

**Anson Au**

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# Low Mental Health Treatment Participation and Confucianist Familial Norms among East Asian Immigrants: A Critical Review<sup>1</sup>

Anson Au

## Abstract

This article applies the stress process model to navigate and evaluate the familial norms embodied in the East Asian culture, grounded on Confucianist principles, in terms of its impact on East Asian immigrants' mental health and low rates of participation in mental health services. Explicating the cultural principles at work in East Asian familial norms, the interplay between demands for preserving the "face" of the family and the stigmatization of mental health complicates acculturation by imposing restrictions on social behaviours conducive to networking. The institution of family, which operates as coping resource through social support, also intriguingly acts as the locus of these Confucianist principles and norms, becoming a site where mastery is challenged by notions of maturity that mandate emotional suppression. Depression, social anxiety, and externalizing problems arise in the absence or failure of these coping resources, which percolate into issues of abuse. Implicated is the need for health care reform to encourage treatment among East Asian immigrants by navigating unhealthy behaviors and familial expectations anchored in culture. To this end, this review articulates a more efficient, adaptive, complex system (global patterns) through self-organization inspired by complexity theory and achieved by introducing reflexivity in health education (local interactions).

**Keywords:** East Asian immigrants, stress process, acculturation, mental health treatment

## Introduction

The concern over stress experienced by individuals has received much attention over the past few decades. Its impact on physical health has been studied extensively, found to contribute to coronary heart disease, cancer, lung ailments, and cirrhosis of the liver (Smith 1985). Also studied extensively, and perhaps the most variable avenue of the impact of stress, is the domain of mental health. In the sociology of mental health, the stress process model has been formulated as an analytical approach to the study of stress, conceptualizing it in the arrangement of three fundamental processes: stressors (sources of stress), coping resources and social support (tools to mitigate stress), and mental and multiple health consequences.

The stress process model has been used to explain mental health in terms of its effects in a variety of contexts, including family (Aneshensel, 1992), the workplace (Glavin, Schieman, & Reid, 2011), and as a consequence of life events (Wheaton, 1994), including daily hassles of everyday routine that can irritate a person per their idiosyncrasies (Aneshensel, 1992), traumatic events such as rape (Wheaton, 2013), chronic stressors such as being structurally trapped in a dislikeable occupation (Aneshensel, 1996; Dressler, 1988; Wheaton 1997), and non-events whereby stress is acquired through anticipation of possible future events like the recurrence of rape (Gersten et al, 1971; Thoits, 1983; Wheaton 1994; Wheaton et al, 2013). The model has also been taken to elaborate on factors linked to structural conditions such as socioeconomic status and factors related to personal attributes such as sexuality (Au, 2015; Green, 2008).

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In the American sociological convention, however, little has been written on a comprehensive organization of stress and mental health of Asian immigrants in the U.S. This is not to imply a lack of sociological research on the mental health of minorities and immigrants (Hurh & Kim 1988; Kuo 1976; Kuo & Tsai 1986; Vega & Rumbaut 1991), but rather, a lack of attention devoted to this area in terms of fundamental elements of stress as conceived by the stress process model. Moreover, previous studies have found that Asian Americans typically demonstrate reluctance to seek services for the treatment of distress (Ying & Hu 1994; Sue et al, 1991; Cheung & Snowden 1991). According to the US Department of Health and Human services (2001), only a small proportion of Asian Americans who are very likely to have a mental disorder, fulfilling criteria for a diagnosis in the DSM-IV, seek services. Rates of service use vary across different Asian groups (Akutsu & Chu, 2006; Kinzie et al, 1989). However, Abe-Kim et al's (2007) study using a national sample of Asian Americans, that included a broad variety of mental health disorders among both foreign and US-born Asian Americans, identified lower rates of mental health service use among Asian Americans (8.6% of the total sample sought mental health-related services). Attempts to expound on the staggeringly low rates in studies of mental health have largely focused on stigma or grand pronouncements on culture without investigating its particular characteristics (Kramer et al, 2002).

