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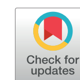

# Asian American mental health during COVID-19: A call for task-sharing interventions

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ABSTRACT

In the age of COVID-19, the Asian American community is facing a number of unique risks and barriers to mental health care. Mounting challenges—including language barriers, unemployment, racialized trauma, and anti-Asian violence—threaten the health and wellness of these communities. Yet, structural obstacles prevent Asian Americans from accessing care within the professionalized behavioral health workforce. Leveraging the resources of Asian American peer networks, collectives, and community-based organizations through a task-sharing program presents an attractive alternative for mental health care provision. Investing in task-sharing approaches to care would both address access barriers and build capacity within the Asian American community.

## 1. Mental health risks in the Asian American community

Even before the pandemic, it was established that certain subgroups of the Asian American population faced heightened mental health risks. Asian American elderly women have the highest suicide rates out of all women over 65 (Sue et al., 2012). Among Southeast Asian refugee communities, trauma, violence, and the struggles of resettlement cause conditions like PTSD and depression (Marshall et al., 2005) while maternal traumatic distress is linked to depressive symptoms in children (Sangalang et al., 2017). Asian American students are at the highest risk for imposter syndrome, a strong predictor of adverse mental health conditions (Cokley et al., 2013). Data from the National Latino and Asian American Study suggest that U.S.-born Asian Americans are more likely than their immigrant counterparts to experience mood disorders, substance use disorders, and other mental disorders (Hong et al., 2014). Still, foreign-born Asian Americans are not free from mental distress; Asian immigrants who feel discriminated against in the U.S. experience depressive symptoms at higher rates than Asian immigrants who did not experience discrimination (Chau et al., 2018).

It appears that the COVID-19 pandemic is exacerbating mental health risks already present within the Asian American community. It is well documented that social determinants of health such as job insecurity, financial instability, discrimination, and violence jeopardize wellness. Recent data indicates unemployment during COVID-19 has disproportionately impacted Asian Americans, who are overrepresented in work sectors with high layoff rates (e.g. food, rideshare, retail, and beauty services) (Khan, 2020). Across the nation, the employment rate for Asian Americans dropped at a steeper rate than any other racial group following the first wave of COVID-related lockdowns, adjusting for education, immigration status, and other covariates (Kim et al., 2021). Unemployment is a known cause of psychological distress; compared to the employed population, unemployed individuals are significantly more likely to experience depression, anxiety, and psychosomatic symptoms (Paul & Moser, 2009).

At the same time, Asian Americans have also seen an upsurge in hate crimes and racist attacks in the past year. Sinophobic discourse in U.S. politics created an ecology primed for violence when COVID-19 struck (Noel, 2020). Historically-rooted tropes of the Asian body as a morally corrupt, perpetually foreign vector of disease (i.e. the yellow peril) resurfaced in the time leading up to the COVID-19 pandemic (Lee, 2007). Elders in the community have been singled out by attackers in incidents which involved slashing, burning, etc (Weiss, 2021; Westervelt, 2021). In late 2020, two Asian Americans in mental health crises were killed by police officers (Coleman, 2021; Fortin, 2021). A 2021 mass shooting across Asian massage parlors in Atlanta, Georgia killed eight people, including six Asian women (Richard Fausset and M., 2021). Those targeted held intersecting vulnerabilities given their status as working class Asian immigrant women, some of whom may have been engaged in sex work. Most recently, another mass shooting in an Indianapolis warehouse left eight people dead, including four Sikh employees (Muhammad & Bowman, 2021). Across the nation, 2808 accounts of anti-Asian hate have been documented from mid-March to December of 2020 (Turton, 2021).

Racialized traumas from the present moment of mass violence weigh on Asian Americans' mental health. A 2020 study of 543 Chinese American families found that half of parents and children surveyed directly experienced COVID-19 discrimination either online or in person (Cheah et al., 2020). Those who directly experienced discriminatory incidents were significantly more likely to show symptoms of possible generalized anxiety disorder and depression. Among youth, witnessing discrimination against other Chinese Americans was associated with heightened psychological distress, demonstrating the vulnerabilities of racial identity formation during adolescent years (Cheah et al., 2020).

