Feminist Reflections on Growth and Transformation: Asian American Women in Therapy

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Asian American Women and Suicide: Problems of Responsibility and Healing

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SUMMARY. Recent data on the alarming suicide rates among Asian American women are directing increasing public attention to this important mental health issue. However, very little is known about Asian American women's suicides from the perspectives of Asian American women themselves. This study examines the narratives of Asian American women suicide survivors about problems of responsibility for the purpose of therapy or healing. In particular, the study examines the role of individually focused healing therapies that seek to adjust the individual to society without questioning the power of racial and sexual subjection in hindering contexts for healing. As a result of a lack of language for suicide that moves beyond binarist discourses of victimhood or re-

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covery, suicidal Asian American women are forced into silence about their psychic traumas or to represent their pain in self-destructive ways. The article suggests a rethinking of psychotherapy and healing that acknowledges the complex coexistence of agency and "illness," as well as the need for empowering Asian American women to change their sociopolitical environments. doi:10.1300/J015v30n03_08

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Recent data on the alarming suicide rates among Asian American women are directing increasing public attention to this important mental health issue. The Centers for Disease Control and Prevention have published statistics demonstrating that suicide is the second leading cause of death among Asian American women aged 15-24 (Centers for Disease Control and Prevention, 2003) and that Asian American women aged 15-24 and over 65 have the highest female suicide rates across all racial/ethnic groups (National Center for Health Statistics, 2003). Furthermore, Asian American adolescent girls (G5-12) demonstrate the highest rates of depression across both race/ethnicity and gender (Schoen, Davis, Scott Collins et al., 1997). In California, these statistics have prompted the State Assembly to proclaim May as API Mental Health Awareness Month in 2003.

While raising consciousness about this data is crucial, very little is known about Asian American women's suicides due to the scarcity of empirical studies on the subject, particularly from the perspectives of Asian American women themselves. Studies of suicide as a sociocultural phenomenon among Asian American women (Ibrahim, 1995; Miranda, 1992; Takahashi, 1989; Uba, 1994; Yu, Chang, Liu, & Fernandez, 1989) cite multiple factors, such as social alienation, depression, acculturation difficulties, trauma, racism, and sexism, as contributors to suicide. However, among these factors, the psychological impact of racism and minority status on Asian Americans, in general, is under-researched (Hall, Okazaki, & Nagata, 2002; Young & Takeuchi, 1998). Although studies may briefly recognize the "psychosocial stressors" of racism and sexism by failing to center sociopolitical factors, they inevitably pinpoint the individual or ethnic culture as the root of suicide or mental illness. The absence of a thorough critique of gender and racial trauma in these studies only serves to reinforce individually focused perspectives that ignore the significance of social structural inequalities in the creation of "mental pathologies." In *Mortality, Immortality and Other Life Strategies*, Zygmunt Bauman (1992) states, "The conscience of death is, and is bound to remain, *traumatic*" (p. 13). I take Bauman's analysis of trauma to mean the ways in which the social specter of death haunts the suicide, including the everyday reality of racism and sexism that threatens to kill the spirit and body. Root (1992) demonstrates that the destructive effects of racism, as well as heterosexism and classism, can be experienced by women as a form of insidious trauma that builds over time. However, within an individually focused framework, the *social* pathology of everyday racism and sexism becomes naturalized as "rational" or "normal." As a result, individually focused therapies seek to repair the individual psyche, instead of addressing systematic oppressions that are themselves pathological. Individually focused therapies are defined as therapeutic practices that rely on psychological theories and models that locate the source of psychic conflict, as well as the focus of change, within the individual. If traditional psychological theories and psychotherapies reflect primarily Western social and cultural philosophies (Bradshaw, 1994; Chin, 1994; Chin, 1998; Espín, 1994), then it can be argued that these therapies are informed by Western ideals that emphasize individualism, both in terms of focusing on the individual as the source of conflict (Butler, 1985) and unit of analysis (Chin, 1994; Comas-Díaz & Greene, 1994; Hall et al., 2002), and individuation or individual change as therapeutic outcome (Bradshaw, 1994; Espín, 1994).

