80s who was living with her son and her daughter-in-law. After her husband's death, the patient became depressed and agitated. Her level of anxiety increased to the level that she was unable to function independently at home. The patient wanted constant attention and assistance from her children. She needed her children physically beside her at all times. Unfortunately, as in many other immigrant families, all of her family members were working. During the daytime, her daughter-in-law was the main caretaker, despite the fact that she was working. In addition, her daughter would visit her twice a day before and after work to check upon her. As the patient's anxiety and agitation became prolonged, the family became exhausted. The family encouraged the patient to be more independent. One day, out of frustration, the son told her that they would consider sending her to a nursing home if she continued to refuse eat by herself. Right after the conversation, she attempted to commit suicide. During her inpatient hospitalization, the children visited her and brought her food every day. They cleaned the patient's bed, walked with her around the unit, and even helped her to shower. It was obvious to the family and providers that the family could not care for her at home and she needed a higher level of care after the discharge. Providers recommended discharging the patient to a nursing home for further stabilization. Unfortunately, the patient strongly objected to the discharge plan; She wanted to go home. Even though the family had already acknowledged that they could not take care of the patient at home, they experienced guilt, shame, and ambivalence during the family meeting.

Despite the fact that the patient's daughter and daughter-in-law were the main caretakers, the son had to make a decision. He was feeling particularly guilty because his mother attempted suicide after he threatened her to send her to a nursing home. Even though the providers recommended to him that long-term care would be beneficial for the patient, making the decision seemed particularly difficult. There were two things that complicated this dilemma; the patient's refusal and cultural and social pressures related to what it meant to be a good son. The stigma attached to sending a family member to a professional care facility added an additional burden in his decision to do so.

> Provider: The interesting thing was that it was the son who actually had to make the decision about whether the patient went to a long-term care facility or not. That, you know, he felt tormented about the idea of sending her there. And the sister actually had said …it was one of her friends that she had talked to about sending her mom to long-term care facility that said how horrible that was that they were sending her away, that they weren't able to care for her and how shameful that was. The sister actually told her brother, the patient's son, about that. So he was just so tormented by the idea because I think he knew he really couldn't care for her the way that she needed. He and his wife were the ones that were taking care of her. The daughter of the patient was providing this input but at the same time saying, "But it's your decision because I'm not the one that's taking care of her." So, yeah, it was a really interesting family dynamic actually because it was really hard. I think they all felt a lot of ambivalence about it. I think that in many ways the daughter wanted her mom to be long term care but, at the same time, just felt so much shame. The son, I think, felt more tormented because he really wanted her to be at the long-term care but there was this pressure to take her back home.

An arrangement was made to discharge the patient to a long-term care facility; however, the family changed their mind at the last minute and ended up taking the patient home. Unfortunately, the patient came back to the same unit for increasing depression and suicidal ideation shortly after discharge. This time, her son and other family members agreed to discharge her to a long-term care facility. This case highlights the struggle of an AA family that is caught between a cultural prescription to care for a patient no matter what and the realities of time and resource limitations. Difficulties during the transition were apparent with aging parents as well as with transitioning a child and a sibling from home to an institution.

AA families experienced particular difficulties when they had to inform their mentally ill member about the decision to discharge them to a place other than home. They often accepted the patients after they walked away from the care facility, instead of sending them back and insisting they finish the program. For practitioners who are inexperienced with this population, such a cultural pull on family caregiving may not be apparent. Thus, they may misinterpret the struggle of AA families as having difficulties in setting boundaries or undermining or sabotaging the treatment plan. When informing the patient about the discharge plan other then home, families felt particularly tormented because they also wanted to convey that they were not abandoning the family member. Cultural pressure to care for family at home was so strong that asking the patient to live with strangers, not family, signaled abandonment. Such dilemmas often resulted in miscommunication and conflicting information between all parties involved in the treatment.

> Provider: …The issue is that the entire family cannot say that he cannot come home. And I think, that what keeps this patient from being completely hopeless is the idea of going home. We always want to be moving towards that. So, in some ways the family not saying that he can't come home is a good thing. But at the same time, they also don't seem to actually have an intention of bringing him home. So that's kind of a difficult mixed message.

ii. When does family caring become too much?

As discussed earlier, providers praised families' dedication to patients. During an inpatient hospitalization, families' frequent visits and assistance were considered mostly positive to patients' recoveries because they fostered a sense of attachment, normalcy and hope. However, providers considered the involvement too much when family caring hindered patients' potential for independence. Providers noted instances where the families' impulse to be helpful crossed a line and proved detrimental to patients' independence or movement toward health.

> Provider: We had a case where a patient had, you know, really needed a good amount of care but she was someone who was also fairly dependent. And family would come and kind of coddle and take care of them. Feed the patient… bathe the patient …and things like that. Things we're really supporting the patient to do on her own and the family would continue to do the things for her, that we are trying to help her do herself. So, in that case it is difficult… That's an important part of the process of getting better instead of enabling the family member of the patient to kind of stay in the sick role... It's no wonder the patient thinks that she can't do anything by herself because the family is just doing it for her.

Providers struggled when family caregiving became too much. They seemed to consider family care unhelpful when such assistance was out of their own expected cultural norm. One provider reiterated that bringing food from home and visiting everyday were understandable. However, when a father in his 70s bathed his son who was in his 30s, married and with children, this was an example of too much of family caregiving.

> Provider: I looked at it as if…like his parents are spoiling this kid. I was amazed when I found out that the father is giving the son a bath every time he visits him, because in Asian culture the father is the dominant guy. He doesn't do those things.

In this case, the provider's ethnic and cultural backgrounds affected how he perceived a family's caregiving. The provider later added that if the patient's wife had helped the patient bathe, it might have been acceptable for him. As an Asian himself, he employed his own cultural heritage and drew a boundary on what he believed was culturally appropriate.

The fact that the extended family members shared the burdens of caregiving was one of the positive aspects of AA family caregiving. However, when families were poor and had limited access to resources, multiple generations of families were forced to live together in small spaces. When multiple generations resided in one house, each generation occupied one room in the same house. For example, grandparents occupied one room and young parents and their children occupied the other room. A person who suffered from a mental illness had to share a room with multiple family members. At times, families were unable to provide the patients necessary space and boundaries simply because there was no more space. Because of the limited resources, each individual member was forced to take on more responsibilities. The mentally ill family member was also forced to take on more responsibilities, which might add stress to the patient.

> Provider: That people in the high EE environment, decompensate more EE, that means expressed emotion. So, if people live so close, sometimes they may have some expectations, they may have some demand, the patient may not be able to tolerate or understand that.

Expressed Emotion being critical, hostile or overinvolved is well known to mental health professionals. However, the practitioner's view is a relatively unique: small spaces make effective conflict resolutions more difficult. In current EE discourse in psychiatric/mental health disciplines, EE is viewed as one of determinants associated with a poor prognosis in people with a mental illness. EE studies observed that a high level of EE increased the risk of relapse in persons with mental illness. (E. Y. Kim & Miklowitz, 2004; Lefley, 1992; Magliano et al., 2000; Miklowitz, 2004). Thus, current family therapy emphasized the modification of the family communication style to one that is more empathic and respectful. Even though studies showed a strong correlation between negative EE and a poor prognosis among the White population, its relationships are not strong among non-White populations (Cheng, 2002) . In addition, there are other questions such as why some families showed more negative EE than others. Identifying families as a cause of mental illness has been harshly challenged because such an approach overlooked the complexities of caring for a loved one who has schizophrenia. Thus, the provider's suggestion that high level of negative EE might be a consequence of poverty and lack of resources deserves further investigation.

iii. Disregard for others

For a few families, the emphasis on the family sometimes led to a disregard for others outside of their own family. In AA culture, one explanation is that mental illness results from an imbalance of Yin and Yang. As a solution for the imbalance, persons with mental illness are encouraged to marry. Providers reported several cases where AA families brought a bride from a rural area in countries of their origin. Sometimes, brides were informed vaguely about the patient's condition, but mostly they were not fully informed. When these young women arrived in the U.S., they were expected to care for the patient. However, most of brides did not have enough information about illness and its management. Some were left with a hypersexual or manic patient or a patient with poor impulse control and violent behavior. There were times when the bride was abused by the patient or the patient's family. The majority of these brides came to the U.S. alone and lacked support. Adjusting into a new family and new environments became more difficult because of the caregiving responsibilities. One provider witnessed that the mother-in-law kept the daughter-in-law's passport to prevent her escape. In another case, the wife became exhausted, depressed and eventually attempted suicide, which led to an inpatient hospitalization. Such family dynamics posed a great challenge to providers, because they had to protect the wife as well as the patient.

