would not be enough to insure her success in college. She reported that her psychotherapy had proceeded well, and had similar expectations for this experience.

Russell had not engaged in psychotherapy previously, and felt uncomfortable and somewhat suspicious of the therapy process, which he feared would be long, expensive, and drawn-out and would lead to the blaming of somebody. Progress in therapy revealed that Russell, himself rather traditional regarding male role behavior, had expected that Carol would be supportive of his career by not requesting of him changes to his well-established and comfortable life. Though he was receptive and willing to challenge both his sexist views and uncommunicated expectations, he did not consider himself racist and had considerable difficulty challenging his racial and sexual stereotype of Carol.

During the initial year of their courtship, Carol had acted in very agreeable and supportive ways toward Russell's needs and expectations, leading him to assume that she would not move in personal directions that would jeopardize his setting and lifestyle. However, over time, Carol in his view had become increasingly feminist and had begun to "demand" things from him that he found surprising. Carol agreed that she had been quite deferential toward Russell during the initial phase of their courtship, but denied that her "feminism" had changed substantially over time. She had been surprised to find his values "so traditional" and wondered why she had not seen this before. Each partner felt betrayed and misled, and therefore doubted the basis for the relationship.

Therapy with this couple revealed that Carol, despite her highly acculturated stance, which departed sharply from traditional Japanese values, had nonetheless internalized some of what she later identified as her mother's ways of being in a marriage. In her self-identification as being primarily American, she was not aware of the ways she acted that reinforced the stereotype held by Russell of the passive, agreeable Asian woman. She herself had expected Russell to embody feminist attitudes and to promote her freedom and equality, which she felt most Asian men were unwilling or unable to do because of family pressures. The interaction of both Asian female stereotype and European American male stereotype had gone undisclosed and operated insidiously in the relationship, only emerging as the couple contemplated marriage and long-range plans for their future. Therapy acted to help Carol understand and cherish the legacy of Japanese values transmitted through her family. Rather than seeing them as liabilities in her pursuit of her career and personal goals, she was helped to see them as important enhancements to her identity and aspirations. Russell was similarly helped in his understanding of Japanese culture and therefore of Carol. The level of Carol's acculturation had aided his denial of her difference from him, in that he perceived her as Asian but the same as he in every other respect. He was also challenged to acknowledge the subtle ways in which he demonstrated his expectation that she would defer to him. Carol's own attempts to disinherit her culture aided in his misperception.

Interracial marriages in a social environment that still holds antimiscegenist values and biases incur special stresses involving complex explicit and subtle forces that challenge their right to perpetuation. These forces apply to minorities who have established lives in the United States, but they are especially difficult for the immigrant woman, the refugee woman, or the wife of the U.S. military man who is brought to the United States without the benefit of family or community support and is thus wholly dependent on her husband for her cultural education, cultural understanding, and livelihood.

MENTAL HEALTH AND PSYCHOTHERAPY

The Cultural Contexts of Psychotherapy

Seeking Help

Asian and Asian American women on the whole struggle with multiple forces in order to achieve belonging in a multicultural environment. These struggles can have significant emotional sequelae that are appropriate for psychotherapeutic attention. However, the treatment literature on Asian Americans indicates that psychotherapy is not sought as often as it is probably needed or useful (Homma-True, 1990; Root, Ho, & Sue, 1986; Tsai, Teng, & Sue, 1980). The reasons for this are complex. How emotional distress is expressed and from whom intervention is sought depends on a number of factors such as gender, socioeconomic standing, length of residency in the United States, place of birth, and education. Earlier literature suggested that the underutilization of mental health services by Asian Americans derived from several sources. These included reluctance to admit psychological disorders and tendencies to use alternative sources of mental health care (Root, Ho, & Sue, 1986; Sue & McKinney, 1975; Sue & Sue, 1974); beliefs that emotional distress results from a lapse in willpower, so that they would try to strengthen will rather than seek help; the desire to avoid social stigma and shame (Tsui, 1985; Sue & McKinney, 1975; Sue & Sue, 1974); conformity to the cultural mandate to suffer in silence; and tendencies to somatize emotional distress (Lin, Kleinman, & Lin, 1980; Sue & Morishima, 1982). Sue and Morishima (1982) have suggested that when Asian Americans finally do seek mental health treatment, it is often after exhausting other means of intervention and the relative severity of problems seen therefore is greater than it might be for other populations.

