UTILIZATION OF MENTAL HEALTH SERVICES BY ASIAN AMERICANS

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Introduction

A number of factors influencing decisions to seek mental health care can preclude individuals from pursuing treatment. According to research on utilization of mental health services among various ethnic groups in the United States, Asian Americans have been shown to have lower rates of treated mental illnesses. (Meyers, 2006)

Asian Americans are often viewed as a "success story" when it comes to assimilating into American culture. According to the Pew Research Center, Asian Americans are the highest earning, best-educated, and fastest growing ethnic group in the United States. (Pew Research Center, 2010) Additionally, the Centers for Disease Control and Prevention found that Asian Americans were more likely to claim they were in excellent physical health than Whites, Blacks, and Hispanic/Latinos. (Barnes, Adams, & Powell-Griner, 2008) Asian Americans were also less likely to be limited in their usual activities of daily living because of a chronic illness compared to White Americans. As far as access to health care is concerned, Asian Americans were more likely to have private health insurance than Black and American Indian/Alaskan Natives. (Centers for Disease Control and Prevention, 2012) For the economic, educational, and positive health outlooks, Asian Americans have been dubbed as the "model minority". (The Economist, 2015)

Significant numbers of Asian Americans have mental health problems. (Meyers, 2006) In a 2005 study, Asian American college students were more likely to attempt suicide compared to White counterparts. (Centers for Disease Control and Prevention, 2008) Asian American females, aged 15-24, had the highest rate of suicide deaths at 14.1% compared to 9.3% of Whites. (Centers for Disease Control and Prevention, 2008) In a 2007 needs assessment conducted by the University of Maryland School of Public Health, adolescents and young adults

who were 1.5 and 2nd generation Asian Americans (1.5 meaning the participant resided in country of origin before coming to America and before age 16 and 2nd generation meaning being born in the United States with parents immigrating from another Asian country) found that mental health was one of the primary health concerns. (Sunmin, et al., 2009) In addition to perceived discrimination, Asian American youth have reported experiencing pressures to assimilate into American culture, and to succeed academically and financially, all associated with high anxiety or depression. Asian American youth have also reported that the cultural stigma against mental illness, their inability to find care providers who understand the Asian American experience, and perceived racism by non-Asian care providers have prevented them from seeking mental health care. (Sunmin, et al., 2009)

While low rates of seeking mental health care may be linked cultural stigma, lack of Asian American mental health care providers, and perceived racism by non-Asian American mental health professionals, there may be other reasons for why Asian Americans underutilize mental health services. Utilization may be low because mental illness is not recognized or symptoms are not attributed to an underlying disorder. For example, Asian Americans with ancestry in the Middle East or South Asia may perceive any illness (mental illness included) as a test from God or another divine entity and as an opportunity for prayer or fasting. (Ciftci, Jones, & Corrigan, 2012) Some individuals may see some mental illnesses as rare gifts granted to them in order to advise their communities on major decisions and dispensing life advice. A study of populations from the United States, India, and Ghana found differences in attitudes toward auditory hallucinations of schizophrenics. The Indians described auditory hallucinations as "spiritual", "playful", and at times as entertaining. Some heard voices of relatives "instructing them to do tasks" and were not as inclined to describe the voices as of a medical or psychiatric

problems. In contrast, none of the Americans had positive views about auditory hallucinations and most were convinced that they had a medical condition because the voices were described as "hateful and violent." (Luhrmann, Padmavati, Tharoor, & Osei, 2014)

This study will examine differences in utilization of mental health services between Asian and White Americans. It applies the Healthcare Utilization Model, investigating whether predisposing factors, perceived need, or enabling factors influence utilization of mental healthcare services. The Healthcare Utilization Model was developed in 1968 by Ronald Andersen who believed that an "individual is more or less likely to use health services based on demographics, position within social structure, and belief of health services benefits." (Andersen R. M., 1995) In this study, demographics (Asian Americans vs. non Asian-Whites) will serve as the predisposing factor, position within social structure (educational attainment) will serve as the enabling factor and self-reported average mental health rating will indicate perceived need. Education was chosen as an enabling factor because previous studies indicated education was significantly associated with depression in adults. (Wang, 2014) Perceived need will be measured by self-reported experience of mental health symptoms. The study tests the hypothesis that Asian Americans are significantly less likely to utilize mental health services than White counterparts. That is, among those reporting poor mental health, Asian Americans will be less likely to use mental health services than Whites.