> Provider: We had cases where the families cared about the patients so much. They believed that the mental illness is the balance of yin and yang. Sometimes they sent their sons and daughters back to China, to Korea, to Vietnam to marry. So they can get the balance of yin and yang. Or if a man was hypersexual or manic, or had a temper with a woman, maybe a marriage would balance the energy and they will calm down. It's bad for the woman, the girl who marries that man. She maybe abused, abused by the husband's family. The family really takes a good care of the patient, but they care too much that they don't care about another person outside of the family. They become selfish…We have to even protect the wife. We may have to contact adult protective services, so that we can help the wife and their children. So, it becomes a social issue.

One provider said that by helping wives, we may have prevented another suicide attempt, or depression, and reduced the wives' stress. The families' act was not only harmful to the bride but had a negative effect on the patient as well. Marriage is a stressful life event. Thus, simply marrying a patient to a person with whom they had limited acquaintance and expecting them to take on the role of husband might have been detrimental to persons with a mental illness. The cases discussed above were extreme cases, yet not isolated incidents. In the San Francisco Bay Area, it seemed that similar cases were prevalent enough that a support group for wives has been established.

iv. What is a meaningful place in the world? Being too practical

AA families' efforts to provide a meaningful place in the world to patients were positive because they fostered a sense of hope and stability. However, there were times when the family's definition of a meaningful place seemed too narrow and too practical, such as having job or finishing a college degree. Pursuit of this goal at times undermined other possibilities for meaningful existence in the world. This was a particularly relevant issue for first generation AA immigrants.

Many first generation AAs immigrated to the United States for a better education for their children (Berg & Jaya, 1993). When they arrived in the new land, they worked at a less prestigious job than they had in the homeland. Parents' sacrifices for their children provided resources and motivation for academic success for the children. At the same time, however, these sacrifices became sources of stressors and emotional burdens for children. However, AA's emotional and economic decisions must be understood within a cultural context. In AA culture, a parent's primary responsibility towards a child includes providing an education. In fact, education is emphasized not only as a way of social success such as getting a good career, but also a way of moral success such as becoming a good citizen. Thus, a child's failure as a citizen often reflected badly on the parent and was seen as failure of parenting. It needs to be emphasized that AA parents invest and sacrifice their current life for the future. The future for them, however, does not mean when they retire. The future means their children's future.

The news that a child's future was not as bright as parents had worked for had a great impact on them emotionally.

> Provider: Just being able to handle that news and accept the reality is nearly impossible to do. A patient's family will say, "Can he start school in the fall? Can he go back to medical school? " He had a mental breakdown and he was the person that all their hopes for the future are on. All of a sudden, he may need to be taken care of for a while. He may not be able to go back to the same school where he was before… The news is very difficult for them.

Many parents expected their mentally ill child to be able to go back to school and continue to be successful academically and professionally. Unfortunately, such expectations were frequently unrealistic because the patient's ability to function optimally was compromised by the mental illness. For some AA parents, it was emotionally difficult to accept their child's mental illness and its consequences for the child's future. Often the family did not grasp the severity of the condition and prognosis and therefore was not able to sufficiently revise their expectations for their child.

VI. CONCLUSION AND IMPLICATIONS

Data from the study are consistent with the current knowledge of strong family supports in the AA population (Bae & Kung, 2000; E. Y.-K. Kim, Bean, & Harper, 2004). However, the study findings show that the AA family caregiving practices should be understood in a much more complex manner. The view that all aspects of family involvement are positive or negative is problematic. Rather, what was once a positive caregiving practice may become negative at some point. Thus, the question is about at what point the positive side becomes negative and how we can help families minimize the negative effect, rather than identifying certain families as pathological. The complexity of AA family caregiving is relevant not only to the mental health care setting but also to all health care settings because the cultural pressure for caring for an ill family member at home applies to all illnesses.

The study findings also highlight that the strong Confucian emphases on the family is still present among AA families. Such emphasis showed up particularly in issues around the caregiving and communication among family members and between families and providers. To illustrate how Confucian notions can shed light on the current family study, we will briefly discuss emotional over-involvement in Expressed Emotion (EE).

Conceptually, EE refers to an aspect of the family environment that has been a reliable predictor of relapse in psychiatric and non-psychiatric illnesses (Butzlaff & Hooley, 1998). The original concept of EE included a set of positive and negative emotions. However, three major negative concepts, criticism, hostility and emotional over-involvement, have been the focus of research. In the literature, Asian families are often found to have a high level of emotional over-involvement (Slote & De Vos, 1998). Emotional over-involvement is indicated by family members blaming themselves for everything instead of the patient. Families feel that everything is their fault and become over involved with the ill member (Lopez et al., 2004). Researchers (Cheng, 2002; Jenkins & Karno, 1992), have noted that what counts as emotional over involvement is a matter of cultural definition. We believe that EE is based on Western individualism, the notion that individuals are the irreducible basis of society and are agents detached from others. However, Confucianism views a person as a part of a family with interdependent responsibilities and expectations. In this study, families' struggles during the transition of patients were due to strong cultural pressure rather than their lack of commitment to treatment.

In the Confucian tradition, the family is the irreducible unit rather than the individual.

Members are expected to be involved with other family members' lives. For example, the parents' ability as parents is judged by how good a citizen their child grows up to be. Thus, when a child is ill or considered to be a bad citizen, AA parents are expected to feel responsible and even receive blame for their failure as parents. Confucianism thus provides some background explanation for why AAs may demonstrate emotional over-involvement at rates that are high compared to non-Asian families. In addition, if a high level of over-involvement is expected among AA families, a low level of family over-involvement may have an adverse affect on an ill family member.

The study findings may be familiar to practitioners who have extensive experience with AA families. However, for those who have limited contact with AA patients and families, cultural differences and lack of cultural competency make it difficult to reach mutual understandings and treatment goals effectively. The following recommendations are geared toward those practitioners with limited experience with AA population.

i. Providers should understand the importance of the family to AA patients and should attempt to include the family in every step of the treatment plan

Despite the fact that AA families play a crucial part in a patient's prognosis as the major provider of emotional and practical support, the current mental health systems makes it extremely difficult for providers to give a reasonable level of support for families. Because family caregiving is enforced by cultural and social pressure, being excluded from the treatment process will produce confusion and frustration in AA patients and families.

Patients' rights to privacy and the right to make decisions for their own treatment should not be ignored. However, involving AA families becomes essential when the patient is going back home and will reside with the family. In addition, residential treatments capable of treating AA patients are rare to non-existent in the majority of the U.S. As a result, AA families are often relied upon to take over responsibility for care during more serious phases of the illness. However, because families are not professionally trained and resources are limited to what the family can mobilize, this care can be burdensome to families.

During the course of psychoeducation, AA families require more aggressive and broader psychoeducation than White families than current literature suggests (E. Lee & Mock, 2005). This is partly because of the lack of understanding of Western psychiatric medicine. It is also because AA families play a much greater role in patient's care then their White counterpart. Thus, it is critical for successful treatment planning that families understand and are included in the planning.

In addition, providers who work with AA patients may wish to assess the level of acculturation and immigration history of the family members who are involved with patient care. Individual members acculturate at different rates, therefore an individual member's acculturation level and its influence on the family dynamic should be also considered.

ii. Providers should be mindful of culturally specific family dynamics and cultural expectations when caring for an AA patient and family

Providers who work with the AA population should be mindful of communication style and family processes in AA families. When discharging patients to the community, it is important to check with the family before making such a decision. Many treatment failures related to placement may be related to families' ambivalence towards transition rather than being a passive aggressive way to sabotage the treatment. In addition, families may need emotional support from providers when patients are told that they will be discharged to a halfway house instead of home. Coaching parent on how to interact with patient could be more effective if conducted privately, away from the patient, in order to preserve family hierarchies and face for the parents when learning new skills.

iii. There is an urgent need for policy and institutional level changes for culturally sensitive mental health care

Institutional and policy level efforts to improve the mental health system in terms of serving its service users from multicultural groups are an urgent issue. The current mental health system is not well fit to AA patients and their families because of the lack of capacity to provide culturally specific care. As rapid growth of the immigrants and minority population in the U.S. (U.S. Census Bureau, 2007), the mental health system need to find a way to adapt its practice for such population and cultural changes. For example, the health care system should be more inclusive rather than exclusive to family caregivers. There should be an institutional level effort to make it easier to include AA families during the treatment when patients reside with their families. In addition, more practical supports such as financial rewards, visiting care nurse support, or tax credits for families caring for a mentally ill person, should be considered.

iv. Further research should focus on culturally specific family processes, inter and intra group differences among AA groups.