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## 2. Barriers and opportunities for mental health care

### 2.1. Data availability on mental health among Asian Americans

Although there is a substantial body of literature on mental health vulnerabilities within the Asian American population, researchers continue to omit Asian Americans from data collection and interpretation (Holland & Palaniappan, 2012). Currently, Asian American, Pacific Islander, and Native Hawaiian (AAPINH) communities make up over 6% of the American population and are the fastest-growing racial/ethnic group in the U.S. (Budiman & Ruiz, 2021). However, between 1986 and 2000, only 0.01% of health disparity studies published on Medline and PubMed included Asian Americans in their sample (Ghosh, 2003). Underfunding on the part of federal agencies plays a role in this exclusion—just 0.17% of the total NIH budget funded clinical research focused on AAPINH populations in the years 1992 through 2018 (Đoàn et al., 2019). Even when the Asian American racial group is included in analysis, studies frequently fail to identify the ethnic subgroups to which participants belong, ignoring the heterogeneity of language, religion, culture, etc. within these communities and making it difficult to pinpoint what needs exist where (Islam et al., 2010). Small sample sizes and insufficient recruitment of Asian Americans (especially those with limited English proficiency) hinder efforts to perform meaningful intra-group analysis (Islam et al., 2010). Studies that successfully stratified their Asian American sample by ethnic subgroup have uncovered meaningful differences in mental health indicators. While the 2002–2013 National Survey on Drug Use and Health found the aggregated Asian American community to be at low risk for alcohol use, a disaggregated analysis paints a different picture (C Kane et al., 2017). Below-average alcohol use among Chinese and Indian Americans masks high-risk alcohol use in Korean, Japanese, and Filipino American communities.

### 2.2. Underrepresentation among mental healthcare providers

Amidst rising challenges, is the psychology workforce equipped to handle the volume of need within the Asian American population? For Asian Americans in search of mental health clinicians from their own background, the shortage of providers is a chief barrier to care. In 2019, the proportion of Asian American psychologists in the mental health workforce was 30% less than the proportion of Asian Americans in the general population ([dataset] American Psychol, 2020). Immigrant communities, those with limited English proficiency, and LGBTQ Asian Americans are even less likely to find in-language, culturally-aware, and gender- and sexuality-affirming mental health professionals.

The underrepresentation of Asian American clinicians is troublesome given evidence that suggests clinicians from the same communities as their clients are more trusted providers. Although studies have shown Asian Americans are only slightly more inclined to prefer therapists of their own racial/ethnic background, Asian American clients provided significantly more positive evaluations of Asian American therapists compared to therapists of other backgrounds (Cabral & Smith, 2011). On the other hand, clients of color being treated by a white therapist assumed that their provider lacked understanding of their racialized experience, and thus steered clear of matters related to race in their sessions (Chang & Yoon, 2011).

### 2.3. Barriers in accessing mental healthcare

In light of these systemic barriers, Asian Americans exhibit disproportionately low mental health service usage. Regardless of gender, age, and neighborhood, Asian Americans are less likely than their white counterparts to receive treatment, and are half as likely to seek help from mental health services compared to the general population (Abe-Kim et al., 2007; Satcher, 2001). Asian Americans who do seek support initially present with more severe symptoms (Satcher, 2001). Among those with diagnosed mental illness, Asian Americans still sought help at lower rates than the general population (34.1% vs. 41.1%, respectively). Immigrants were the least likely to seek out mental health services, followed closely by second-generation Asian Americans (Abe-Kim et al., 2007). Immigrant Asian Americans, like other immigrant populations, face linguistic and economic barriers insufficiently addressed by mental health systems. Undocumented Asian American immigrants experience additional risks, including the threat of deportation and family separation (Sudhinaraset et al., 2017). Additionally, stigma within the Asian American community deters individuals from seeking mental health care, contributing to the underutilization of services. Culture-specific stereotypes associated with mental illness are prevalent among Chinese American and Vietnamese American populations, among other communities (Do et al., 2018; Yang et al., 2013).

### 2.4. Need for culturally-informed interventions

Even when Asian Americans do access psychological help, traditional modes of care are not always therapeutic. One study investigating suicidal ideation among Asian American women through narrative testimony offers a sociohistorical perspective on individuals' aversion toward psychology (Noh, 2007). Several of the women interviewed expressed frustration with their therapists' tendency to see social pathology (i.e. racism, sexism) as an interpersonal issue or individual shortcoming, rather than a systemic problem. Simultaneously, women reported feeling pathologized for performing what they understood to be survival strategies to cope with systems of oppression. For example, one woman who veered from the model minority stereotype (a trope which paints Asian Americans as universally submissive, docile, high-achieving, and well-resourced) by challenging institutional norms noticed that her psychiatrist prescribed medication to help with her "trust issues." Unfortunately, it can be a disempowering experience to receive care from systems not built with Asian Americans' needs in mind.