This article examines the narratives of Asian American women suicide survivors about problems of responsibility for the purpose of therapy or healing. In particular, the article examines the role of individually focused healing therapies that seek to adjust the individual to society without questioning the power of racial and sexual subjection in hindering contexts for healing. As a result of a lack of language for suicide that moves beyond binarist discourses of victimhood or recovery, these Asian American women are forced into silence about their psychic traumas or to represent their pain in self-destructive ways. This article suggests a rethinking of psychotherapy and healing that acknowledges the complex coexistence of agency and "illness," as well as the need for empowering Asian American women to change their sociopolitical environments.

STUDY BACKGROUND

This article presents a portion of a larger study that examines how American women of Southeast Asian, East Asian, and South Asian descent experience suicide in relation to racial and sexual subjectification. Using original empirical research about suicide survivors, the study employs interdisciplinary methods of discursive and historical analyses of Asian American women's narratives in order to contextualize suicide within a sociopolitical framework. The research comprises interviews with 26 Asian American women, from college-age to their 50s, living in three major geographical areas of the US–San Francisco/Bay Area, Houston and New York. The study inquires about their suicide attempts and suicidal behaviors and thinking. The majority of the women interviewed represented the entire age range of the 20s, and totaled 15 in number. The breakdown of other ages is as follows: 6 adult teenagers, 3 in their 30s, 1 in her 40s and 1 in her 50s. As for ethnic breakdown, the study sample included 10 Chinese Americans, 4 Korean Americans, 3 Filipina Americans, 2 hapas or mixed-race Asian Americans, 2 transracial adoptees from Korea, 2 bi-ethnic Asian Americans (1 Chinese-Japanese and 1 Filipina-Chinese), 1 Indian American, 1 Vietnamese American, and 1 Japanese American. The actual composition of the geographical locations is more complex because although I interviewed women in the San Francisco/Bay Area, New York and Houston, many of them had previously moved from places that they considered more socially influential during their formative years. The following is the precise geographical breakdown: 10 from SF/Bay Area, 7 from Houston, 4 from New England/East Coast cities, 2 from Southern or Central California, 2 from Hawaii, and 1 from the Midwestern heartland. While quantitative studies of Asian American suicide are needed, this study attempts to contribute to Asian American suicidology, first, through an in-depth, qualitative examination of suicide narratives, and secondly, by demonstrating how racism and sexism influence Asian American women's suicides. However, since the topic of the larger study is beyond the scope of this article, this essay will focus on suicide narratives that deal with problems of race, gender, therapy, and healing.

THE PROBLEM OF RESPONSIBILITY

To integrate an understanding of suicidal subjectivity as both a product of socialization and an agent of healing, I suggest an examination of

Asian American suicide through the trope of "responsibility." Elizabeth Alexander's (1994, p. 91) question, "What do a people do with their history of horror?" is important in a consideration of racial trauma or terror in suicide subjectification because it reminds us first to think about the problem of responsibility–which, broken down etymologically, may be interpreted as the ability (or inability) to respond–before we begin to consider the possibility of representing trauma or recovery. What *do* we do with our histories of horror? That is, assuming we are not already so damaged as a result of trauma, or are still experiencing trauma on a regular basis that we are unable to find our tongues. Do we want to respond by representing our pain? Are we concerned that representation may never be enough to "correspond" with the pain, or that it may maintain the opening of our wounds? Are we not already doomed to represent the pain anyway? These are questions that must be considered before exploring ways to represent the suicide's racial trauma for the purpose of recovery. The idea of responsibility in healing also acknowledges the diverse range of abilities that Asian American women develop to address gender and racial traumas, from traditional therapies to alternative, individual, and communal acts of agency. Moreover, responsibility stresses social accountability and the necessity of transforming oppressive racialized and gendered relations of power to create social contexts for healing.

In order to examine questions of responsibility, I turn to Wendy Law-Yone's novel *Irrawaddy Tango* (1993), which thematizes the costs of representing psychic trauma. The text's response to trauma is fiercely anti-historical and anti-political, as well as anti-commemorative, as a result of the protagonist's simultaneously conditioned inability and refusal to participate in civilized conventions of responsibility. *Irrawaddy Tango* is an account of everyday terror, which Taussig (1992) similarly calls, "terror as usual." Departing from an elaboration of torture that relies on a separation between civilization and domestic safety on one side and worldlessness and pain on the other (Scarry, 1985), *Irrawaddy Tango* compels us to consider torture's dynamic as an everyday occurrence. If everyday objects of civilization can be made to disappear through torture's conventional strategies of inversion, then what is the status of torture in situations where terror, and its routine disappearance from social analysis, *is* the everyday–except an unusual epistemology of pain that forces us to reexamine altogether our ability to respond to the world. What would it mean to create an account of horror then?