There is an urgent need for culturally appropriate family theories for minority families. Such an endeavor will also contribute to the general field of family studies, as it will provide a broader, and more variegated picture on family. In addition, we need to understand culturally specific interpersonal and family processes and how they affect on individual and family health. In studying cultural groups, inter- and intra- group differences are particularly important. Issues of non-traditional families such as a single-parent family, divorced family, mixed family, gay, and lesbian family should be explored.

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CHAPTER 5

STUDY RESULT FOR PURPOSE 2:

PROVIDING CULTURALLY COMPETENT MENTAL HEALTH CARE

I. INTRODUCTION

As the number of immigrants and multicultural families increases in the U.S., the issue of cultural competency in the health care system is an integral skill for all providers working with these families. Cultural competency is critical in the realm of healthcare because of its potential impact on quality of life and health. Patients' and the family caregivers' navigation of the mental health system is largely influenced by providers. At the same time, the providers' ability to provide good care often relies on the patient and family. Unfortunately, the notion of cultural competency is difficult to define. In recent years, the interest in cultural competence has drastically increased, as it was identified as a tool to overcome health disparities in mental health care for ethnic minorities (Vega, 2005). A lack of cultural competence often results in systematic errors in clinical practice and ineffective quality of care. Inadequate cultural understanding often results in misdiagnoses, inappropriate treatment choices, miscommunication between health care professionals and patients, and premature treatment closure; however, there is scarce empirical research data on the efficacy of cultural competency training. Also, in practice and education, there is little consensus on the mission and core practical tenets of cultural competency. Even though the field of cultural competence field eclectic, dynamic and unstandardized, some studies show utility, quality and practical value (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Regardless of its conceptual instability, there are numerous providers who successfully deal with cultural differences in daily practice. Thus, investigating their experience and how culturally competent care is provided on an everyday practice level provides a better grounds for theorizing cultural competency. The purpose of this paper is to discuss how various mental health practitioners approach AA patients and families and provide culturally appropriate mental health care.

II. PARADIGM CASE

Before discussing the providers' practice pattern, I will present a paradigm case of culturally sensitive practice. This case illustrates the approach of meeting a family and patient where they are in terms of addressing cultural differences. The patient was a Vietnamese American, who suffered from severe PTSD, because of his experience of living in a concentration camp during the Vietnam War. He was irritable, vigilant and sometimes unreasonable with his family. The family tolerated his illness for a long time and finally brought him to the hospital after trying herbal medicines and other remedies without success. The patient also had multiple somatic complaints including backaches and migraines. When the provider evaluated him and came up with a diagnosis, he explained to the patient;

> Provider: Well, what he went through is very traumatic, incredible torments. I told him that if I were he, I would have the same mentality. I would be confused and I would have nightmares like that.

When asked about hallucinations the patient admitted that he had auditory hallucinations, after a long hesitation. He asked the provider if a ghost was causing the voices. The patient explained that he would not tell people about the voices because it would make them think he was crazy.

> Provider: I explained to him that the torment that he witnessed could cause all these symptoms even though he may not be convinced at first, but then you have to explain to him again.

With time and perseverance, the provider convinced the patient that his symptoms were a result of the earlier trauma. Only then did the provider offer medication to treat the symptoms; however, the patient was reluctant to take psychiatric medication stating that he should eventually overcome his symptoms because he was a military man. The provider continued to take an easy stance toward the patient, and avoided threatening or pressuring him.

> Provider: I told him ‘O.K. you don't want to take medication. Then I cannot force you. You tried so many alternative therapies that didn't work. Why don't you try some of this medication and it may help you with your sleeping first. Later on if it helps you with some nightmares then other things may be better. See? So I will just give you the medication. You want to take it or not, you have your free choice. No pressure for you. You come back here and we can talk more’.

The provider’s approach built trust with the patient as evidenced by the fact that the patient revealed his beliefs about his somatic symptoms. The patient was experiencing joint pain and muscle pain and he believed these pains were caused by lying on the floor of the concentration camp, where the cold air soaked into his bones.

> Provider: What I explained to him is that ‘that may be true, your belief. I have no knowledge to dispute that. But you know, because of that, the cold air, cold energy...it drained all your energy. So you don't have hot energy to motivate you and activate you to do things. And that fits in with depression, the low energy that is; you don’t want to do anything. And I told him that you are not lazy, you want to do lot of things but you cannot.

The provider’s explanation for using an antidepressant was tailored to the patient’s illness explanation.

> Provider: I had to go with Yin and Yang to explain it to him. ‘The antidepressant that I gave to you may have some side effects. And apparently, antidepressants have lot of anticholinergic effects. And anticholinergic effects make people have dry mouth, constipation, so in terms of Yin and Yang, dry mouth and constipation will fit in with hot energy. So the medication has side effects of a hot medicine. That will balance with your yin, basically the cold energy. So in that way (the medication provides) some more hot energy. So you have more energy.’

After the provider established therapeutic rapport, he proceeded to help the patient’s family. The patient had been irritable with his family, and he felt guilty for expressing this irritability in interactions with his family.

> Provider: He cried when he talked about these things later on. I told him that, ‘Maybe you can ask your family come in, so that I can explain to your family about what happened to you, so they can understand you and they can forgive you’. Because he cannot apologize, he is the man of the house. He is so strong. So, I became the ‘go between’ to apologize to the family for him about his behavior.

The provider explained the patient’s difficulties to his family on the behalf of the patient so that they could understand and share the pain that the patient was experiencing. The provider summed up his experience and why it was so rewarding to him.

> Provider: I was able to understand the culture and able to flow with the culture and explain things to them using their language. That way, they understood more than if I explained to them about SSRI, serotonin reuptake blocker. That would be so strange to them…

In this case, the provider successfully accomplished two things. First, he was able to understand the patient and his family. His understanding stemmed from his initial sense of the patient and his extensive experience with Asian patients. However, the personal understanding was only possible because the provider was open to what the patient had to say about his illness and life experience. In addition, the provider was patient enough to wait until the patient trusted him and shared his personal stories. The provider's second achievement was that he was able to be understood by the patient and his family. Clearly, the patient and his family had drastically different illness explanations from the western biomedical version. Thus, to establish a mutual treatment goal could have been extremely difficult. One option to bridge the divide could have been to take the positionality of a medical authority and to teach the patient the 'proper' understanding of his condition. Indeed some texts recommend taking a more authoritarian position when dealing with Asian patients (Paniagua, 1994). Unfortunately, such an approach may have led the patient to flee the relationship. Such premature terminations in treatment in the Asian American population are well documented (Takeuchi & Kramer, 2002). In contrast, the provider's approach was to try to meet the patient and his family where they were. He did not attempt to persuade them to his way of thinking. Rather, he started with the symptoms that the patient and family could easily understand. Because the patient and the family understood the provider's intention and his treatment approach, they were able to communicate with him more openly, which in tern allowed the provider to understand them better.

III. PRACTICES AND LESSONS LEARNED

Providers' practices were bound by their practice setting. For example, federal and state mental health policies largely limited providers' scope of practice, including their client population, which is segregated by insurance status, length of treatment and medication options. In addition to governmental limitation, providers faced culturally unique challenges when working with AA families. Despite the complex challenges, providers developed practice strategies that worked for them and for the patients and their families. As discussed earlier, the strong emphasis on family in the AA population presented unique challenges and opportunities to practitioners as well as to families. One of the most important strategies for working with AA patients was to include the family throughout the illness courses. To do this successfully, providers developed unique understandings of AA family dynamics.

Providers' narratives of care with AA patients demonstrated how they envisioned their roles to be broader and more diverse than when they are caring for White patients. By factoring in patients' families, providers expanded the horizons of their practices. In attempting to construct 'the best practices' with AA patients, providers extended their efforts well beyond the minimum legal requirements for care. Providers assumed multiple roles while caring for AA patients and families, which included; 1) Being a cultural broker: Bridging two cultures, 2) Being a competent provider: Providing culturally appropriate care based on recognition and appropriate treatment, 3) Being a Zen practitioner: Persevering with humor. These aspects of practice are separated for discussion, but are demonstrated simultaneously as narratives of care.