In an attempt to bridge these two gaps, and without meaning to eschew the heterogeneity of the (East) Asian American group<sup>2</sup>, this article applies the stress process model to evaluate and navigate the familial norms embodied in the East Asian culture, grounded on Confucianist principles, in terms of its impact on the mental health of East Asian American immigrants, and their use of mental health services. One of the major contributions of this article is the understanding of the cultural principles at work in East Asian familial norms, and their intersection with mental health through their impact on acculturation and social perspectives. Another significant contribution is an elaboration on social support and coping resources specifically available to East Asian cultures to buffer stress, and the deleterious mental health consequences in the event of their absence or failure; as a corollary of these conditions, the potential percolation into issues of abuse arises, which centers on their implications for the family structure of East Asian Americans. The remainder of this article discusses health care reform in appreciation of two approaches, focusing on culture-specific services and a complexity theory perspective that posits the need for self-organization on a systemic level obtained through local interactions. This article navigates the debate over this theoretical application in literature by asserting the significance of reflexivity, and its link to the self-organization process. The implications of this article corroborate the need for cultural sensitivity in health education and treatment in research and clinical environments.

### **Acculturation and the Generational Effect**

The cultural orientations of East Asian immigrants from collectivistic cultures are fundamentally distinct from those in the American, individualistic one that they become immersed in post-immigration. Drawing from this, the cultural values embedded in Asian, collectivistic cultures exact both beneficial and deleterious influences on mental health in terms of stress.

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<sup>2</sup> This article examines the familial ideals and norms of East Asian cultures, grounded on Confucianist principles, as they influence and/or are relevant to the mental health of families who immigrate from such cultures. This article does not attempt to generalize these cultures and dismiss their histories and geographies, nor does it suggest they are reducible to any one or more traits discussed here.

East Asian cultures, as influenced by Confucian traditions (Leininger & McFarland 2006), emphasize the prominence of the family's needs over those of its individual members. This notion serves as the metrics for individual worth, which becomes based on the success of the family rather than one's own achievements (Lee 1985). Consequently, their autonomy and sense of control erodes, creating stress and giving rise to behaviours that further compromise this autonomy – committing acts for the family rather than for the self per obligations to maintain a sense of filial piety. It renders the individual more susceptible to indoctrination by family traditions, such as the discouragement of mental health treatment for social status. Incidentally, while this focus provides the environment facilitating stress and stigma against mental health, the affection associated with family is perhaps the only factor strong enough to counteract this very stigma surrounding mental health. For example, Bernstein (2007) indicates that the few Korean immigrants who do seek mental health help is often for other family members.

Mental illness is also defined as a curse inflicted on families, rather than a legitimate disorder. Depression and its causes, for instance, are believed to be a natural part of life (Bernstein, 2007), while other mental health disorders are dismissed unfortunate predicaments for which no remedy exists. Asian Americans seeking professional help only do so when a mental illness has progressed to the manifestation of psychotic or dangerous behaviours, instead of in their preliminary stages where they are more easily curbed, such as personal problems or emotional distress (Moon & Tashima, 1982; Tracy, Leong, & Glidden, 1985; Yang, Phelan, & Link, 2008).

Maturity is construed as the ability to control personal feelings, particularly those of discontent, giving rise to a common hesitation among East Asians toward broaching the subject of emotions or discussing reflections (Kim et al, 2002). Deriving self-esteem from avoidance of confrontation resembles an emotional suppression similar to the syndrome identified in Korean culture as *Hwabung*, characterized by the repression of anger, disappointment, and unfulfilled dreams within an individual (Pang, 1990). The dissonance in attitudes between Western and Asian cultures is brought to the fore with this phenomenon, as the *Hwabung* is considered a natural symptom among Koreans, notably in elders, while it is interpreted as a psychosomatic illness in Western society (Bernstein, 2007). Continuing from this example of avoidance, East Asian individuals are generally encouraged to communicate more through nonverbal or metaphorical means (Uba, 1994). Symptoms of emotional disarray are thus described somatically with unexplainable aches and vague pains (Bernstein, 2007), substantiating the influence of cultural norms on the perceived legitimacy of mental illness.