Law-Yone's novel asks important questions about responsibility that should precede a practice of therapy and healing, such as how to deal with the difficulty of representing trauma, the problem of healing within oppressive contexts, and perhaps the impossibility of recovery itself. Many of the women I interviewed also raised these issues, in terms of their silence about their suicide attempts and their experiences of racial and sexual violence; the inescapability of their traumas, manifested through bodily self-mutilations and recurring memories of psychic pain; their resistance to traditional mental health services; and their rejection of easy narratives of healing. Bulhan (1985) argues that a psychology of oppression should address these issues:

> Why, for instance, do the oppressed manifest high resistance and suspicion when confronted with seemingly innocuous research questions? Why do they fail to take advantage of health services even as they admit a dire need for medical care? How can one explain the high drop-out rate observed among those of them who seek therapy? Why is it often so difficult to arrive at a correct diagnosis regarding maladies of the oppressed? And even when they are correctly diagnosed, why do such patients deliberately subvert the very prescriptions that would restore their health? (p. 11)

A Report of the Surgeon General (U.S. Dept. of Health & Human Services, 2001) confirms the prevalence of these issues, in particular for Asian Americans, who possess the lowest rates across gender, age, and geographic location for utilization of mental health services compared to other ethnic populations.

Reflecting these outcomes, the majority of the interviewees possessed either negative or ambivalent attitudes towards mental health services rather than positive experiences of therapy, in a ratio of almost two to one. For example, Lydia,[2] a Korean American woman in her early 20s, discusses her distrust of therapy's authoritative claims to objectivity:

> I don't really need a shrink. . . . Perhaps I can get hooked on a shrink or psychiatrist. . . . I think I do a good job of psychoanalyzing myself on a daily basis, let alone *pay* somebody to psychoanalyze me, who can be *completely* wrong about what I am.

Besides the dependency that psychoanalysis seems to cultivate, Lydia objects to the commodification of psychic care, especially among those

with few financial resources. Interviewee Vicki, a woman of Chinese and Japanese descent in her 30s, similarly draws a connection between medical discourses and commodification:

> This seems to be a really, I guess, recent phenomenon of people deciding that it's a biochemical thing, and I think . . . that it's more cultural and it's also kind of *capitalistic*, because of marketing Zoloft and Prozac and all that. I think also it starts to become a middle-class phenomenon, maybe. It's just like eating disorders; you *can* have an eating disorder when you have the *means* to have one. It seems to be a really masturbatory, self-involved kind of thing. . . . And somehow that seems to be an easy *out*, so this friend of mine who defines herself as being a depressed person who can be cured by taking Zoloft, and I think there's something kind of fucked about that. First of all, it's defining yourself that way; then it's kind of a foregone conclusion. Second, relying upon pharmaceutical companies to cure you of some supposed ill. If you're saying, "I'm a depressed person," then that's *it*, "I'm just a person who's depressed," and it's like, "So you're a person who's depressed, but there's other things, too, like maybe it would help if you thought of yourself as a person who responds to stimuli in a certain way, and if you changed your response to stimuli, you would no longer fit into that category of a depressed person."

Vicki criticizes the circular logic that is contained in the labeling and treatment of clinical depression. Michel Foucault (1988) noticed that a similar circular logic characterized psychoanalysis in nineteenth-century European asylums:

> The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification. It would not be a dialogue. . . . It would be fairer to say that psychoanalysis doubled the absolute observation of the watcher with the endless monologue of the person watched–thus preserving the old asylum structure of non-reciprocal observation but balancing it, in a non-symmetrical reciprocity, by the new structure of language without response. (pp. 250-251)

Thus, a new practice of managing pain and containing deviance was dissimulated through another enlightened discourse of rationality. However, this was not just a problem of European modernity. Psycho-

analytic theories continue to be entrenched in American therapies (Schnog, 1997), even in spite of attempts to radicalize psychoanalysis and to correct the power imbalance inherent in the monological, confessional structure of psychotherapy:

> Although feminist, Marxist, and cultural critics have challenged the liberatory possibilities of a therapeutic practice marked by racial stigmas, class privilege, gender bias, and social myopia, such critiques and movements have not always succeeded in extirpating Freudian concepts from their own theories of group empowerment. This is particularly evident in the case of women's consciousness-raising groups, which rejected Freud's domestic reading of female nature (and his ever-loathed theory of "penis envy"), while incorporating his method of talk and self-confession as their baseline tactic for their remaking of the social order. To remodel psychotherapy as a "radical therapy" is still to envision radical politics within the conceptual frame of therapeutic talking cures. (p. 7)

The apparent difficulty of transforming psychotherapy's "talking cure" is one of the factors in its failure as an effective healing tool. As interviewee Janelle, a Chinese Canadian in her 20s, observes, "I think Western psychology–there's just no mystery to it. It's always the Freudian thing. It's always, 'What happened is the cause of this', and it's always the same conclusions, and I think I never had much trust in it, because it seemed so sterile to me."

The distrust of psychotherapy that Janelle describes is not uncommon among the suicide narratives because of power dynamics built on social stereotypes of Asian American women as passive, malleable creatures. In particular, the prevalence of the model minority ideology serves to discipline unruly Asian American subjects that disrupt the American myth of meritocracy and progress. P. W., a Chinese American woman in her late 50s, describes how her psychiatrist pathologized the distrust that she felt towards the larger society:

> [My therapist] saw my *distrust* of people as pathological. *Now* I don't see my distrust of people as pathological, *I see it as reality* . . . . I think a *lot* of how they saw pathology in me had to do with the whole model minority syndrome. The fact that I veered from what they felt was a *norm*, I think, really made it easy for them to see pathology in me. I think certainly the *psychiatrist* I was with was *more than willing* to see pathology. He gave me *all the drugs* for manic depressive illness.

P. W.'s experience demonstrates how the mental health system can help to enforce conformity by pathologizing individuals and disregarding structural oppressions, silencing them with clinical labels and pharmaceutical drugs. The result of this trend in the praxis of psychology is the systematic disempowerment of those in need of care from seeking healing strategies that attempt to change their social contexts:

> The fact that the vast majority of all our difficulties in life stem from oppression is ignored. The fact that we can reach out into our environments and change them is also downplayed and ignored. The fact that thousands of people are suffering in very similar ways from the structure of society is also ignored. We are discouraged from talking to each other, speaking out, organizing, etc. (Re-evaluation Counseling Communities, 1991, p. 57)

In some cases, the psychological counseling professions not only discount the reality of oppression and fail to support proactive efforts to resolve problems, but also directly contribute to the mental anguish of their patients by invalidating their perspectives and substituting them with their own. Marine, a hapa[2] in her late 20s, illustrates the violation of trust she experienced with her psychiatrist:

> I've had experiences with psychiatrists that have been fucked up. There was one psychiatrist who realized I worked at this one good company, and she said, "Is it OK if I mentioned your name so my friend could inquire about a position there?" I was like "yeah," and then the next thing I know the human resources person says, "I know she's your doctor, but she keeps on calling me." So that was very scary. The other psychiatrist that I found very difficult–she truly was very difficult. She was passing moral judgments on my lifestyle. Like about my sexuality, like about racism. She was a white woman, so she just thought that I was being very uppity and difficult and making things more than they were. So she just said, "Come on, it's not like that." And she'd say, "I don't think that's what it means," and "Are you sure that's what you should be doing?" She was like, "I find you very difficult, and the kind of medication you are on, you are bipolar anyway, so obviously you're going to be very violent." And she starts using my illness against

me, and she starts saying, "It's obvious you're going to act this way because you're sick anyway."

As exemplified in Marine's case, the individualization and invalidation of women's traumas often have to do with the illegibility of the oppressions that Asian American women experience. As discussed earlier, the terror of everyday racism and sexism seems simply to disappear from social analysis because terror and its social ignorance are so integrated into our "civilized" cultural thinking. As a result, women like Andie, a Korean American trans-racial adoptee in her 20s, are forced to second-guess the reality of racist oppression since there does not seem to be a legitimate language for it: "I think it *did affect me*, that subtle kind of racism that you can't really pinpoint because they're not *saying* anything wrong." Similarly, Jill, a Japanese American woman in her 30s, describes the lack of accountability for everyday racism and its damaging, cumulative impact on her psyche:

> It's always difficult to articulate, because there is nothing you can directly point to. . . . These minor incidences of racism, I think they accumulate over time. So it's often hard to point to one incident. Point to one person. But it gave you this kind of sense of yourself through these small incidences that say, "Well, maybe I'm not good enough. I'll never be good enough. I always have to measure up to these other people." And if I do call it out, then there's certain ramifications I really have to think hard about before I do, . . . like people getting angry over the race issue at me or . . . trying to accommodate it and sometimes not even in the right ways. . . . But that still doesn't erase institutionalized racism across the board.