A. Cultural Brokering

Cultural brokering is when providers try to address the cultural differences between themselves and families, or between the patients and their families. Providers who were representing the Western psychiatric/mental health culture attempted to explain it to the AA families. Such explanations were usually geared to promote understanding and to minimize resistance to the Western way of understanding mental illness. At times, providers came between patients and families and helped them communicate with each other or advocated for patients with the family. When there was a generational gap because of the different levels of acculturation among the family members, providers attempted to explain the American culture to families for patients.

i. To establish common ground for treatments

AA families' involvement in caring for mentally ill persons was fundamentally different from that of their White counterparts. Thus, such differences made it necessary for providers to develop different practice strategies. Often times, the most important step in psychiatric/mental health treatment was to reach a mutual treatment goal between patients and providers. Without such a goal, the treatment is likely to fail. Reaching a mutual treatment goal between a provider and a patient from different cultures can be tricky. This was especially true when each had different expectations about the other party's role such as the problem, the nature of the problem and means of addressing the problem. For AA patients, the problem was complicated by the fact that the families' involvement in their care was high and involving them in patient care was crucial to the prognosis of the patient. Many AA patients lived with their families. AA families accompanied patients to appointments, reminded patients to take medication, and provided stable housing. As one provider articulated, it was crucial as well as possible to include families during AA patient treatment.

> Provider: I do think that it is more important for my Asian American patients to include family. If I don't have the family's agreement on what the nature of the problem is, and what ought to be done about it, then there is very little chance that the treatment recommendation will happen. So, for a lot of reasons it seems to me that is more important...well more important and more possible…

The AA patients whom providers treated were first generation immigrants, poor and underserved. They were mostly new immigrants and were not familiar with American culture and the American mental health system. Providers often had to prepare families for Western medicine so that they could at least understand what the provider was talking about. Thus, psychoeducation was a big part of providers' practices. Often times psychoeducation was geared towards the family, so that the family could cope with their member's mental illness. This type of psychoeducation allowed providers to establish middle ground with patients and families before the treatment started and was provided throughout the treatment.

Psychoeducation covered subjects that were usually included in the education of all ethnic groups. However, providers provided more extensive information about various subjects in this population. Because of the lack of understanding of the Western psychiatric mental health system and framework among the AA patients and families, the providers forced to cover much broader subjects. For example, families might not understand the role of each profession, thus, many providers included their role at the early stage of the therapeutic relationship. For psychologists or therapists with private practices, difficulties arose when families were unfamiliar with their role or unable to differentiate them from psychiatrists.

> Provider: Well, I think for those people who have no understanding of what a psychologist does then I will do something like education telling them what I actually do. I specifically will explain to them that I am not the type of doctor that gives medications or gives shots, so they don't have this, I guess, false expectation of my service. I would also explain to them it's a process that takes time. It's not something that you will see immediate results in just one or two visits. Sometimes it takes maybe 10 or even 20, or six months of treatment before they see some improvement… … So, that kind of treatment model is something new to them and they need to learn the Western way of how things are done…

Providers also included seemingly basic subjects such as when and where to call for help. Especially for the AA families who had been tolerating patients' symptoms for a long time, situations that warranted a call o the police or 911 needed to be pointed out. The education also helped the family understand that it was o.k. to call for help with a mentally ill family member. The EA families' lack of understanding about available resources, or the function of each facility also had to be spelled out to them in detail.

> Provider: So, that's one of the things I typically do is a lot of psychoeducation which involves educating them and giving them terminology and concepts and dissuading them from the old concepts and getting them to buy into the new ones.

Even though psychoeducation was emphasized, providers were neither forceful nor authoritarian. Their approaches were gentle and they attempted to understand and set up a plan that made sense to the families. They were flexible and respectful. Many times, providers did not use Western Psychiatric terminology such as psychosis or depression. Rather, they focused on the symptoms and how to relieve the symptoms. Educating patients regarding psychotropic medications on a level that the patients and the family would understand and accept was a big struggle to providers. Emphasizing the chronic nature of the mental illness and the importance of medication compliance was particularly important. Comparing mental illness to diabetes was a commonly used strategy reported by many providers.

> Provider: One way that I have tried to educate them as to why they are on medication is to use the analogy of something that is considered acceptable to them: Taking diabetes medication for diabetes and taking blood pressure medications for high blood pressure, so taking antidepressant for depression…

> Using an analogy like 'some people are just on these medications to treat a problem. However, it doesn't mean that it's a lesser problem or a greater problem. It's just a problem that we want to help you with.

Also, a provider stated that trying to emphasize a future goal-oriented perspective was very helpful.

> Provider: we want you to be able to do some of the things you wish to do and so with these medications it will hopefully resolve some of the interference or noise that's preventing you from getting up and doing what you want to do.

Such an approach was quite common among providers. For example, in the exemplar case the provider used a similar approach by addressing the current problem that the client was experiencing and the medication that would be able to alleviate it.

ii. To go between generation and cultural gap

Providers had to be a 'go-between' to help the family and patient understand each other. This did not only involve advocating for the patient with family, but also entailed helping the patient express feelings and thoughts, so that the family could cope with patient's illness better. Even though the family played an important role in the EA patient's life, providers also saw that such strong family support could turn into overprotection of the patient and hinder the patient's independence. Providers were mindful of the pull and push between the independence of the patient and the loyalty to the family. In some cases, providers helped patients and families to accept the importance of transitioning and even separation. For example, in the following case, the patient immigrated to the U.S. with his family. However, it seemed that he was not able to fully integrate into life in the U.S. He ran away from home and stayed on the street frequently. It was not until the family couldn't handle him at home that he was brought into the hospital. Providers understood the patient's desire to live on his own and helped his family to accept his decision.

> Provider: He wanted to live on his own and then we encouraged the family to let go of him. They felt that they had to take care of the patient. They tried to control his behavior, but he just left home. So I was very concerned about him. So we educated the family that the patient is going to have, although he has a mental illness, he can choose his own lifestyle. So he eventually...he preferred to stay in shelter. And he tried that for maybe a month or two. We had a case manager following him. And then eventually he decided to return to Shang-Hi because he felt more comfortable at living there. And family was able to accept that. I said that

> maybe he has grown and he has the right to choose where he wants to be.

In the previous case, it was a very difficult thing for the family to let a mentally ill family member live by himself on the street as a homeless man even though the patient preferred this. Providers supported the family and help them accept that ultimately letting the patient choose what he wanted to do was supporting the patient and that the family was not abandoning him.

Providers often observed the generational conflict between family members because of the different acculturation rates among family members. In this case, providers tried to help members to increase their understanding of each other by interpreting and reiterating the ideas to the other members.

> Provider: Well, I try to act as the mediator between the two parties. I will try to throw out to the parents that this is how the child sees things and maybe it will come to a conflict. The reason the child is seeing things differently from you is because she is coming from the direction that she was born in the States. And she is thinking and her way of seeing things is definitely different then where you came from and so hence there is this difference

The traditional AA family dynamics often made it difficult to have open discussion between family members. One reason is that because parents were assumed to hold absolute authority and a child was supposed to be obedient of their decisions. Thus, contradicting parents in front of a stranger was considered not only bad behavior, but also a sign of parenting failure that brought the family shame. Thus, if a family had a rigid role expectation, it made it difficult for communication to go on. In such cases, providers took on the role of referee at times siding with the child and advocating for him/her.

> Provider: So it’s very lopsided and the therapist has to kind of act like a referee and I guess even side with the children to show support for them to say things to their parents so that they won’t be intimidated by their parents.

There were cases where the family’s involvement seemed detrimental to a patient’s prognosis and in these cases, providers actively called a family meeting in an attempt to advocate for the patient to the family and to mitigate the negative impact on the family. In the following case, the patient had been taken care of in the home even though he had been disruptive to family functioning. The provider observed that this family would have difficulties saying no when the patient wanted to go home. The provider also appreciated that even though the patient was hostile to his family, he would want to stay at home with his family after the discharge. This wish made him a high AWOL risk when he was placed in a lower level care facility after discharge.