Social status, commonly referred to as face, is a pre-eminent value in East Asian cultures. Coupled with the traditional Confucian emphasis on the importance of family above individual needs, people are driven by the pressure to elevate their family's social status. Seeking treatment for and even acknowledgement of mental health problems are conceived as smearing the family honour with shame (Bernstein, 2007), therefore impeding emotional acceptance of one's stresses and the search for solutions. Opening small businesses are considered means to enhance material and social status in Chinese culture (Chin, 1999). The desire for social status elevation persists even in critical moments of immigration, evidenced by the majority of take-out restaurants in the Northeast, nearly 90%, being owned by Chinese (Fuzhounese) individuals (Chin, 1999).

Prominence of educational competition is highly – and commonly – regarded as a mechanism to ascertain social mobility (Lee, 1985). Believing children's actions reflect on their families, they are pushed to pursue educational achievements. Attached to this ideal is the intense stigma assigned to children who fail to obtain educational merit and especially those who engage

in delinquency (Huang et al, 2012). Therefore, while children succeed as individuals, their attitudes and intentions, oriented to the collective good, perceive it instead as the rightful homage to their familial social status.

Sexism exists within and shapes East Asian familial structures, organizing it around a patriarchal system in which females are expected to be complacent and supportive. For example, mothers are pressured to replicate the image of a submissive wife and a sacrificial mother, or known in the Korean culture as the *Hyun Mo Yang Cho* (Kim, 1985). Chang and Kim (1988) discovered that the advancement of technology and its integration in the household rendered household maintenance convenient, but boring. Consequently, mothers experience emotional problems as she becomes culturally confined to a role whose duties are no longer as occupying. Post-immigration, however, they become immersed in a new culture: in lieu of submission, she is exposed to and encouraged toward accepting the idea of a more autonomous mother. Kim (1985) notes that this creates a new social reality built on biculturalism: a mother's mentality is shaped by her social environment that bifurcates into the East Asian traditional community and the American majority society. Failure to adapt to this new sociocultural setting could be a chronic stressor for her, possibly creating a sense of helplessness, misplacement, and loss of identity.

The erosion of the submissive wife ideal becomes a traumatic stressor for her family. While her autonomy allows for fewer emotional problems within her person, problems emerge in her family: she could obtain autonomy in manners perceived nonchalant or even hostile by her family – for example, socializing with friends more than fulfilling domestic roles at home, resulting in an immoderate balance between family and social life. Deviation from the ideal could cause distress for the other members from shock, leading to disagreements between and emotional problems for both parties, unable to cope.

Thus, acculturation, particularly when adapting to an individualistic culture, can constitute a momentous determinant of mental health. Choi and Thomas (2009) contend that attitudes toward acculturation itself are affected by education and English fluency, in addition to cultural organization and values. Their study of Filipino, Korean, and Indian immigrants also revealed that Koreans were the most resistant to acculturation, which can be interpreted to support the idea that Confucianist cultures, even among collectivistic ones, are rigid in their expectations of family organization.

Language plays a pivotal role in facilitating acculturation; although language may be taken an indicator by which to measure the degree of acculturation, it in fact acts more positively amid immigrants as a facilitator of acculturation (Nguyen, 2011). Among East Asian American immigrants, those with less proficiency in English perceive greater mental health needs than those with more proficiency (Nguyen, 2011). Explanations can be traced to the social role of language – less language proficiency results in social isolation, characterized by fewer interactions and subsequent reduction in available networks and relationships, and even greater strain on personal coping resources.

### **Coping Resources and Mental Health Problems**

Buffering capacities of social support on mental health problems and substance use are well evidenced in literature across social and work environments in non-immigrant populations (Stewart 1989; De La Rosa & White, 2001; Prati & Pietrtoni, 2010). These protective effects are further documented in intervention studies with non-immigrants (Dobkin et al, 2002; Thompson et al, 2001), and while similar results can be observed with immigrant populations

(Agudelo-Suarez et al, 2009; Noh & Kaspar, 2003), the effect is much more variable (Tsai & Thompson, 2013).