## 3. Task-sharing and peer-based approaches to care

When a healthcare system becomes overwhelmed by the needs of its population, it is necessary to imagine alternate ways of providing support to the public. In low- and middle-income countries, as well as other under-resourced settings, a strategy called task-sharing has substantially expanded the availability of care (WHO (World Health Organization), 2008). Task-sharing in a mental health context is the process of training non-specialists with limited to no background in clinical psychology to facilitate psychosocial support interventions. Task-sharing interventions are brief, scalable, and culturally-informed, as they are run by members of the same communities to which participants belong.

Evidence for the feasibility and efficacy of task-sharing initiatives shows promise. A Cochrane review of 38 studies assessing the impact of non-specialist mental health workers in low- and middle-income countries suggests that such interventions are associated with a reduction in symptoms of anxiety, depression, perinatal depression, PTSD, dementia, and alcoholism (Van Ginneken et al., 2013). Additional research indicates task-sharing interventions are associated with a drop in depression scores among adolescent survivors of war and displacement, and are a cost-effective tool with potential to reduce the prevalence of common mental health disorders (Bolton et al., 2007; Patel et al., 2011).

Task-sharing takes many forms, including building the capacity of lay community members, key stakeholders and healthcare professionals; developing therapeutic relationships in a group setting or one-on-one; and orienting care providers through one of the many trainings programs available for public use. Some of the more popular task-sharing trainings include mhGAP, an initiative designed to expand the mental health care capacity of primary care providers (World Health Organization, 2008), and PM+, a transdiagnostic guide for non-specialists to facilitate brief psychosocial interventions (World Health Organization, 2016). These interventions have been successfully used to address psychological distress, depression, and anxiety among vulnerable

populations, including residents of a Pakistani post-conflict zone and Kenyan women who experienced gender-based violence (Bryant et al., 2017; Rahman et al., 2019).

While task-sharing is still mainly used in low- and middle-income countries, these interventions have just begun to make their way to higher-income countries as well. In 2017, Europe commenced a five-year-long PM + intervention scheme (the STRENGTHS Programme) to address the mental health needs of Syrian refugees (Sijbrandij et al., 2017). This year, the U.S. began piloting a remote version of PM + to address high mental health needs and access barriers in light of the COVID-19 pandemic (McBride et al., 2021).

In the preliminary stages of introducing task-sharing to the U.S., Asian Americans are ideal candidates to participate in and facilitate these interventions. Task-sharing approaches to mental health care have the potential to fill an urgent need in the landscape of Asian American psychology. Expanding this model of care to the Asian American community is apt given the help-seeking behaviors of the population and the stigma some community members associate with traditional mental health care. Asian Americans are more likely to seek psychological support from peer networks such as friends, family, and religious community members than they are to seek professional help (Spencer et al., 2010). As such, community health worker (CHW) programs—involving frontline public health professionals who are members of the same communities that they serve—have already shown promise in affecting positive change in health outcomes like Hepatitis B, HIV/AIDS, diabetes, etc. within Asian American, Native Hawaiian, and Pacific Islander communities (Islam et al., 2015, 2018; Trinh-Shevrin et al., 2019, p. pp167). Still, given some Asian Americans' hesitancy to disclose mental illness to fellow community members, task-sharing and capacity-building interventions will need to address culture-specific forms of stigma that impede access to care.

Asian American networks have long been engaged in grassroots mental health work, and thus task-sharing would be a natural expansion of the capabilities that community members already have. In the wake of the mass shootings during the COVID pandemic, community-based organizations rapidly pooled resources to process and organize around mass trauma. They held vigils, protests, healing circles, Zoom meditations, teach-ins, and workshops (Goel, 2021; Shivaram, 2021). These spaces will be crucial for care provision in years to come, beyond the immediate aftermath of crisis. Mobilizing Asian American community networks through more formalized task-sharing programs will further cultivate the healing capacity of organizers and community members. Peer-based approaches to mental health ensure that self-determination is at the forefront of care, centering linguistic and cultural access for the diverse ethnic groups that make up the Asian American community.

Task-sharing will not singlehandedly remedy the racial inequities and social determinants that negatively impact health; systems-level solutions are imperative to resolving such challenges. But the act of connecting Asian Americans with peers provides opportunities to mobilize and advocate for structurally-informed care, community resources, and health equity. Investing in task-sharing programs will not only enhance care provision for an increasingly vulnerable population, but also build power and capacity within our communities, ultimately moving us toward systems change.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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