As Jill relates, efforts to speak up about racism usually result in racist backlash, whether to make claims of "reverse discrimination" or offer accommodating concessions. Meanwhile, institutional racism continues unrecognized, pushing women like Jill into a marginalized position of either stigmatization or pathological silence and self-blame.

Many Asian American women remain silent about their psychic suffering in order to avoid compounding it through abuses by the mental health system. Lydia, for instance, did not attempt to seek care after she overdosed on pills. She explains:

> The reason why I didn't want to go to the hospital was because I knew that regardless they were going to ask me about my health insurance situation or whatever. I just knew that I don't really want to go to the hospital because I can't afford it. And if there was anything about like, oh, they would bring in the child protective services or whatever, like I knew that it was shitty to be in my family, but I knew that it would be even shittier if I *wasn't* in the family. Just in terms of physically being transplanted to a foster home or something. And I didn't want that, so I didn't really tell anybody.

Lydia represents one of many Asian Americans who lack the financial resources to afford appropriate health services, which seems to be more and more prevalent in America's HMO/insurance company-driven health-care system. On another institutional level, Lydia must face the additional obstacle of social services, which only serve to alienate her further by trying to remove her from her only place of familiarity. Lydia describes an instance when she could not seek help for herself because she felt she was forced to choose between her family and the social work system:

> I hate the social work system. This is after my brother hit me pretty bad. I was pretty messed up in high school. They took me out of class, and this social worker came from the child protective services, and he said that I'd have to go to a foster home . . . the *approach*, logistically in how they *come* and *bombard* your whole house and system, I'm really not for that. You're not going to sit there and conform to this *White* family like they wanted me to; they wanted to send me to some *White* family. A, I already have White people issues, and B, I'm not going to sit there and be like, "OK, Mom, they're going to put you under questioning, while I'm sitting here thriving in some affluent, *White* family." I wasn't for that either.

While some women that I interviewed did seek the help of social services, they usually saw it as a last resort and tended to have ambivalent attitudes toward the system because of its lack of cultural understanding and sensitivity about their home situations. In the instance that Lydia describes above, the inappropriateness of the social work approach extends beyond a cultural insensitivity about Asian Americans' tendency to stress family cohesion and reluctance to speak out about personal or private issues. The social work system failed to take into account the impact of racism on this family. It placed Lydia in an impossible position of dividing her family, labeling it as "pathological" in contrast to

the White foster family. With her use of the word "bombard," Lydia indicates an antagonistic relationship between her family and institutional authorities. Other women I spoke to also objected to the forced nature of counseling and social services:

> Janice (19-year-old Chinese American): I remember one time in the middle of it, this other nurse said, "Okay we're going to have this social worker come talk to you. And did you know it's a federal crime to commit suicide in the state of California?" and something like, "It's against the law to kill yourself." And I thought that was totally ridiculous.
>
> Andie: . . . It was forced counseling. The way it was explained to me was that it's illegal for somebody to try to kill themselves, and so when you're a minor, it means you either have to go into a mental hospital or you have to go through counseling once a week. So that's what I did, and the counselors were kind of worthless.

As Janice's and Andie's experiences illustrate from the perspectives of individuals in pain needing care, it seems surprising that there would be a penal aspect in the treatment of suicide attempts. This raises the question of the policing function of mental health care, according to Supeene (1990): "Psychiatry is the only branch of medicine that expects to force treatment on people and which can invoke the aid of the police to do so" (p. 73). In cases of mistreatment through the mental health system, it is no wonder, then, that Asian American women develop a distrust of these social institutions.