Literature Review

Burden of Mental Illness:

The World Health Organization (WHO) defines the concept of health as, "...a state of complete physical, mental, and social wellbeing and not merely an absence of disease or

infirmity." (World Health Organization, 2014) It is important to note that the term "mental" is included. Incorporating the concept of mental health into the definition of overall health, suggests that mental health is critical to daily living and functioning.

However, mental health is often ignored and or seen as secondary compared to physical wellbeing and absence of disease. Mental disorders are major contributors to the burden of disease. Globally, approximately 400 million people of all ages suffer from depression, 60 million people have Bipolar Affective Disorder, 21 million people are afflicted with schizophrenia, and over 35 million people have dementia. (World Health Organization, 2014) Suicide is the second leading cause of death for individuals aged 15-29 globally. (World Health Organization, 2014) According to Healthy People 2020, mental disorders contribute to 25% of all years of life lost to premature mortality and disability in the United States (Healthy People, 2015) Physical health, a critical part of our daily living and ability to contribute to society, is heavily influenced by mental health. If a person is mentally unwell, they are often unable to care for themselves such as partaking in a healthy diet, getting enough physical exercise, and being well rested. People with mental illnesses or disorders are also likely to engage in risky health behaviors such as unsafe sexual practices or substance abuse, which further endangers physical wellbeing. (Mental Health, 2014)

Mental health has an impact on chronic illness and vice versa. According to studies by the Centers for Disease Control and Prevention, there is a strong correlation between chronic illness and mental health. For example, depression occurs in 17% of patients with heart disease, 23% in cerebrovascular patients, and 40% in cancer patients. (Centers for Disease Control and Prevention, 2012) Mental health also has a strong impact on society through loss of productivity and burden on the healthcare system. Approximately 80% of individuals with depression report

some level of functional impairment and 27% report serious difficulty in work and home life due to their condition. (Centers for Disease Control and Prevention, 2012) In 2006, $57.5 billion dollars was spent on mental health treatment in the United States. However, the amount of indirect costs accumulates from absenteeism, expenses for social support, and short-and long-term disability.

Mental health is sometimes is overlooked as an important contributor to well-being in populations. Mental illness may be viewed as an inability to control emotion, something dangerous, or a personal flaw. (Overton & Medina, 2008) In several cultures and societies, mental illness may be seen as an embarrassment and something that delays progression of a group. (Sue & Morishima, The Mental Health of Asian Americans, 1982) Mental illness may not be recognized due to stigma. A lack of understanding could result in mental illness being ignored or individuals being expected to address such problems on their own and some may be shamed into hiding their condition. (Cheong & Snowden , 1990) This leaves individuals to struggle on their own, unable or unwilling to seek treatment. In the United States, all ethnic groups may experience stigma with symptoms of mental disorders, but with Asian Americans, the stigma may be particularly felt by Asian Americans. (Nishi, 2016)

Healthcare Utilization Model:

The Healthcare Utilization Model was developed in the late 1960s by Ronald Andersen. The intent of the model was to explain why families use health services and to define and measure equitable access to healthcare. (Andersen R. , 1995) Andersen believed that use of health services was a function of predisposing and enabling factors that made it easier or difficult to utilize services and whether or not individuals believed they needed care. This model might help examine whether Asian Americans are less likely to seek mental health services and why.