One study surveyed adult residents of San Francisco's Chinatown in an attempt to evaluate some of these conjectures (Loo, Tong, & True, 1989). Results revealed an extremely low rate of utilization (5%), consistent with earlier reports, roughly comparable to the rate of utilization for the

general American population 30 years ago (Loo et al., 1989, p. 293). However, contrary to suggestions that expressions of emotional distress are inhibited, Loo et al. found that reported psychological disorders in the community were prevalent, with a sizable proportion of respondents admitting to emotional tension, depression, loneliness, and psychological–physiological symptoms. The researchers concluded that underutilization results not from inhibitions about admitting psychological distress or use of alternative resources, but rather lack of knowledge of available services, belief that mental disorders cannot be prevented, lack of awareness that psychological problems can be treated, and low priority for seeking professional help for depression. As Loo et al. observed, respondents were Chinatown residents, who are more likely to be low-income immigrants, with limited education, having low occupational prestige, and limited resources. Conditions of poverty, immigration difficulties, aging, and life pressures represent real pressures, and coping with them is differentiated from "craziness," thus inclining these respondents to admit to difficulties regarded as normal and unavoidable.

Regarding more severe psychopathology, stigmatization may still occur. It appears that at least for Chinese Americans in this sample, education about available resources, causes of psychological distress, and its prevention and treatment would help to increase the use of mental health services. It is not clear that these results are generalizable to other populations of Asians or Chinese who do not live in Chinatowns. Additionally, there is growing awareness that socioeconomic status, regardless of immigration status, significantly affects help-seeking behavior. Among the better educated and more affluent, there is often a corresponding familiarity with Western ideas about mental health, greater bilingual capabilities, and increased likelihood of seeking independent practitioners for psychotherapy (Tien, personal communication, April 1991). The need for more detailed investigations is clear, as is the need to investigate assumptions about cultural proscriptions to mental health treatment. It may be that the frequent reference to the function of shame and stigmatization in inhibiting participation in psychological treatment is overgeneralized.

Homma-True (1990) cites that nearly 50% of the Asian American clients seen at a San Francisco Community Mental Health Center in 1987 were women. Due to the lack of other surveys, it is not clear how generalizable her data may be. However, Homma-True reports that this pattern is consistent with the impressions of a number of Asian therapists. These reports are not surprising, in light of the multiple pressures Asian and Asian American women face. Explanations for the higher rates of use by Asian American women are not given. Homma-True (1990) suggests that rates of affective disorders among Asian women are greater than among Asian men, paralleling the problems of White American women. Women are more vulnerable to multiple oppressions with which they must cope: sexism that favors men in getting dependency needs met in the family, for

example, and lack of resources for dealing with or escaping dangerous or oppressive conditions. Extrapolating further, it appears that Asian and Asian American women are more likely to seek mental health intervention due to the lack of other resources that recognize their problems within their own communities. Intentional efforts to seek an authority who will support changes that the family or community may be unwilling or unable to support, desperation, or perhaps a tendency to acculturate to Western views more flexibly are possible explanations for Homma-True's findings. These hypotheses are suggested for clinical consideration, although they have not been empirically validated.