> Provider: We do understand if we send him to a hotel or a board and care home, he is going to go home...And we do understand that, for most families, it will be very difficult to say no when the patient returns home. So we see the family as a unit and we see the bigger picture

Providers decided to approach the family as part of surrogate treatment team. When a family meeting was called to discuss patient's discharge plan, providers identified that the father was over involved and exhibited controlling behavior which eventually could be detrimental to the patient's prognosis.

> Provider: And in that case, um...the family...some families are very dominant and they consider their children as their own property and they are overprotective of the patient. For this patient, a young Chinese man who had schizophrenia …and dad was controlling...trying to control his treatment. Very detailed and recording everything, every behavior, every concern. …And so basically, because the father is so dominant and, I mean, in contrast the patient becomes so small, no so...called self. That's why the patient will frequently become mute and suppress his emotion; eventually, he will have anger outbursts and resort to violence.

The provider included the father in treatment and attempted to modify the patient's family environment to be more supportive and therapeutic to him. However, providers proceeded with care and respect of the cultural family structure. They attempted to be respectful of the father's authority rather than confronting him about his dominance and its negative impact on his son.

> Provider: And the treatment...we will be working with the father and sort of help him understand and try to give the patient more control. And then we try to find a middle ground. Like we try not to confront the dad, I mean face to face. Rather we work as a team. I… mean usually we will ask him to leave the medication treatment to doctors and...So if he has problems, then we are aware...we interchange medicine and adjust the medicine already rather than having him dominating treatments. So we find a middle ground and then we try to...just say we try to find the best treatment for the patient so we all work as a team. So that's pretty much our parts.

iii. To expand alliances

Many treatment approaches that providers used with AA families are probably applicable to patients and families from other ethnic groups. However, in reality, non-AA patients often did not have family who would support the patient so extensively. Thus, treating AA patients and families was a unique matter. Also, even though the treatment goals may be similar, providers need to be attuned to and culturally specific about the details of treatment goal.

Providers frequently attempted to form some types of alliance with patient and families, but did not limit their alliance to the Western mental health model. When an AA family asked to use herbs or acupuncture, a provider attempted to extend his alliance to the acupuncturist. He tried to remove any pressure for the family to choose one style of treatment over another. Instead of telling the family that acupuncture might not be compatible, he simply expressed his concern that he did not have enough knowledge about the alternative treatment the family proposed.

> Provider: So there is no pressure. And still respect the culture and respect their choice in a way. So in that way, only by that way, they feel that they get approval from the doctor and doctor respects their culture. In that process, you build up the alliance with the patient. And if you have a good herbalist, you can talk to them. I did call them and talk to them and ask them whether their medication works in treatment and psychosis and some of them, good herbalists, says ‘no no it doesn't work. It may help to alleviate some symptoms, kind of help patient sleep better, but I don't think that it helps with delusion’. So I can ask the herbalist to explain this to the family. In that way thef amily trusts us more. And they listen to the herbalist and listen to us. Instead of looking to the herbalist as an opponent, we ally with them, because the focus is the care of the patient. A similar situation is, one of the patients thought that acupuncture can help him. So I did refer him to an acupuncturist. The acupuncturist talked to them that acupuncture might help with some side effects of the antipsychotic medication. For example, it helps people with tremor to be less rigid and they can be more relaxed and less anxious. But it doesn't help them with hallucinations or delusions.
>
> So by working parallel with acupuncturists like that, you can gain trust from the family more. So the key things here are that you are working with people. And compromise with them to flow with the cultural belief more than become opponent or become black or white 'you go with me or you go with them'. We are all working to care for the patient. I think that’s the reason we have this Asian Pacific focus unit is because we practice a lot what we call the cultural psychiatry. We understand other people's culture and then we work with them in their framework.

The provider had enough patience to suggest that there may be a time when the patient would have to stop antipsychotic medication while he was taking herbs. As the interests and use of alternative medicine increases, providers need to develop strategies on how to approach these issues. The above case highlights a provider's approach that might be considered a benchmark for providers without much experience with the AA population.

B. Supporting the Family in Transition

In the previous chapter, providers reported that AA families were extremely tormented and reluctant to transition their ill family members out of the home and into professional care. For example, AA families experienced extreme difficulties when discharging a patient to a long-term care facility or transitional treatment facility because to them, it represented abandonment. Providers were attuned to the families' dilemma regarding letting their family member be institutionalized. Providers used an indirect mode of communication rather than direct confrontation because they understood that the decision to send a mentally ill family member to a hospital might be a difficult one.

> Provider: Sometimes we have to kind of support them to do that (discharging patient to facility rather than to home). Sometimes they just can't do it and so we have to work around that in different ways. But, it doesn't have the same feeling like… it's not a shame issue so much. It doesn't seem like it. I think it's just plain painful for a parent to feel like they are rejecting their child in that way. I would hypothesize that it could be that feeling of not wanting to admit that they can't care for their child…

C. Recognizing and Treating Culture-Bound Syndromes

When working with AA population, providers face many cultural bound syndromes, some of which were listed in the DSM series and some of which were not yet identified as diagnoses. Providers were attuned to cultural influences on patients' psychiatric symptomatology and attempted to diagnose and treat them accordingly. For example, a Chinese woman was brought to the hospital after she practiced qi-gong by herself and became confused. She couldn't sleep and became restless and bizarre. The admitting diagnosis from psychiatric emergency services was psychotic disorder Not Otherwise Specified. However, after evaluating the patient, the provider decided that she maybe experiencing qi-gong deviation syndrome; the patent was successfully treated without antipsychotic medication. Qi-gong deviation syndrome is known also as qi-gong psychotic reaction. It is an acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or nonpsychotic symptoms that occur after participating in the Chinese folk health-enhancing practice of qi-gong (American Psychiatric Association, 2000). Especially vulnerable are individuals who become overly involved in the practice.

> Provider: Actually we talked with the family and talked the patient. We actually found a Qi-gong master. And we had the Qi-gong master come in during the family visiting time and work with her for an hour a couple times a week, maybe twice or three times a week.

The patient improved and was discharged to home with a recommendation to practice Qi-gong with a Qi-gong master to guide her instead of giving her medication. The patient was monitored by providers during and after the inpatient treatment. In this case, providers respected the patient's culture and also understand the culture and worked with it. In so doing, the provider was able to avoid a misdiagnosis and provide a treatment that was culturally and diagnostically appropriate.

> Provider: This case, made me so happy because we pick that up. If she went to other places, maybe they would think she's psychotic and maybe give her antipsychotic medication. She would have lot of side effect, the more she have side effect, and maybe she look more bizarre. And the Qi-gong deviation syndrome will be still there. So that makes me happy.

For AAs, the individual's role in the family was relatively well defined. Such a strictly defined family role may become stressor for some, yet this could be a source of meaning for others. When an elderly patient was diagnosed with cancer and became depressed and suicidal, the provider was able to appeal to the patient by reminding him about his role as a father and the head of the family.

> Provider: The elderly guy was diagnosed with cancer and became very depressed. He wanted to kill himself. He was referred to the psychiatric consult service when he was in the medical unit. The psychiatrist told him; 'well, in your family, I mean what would be the role of the head of household? What do you want to teach your children? I mean, when they have challenged in life and became depressed in their life, do you want to show them that this is a good way to carry themselves?'…

The psychiatrist's words helped the patient to realize his commitment to his role as the head of the household. The patient was able to try to resume his role while he was in the hospital and no longer experienced suicidal ideations.

Certain culturally bounded beliefs were unknown to providers even though they are

Asians. Respecting patients' and families' beliefs, as long as they were not harmful to patients or to the others, was the strategy providers used. The flexibility of the treatment approach might come from the provider's approach and attempt to understand the patient's place. For example, a female Laotian patient was brought to an inpatient psychiatric setting after being depressed after breaking up with her boyfriend. She also believed that there was a ghost in the corner of her room watching her and aware of what was going on with her. She felt depressed and ashamed because of this. Generally these symptoms she exhibited would be identified as psychotic symptoms. However, the providers who were familiar with the Laotian family understood that, in Laotian culture, people believe that there is a ghost at the corner of every room watching the activities of the house. And this ghost catches people being bad or good. Providers decided that the patient's symptoms were appropriate within her cultural norm.

> Provider: So, we had a shaman come in to work with the ghost. The ghost went away from the hospital and was no longer in her room in the hospital. So she improved.

However, this provider's approach did not mean that he abandoned his own illness and treatment model. He maintained the role of psychiatrist, standing by the patient and monitoring patient. He also approached the patient and educated her about the depression and medication.