Potential Limitations of the Healthcare Utilization Model:

A possible limitation of the Healthcare Utilization Model in pluralistic cultural settings is reported in a study by Subedi (1989). In this study of healthcare utilization in Nepal, Subedi found that "established indigenous forms of health care" were often used in lieu of Westernized and modern medicine. The study examined the impact of "medical pluralism" and its role on modern medicine use. (Subedi, 1989) Medical pluralism is "the employment of more than one medical system or the use of conventional and complementary, and alternative medicine." (Wade, Chao, & Kalmuss, 2008). Subedi used Andersen's Model, examining the predisposing and enabling factors and perceived need. Predisposing factors included demographic information such as age, sex, and marital status. Also included was education, size of family, religion, and employment status. As a predisposing factors, health beliefs and attitudes were included. Enabling factors were individual's resources, community resources, and access to care including distance to healthcare facilities. To measure perceived need, participants were asked about severity of their health problem, the timing of the health issue, and the nature of illness (chronic or infectious). The study found that all variables influenced seeking care but not all predicted the use of modern western providers in a society with medical pluralism. For example, some participants delayed seeking professional help in favor of home remedies. If home remedies were unsatisfactory, they sought indigenous health services such as a local healer. Finally, some would go on to seek out modern medical health services. However, participants utilized modern medical professionals only after experiencing dissatisfaction with home remedies, indigenous health care or when an indigenous health professional advised them to do so. Utilizing Western providers may have been delayed but this was because of their reliance on indigenous healthcare. (Subedi, 1989) Subedi reported that the Health Utilization Model was problematic because the

Health Behavioral Model did not indicate why individuals were more inclined to seek out traditional/indigenous medicine over Western medicine.

Asian Americans and Mental Health:

As noted, Asian Americans, as a whole, have more resources than other ethnic groups in the US. At least 49% Asian Americans have a Bachelor's degree or higher and have a median household income of $66,000 compared to the rest of the general American population at $49,800. (Pew Research Center, 2012) Despite their educational and financial success, Asian Americans are not immune to mental health issues. The National Latino and Asian American Study reported Asian Americans had a 17.03% overall lifetime rate of having a psychiatric disorder but were three times less likely to seek mental health services compared to Whites. (Abe-Kim, et al., 2007). Asian American females in the age group of 15-24 have the highest rate of suicide deaths among other groups in the US and Asian American males in the same group have the second highest rate of suicide deaths. (CDC, 2005) With the high prevalence of mental health related problems, it is important to examine why Asian Americans have a lower utilization of mental health services despite educational achievement and overall affluence.

Applying the Health Care Utilization model, researchers Ting and Hwang examined cultural influences on help seeking attitudes in Asian American students. They also examined perceived need, predisposing factors, and enabling resources. Predisposing factors included age, gender, and social support. Enabling resources included higher SES, and availability of health insurance. The study found that neither degree of need for help nor social support were associated with help-seeking attitudes of Asian college students. They also found that the amount social support was not associated with help-seeking attitudes. Neither enculturation nor adoption of American culture had an impact on help seeking behaviors. However, stigma tolerance was

strongly related to help seeking attitudes. Low tolerance for stigma was associated with less inclination to seek help whereas higher stigma tolerance was associated with a greater inclination to seek help. (Ting & Hwang, 2009)

If Asian American students felt that help-seeking was culturally acceptable and compatible with their beliefs, they were more likely to seek care. Although the study found that social support was not associated with attitudes about help seeking, social support (such as close friends or significant others) had an impact on help seeking behaviors. (Ting & Hwang, 2009) If Asian American students observed close friends from their culture utilizing mental health services, they would be more likely to do the same or believe that help seeking is not something to be ashamed of. Unfortunately, the study was limited in not having a comparison group of non-Asian Americans nor did it differentiate between the different types of ethnic groups comprising Asian American students. There apparently were more Asians from East Asia rather than South or South East Asians. (Ting & Hwang, 2009)

Previous research has found a significant difference between utilization of mental health services between Whites and Asians. A study using data from the National Epidemiological Survey of Alcohol and Related Conditions (NESARC) found that Asians with lifetime mood disorders were significantly less likely to utilize mental health services than Whites. (Lee, Martins, & Lee, 2009) Participants of the study were asked to report on lifetime mental health service utilization for psychiatric disorders such as major depression, dysthymia, mania, panic attacks, or general anxiety disorder. Mental health utilization was measured by whether the participant had ever utilized outpatient services such as a physician, counselor, or therapist or if they were recipients of inpatient services or were prescribed medication. The study found that Asian Americans' lifetime prevalence of utilizing mental health services with disorders such as

major depression (38.8%) and bipolar (18.8%) was substantially lower than Whites (65.9% and 54.6%, respectively) (Lee, Martins, & Lee, 2009). Overall, the findings suggest that despite having a diagnosis of a DSM-IV disorder, Asians underutilized mental health services compared to Whites.