Pre-therapy Expectations

Many, though not all, Asian and Asian American clients will have had little or no previous experience in psychotherapy. Familiarity with psychotherapy is also mediated by the length of time since a person's immigration, with successive generations being more likely to have experience with it. Therefore, one of the first tasks in establishing the therapeutic alliance will be to educate oneself about client expectations and to educate the client about therapeutic process and behavior. Sue (1981) and Sue and Morishima (1982) are widely cited for their suggestions regarding the value conflicts that may arise for Asians engaged in standard Western psychotherapy. Some of these include: that Western thought draws a distinction between the mind and the body, whereas Asians may think of the two realms as highly interconnected if not synonymous; that verbal expression and communication, especially of criticism or dissatisfaction may be indirect and restrained, whereas Western socialization encourages verbal expressiveness as a sign of honesty; that silence in the Asian tradition may reflect respect instead of resistance or repression; that Asian clients may expect that therapy will enhance their willpower to withstand morbid or ill thoughts, and on this basis may misunderstand the therapist's nondirectiveness when a client-centered or psychodynamic approach is taken; and last, that the Western psychotherapeutic orientation toward self-examination or self-actualization will run contrary to some Asian cultural practices and potentially drive clients from therapy.

Case ex

Mrs. F. was a 36-year-old interracially married native Japanese woman who immigrated to the United States with her White husband. The family, which consisted of their three children, herself, and her husband, lived in an affluent, White suburb in the Northeast. Her husband, a hard-working executive was supportive but most often unavailable regarding domestic responsibilities and childrearing. Over the course of her marriage she experienced many years of moderate depression, which escalated, eventually resulting in an episode of acute paranoid psychosis. She was briefly hospitalized and referred for outpatient psychotherapy with a White male psychiatrist, who initiated traditional psychodynamic insight-oriented psychotherapy. Over the course of six ses-

sions he encouraged self-expression, after which she terminated psychotherapy. She explained that she was determined not to succumb to depression again for the sake of her children, for whom she felt total responsibility. She regarded psychotherapy as an unnecessary expenditure of time and money that encouraged being self-centered and self-pitying; rather, she thought that she should straighten herself out, avoid "stupid" thoughts, and attend to her duties. She viewed the episode as a lapse in her ability to be selfless, which resulted in her indulging temporarily in selfishness and self-pity. Her husband's high level of affluence afforded her access to domestic privileges, but she had not taken them because she regarded the use of domestic help and accessories as a waste of financial resources, which could be retained for the children's future benefit if she would simply meet her domestic responsibilities. Although she was bilingual and had been substantially acculturated, having immigrated 10–15 years previously, she retained traditional Asian values with respect to her role in the family while following Western family practices and raising her children in the Western style.

Specifically, the Asian or Asian American woman is likely to have a range of pre-therapy expectations that need specific evaluation. The suggestions in the literature pertaining to psychotherapeutic concerns for Asians (Homma-True, 1990; Root et al., 1986; Root, 1985; Shon & Ja, 1982; Sue, Sue, & Sue, 1983; Sue, 1981; Sue & Morishima, 1982; Tsai, Teng, & Sue, 1980) in general apply to Asian women as well. Furthermore, it is my opinion as well as that of Homma-True (1990), Ho (1990), and Chow (1989) that therapy with Asian women differs from therapy with Asian men in that there is an implicit need to respond in a way that is politically and culturally activist in order to challenge the multiple oppressions that are causing or exacerbating emotional distress or mental illness. Therapy concerns that distinguish treatment with Asian and Asian American women from more general culturally sensitive treatment for Asians involves the therapeutic understanding and treatment of these women in light of the interactive effects of gender and race discussed earlier in this chapter. The need for more Asian women professionals to act visibly toward this expanded perspective is imperative. Role models are few who are able to demonstrate that changes toward more egalitarian cultural rules can be adopted without threatening the basic fabric of Asian cultural identity. Women of color in the mental health professions are in a particularly potent position to support such changes both among women of their own ethnicity, and also in their community at large.