In some studies of the mental health of Asian immigrant workers, the suggested buffering effects of social support on social discrimination, job and employment concerns for the immigrant, or mental health problems and substance use are unobserved (Tsai & Thompson, 2013). Implicated is the necessity to better recognize and map the mechanisms whereby distinct aspects of coping resources affect or buffer health outcomes (Sarason et al, 1987; Schwarzer & Leppin, 1989; Haber et al, 2007), unique to immigrants. Emotional support from family or friends, for instance, demonstrates the capability to mitigate stress and prevent the emergence of adverse mental health or substance use problems, but this effect may be leavened for serious stressors like social discrimination.

Social support primarily comes from family or ethnic communities, providing a supportive environment for the second generation (Portes & Rumbaut, 2001) as well as emotional support for coping with external challenges in acculturation (Wierzbicki, 2004; Wong & Mock, 1997). Although the presence of such communities may promote assimilation (Zhou, 2004), it can also shield against the pressure to discard home cultures among immigrant youth (Feliciano, 2001; Gibson, 2001). This effect, however, may only strengthen resistance to acculturation as might be in the case of Confucianist cultures, recalling that Korean culture, for instance, is comparatively more resistant than that of Filipino or Indian (non-Confucianist) cultures (Choi & Thomas, 2009). Yet, immigrants suffer a loss in social support due to the physical displacement from these networks in their home country, and receives fewer opportunities to build new connections in host countries on account of language, cultural, and socioeconomic status barriers. In the absence of non-familial social support, other personal resources must be considered: coping and mastery (Pearlin & Bierman, 2013). Emotional confinement would, per cultural obligations, be foremost choice for an Asian immigrant. Other forms of coping, as understood in the stress process model (Pearlin & Bierman, 2013), would likely fail to count among viable resources for East Asian immigrants: (i) changing the meaning of a situation – certain chronic or traumatic experiences of immigration may be too urgent and taxing to be reinterpreted, such as illegal statuses, threat of deportation (Salas, Ayón, & Gurrola, 2013), and social discrimination (Tsai & Thompson, 2013). (ii) Avoidance or detachment from family as a source of distress – since families exist as the primary support immigrants have, in addition to cultural emphases on family.

Mastery, the individual perception of ability to handle stress (Salas, Ayón, & Gurrola, 2013), would likely be low for the immigrant. The higher one's socioeconomic status is, the higher his/her educational and occupational prospect, leading to reassurance of secure futures and higher self-confidence (Schieman & Plickert, 2008). Given the typical immigrant's immense debts (Chin, 1999) and low socioeconomic status (Huang et al, 2012), self-esteem may be volatile. Inability to communicate with sufficient language proficiency and unawareness of the host country's culture, norms, and systems could additionally depreciate one's sense of control and self-confidence.

Mental health of immigrants, typically worse than other American citizens (Huang et al, 2012), can be further considered in the context of separate generations. As aforementioned, Asian American immigrant children experience more pressure to succeed in education for familial social status (Bernstein, 2007). Huang et al (2012) discovered that the Asian immigrant child's exclusive dedication to education made them less likely to develop externalizing problems and had higher self-control. However, studies have found that while the academically

driven student may be less inclined to behave problematically or in delinquent ways that could compromise family status, he/she also exhibits greater rates of clinically impairing internalizing problems, namely depression, social anxiety, and suicide (Austin & Chorpita, 2004; Chang, Morrissey, & Koplewicz 1995; Choi, Meninger, & Roberts 2006; Lee, Lei, & Sue 2001; Okazaki 2000). Thus, this dedication, while it may improve sense of control, it follows the same problematic tendencies of social support and social discrimination – the practice that creates this self-control simultaneously creates stressors that are too difficult for the resource to adequately buffer.

Rigorous expectations of education coupled with lack of language proficiency creates social isolation among East Asian immigrant children. These practices precipitate into the attenuation of social life, effectively depreciating their potential to acculturate and develop social networks that could alleviate the immense stress they commonly experience. Deprivation of interpersonal skills or social ineptitude deepens their cultural isolation and contributes to a long-term effect of exacerbating their integration into society (Huang et al, 2012). Formal, professional help is also discouraged in light of the cultural stigma associated with even the recognition of mental health disorders, perceived as curses to the family, and the cultural perception that equates maturity with emotional suppression (Kim et al, 2002) or *Hwabung* for Koreans (Pang, 1990). Financial precarity from a family's post-immigration economic status further deprives children of other resources for coping or recreation, such as storybooks or childcare services (Huang et al, 2012). Thus, externalizing problems as well as depression may arise in children.