Immigration status may also have an impact on whether Asian Americans seek mental health help. In the original NLAAS study, researchers examined the utilization rate of mental health services (any general medical or specialty care). The study showed that while Asian Americans were still quite low in utilizing any mental health services (only 8.6%), US- born Asian Americans had a higher rate of utilizing mental health services than their immigrant counterparts. (Abe-Kim, et al., 2007) The third generation of Asian Americans in the US held the most positive perception of mental health services as helpful while second generation Americans were more similar to their parents' generation (coming from an Asian country) in believing mental health services to be less helpful. (Abe-Kim, et al., 2007)

Other Factors Influencing Utilization of Mental Health Care Services:

Education has also been associated with prevalence of reported mental health problems and treatment. Education is also associated with better health outcomes. (National Poverty Law Center, 2007). Individuals with higher levels of education are less likely to report having depression or anxiety. (Picker, n.d.) Conversely, individuals who report higher rates of mental illness are also likely to have lower levels of educational attainment. (World Health Organization, 2012) Research has found that with each additional level of educational attainment, participants were 15% more likely to see a psychiatrist, 12% more likely to see a family doctor, 16% more likely to see a psychologist, and 16% more likely to see a social worker. (Steele, Dewa, Lin, & Lee, 2007)

Related to education is mental health literacy. Mental health literacy is the "knowledge and beliefs about mental disorders which aid their recognition, management, and prevention". (Jorm, et al., 1997) This involves being able to recognize specific disorders, knowledge of risk factors and causes, knowledge and beliefs about self-help interventions and professional help, attitudes that facilitate help seeking behaviors, and how to seek mental health care information. One study revealed that many people in the US have trouble recognizing a mental illness and although most individuals were reasonably capable of recognizing symptoms of depression, they were not as successful at recognizing somatic changes, such as headaches, weight gain, or disturbances of sleep and appetite. (Regier, et al., 1988) (Kapfhammer, 2006) People believed their symptoms of depression were less treatable by psychologists and psychiatrists than by general practitioner physicians. (Jorm, et al., 1997) Many cultures in developing nations view traditional medicine as sources of help for mental disorders (i.e. holy water, traditional healers, and herbalists) while Western medicine was overwhelmingly preferred for physical ailments. (Alem, Kebede, Woldesemiat, Jacobsson, & Kullgren, 1999)

This study will examine whether Asian Americans, perhaps because of cultural differences, are less likely to seek mental health services than Whites.

Methods

Participants

The National Latino and Asian American Study included total of 2, 095 Asian American participants. (Asian American Pacific Islander Data & National Council of Asian Pacific Americans, 2015) Initially, only Asian Americans who were born in the United States were to be included in the survey but to avoid having a small sample size, all Asians within the US were included. The survey therefore includes both Asians who were born in the United States and

those who immigrated. Males and females between ages 18-50 were included. There are many Asian cultures and while some may share common experiences and beliefs with others, they are rather varied. In the NLAAS, Asian Americans included Chinese, Filipino, Vietnamese, and other Asians. The NLAAS study excluded individuals under 18 years of age and those institutionalized (in either jails, nursing homes, or long term medical care facilities) or residing on military bases. (Collaborative Psychological Epidemiological Studies, 2015)

Procedures

The NLAAS is an epidemiological survey conducted from 2002-2003. All answers were self-reported in interviews. The sample design was a "four stage national area probability sample with special supplements for adults of Chinese, Filipino, and Vietnamese national origin." (Collaborative Psychological Epidemiological Studies, 2015) The survey included 27, 026 housing units that were screened for eligible adults, resulting in total of 4,649 interviews. In this study, responses of Asian Americans were compared to Whites asked similar questions in the National Comorbidity Survey-Replication (NCS-R). (Collaborative Psychological Epidemiological Studies, 2015) The NCS-R was also a four-staged national area probability sample. The populations sample size of eligible participants was 13,054 of which 9,282 interviews were completed.