As a result of a lack of social resources, those Asian American women who have experienced traumas must continue to suffer in silence and learn to suppress their psychic pain as a means of coping. Lydia says about her painful experiences, "I think a lot of it has been suppressed for so long that why even bring it out? I've just been so used to not telling anybody things that it just comes to me second-nature not to say anything. And just like history, you can be selective in what you want to tell people." Lydia creates self-denial about her pain, but as she explains in the following passage, her silence also functions as a survival mechanism:

> Do you know in my lifetime, I never once said that I was depressed, which is weird. . . . Guilt and depression are two highly paralyzing emotions for me because you can't do anything about it. . . . For me personally, things have been *bad*, but at the same time, I was always busy *hiding* the fact that it was bad that sometimes I wouldn't even think that it was bad. . . . I think the reason why I don't tell people is because I don't want them to view me in a different way, and perhaps it's very deceiving and whatever, but that's really how I look at things. I don't want them to, A, feel pity or whatever, *or* feel like, "You've overcome so much adversity. You persevered in life." I don't really want to hear that either. If anything, it was just like a survival method, like this is what you do in order to get where you want to be.

Lydia echoes the perspectives thematized in *Irrawaddy Tango*, in which the female protagonist rejects self-disclosure due to discourses of containment implicit in public confessions. Perhaps Lydia uses her silence and, to an extent, her denial to deal with the lack of understanding and empathy that exists socially, particularly within the dualistic social discourses that she describes, which offer only two modes of expressing injury–either victimhood or recovery.

As in *Irrawaddy Tango*, many of the women I interviewed confronted problems of responsibility, or of representing their pain. They found speaking about their suicide attempts either impossible or insufficient to express their psychic pain, so their traumas became inscribed instead through their physical bodies. Sometimes the women consciously inflicted physical self-abuse. For example, Gabrielle, a Korean American in her late 20s, often strangled or hit herself. Soyeon, another Korean American in her late 30s, attempted suicide three times, as well as abused drugs and alcohol. During her second attempt, she burned her own hands in boiling water so severely that she required surgery. She feels that she burned herself to show her pain and anger in a physical way because of her suppressed feelings. Sometimes psychic pain exhibited itself psychosomatically, as in the back and neck pains of twenty-something Chinese American Laney. In other cases, pain registered through a combination of intentional or unintentional physical acts of self-destruction. Mindy, a Filipina in her mid-twenties, cut her wrists and experienced anxiety attacks, eating disorders, and breakdowns that manifested physically as well as emotionally. P. W. suffers from asthma and agoraphobia, which she believes are related to many years of stifled self-expression and confinement. She also developed a nervous facial twitch, which she believes resulted from her childhood anxiety about speaking only English. Vicki expressed her suicidality not by attempting suicide, but by placing herself in physically danger-

ous or risky situations: abusing drugs, hitchhiking with strangers, having indiscriminate sex, and cutting herself with razor blades. Rachael, a twenty-something Korean American adoptee, showed several physical manifestations of suicidal tendencies: chronic migraine headaches, agoraphobia, and alcohol and drug abuse, explaining that "it was like, 'maybe I could just O.D'." As in Rachael's case, addiction was prevalent among the suicidal women.

Among the physical acts of self-mutilation, cutting or scratching seemed to be most common. For instance, in addition to abusing alcohol, Marine attempted suicide twice by slashing her wrists. Gabrielle, Jerry, and Hayley, a 19-year-old Korean American, all describe cutting or scratching themselves with blades, pins, or their own fingernails. For some women, like Gabrielle and Jerry, self-abuse was an expression of anger that they directed towards themselves. In addition to abusing drugs and alcohol, Asha, a 19-year-old Indian American, regularly cut her arms with razors, scissors, and needles, which she says was due to unexpressed anger from having to "hide everything." Vicki explains that cutting herself was like having "an intense bodily experience" that she could not express verbally: "Being able to articulate my feelings wasn't something that I was raised to do and so it just was very gratifying, and it's like this real tangible thing." Similarly, Jill believes the idea of cutting herself made her pain more real:

> It seemed so attractive to kind of feel the pain. Like my last willful act to actually be able to feel something because I was totally not able to feel anything at that point or very little. . . . Just putting the knife to my wrist, going through the motion in my head, was some kind of *release* in a way. . . .