Similarly, for social status, adults are obliged to disregard mental health disorders, avoid professional mental health treatment, dedicate themselves to the future of their families, and persist in their assigned roles: children as students, men as breadwinners, women as submissive supports (Bernstein, 2007). The same effects can thus be observed: the compromising of social networks, deprivation of interpersonal skills, self-esteem, sense of control, and mental health disorders such as depression and anxiety.

### **Multiple Health Problems: Substance Abuse and Implications for the Family**

In addition to mental health problems, the Asian immigrant is more vulnerable to experiencing multiple health problems, notably alcohol and substance abuse problems. The prevalence of alcohol abuse issues has been rising among Asian populations (Shin & Hutton, 2002). In addition to health problems from excessive drinking or substance use, such as liver disease and cancer (Meyerhoff et al, 2005), social problems also arise.

It is widely recognized that alcohol abuse has been increasing due to life stress, as is observed among Koreans (Choi, 1997). Yamamoto, Rhee, and Chang (1994) found that the lifetime prevalence of DSM-III defined Alcohol Abuse/Dependence for elderly Koreans in Los Angeles was a rate of 22%, while the lifetime prevalence of Alcohol Abuse/Dependence was 35% for men and 2% for women. This gendered pattern can be observed in other studies. It has been found, for instance, that 26% of Korean American men identified as heavy drinkers, in sharp contrast to the 0.8% among women (Chi, Lubben, and Kitano 1989). This observation is consistent with the Korean cultural schema that allocates more freedom to the man: the breadwinner is allowed to engage more freely, but the traditional wife is confined to a domestic role.

However, this discrepancy can also be explained by the choice of research method – those indicating low alcoholism typically used self-report methods, whereas those that concluded

high alcoholism used Western standardized measures, such as the Diagnostic and Statistical Manual and the Michigan Alcoholism Screening Test (Cho & Faulkner, 1993). Other scholars posit that perceived family problems, handling of frustration, and forgetting problems are the most common reasons for ethnic communities to drink excessively (Legge & Sherlock, 1991). This can be extended to the case of the immigrant who, deprived of social support and whose personal coping resources wane in potency, feels the need to resort to alcohol or substance use to alleviate stress. A collectivistic culture may inhibit alcohol practices, on account of interpersonal responsibility (Rolando & Katainen, 2013), but the reverse may be true for an immigrant – in a group where only a minority represents collectivistic cultures, the opposite effect may be observed. For the Asian immigrant, motivations for drinking could be drawn from the desire to fit in, heightened by the collectivistic cultural goal of social harmony in a group, through shared practices. Thus, an individual may not perceive his/her practices as harmful not simply due to peer pressure, but for the support he/she is giving to the group by promoting a practice they can all partake in to foster solidarity.

Another health problem that arises from alcohol or substance abuse is partner violence: domestic violence patterns reflect the patriarchal familial structure that favours the husband's position over the wife's, making the wife the common victim of abuse (Han, Kim, & Tyson, 2010). Immigrant husbands who abuse alcohol, coupled with diminished social support and personal coping resources, are more prone to act violently toward their wives (Han, Kim, Tyson, 2010). The impact of this abuse extends into family health, increasing the level of depression and decreasing sense of control and self-esteem in women and their children (Rhodes & Mackenzie 1988). These groups consequently become more susceptible to emotional suppression, accruing pent-up stress from abuse in addition to reluctance to resist patriarch abusers (Lee, 2003) – partner violence is thus associated with depression, posttraumatic stress, and issues with social or interpersonal functioning (Gordon et al, 2000).

### **Discussion: Approaches to Health Care Reform**

Although strong connection to a tight ethnic community is identified as a catalyst for assimilation (Portes & Rumbaut, 2001), it emerges that this may be underrepresented in studies of recent immigrants. However, the length of stay and generational status of immigrants or ethnic individuals located, in host countries, demand appreciation in future sociological studies dealing with these populations. The role of acculturation must be reconciled with findings implicating relationships within ethnic communities, as attachment to home culture carries weight on the extent to which such findings are applicable.