Measures

Approximately, 2095 Asian American completed a 41 item survey of the NLAAS. The study includes the following variables: mental health rating, race, and education. Whether participants ever utilized professional services in their lifetime for emotions, nerves, and or substance abuse was a measure of utilization. The predisposing factor is ethnicity (Asian

Americans vs Whites) while the enabling factor is educational level. Self-assessed mental health rating was the measure of perceived need. Although Whites were not a comparison group in the NLAAS study, White responses as comparisons are found in the NCS-R which includes the same variables and questions as the NLAAS. All participants between 18-50 years of age will be utilized for data analysis. The age of 50 was chosen as the cut-off to limit the confounding variables of age-related dementia and other factors that might confound comparisons between Asians and Whites.

Enabling factors, perceived need, and education level were examined. To determine perceived need, respondents were asked "How would you rate your overall mental health?" Answer options were "excellent" "very good", "good", "fair", and "poor ". In the analysis, mental health rating was dichotomized as "positive" and "negative". "Positive" was composed of those who responded "excellent", "very good", and "good" and "negative" was those who responded "fair" and "poor". The questions on self-assessed mental health were first utilized in the World Mental Health Composite International Diagnostic Interview (WMH CIDI) and have been used in both the original NCS study and NLAAS studies.

Education level was determined by asking "What is the highest grade of school or year of college you have completed?" with choices that ranged from "0-11 years", "12 years", "13-15 years" to "greater than or equal to 16 years". For this study, education was dichotomized as "low education" and "high education". Participants who earned a high school degree or less were classified as "low education" while those with some college or higher were classified as "high education". Respondents who answered "don't know", "refused" or skipped the questions altogether were dropped from the analysis.

Utilization was measured by the how subjects responded to the question "Did you see a professional for emotions/nerves/substance abuse ever in lifetime?" Answers are dichotomized by "yes" or "no". Participants who answered "don't know", "refused", or skipped the question were not included in analysis.

In addition to frequency distributions for each question, the findings include cross-tabulations examining bivariate associations. A logistic regression analysis examined the association between ethnicity, education level, and mental health rating with utilization.

Results

Frequency distributions are presented in Table I. For this study, responses of Asian and White Americans were compared. Asian Americans were 27.2% (n=1725) of those included while Whites were 72.8% (n=4626). Education was dichotomized into low education (3-12 years of education) which comprises of 34.6% (n=2200) and higher education (some college to graduate school) includes 65.4% (n=4626) participants.

Mental health based on self-reports was dichotomized. Those rating their mental health as "Excellent", Very Good", and "Good" comprised of 88.5% and were classified as having "positive" mental health. Individuals who perceived their mental health negatively (categories of "fair" and "poor") constituted 11.5% of the total participants. Participants who indicated they did not know, refused, or skipped question were considered "missing values" were not included in the analysis.

The survey asked whether respondents had their ever seen a professional for nerves, emotions, and substance abuse in their lifetime. Of the participants who answered, 4.5% (n=157) responded "yes" while 95.5% (n=3310) indicated "no".

Table I: Frequency Distributions

Race

	Frequency	Percent
All Asians	1725	27.2
White	4626	72.8
Total	6351	100.0

Education Level

	Frequency	Percent
Low Education	2200	34.6
High Education	4151	65.4
Total	6351	100.0

Mental Health Rating

	Frequency	Percent
Positive	4743	88.5
Negative	616	11.5
Total	5359	100.0

Seen professional for emotions/nerves/sub use in lifetime

	Frequency	Percent
YES	157	4.5
NO	3310	95.5
Total	3467	100.0

A comparison of Asian and White Americans' perceived mental health status is presented in Table II. Only 1069 Asian Americans and 1865 White Americans provided both ethnic identity and mental health status. Of those who responded, 88.4% (n=945) of Asian Americans reported having positive mental health whereas 11.6% (n=124) reported negative mental health. Of the 1865 White respondents, 88.3% (n=1647) indicated having positive mental health and

11.7% (n=218) reported negative mental health. There was no difference in self- reported mental health status among Asian Americans and White Americans.