Both Jill and Janice, who cut her arms and legs with pins, describe feelings of release, as if physically cutting themselves offered a kind of relief of pent-up internal pain. In Gabrielle's case, her psychic experience was made real not only through the feeling of pain, but by the resulting physical wounds, like a hieroglyphics of the flesh that would display and legitimize her pain:

> It was like a visible reminder to me, and maybe half-wanting people to see it as well. I think it helped me to feel some of the things that I wasn't allowed to feel. Or things I couldn't talk about. So it just kind of made my angst real for me, since I could say, "It *hurts*."

By manifesting their psychic states physically, the women's experiences speak to a problem among Asian American women of articulating trauma and of suicidal agency. For Jill, feeling the sharp pain of cutting represents a final willful act within her otherwise numb existence. In this sense, the body responds, expressing pain where words fail. For Vicki, however, ultimately taking her own life would require agency that she feels she did not possess:

> I didn't even feel that I had enough ownership of my own self to say, "Okay, I'm going to kill myself," because I didn't feel like I could *do* that, like I even had that much authority over my own self to do that. Sometimes that's the *one* agency that you feel that you have, and I think I actually didn't feel I even had that. . . . I have this belief that the power over your own existence is the *most* power that you can have, and maybe that was why I couldn't embrace suicide, because I didn't feel that I had the sanction to have that kind of power, and I didn't ultimately act. That is the *one* most *defining* act of power, is to kill yourself.

Vicki describes a feeling of suicidal abjection that maintains her trauma's illegibility and ultimately her silence. Except for a series of reactive, self-destructive behaviors, subjective agency fails to materialize through words or through bodily inscriptions, foreclosing the possibility of response-ability or healing.

IMPLICATIONS

These narratives about suicide and healing demonstrate problems of therapies that individualize psychic traumas. Focusing on individuation as a therapeutic outcome is particularly problematic for Asian American women whose sources of identity and support may be found in their ethnic communities and families. Furthermore, by focusing solely on individual or intrapsychic conflicts and ignoring sociopolitical causes of Asian American women's suicides, particularly racial and gender oppressions, these therapies hinder effective healing contexts. As anti-racist and feminist therapies demonstrate, health and illness must be understood as emerging out of ever-present social contexts of racism and sexism (Bair & Cayleff, 1993a; Espín, 1994). Without necessary validation of their individual experiences as being connected with larger social forces, Asian American women deal with problems of re-

sponsibility, or of representing their pain through silence, self-blame, and self-destruction. But also expressed in these narratives of self-destruction are moments of agency, through the women's desire to maintain authentic responses to their pain, whether by rejecting easy narratives of recovery or expressing pain through non-verbal means. Therefore, it is necessary to move beyond binarist conceptualizations of healing by recognizing the complex and sometimes contradictory subjectivities within suicidality. The coexistence of illness and agency suggests that an Asian American feminist approach to healing cannot be found within the cult of the individual, where a unitary conceptualization of self-healing translates into the goal of recovery and wholeness, but rather in the adaptive realities of ambivalence that Asian American women actually live. For Asian American women, maintaining ambivalent feelings, such as anger, about their colonized mentalities can be seen as a strategy of resistance against colonization, instead of as pathology (Bradshaw, 1994; Comas-Díaz, 1994). Moreover, within a social context where the "pursuit of happiness" is ideologically hegemonic and antithetical to the reality of suffering, the therapeutic goal of achieving happy wholeness can create problems (Bradshaw,1994) of guilt and inadequacy for Asian American women who do not fit this image. The pressure of letting go of any feeling that does not conform to the stereotype of the meek and mild model minority is particularly salient for Asian Americans who are always expected to assimilate and not make waves.