Emotional suppression becomes a common coping resource for Asian immigrants per cultural traditions, such as the *Hwabung* for Koreans (Pang, 1990), albeit generally associated with negative consequences, including avoidance, reluctance to share emotions, reduced social support, less relationship closeness, and less social likeability (Butler et al 2003; Gross 2002; Gross & John 2003; John & Gross 2004). Yet, collectivistic values may mitigate these effects even when suppression arises from the culture itself (Butler, Lee, & Gross, 2007). A stark cross-cultural distinction exists between Asian values and Western values in the function of emotional suppression: in a study of Americans of different ethnicities, emotional suppression was found less harmful in Asian Americans, in contrast to the deleterious effects observed with others with Western European values (Butler, Lee, & Gross, 2007). The interpretation arises that emotional suppression is a function of Asian values (mark of maturity) and differs in frequency from other cultures. As very little research exists on suppression (Butler, Lee, & Gross, 2007), the extent of



this effect should be explored in the context of Asian immigrants, rather than native-born Asian Americans. More focus should thus be attributed to recognizing discrepancies between collectivistic versus individualistic cultures, as well as acculturated versus recently adapting immigrant, to develop a holistic framework through which mental health issues and the mediating influence of culture are better understood.

What are the clinical implications of this ethos? How can such a framework be integrated into practice? The interactions between principles of East Asian, collectivistic cultures and post-immigration circumstances that invoke the use of compromised coping resources, gives rise to a diversity of personal mental health problems and multiple health problems. Upon examination, these coalesce into two interrelated approaches that propose to ultimately reduce mental health problems and improve mental health service use.

One possibility centers on working toward a balance of culture-specific and culture-general approaches (Bezanson & James, 2007). Recognizing one's own status as an outsider to other cultures, practitioners must be educated on the values of specific cultures in order to build therapeutic relationships that improve treatment progress through self-esteem and adherence (Wampold, 2001). It gives credence to the vital need for researchers to understand the mental health of immigrants in recognition of social complexities (Tsai & Thompson, 2013), that may differ between different cultural backgrounds (Bernstein, 2007) and which call for greater attention to educational policies for specific cultures among healthcare practitioners. The central issue with this approach is uncertainty surrounding the application of cultural elements in treatments itself. Some treatments, such as Buddhist theories in counselling or psychotherapy, require more investigation into efficacy and outcomes (Cheng & Tse, 2014). Nevertheless, implicated in this approach is an appreciation for culture as a lens for how individuals conceptualize mental illness (Bojuwoye, 2001). Since professional help is discouraged in East Asian cultures – due to the cultural stigma associated with mental health disorders, perceived as curses to the family, and the preference for emotional suppression – the assurance of diagnostic accuracy and appropriateness of treatments requires addressing cultural context (Pederson, 1997; Tatman, 2004).

Adopting such a focus is linked to the dissemination of a universal mindset for health care practitioners oriented toward inclusivity. This second approach compels recourse to complexity theory to conceptualize health care reform. Complexity theory figures around the model of an open, dynamic, adaptive system to be addressed holistically (Morrison, 2005), wherein individuals shape their environment to the effect of creating global level change from local-level interactions (Paley, 2010). Within health, applications of the theory have been found in palliative care (Munday et al, 2003), supply and demand of health care (Brailsworth et al, 2011), health education (Bleakley, 2010; Doll & Trueit, 2010), among other areas (see Litaker et al, 2006). Its distinction from the first approach relies on its conception of an interplay of events that is characterized by ambiguity or multiple ways of understanding over a single representation (Mennin, 2010a). Only in this way could the messiness and overlapping possibilities of lived experiences be accounted for, making it ideal for navigating the multi-faceted issues pertinent to mental health. Reluctance from East Asian patients to disclose feelings, for instance, may be rooted in a combination of cultural obligations – containing emotions to appease standards of maturity or fear of stigmatization from family.

