The Prevalence of Mental Health Problems Among Asian American Adolescents and Children: Symptoms and Treatment Issues

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A Statistical Profile of Mental Health Issues among Asian American Children and Adolescents:

- 96% of Asian American children are immigrants or children of immigrants (1996 Housing and Vacancy Survey).
- 33% of Asian American students in public high schools drop out or do not graduate on time (Class of 1999 Four Year Longitudinal Report and Event Drop Out Rates, NYC Board of Education).
- The number of Asian American youths arrested for major felonies increased 38% between 1993 and 1996 (NYPD, Office of Management Analysis and Planning).
- Asian American children and adolescents are considered by mental health providers to be highly prone to depression (Fact Sheet April 2001, Coalition for Asian American Children and Families).
- In a national survey, 30% of Asian American girls in grades 5-12 reported suffering from depressive symptoms. Also, Asian American girls reported the highest rates of depressive symptoms compared to White, Black and Hispanic girls (The Commonwealth Fund Survey of the Health of Adolescent Girls. The Commonwealth Fund, 1998).
- Asian American teenage boys were more likely than their White, Black and Hispanic peers to report physical or sexual abuse (The Commonwealth Fund Survey of the Health of Adolescent Boys. The Commonwealth Fund, 1998).
- In 1997, suicide alarmingly ranked as the leading cause of death among South Asians ages 15-24 in the U.S. (Monthly Vital Statistics Report. Center for Disease Control and Prevention/National Center for Health Statistics, Vol. 46, No. 1, Aug. 1997).
- Asian American women ages 15-24 have a higher rate of suicide than Whites, Blacks, and Hispanics in that age group (Monthly Vital Statistics Report. Center for Disease Control and Prevention/National Center for Health Statistics, Vol. 46, No. 1, Aug. 1997).
- In New York City in 1999, suicide was one of the ten leading causes of death for Asian Americans of all ages, but was not a leading cause of death for any other ethnic group (Summary of Vital Statistics 1999, The City of New York, Office of Vital Statistics, New York City Department of Health).
- Of all the children in New York City receiving licensed mental health services in 1995, only 1% was Asian Americans (New York State Office of Mental Health, 1995 Patient Characteristics Survey).

Mental health stressors for Asian American children and adolescents:
As minority members and descendants of immigrant families, there are many psychological burdens created by:

- the prevalence of racism in society
- the lack of Asian mentors in the school system who could serve as advocates and role models
- cultural and generational conflicts with parents
- the lack of emotional nurturance from parents who are often overworked and experience difficulties in adjusting to a new country.

Some debilitating conditions:

- verbal and physical abuse by parents
- sexual abuse by parents or family members
- scapegoating in school or at home
- prolonged separation from parents/placement with different caretakers during infancy and childhood

Depressive Disorders:

- Major Depressive Episode (6 – 9 month duration)
- Dysthymic Disorder (2 – 4 year duration)
- Transient Depressive symptoms

Anxiety Disorder as a comorbid condition:

- Separation Anxiety
- Generalized Anxiety Disorder
- Social Phobia
- Specific Phobia
- Obsessive Compulsive Disorder

Depressive symptoms among children and adolescents are often different from those observed among adults.

Behavioral and attachment symptoms are frequently observed among infants and children of very young ages who are physically or emotionally separated from their primary caretaker.
Examples with infants: whining during initial separation period with caretaker; after prolonged separation, symptoms may include impaired social interaction; slow motor responsiveness; dazed and immobile facial expression; slowed or stunted growth; susceptibility to infection.
Examples with toddlers: irritable moods; delays in developmental milestones such as walking, language, and toilet training; nightmares; self-stimulating behaviors (rocking, head banging, masturbation); clinginess; excessive fears; oppositional behavior; decrease in play.
Examples with pre-schoolers: sadness, tiredness, anger, apathy, irritability, social withdrawal, weight loss, motor retardation.

Cognitive and emotional symptoms are more common with older children and adolescents.
Examples with older children: anxiety, phobias, somatic complaints, reluctance to leave the room or house, complaints of boredom, disruptive behavior at home and/or at school, decline in academic performance.
Examples with adolescents: volatile mood, rage, intense self-consciousness, low self-esteem, poor academic performance, truancy, delinquent behaviors, substance abuse, sexual acting-out, social withdrawal (anhedonia), eating and sleep disturbance.

Cultural values and norms that may contribute to depressive symptoms/syndrome:

- Family is the central unit of life and one's sense of self and identity revolves around meeting family expectations and needs
- Total obedience and compliance toward authority and parental figures.
- Communication patterns that sanction internalization of negative feelings and indirect expression of love.
- Academic achievement of children perceived as validation of parents as "good" parents, and the pathway to a successful life for the children

Suicidal Risk Factors:

- Poor problem-solving and coping skills in handling disappointments and losses in life
- Difficulties in managing or expressing anger
- Isolation in family and school
- Dysfunctional family environment
- Family history of suicide/ suicidal attempts/ suicidal threats
- Family history of loss of loved ones and views of death and dying

Suicidal Risk Symptoms:

- Accident-prone behavior (children)
- Preoccupation with death and morbid thoughts (children)
- Self-hate ideations
- Inability to recover from relationship breakups (adolescents)
- Fascination and identification with icons who embrace the idea of "death" (adolescents)

Recommended Treatment approach:
Combination of individual and family therapy
Use of culturally sensitive interventions:

- Family-syntonic approaches versus blaming parents, i.e., reframing generational conflicts to project a sense of hope for the family; validating the hardships and aggravations of the parents.
- Role-modeling parenting techniques that are culturally meaningful, i.e., some discipline and goal-setting; a balanced focus on outcome.
- Cognitive and behavioral approaches in working with the individual child/adolescent to improve self-esteem and coping skills.
- Facilitating communication of positive feelings between parents and child.

Medication to alleviate/stabilize more severe symptoms

Treatment Issues:

- Parents' perception of problem: child is being "lazy", "defiant", etc;
- Parents' perception of solution: child needs to develop better will power, get closer supervision, spend more time at home, etc.
- Parents find it difficult to understand the concepts of "blanking out", "lack of motivation and concentration", "anger outbursts" as depressive and anxiety symptoms.
- The lack of commitment to seek mental health treatment because of the stigma associated with mental illness, and the lack of understanding of the goals and means of psychotherapy.

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