Moving beyond individualist approaches to healing and taking into account social context mean that we may need to rethink the role of psychotherapy, including those emphasizing "culturally sensitive" approaches. Most therapies concerning Asian Americans focus on cultural differences or advocate cultural sensitivity (Bradshaw, 1994; Chin, 1998). Culturally sensitive models address the need to challenge the Eurocentric (as well as androcentric) focus of psychotherapy, and of psychology in general, which, as some have argued, are inappropriate for diagnosing and treating Asian Americans (Chin, 1998; Homma-True, 1997). Notwithstanding the importance of cultural competence in psychotherapy, I believe that there is a bias toward viewing Asian Americans through a culturalist lens due to contradictory racial ideologies prevalent in the US that continually objectify Asian Americans as cultural others and, at the same time, ignore their subjectification as racial others. Moreover, culture is over-emphasized and race de-emphasized in regards to Asian Americans for the same reason that race is over-emphasized and culture de-emphasized in regards to Black Americans, which has to do with how each group has been socially managed throughout US racial history (Chin, 1994). For example, Asian Americans are commonly racialized as immigrants, whose cultural status, i.e., their ability or inability to assimilate or acculturate, always seems sufficient to explain their existence in the US, resulting in social stereotypes preoccupied with their cultural assimilation, such as the "model minority" or the "perpetual foreigner." (Whereas, Black Americans are racialized not as immigrants, but as slaves or property lacking in cultural history, so that only their skin color or "race" seems important.) While some Asian American psychologists have called for an analysis of race and minority status, along with culture (Chin, 1998; Hong & Domokos-Cheng Ham, 2001; Sue, 2002), relatively little research has actually addressed race and the sociopolitical context (Hall et al., 2002). As a result, Asian American feminist therapy risks creating what Bair and Cayleff (1993b) call a "new cultural relativism" or "the danger of becoming so immersed in ideas of cultural difference that the political and socioeconomic origins of illness . . . are overlooked" (p. 89). Another danger of cultural relativism is the tendency to view culture in static terms and to culturally objectify Asian Americans as always different or other. Rooted in Western racial perspectives about Asian Americans, psychotherapies that focus on acculturation, assimilation, and conformation to mainstream cultural values as therapeutic outcomes should be called into question as hegemonic strategies of social control (Bradshaw, 1994; Chin, 1994; Chin, 1998). Therefore, it may be useful to combine an analysis of racial and gender ideologies with analyses of culture when counseling Asian American women.

My own empirical research, which demonstrated that Asian American women suicide survivors employed diverse healing strategies from traditional therapies to alternative practices (cultural decolonization through writing and art, spirituality, social activism, and Asian medicine–the details of which are beyond the scope of this essay), seems to suggest that healing models must be flexible enough to accommodate therapeutic as well as extra-therapeutic interventions. While anti-racist and feminist therapy have drawn attention to the impact of racism, colonialism, and sexism in psychology, and suggested ways to modify traditional therapy to be less Euro- and andro-centric, I think that revisionist therapies are limited and more radical approaches are necessary, especially when it comes to matters of life and death as in suicide intervention. Comas-Díaz (1994) asserts that for women of color, therapy should be nothing short of a process of "psychotherapeutic decolonization," by affirming racial

and gender identity, self-determination, and autonomous dignity. Chin (1998) similarly argues that mental health services need to move beyond the perspective of Asian Americans as a group that needs to be accommodated, through modifying current models to creating delivery systems based on ethnic-specific principles. There is much room for ethnic and cultural specificity since most therapists continue to be trained in theories that are Western- and male-oriented, and even feminist scholarship on mental health and health care continues to focus on the experiences of White, middle-class women (Bair & Cayleff, 1993a; Bradshaw, 1994; Comas-Díaz & Greene, 1994a; Espín, 1994). If "feminist therapists acknowledge that therapy per se is not a cure-all" (Butler, 1985, p. 37), then they should be mindful of their own myopic gaps and take seriously the healing power of transforming the social context beyond therapy. When working with Asian American women, this entails providing extra-therapeutic support services, such as advocacy and information, fostering community networks, and encouraging social action and empowerment (Bair & Cayleff, 1993; Bradshaw, 1994; Chin, 1998; Comas-Díaz, 1994; Espín, 1994; Lee, 1997). The therapeutic relationship itself should be a bottom-up rather than a top-down dialogue, in which the therapist evaluates issues on a case-by-case basis through active listening and taking cues from the client in an attempt to put aside monolithic stereotypes about Asian American women (Bradshaw, 1994; Comas-Díaz, 1994). This dialogue is also critical, given the low utilization rate of mental health services among Asian American women. Moreover, it should lead psychotherapists to pay attention to the usefulness of diverse responses to healing, rather than simply trying to get Asian American women to accept conventional therapy. Ultimately, it may be that achieving mental well-being cannot be found simply through psychotherapy, but by making necessary changes in the sociopolitical environment and creating new, empowering forms of subjectivity that draw from the unique experiences of Asian American women.

NOTES

1. All subjects' names used are pseudonyms.
2. The term hapa refers to Asians or Pacific Islanders of mixed ethnic or racial heritage. Marine identifies as Filipina, Chinese, Mexican and European.

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