A complexity theory perspective has been brought to the health care team as the unit of analysis to proffer insights on how to improve efficiency in clinical settings (Arrow & Henry, 2010). Scholars employing this theory conceive the team as a form of collective intelligence

organized around collaboration and sharing knowledge (Bleakley, 2010). The clinical setting effectively becomes an open system perpetually regulating and adjusting through feedback spurred by experiences in changing environments. Thus, applied complexity theory “orients us to the work of the environment shaping activity rather than the cognition of practitioners dictating events” (Bleakley, 2010; Mennin, 2010a). Some scholars urge the need for introducing diversity to teams, where different skills, knowledge, and abilities are shared to facilitate self-organization and adaptive learning (Mennin, 2010a,b).

Yet, this application of complexity theory has drawn criticism for its treatment of the connection between order and design (Paley, 2010). Studies have been accused of misinterpreting “self-organization”. Mennin’s (2010b) conception, for instance, would depend on members of a team consciously gathering to plan and design effective treatment in preparation for and particular to individuals from certain cultures. Order and design in this scheme become causally linked, running counter to their apparent dissociation intended by original complexity theory (Paley, 2010). In keeping with a process where global structures are explained by local interactions between individual units and their immediate environments, a self-organizing system involves individuals acting unilaterally and blind to the phenomenon they might create (Paley, 2010).

What are the benefits of separating order and design? At first, it may appear to be a pointless theoretical abstraction with no bearing on clinical practice. However, inherent in this rebuttal is another assumption: that the clinical conditions required for each individual to perform efficaciously are already existent. That, after all, is the only way a global pattern could emerge through individual conduct without collaboration. The difficulty thereafter – glaringly apparent – is how to ascertain this standard of conduct. Cultural reflexivity lends itself as a critical element of this potential reform. Reflexivity refers to the ability to engage with and understand how one’s social locations have shaped their understanding of their world. It helps practitioners understand culture “in a textured, nuanced, and structurally situated way [that] can reveal contradictions of culture, its internal variability in particular places, and the external conditions that enable, constrain, and transform local cultural arrangements” (Aronowitz et al, 2015). In other words, it instills a consciousness that trains practitioners to appreciate layered meanings and multiple potential explanations for the emergence of a mental health issue in East Asian immigrants; when health care practitioners are capable of doing so individually, treatment also becomes more efficient by ruling out the need to rely on continual consultation with others and preserving the potential for self-organization.

The ways in which reflexivity can be obtained are fragmented. A recent systematic review found that literature does not support one educational technique to the exclusion of all others (Landy et al, In Progress): methods of reflection, transcultural encounters, values awareness, disorienting situations, experiential learning, debriefing all managed to improve reflexivity. Although this indicates a paucity of research in charting the efficacy of each (type of) educational method for reflexivity, it demonstrates the versatility of reflexivity and makes available a greater number of options to reforming health education.

## **Conclusion**

What kinds of stressors are embedded in immigration processes for the Asian immigrant? How are these stressors – and stress itself – perceived by members of Asian, collectivistic culture? Asian cultures, grounded on collectivistic principles, have distinct consequences on mental health processes. While families in Asian cultures can bolster ability to cope with stress by acting

as a form of social support, their patriarchal structure clashes with Western conceptions of the family. It further facilitates deleterious mental health conditions with stringent prioritization of family above individual interests and stigmatization of mental health. Implicated are challenges to coping resources in attenuating stress in the immigration process: the ability to interact with others in terms of cultural awareness as well as language, and the opportunity for self-development (mastery). However, pressures to acculturate may be met with explicit sentiments not to, as in the case of the Korean (Choi & Thomas, 2009).

In spite of documentation of issues of mental health that include lack of self-esteem, sense of control, uncertainty, and depression, stigmatization continues in Asian culture, perceiving mental health as a curse. Perceptions of mental health derived from culture must be accounted for and addressed in treatment settings to improve access to professional help. Analyzing immigration through a stress process model lens reveals the need for more accommodating culture-specific services that assuage stress and its sources among East Asian immigrants and which bolster their personal coping resources. Drawing from complexity theory, teaching reflexivity in health education (local interactions) would improve self-organization to the effect of creating a more efficient, adaptive, complex system (global patterns) that better addresses the plurality of cultural principles underlying mental health problems among East Asian immigrants.

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