> Provider: So you respect the patient's culture to the degree that you see that it is not harmful to the patient. And then you have your limit. But the goal here is how to care for the patient. And then later on, you can talk about the depression and stress after she broke up with the boyfriend and how antipsychotic and depression medications work, to help her back to school and so forth. But that will come later after you gain trust from the patient. So I think that it is important for you to find a way to reach out to the patient and help the patient.

D. Becoming a Zen Practitioner: Persevering and Humor

Working with patients with chronic mental illness is tiring work. Repeated admissions and the chronic nature of the illness can make everyone involved emotionally fatigued. Interestingly, providers developed approaches that took one step back from the situation and enabled them to look at the situation with humor. This ability differed from the attitude of detachment where emotional involvement was limited. During the interviews, many providers used expressions to represent the chronic nature of mental illness. For example, one provider described mental illness as a ‘revolving door’ where many patients were discharged home but brought into the hospital again and again.

> Provider: I think families need to be educated as to the mental illness and the importance of medicating these patients because we have patients who will come three days after the got discharged and in another week they come back again, so it’s like a revolving door to them.

Another provider described success in psychoeducation with families as hitting the ‘jackpot’. He would repeatedly educate patients and families about the relationship between medication compliance and patient prognosis. Yet many times, the patient and family denied or were unable to see the relationship between medication and prognosis. However, the provider would continue to educate them and treat them. One day, when the patient and family finally genuinely understood this connection, he said that he felt like that he hit the ‘jack pot’. Such lingoes among the providers were neither degradating nor judgmental. It was instead a humorous observation of the situation that the patient, family and providers all were involved in and experienced.

> Provider: Eventually, hopefully they make a connection between what they are doing wrong and not appropriately, and the patient's decompensation. So… the patient comes back. So… you try once and you try 99 times, it doesn't work. But you never know. Maybe in 101 times, it works. Some other times, you keep trying until 31 times, it works. In some cases, it maybe five times and it works. So, it's like you have a slot machine. You don't know when the jackpot comes out. So you keep trying and then, eventually it should work. But I have cases, you have tried for so many years, but it doesn't work. The patient comes so many times; he says 'No I don't need medication', individually. But most of the time, if you give some time, it is working. But there's cases we tried everything, it doesn’t work.

This provider’s engagement with the process of educating and working with patients and families in the chronicity of mental illness is remarkable. He expressed a deep acceptance of the unpredictability of his efforts to change perceptions At the same time, he seems fully committed to pursuing the goal, irregardless of if it takes 101 times and multiple years of effort.

IV. CONCLUSION

In this chapter, the clinical realities of culturally competent care were illustrated. Providers confront difficulties related with cultural differences between their clients and themselves, and develop various models for successful treatments. Despite the fact that the notion of cultural competency in psychiatric care has been emphasized in the literature, the practices developed and practiced on a daily basis by providers who worked with AAs on the front line has rarely been investigated. The knowledge developed via practice is important because it provides us with a realistic understanding about the practice. Such knowledge, however, can be understood only by studying the practice itself. Thus, it is important to carefully listen to providers' voices about their practices and their understandings on their practices.

In this study, providers working with AA patients and their family played multiple roles. Providers were able to admit what they did not know to patients and their families. They were also open to exploring ways to reach out and help patients and families even though it meant expanding their alliance with practitioners who provide non-western medicine, such as herbalists, acupuncturists or those who were not in the medical field at all, such as Qi-gong masters or shamans. Providers persevered in their pursuit of educating patients and families and of reaching a common treatment goal, and accomplished this with grace, humor and dedication.

CHAPTER 6

DISCUSSIONS

I. INTRODUCTION

This chapter provides interpretation, discussion and recommendations based on the overall purpose and the specific aims of the study. The presentation of results is organized according to the purpose of the study: to 1) understand Asian American (AA) family caregiving practices for a person with a mental illness and 2) understand how mental health care providers develop and provide care for AA patients and families.

The sections that follow provide the clinical significance, meaning of the findings and their implication to current mental health practices. To do so, study findings are compared to and contrasted with current treatment recommendations for AA families in the literature. Limitations and strengths of the study will follow. This chapter ends with recommendations for future practice, policy, research and education.

Because of the unique structure of this dissertation, the extensive discussion and implications of study results related to the first purpose of the study have been presented in the chapter 4. Thus, in this section, I will focus on discussions regarding the second purpose of the study; providers' practices. In addition, the implications are focused on both the practitioners' practices and the general study.

II. UNDERSTANDING ASIAN AMERICAN FAMILY CAREGIVING PRACTICES FOR A PERSON WITH A MENTAL ILLNESS

Findings of the study are consistent with the current knowledge that there are strong family supports within the AA population (Bae & Kung, 2000; Kim, Bean, & Harper, 2004). However, AA families' therapeutic contribution to the patient's prognosis is not stressed enough in the literature. In addition, study findings show that the AA family caregiving practices should be understood in a much more complex manner. Such intricacies put into question our effort to describe Asian American family, and any minority family to some degree, in a simple manner. Study findings also point out that the view that all aspects of family involvement are positive or negative is problematic. Rather, what is once a positive caregiving practice may become negative. Thus, the questions become at what point does the positive side become negative and how to recognize the tipping point so that we can help families minimize the negative effects, rather than identifying certain families as pathological. Further discussions have been presented in the chapter 4.

III. UNDERSTANDING HOW MENTAL HEALTH CARE PROVIDERS DEVELOP AND PROVIDE CARE FOR AA PATIENTS AND FAMILIES.

The notion of cultural competency in health care has gained momentum in recent years as it is viewed as a remedy to one of the sources of health disparities. Government and professional organizations have published multiple guidelines for practitioners: e.g. the Center for Mental Health Service (2002), American Psychological Association (2003). Recently, Sue (2006) has argued that cultural competency is composed of general processes as well as a series of concrete and trainable strategies. Concrete steps include self-awareness and stimulus value, assessments of client, pre-therapy intervention, hypothesizing and testing hypotheses, attending to credibility and giving, understanding the nature of discomfort and resistance, understanding clients' perspectives, strategies or plans for intervention, assessment of sessions and willingness to consult. In terms of cultural competency as a general process, culturally competent practitioners are scientifically minded, posess culturally specific expertise and know when to generalize and be inclusive and when to individualize and be exclusive in working with clients. Findings of this study are particularly relevant to the current discourse of cultural competency. The paradigm case illustrated the cultural competency as a general process as well as concrete steps that might be taken. Zane and colleagues (2005) argue that ethnically similar clients and practitioners may differ in cultural attitudes and level of acculturation. Thus, cognitive matches in attitudes, beliefs, and expectancies maybe more direct and important predictors of treatment outcomes.

Long before cultural competency drew governmental and policy attention, practitioners were already coping with these very issues. Practitioners who had long experience with a specific minority population understood ethnically and culturally specific issues and developed practices that were tailored to the specific minority population. There are textbooks and journal articles that provide guidelines for treating AA patients and families, but this study is the first known project to describe providers' practices when caring for mentally ill AA patients and families. Such detailed illustrations provide insight for novice practitioners or those with limited opportunity to work with this population. The findings of this study support some guidelines while challenging others. In the following section, I present selected guidelines for practitioners dealing with AA patients and their families, the approaches that the study findings supported, and finally the approaches that were not supported by this study.

There are a number of guidelines offered for the practitioners on how to respond to AA cultural styles. For example, Sue and Zane (1987) emphasize to two therapeutic processes; gift giving and credibility. By gift giving, they mean that it is important for AA clients to feel that they receive a benefit early in the treatment process. Paniagua (1994) proposes several treatment strategies, such as the therapist exhibiting expertise and authority, maintaining formality and conversational distance, providing concrete and tangible advice, and giving assurance that stress will be reduced as quickly as possible. Lee and Mock (2005) suggest a three phase model: beginning, problem solving and termination. In the beginning phase, the primary goal is to engage the family in therapy. In this phase, assessing family readiness for therapy and mutual goal setting is emphasized. In the problem-solving phase, focusing on the problems as presented by the family, applying a psychoeducational approach, assuming multiple helping roles, and utilizing intermediary functions are emphasized. In the termination phase, culturally appropriate behaviors, such as wanting the clinician to continue as a friend after termination, should not be interpreted as pathological. They argue that, in contrast to their White counterparts, AA value interdependence, self-control, repression of most emotions and short-term result oriented solutions.