Table II: Comparison of Asian and White Americans by Mental Health Status

			Race Recoded into Groups		
			All Asians	White	Total
Mental Health Rating	Positive	N	945	1647	2592
		%	88.4%	88.3%	88.3%
	Negative	N	124	218	342
		%	11.6%	11.7%	11.7%
Total		N	1069	1865	2934
		%	100.0%	100.0%	100.0%

Table III compares Asian and White Americans by perceived mental health and whether or not they used mental health services. Of those with reported negative mental health status, 2.4% (n=3) Asians ever sought mental health services in their lifetime. Whereas 5% (n=11) of with reported negative mental health status reported using mental health services. While this is not a statistically significant difference, there is a difference in the predicted direction for those with negative mental health status, Whites utilizing mental health services more than Asian Americans.

Table III: Comparison of Asian and White Utilization of Mental Health Services by Mental Health Status

				MH		
Race Recoded into Groups				Positive	Negative	Total
All Asians	Seen professional for emotions/nerves/sub use in lifetime	YES	N	34	3	37
			%	3.6%	2.4%	3.5%
		NO	N	911	121	1032
			%	96.4%	97.6%	96.5%
	Total		N	945	124	1069

			%	100.0%	100.0%	100.0%
White	Seen professional for emotions/nerves/sub use in lifetime	YES	N	73	11	84
			%	4.4%	5.0%	4.5%
		NO	N	1574	207	1781
			%	95.6%	95.0%	95.5%
	Total		N	1647	218	1865
			%	100.0%	100.0%	100.0%

A Chi-Square test was run for Tables II and III. The Chi-Square test for race/ethnicity and mental health rating showed no significant difference (p=.497) and the second cross tabulation which included utilization of services also did not show significant differences (p=.559).

To take the analysis one step further and to include the impact of education as an enabling factor, a logistic regression analysis was run. Results of the regression model suggest that there was no significant association between mental health rating and seeking mental health care from professionals (p=.986). There was no significant association between ethnicity and seeking mental health care from professionals (p=.217) nor was there a significant association between education level and seeing professionals for nerves, emotions, or substance abuse (p=.389).

Table IV. Logistic Regression

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	Ethnicity (1)	.251	.203	1.525	1	.217	1.285	.863	1.913
	Education (1)	-.165	.192	.741	1	.389	.848	.582	1.235
	Mental Health Rating(1)	-.005	.290	.000	1	.986	.995	.563	1.758
	Constant	3.128	.291	115.562	1	.000	22.832		

a. Variable(s) entered on step 1: Race_Recoded, Education_Level, MH_Rating.

Discussion

This research is informed by the Health Utilization Model postulating that the use of mental health services would be influenced by perception of need, predisposing, and enabling factors. In this case, need was measured by self-reported mental health, ethnicity was the predisposing factors (as Asians have been found to be less receptive to using mental health services than others), and the enabling factor included in the study was educational attainment. The principal hypothesis investigated by this study, that Asian Americans are less likely to seek mental health services than White Americans, was not supported by the analysis of the NLAAS and NCS-R Survey. Among Asian and Whites who reported negative mental health, there was no significant difference between Asians and Whites in the proportion reporting if they ever saw a professional for emotions, nerves, and or substance abuse in their lifetime. Controlling for education level, perhaps a measure social class, (Zhang, Snowden, & Sue, 1998) also had no impact on the differences in utilization of mental health services between Asian and Whites.