Whereas most guidelines looked at the AA population as a single group, practitioners also acknowledged diversities within the AA population and came up with recommendations targeted to specific AA sub-groups. For example, Kim and colleagues (2004) review experts' recommendations for family therapies with AA families and generate 11 guidelines specific to Korean Americans: 1) assess support systems, 2) assess immigration history, 3) establish professional credibility, 4) provide role induction, 5) facilitate saving face, 6) accept somatic complaints, 7) be problem/present focused, 8) be direct, 9) respect family structure, 10) facilitate non-confrontational interactions, and 11) provide positive reframes. Recent publications on family therapy (McGoldrick, Giordano, & Gercia-Preto, 2005) provide guidelines to specific ethnic subgroups as well as larger minority groups.

There are three specific approaches that these guidelines commonly identify as important tenets of family therapy for AA families. Study findings are used to articulate and qualify these recommendations.

Provide short-term result oriented solution and Gift Giving

Many recommend short-term, result oriented, solution focused treatment for AA populations. Such practical approaches may be effective in some families; however, considering the chronic nature of mental illness, such short-term problem solving approaches may be effective for limited clients and problems. In this study, providers offered short-term problem solving approaches and long-term problem solving approaches at the same time. For example, for AAs the fact that the patient may have to take psychotropic medications even when the patient does not experience psychotic symptoms is difficult to cope with. Patients often stop taking medication and eventually experience psychotic symptoms. Thus, the providers repeat psychoeducation regarding medication until they are successful.

Establish expertise and authority:

First, it was true that AA families believed that providers were experts in Western mental health treatment, but not in other treatments modalities such as acupuncture and herbs. Thus, assuming expertise and authority in all matters may have negatively effect establishing trust and therapeutic rapport. It also can be difficult to build such authority when the practitioner is a novice or much younger than the client. This is particularly important as many AA families use western medicine and as well as eastern medicine. In this study, practitioners employed an egalitarian approach instead of an authoritarian approach. Instead of ignoring or discrediting the patient's cultural illness beliefs, admitting that one does not have enough knowledge to comment on it may be more helpful. For the providers, treating patients and families was a joint venture with other professionals and resources rather than one expert's undertaking. By extending the alliance to family and other health providers, providers were able to establish solid therapeutic rapport with patients and their family.

Importance of psychoeducation

The literature it was often describes psychoeducation as an important part of treatment when helping Asian American clients (Lee & Mock, 2005). However, the extent to which practitioners should cover psychoeducation has not been fully explored. In this study, psychoeducation for AA patients and families covered much broader and deeper subjects than usual psychoeducation guidelines suggests. As a large portion of AA population are foreign born or recent immigrants, and are not familiar with American society in general, or with the American psychiatric system, psychoeducation must cover areas that are not directly related to psychiatric care. For example, teaching patients and families how to access care in general, how to access emergency care, and how to obtain pharmacotherapy may be essential to successful treatment. Such needs for wide-ranging psychoeducation may be a daunting task for novice practitioners. Inexperienced practitioners not notice subtle signs that indicate clients misunderstand or are unaware of cultural differences.

As cultural brokers, providers introduce not only psychiatric/mental health related issues but also some cultural differences in values and customs. Cultural variation between generations may be the source of family conflict. In such cases, providers may need to enact the role of a cultural broker and go-between, interpreting the patient's wishes to be independent from the family and eventually advocate the patient's position to the family.

IV. LIMITATIONS AND STRENGTHS

While the findings offer information that can inform and influence clinical practice and future research on AA families and AA patients, there are some limitations to this study. First, because of the limitation of time and resources, the recruitment of participants was limited to the San Francisco Bay Area. As discussed earlier, the dedication to cultural diversity in the area is unique compared to other areas of the United States. Also the AA population in the study site is unique because of its large AA population. Thus, AA families who live in other areas where there is limited access to multicultural health care systems may develop different family processes and adjustment strategies to their health issues. Unlike the providers who participated in this study, health care providers who rarely encounter AA patients and families may have difficulty in finding institutional and structural support. However, the goal of this study was to address the pressing issues of everyday AA family practices so that providers can appreciate the complexity of AA family life with a mentally ill member in full. In addition, I tried to illuminate the excellence in providers' practice and practice philosophies that developed through extensive practice and training so that other providers could learn from their experience.

Providers who participated in this study were serving a poor and underserved population; most patient did not have health insurance and relied on public health care systems, such as Medicare. Thus, the practice setting and clients may differ from those who have additional resources and private health insurance.

Because this research project focused on the family caregiving practices among families who reside with, or have at least weekly contact with the person with a mental illness, this study does not address how AA families support and care for a mentally ill member when they do not reside with the ill family member or when they live far away from the patient. This study was not able to address the issues of the families that do not fit in with the traditional structure of the traditional AA family, such as same sex couples, single parent or mixed families. Considering the important role of family for AA individuals, it is important to study how the notion of family is modified and adjusted as the family structure changes.

Despite the limitations, there were several strengths of this research effort. Recognizing the challenges associated with recruitment and retention of minority populations and populations suffering from highly stigmatized illness, this study explored a new way of investigating the phenomenon. By investigating the practitioners' narratives, families' concerns and their practices were investigated.

Unlike a case study method in which each case is independent from the other, by employing hermeneutic phenomenology, various cases were compared to and contrasted with each other enhancing our understanding of AA family caregiving practices and providers' practices.

V. IMPLICATION FOR PRACTICE

The study findings may be familiar to practitioners who have extensive experience with AA families. However, for those who have limited contact with AA patients and families, the cultural differences and lack of cultural competency makes it difficult to reach a mutual understanding and treatment goals effectively. The following recommendations are geared toward those practitioners with limited experience with AA population.

A. Providers should understand the importance of family to AA patients and should attempt to include family in every steps of treatment plan

As was observed in the study, the AA families are a crucial part of the patient's prognosis. They provide strong emotional support. In addition to emotional support, AA families provide much practical support and assistance to the patient. However, the current mental health system makes it extremely difficult for providers to provide reasonable level of support for the AA patients and families. Current law hinders such processes by excluding families. Excluding families is often required by law and procedure in psychiatric settings. I do not claim that some characteristics of families might be detrimental to patient's progress. However, for AA families, strong family involvement is not only encouraged but also rather enforced by cultural and social pressure. Thus, being excluded from the process will produce much confusion and frustration to AA families.

Providers who work with AA patients need to be mindful of the fact that most AA patients have family involved with the patient. In addition to inclusion, AA families require relatively aggressive, and broader psychoeducation. Surely, the family's level of acculturation and immigration history should be considered carefully. Also, as individual members acculturate at different rates, individual member's acculturation level and its influence on family dynamics should also be considered.

B. Provider should be mindful about culturally specific family dynamic and cultural expectation when caring for AA patient and family

Providers who work with the AA population should be mindful of communication style and family processes exhibited in each family. For example, instead of confronting parents in front of the patient, a parents-only session can be arranged. When discharging patients to community, it would be prudent to check with families before making any decisions, or at least negotiate with families how and when the patient will be discharged. Many AA families and patients will prefer to care for the patient at home, and thus families are appropriately consulted in discharge planning.

Providers have to be sensitive to families' dilemmas surrounding sending a mentally ill family member to the hospital, or other facilities. Families' eagerness to convey messages of love and belonging should be encouraged. Many treatment failures related to placement maybe related to families' dilemmas and struggle with separation rather than attempts to sabotage the treatment.

C. A new framework for cultural competency is necessary

Current discussions of cultural competency as a set of knowledge about a specific culture or a set of skills to deal with a particular cultural population are problematic, as seen in this study. Such an approach to cultural competency is even dangerous because it may promote essentialized and biased views. It is also impractical and may even be useless because in many minority immigrant population experience drastic cultural changes.

Because of the individual differences in terms of SES, level of acculturation and values, one standardized approach to a cultural group is even dangerous. Thus, knowledge of a culture is only the first step. And it has to be particularized to the specific realities of each patient and family.

VI. IMPLICATION FOR POLICY

Berry (2003) argues that acculturation is mutual processes affecting all groups in contact as opposed to affecting only immigrants groups. With these notions, Berry proposes a bi-dimensional/multi-level acculturation model. He proposed that acculturation occurs on group level (cultural) and individual level (psychological). On the individual level, acculturation occurs based on the orientations toward one's own group and toward other groups. Individuals from both cultural groups in contact undergo change. On a group level, the larger society and ethnocultural groups might have different sets of acculturation strategies. These strategies are based on the attitude towards maintenance of the heritage culture and identity and the relationship sought among groups. For the larger society, Berry observes that four strategies are possible: Multiculturalism, melting pot, segregation and exclusion.

The rigidity of the current health system often forces immigrants and minority groups to adapt to it. Often because of the inflexibility of the system, the immigrants and multicultural families are excluded from the health system and marginalized. Such institutional inflexibility may increase health disparities in minority groups including AAs. This includes the fact that some AA families were excluded or even pathologized by providers. Lack of a support system and forcing families to take the patient back home, does not give families a chance to participate in the treatment decision. The U.S. mental health system is built on the assumption of sanctity of individual rights and individualism, which is at odds with the collectivism practiced in AA families

Policy makers should attempt to adapt the mental health system to more flexibly meet the needs of AA patients and families. Current problems are created by differences in worldview, and require fundamental transformation on a systematic level. As it is projected that immigrants and non-EA populations will grow in the U.S., practices and policies urgently need to be modified to adapt to such populations and cultures.

The economic impact analyses of family caregiving on health care finances are necessary. AA families undoubtedly burden public care systems less because they care for patients at home instead of sending them to halfway houses. A policy for family caregiver support such as tax credits, monetary rewards, or home care nurse visits should be expanded to include services for mental illness.

VII. IMPLICATIONS FOR RESEARCH

A. Data collection – Data collection as a form of collaboration

In many populations, recruitment and retention are a big issue. However, many qualitative study designs allow such data triangulation. As discussed earlier in the methodology chapter, our understanding of a particular phenomenon is always shaped by the hermeneutical circle. Providers, families and researchers hold different positional relations with the phenomena, and each has unique perspectives.

Current health care systems, where the families struggle on a daily basis also influence their experience. The health care providers who contact families caring for a mentally ill member witness and engage with them often. Such engagements between families and providers influence and shape the experience of both parties. Thus, caring is co-constituted. The study both of families and providers in their intersections allows a better understanding than studying them from only one perspective and allows for a more complex picture to develop.

B. Further research should explore culturally specific family processes, and inter and intra group differences among AA groups.

There is an urgent need for culturally appropriate family theory. Such an endeavor will also contribute to the general field of family study, as it will provide broader picture on families. In addition, it will help us to understand culturally specific interpersonal and family processes and their affects on individual health. To do so, comparative studies about inter-and intra- group differences among AA subgroups are necessary.

In addition, study about the relationship between institutional determinants and individual experience is necessary when studying health disparities. For example, what are some institutional level determinants that hinder or promote health outcomes among the minority population? Because AA emphasize the traditional family structure, issues and experiences of non-traditional families such as single family, divorced family, mixed family, gay and lesbian family should be explored.

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APPENIX A
INFORMED CONSENT – PROVIDERS

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO AND CONSENT TO BE A RESEARCH SUBJECT
Working with Culture:

A. PURPOSE/BACKGROUND

Mijung Park, MS, RN, PhD(c), a doctoral student and Catherine Chesla, RN, DNSc, FAAN, Professor from the Department of Family Health Care Nursing at UCSF are conducting a research study to understand what it means to Asian Americans to have a mentally ill family member. You are being asked to participate in this study, because you have indicated that you have provided care to East Asian patients with mental illness in the last 5 years. .

B. PROCEDURE

If you agree to be in this study, the following will happen:

1. You will meet with Ms. Park to talk about your experiences in caring for East Asian patients with mental illness and their families. You will be asked about the difficulties and skills that East Asian American families demonstrate when a family member has mental illness. You will also be asked to reflect on positive ways you have found for engaging and working with these families. This interview will be no more than 90 minutes.

2. Second interview, no more than 90 minutes, may be scheduled with your consent

3. All interviews will be done at a time and a place that is convenient for you.

~~4.~~ The total time of participation in this study expected to be no more than 180 minutes.

C. RISKS/DISCOMFORTS

1. Emotional discomforts: During the interview, you may feel distressed or upset by exploring and sharing your experiences. You always can stop and take a rest, stop the interview, or decline to participate further in the study.

2. Confidentiality: A possible risk of participation in this study is a loss of confidentiality. However, to protect your privacy and maintain confidentiality, your name will be erased and all case records will be numbered. All the data will be stored in the locked file cabinets. When the study has been completed, all identifying materials will be destroyed. To protect your client's confidentiality, you will be asked to use pseudonyms or no names when discussing family issues.

D. BENEFITS

There will be no direct benefit to you from participating in this study; however, you will able to share some of your experiences that you might not have felt comfortable talking about before. In addition, the information that you provide may allow other health professionals to better understand how to help other people in similar situations.

E. COSTS

There will be no costs to you as a result of taking part in this study.

F. PAYMENT

A $25 Borders bookstore gift card will be presented to you for your participation in this study. You will be provided $20 Starbucks coffee gift card after second interview.

G. QUESTIONS

You have talked to Ms. Park about this study and have had your questions answered. If you have further questions, you may call Ms. Park at 1-800-518-6848 or Dr. Chesla at (415) 467-4439.

If you have any comments or concerns about participation in this study, you should first talk with the researchers. If for some reason you do not wish to do this, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco/San Francisco, CA 94143.

H. CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status at any level.

If you wish to participate in this study, you should sign below.

____________ ____
Date Subject's Signature for Consent

____________ ____
Date Signature of Person Obtaining Consent

Appendix B
Interview Guide: PROVIDER

In the actual interview, the narrative will guide the direction of interview and the questions. However, followings are the questions that the investigator will use as a guide. Actual words in the interview also will be modified depends on the participant.

General background

- **How long have been working as a mental health provider?**
- **How many Korean Americans have you had client?**
- **What is you professional back ground?**
- **Tell me briefly about your current work?**

Practice questions

- **Can you tell me about any unique issues or dilemmas that you have observed in Chinese, Japanese and Korean American patients with mental illness and their families?**

  Probes: Delays in seeking health care
  Concern about stigma and illness disclosure
  Concern about loss of face within the family
  Other patient and family concerns?

- **Can you tell me about any unique strengths or skills that you observed in Korean and Chinese American patients with mental illness and their families?**

  Probes: Patterns of family support in the illness.
  Sensitivity to the illness experience of the patient.

- **Can you describe specific practice approaches that you have used with East Asian American patients and their families that have been particularly successful?**

- **Can you describe specific practice approaches that you have used with East Asian American patients and their families that have not worked particularly well?**

- **Now I would like you to think of a specific incident where you felt particularly good about your care of an East Asian patient and family. Without disclosing any names or identifying information, can you talk about this incident and how you proceeded. Please tell me the story of what happened.**

  Probes: Why was this episode of care unique to you?
  What helped you to be successful with this family?
  What stood in your way?
  If you were to care for this patient and family today, what would you do differently?

- **Now I would like you to think of a specific incident where you felt that your care of an East Asian patient and family was less than optimal. Without disclosing any names or identifying information, can you talk about this incident and how you proceeded. Please tell me the story of what happened.**

  Probes: Why was this episode of care unique to you?
  What helped you to be successful with this family?
  What stood in your way?

If you were to care for this patient and family today, what would you do differently?

- **How are East Asian American patients and families that you care for similar to other ethnic group that you are treated?**

  Probes: If different how so?

  Can you give me some example to illustrate the differences?

  Is there any time that you were taken by surprise because client and client's family did not fit your stereo type?

  Do you have specific strategies to approach to client from specific ethnic group?

  Is there any time that you regret or think that you should take different approach to patient and family?

<u>General prompt</u>

- **"Is there any thing that you think I need to know or you want to tell me about?"**
- **"Please tell me more about it"**

APPENDIX C
Flyer – Provider

Looking for Mental Health Care Providers

Are you a mental health care provider?
Have you provided care to East Asian American patients with a mental illness in the past 5 years?

Catherine Chesla, RN, DSNc, FAAN, professor and Mijung Park, MSN, RN, PhD(c) from the Department of Family Health Care Nursing at University of California San Francisco are conducting a research study to understand East Asian American patient and family’s dilemmas and strengths from the perspectives of families and mental health providers.

The interview is confidential and your privacy will be protected.
Small compensation will be presented to you for your participation in this study.

Thanks you for considering participation in my study. For more information, please contact Mijung Park by phone 1-800-518-6848

Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848	Asian Family Care Research Tel) 1-800-518-6848

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