Among Asians reporting negative mental health, 2.4 % of Asians sought mental health professional care. Among Whites with negative mental health, 5% sought professional mental health services. The differences are in the predicted direction but not statistically significant. This finding is inconsistent with other research showing Asians are significantly less likely to seek mental health services. For example, Zhang et al reports Asian Americans as more reticent to share feelings of mental distress with professionals than Whites. (Sue, 1994)

Contrary to what has been found in other research, Asians did not differ from Whites in reporting negative mental health. (Mcguire & Miranda, 2008) Interestingly, the prevalence of negative mental health is significantly lower than reported in other surveys (Takayanagi, et al.,

2014). For both Asians and Whites, high proportions reported positive mental health (excellent, very good, and good mental health). As one would expect, Asians and Whites reporting positive mental health also had low likelihood of seeking mental health care.

Research suggests that those with higher education are more inclined to seek out health care services (National Poverty Center, 2007) compared to individuals with lower education. However, education was not associated with utilization of mental health services. Indeed, a greater proportion of lower-educated Asians and Whites reported seeing a mental health professional for emotions, nerves, substance abuse than higher educated Asians and Whites. The bivariate associations showed no differences between education levels and self-reported negative mental health within Asians and Whites. This is surprising given research that shows among young adults, more highly educated people (e.g. having a college degree or higher) have more positive attitudes towards seeking help for mental health problems and are more likely to seek out professional care. (Vogel, Wester, & Larson, 2007)

The findings in this study may indicate that utilization of mental health services is so stigmatized that they are avoided by both Asians and Whites reporting negative mental health status. Mental health care utilization is still heavily stigmatized and seeking care is often met with consternation from family, friends, and colleagues. (Sue, 1994) Seeking help may indicate that people are incapable of controlling emotions, e.g., that it is a moral and personal failing.

Mental health literacy may be lacking and people may not understand the nature of mental health. Previous research has shown that some people have mentioned trouble distinguishing symptoms of mental illness (Jorm, et al., 1997) or believe that in order to have positive mental health, one must be completely devoid of negative feelings. When it comes to the

identification of mental disorders, some patients may express mental illness in somatic terms, which has been observed particularly among Asian populations. (Tseng, Asai, Liu, & et.al, 1990)

Although Asians were not less likely to seek mental health services than Whites, it is nevertheless important to consider cultural competency of care providers. The "model minority" myth, although long since debunked, may contribute to a reluctance to seek mental health care. Asians may have an even greater need for mental health services than others, given reports of pressure to succeed in both academic and professional enterprises by Asian American families. (Panelo, 2010) Asian Americans report levels of discrimination by their health care providers who appear less accepting of mental health complaints from Asian patients than others. (Takeuchi & Uehara, 1996)

Finally, Andersen's Model of Utilization may need to be broadened to consider a more pluralistic system of health services (Subedi,1981). In this study, the provider of mental health services was presumed to be a Western medical practitioner. While the survey asked questions regarding different services, the study focuses on professional mental health care providers and utilization of these services. Studies show that in the US, the population as a whole commonly seek care from alternative providers and therapies more often than conventional primary care (Eisenberg, et al., 1998). Eisenberg's study found that alternative medicine was more likely to be utilized by "those…who had relatively more education and higher incomes." (Eisenberg, et al., 1998) Another study showed that younger adults in the population are likely to use online or mobile mental health support services. (Horgan and Sweeney, 2010) This study may overlook utilization of a range of providers and therapies that are not reported as respondents were asked about seeking of medical care.

Limitations

It is not clear why reported mental health over the lifetime is so much lower than that found in other studies. For example, the National Latino and Asian American Study reported that 17.03% of Asian Americans reported having a mental health disorder during their lifetime. This study asked people to evaluate their overall mental health status at present, which may explain the divergence in findings. Other studies have shown that populations in the US have had significantly higher reports of episodes of depression and poor mental health. (Kessler, et al., 1996).

It is also not clear why the sample size dropped, apparently because of missing responses, when use of mental health services was examined. The item reporting on use of mental health services over the lifetime had total of only 3467 respondents, a loss of 2,884 Asians and Whites. When perceived mental health status was included with ethnicity as associated with utilization, the total number dropped to 2934, a loss of 3597 Asians and Whites or 656 (rather than the total 1725) Asians and 2761 (rather than the total 4626) Whites. The missing values threaten the validity of the analysis.

It is important to note that the measure of negative mental health does not look at the level of disruptiveness brought on by poor mental health. While respondents may have periods of poor mental health in their lifetime, it could be the symptoms were not severe enough to interfere with daily living, Hence, the symptoms may not have been perceived to be so serious that they required mental health services. Other research shows that severity and disruptiveness of the disorder may play a role in seeking mental health services. (Ahmedani, 2011)

This study also did not consider health insurance as a factor for mental health service utilization. According to the Commonwealth Fund, a report released in 2002 stated that one in five Asian Americans, aged 18-64, did not having health insurance in the past year. (Collins, et

al., 2002) If there is a lack of health insurance or substantial enough coverage, it might result in limited access to specialty services, such as mental health. Different levels of insurance coverage was not evaluated in this study. It should be noted that mental health care is often received from a primary care physician, rather than a psychiatrist or counselor. In a previous study, only 8.6% of Asians sought any care from a health professional. However, only 4.3% sought care from general medical providers whereas the remaining 3.1% sought care from mental health care professionals. (Abe-Kim, et al, 2007) Additionally, Asian Americans have a tendency to present mental illness through somatic symptoms. This may result in Asian Americans seeing primary care physicians to treat the physical symptoms instead of seeing mental health professionals. (Tseng, Asai, Liu, & et.al, 1990)

Several limitations are related to the data set available for secondary analysis. The first limitation is the way Asians were grouped into one ethnicity category. The NLAAS survey included a set of Asian groups: Filipino, Vietnamese, Chinese, Korean, and other Asians. In this analysis, all were grouped into a single category, defined as "Asians." This is problematic in that Asian groups such as South Asians, Central Asians, and Middle Eastern Asians all have differing cultures and health expressions. The term "Asian culture" is an over generalized statement and varying Asian ethnicities should not be considered a single group of "Asians".

Further, the initial NLAAS and NCSR are from the years 2001-2003. A follow up study of the NLAAS was completed in 2006 which may have more current results but it was not available when this study was underway. With an increased focus on mental health in recent years, results from a 2006 survey may reveal a higher rate of mental health service utilization.

A third limitation associated with data set was the capacity to differentiate between Asian Americans born and raised in the United States, those who have arrived to the country at a young

age, and those who have been naturalized as American citizens in adulthood. Based on exposure and assimilation to American culture, attitudes towards mental health care treatment differs from age group and amount of assimilation. (Abe-Kim, et al. 2007) In this study, the numbers were too small to compare Asians with different immigration backgrounds so all were included in the group labeled "Asians". Hence, the study may have overlooked the important differences within the population of Asians regarding their recognition of mental health and use of services.

A fourth limitation related to the secondary analysis was the measure of utilization, itself. It was measured by a response to the question, "Have you ever seen a mental health professional for nerves, emotions, or substance abuse in your life time?" Not all participants may recall correctly if they have seen a mental health professional over the course of a lifetime, which includes childhood. Research shows that recalling life events over time can be unreliable or invalid. (Del Boca, 2000) Finally, the measure of mental health was based on self-reports. Self-reported mental health may also be unreliable although some studies show self-reported health to be predictive of mortality and morbidity. (Idler & Stanislav, 1995)

Implications

With low utilization of mental health services for both Asian and White Americans, it is critical for future public and mental health professionals to engage in anti-stigma work to increase utilization of services. It is also critical to improve cultural competency training for mental health care providers.

It is also important that data sets completed in 2006 are made available for researchers in 2016. Recent data will ensure accurate and consistent findings with previous research and provide better support for findings. It is also more reflective of current attitudes, beliefs, and

understanding towards a health topic such as mental health, given that it has become a critical subject in national discourse and is a highly politicized issue.

Lastly, it is important to clearly define what we mean by a mental health provider when measuring use of mental health services guidelines of what is a mental healthcare provider. Resources such as online counseling, peer to peer mental health services, or gatekeeper programs are increasing in popularity and providers from these venues may be the only source of service a person may use when seeking help. If these resources are not included as a mental health provider, it may explain why there are low utilization of mental health services.

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