Assessment and Diagnosis

Kleinman, Eisenberg, and Good (1978) (cf. Root, 1985) state that proper assessment of psychological functioning, dysfunction, and guidelines for healthy functioning must take into account the individual's culture, level of acculturation, and existing community standards for a particular behavior. As the influences of cultural assimilation increase, the effect of the minority values may decrease, but as in the case cited above, they nonetheless influence behavior in subtle ways. Context is crucial to the understanding of the presenting problem. As Root (1985) states, "The influences of ethnicity are powerful and cross-generational," (p. 352) such that the individual's current involvement with his or her family of origin may not be indicative of its influence or the influence of cultural values and expectations.

Attention to nativity (place of birth), length of time since immigration, language capability, the generation since immigration, level of acculturation or assimilation, adherence to traditional values and beliefs, beliefs about expression of feeling, beliefs about prevention and treatment of mental disorders, minority identity development, socioeconomic status, current social context, and contact with family of origin and extended family are some of the issues that will be critical to the assessment and diagnostic process. Thorough evaluation of these issues on an individual basis, in an attempt to put aside monolithic, homogeneous stereotypes about Asians, will yield rich information that will quite naturally illuminate treatment goals.

In the case of Mrs. F., the failure to recognize cultural differences regarding self-importance versus self-sacrifice led to the sense on Mrs. F.'s part that the therapy was promoting more of what had made her ill. She resolved to repress morbid thoughts in a culturally consistent response. Several years later, she was again seen in psychotherapy when adolescent misbehavior on the part of her child resulted in referral. After careful assessment of the previous incident, it was learned that she had been considering divorce, but could not justify her feelings in the absence of overt abuse on the part of her husband. Conjoint counseling was initiated with positive results.

Psychotherapy Modes and Orientations

Western Psychotherapeutic Approaches

Attempts to provide a comprehensive review of the current psychotherapeutic approaches for minority women are essentially lacking in the literature. The field appears still preoccupied with minority- and culture-sensitive treatment, without extending these conclusions to the gender by race or ethnicity interaction (Homma-True, 1990). In an initial effort to address this need, Homma-True briefly surveyed several of the major schools of therapy and their application to the treatment of Asian American women. It is, however, this author's opinion that efforts to evaluate the efficacy of Western modes of psychotherapy for minorities will not yield data pertinent to minority group individuals. The research on Western psychotherapy gives only moderate indication that specific techniques constitute the

potent variables accounting for psychotherapeutic effectiveness (Smith, Glass, & Miller, 1980; Strupp & Binder, 1984). Rather, Strupp and Binder suggest that psychotherapy works best "if patients desire change of their own accord and are motivated to work toward it; if the environment in which they live tolerates the possibility of change; and if the inner obstacles to learning (defenses and rigidities of character) are not insurmountable" (p. 269). It is evident that goals for therapy will meet with fundamental resistance and failure from clients whose environments (external) and personal beliefs (internal) fail to sustain and validate the values therapy promotes. To the extent that most Western psychotherapies have as a goal individuation of the client, Asians whose ideological assumptions conflict with this goal will be poorly served. Psychotherapeutic techniques must be altered to accommodate the Asian client's particular values. Culturally sensitive techniques will help identify and surmount barriers to psychological access and change; community advocacy about mental health functioning and women's issues will help establish external supports for these changes.

If we accept this conclusion, what then are the curative or efficacious factors of which we need to be aware in order to discern how to alter what we know, as Western trained therapists, in order to help non-Western clients? What must be altered or reconsidered in therapy with minorities and, for our purpose specifically, Asian and Asian American women? Again, the literature on psychotherapy research can help. Though it still seems unclear what specific factors of psychotherapy exert specific effects on outcome, some nonspecific factors seem to contribute reliably to positive outcomes: when clients feel accepted, understood, and liked by the therapist; when the client's active participation and collaboration is fostered; when there is respect for the client's freedom and autonomy to influence the goals and process of therapy and these are clear goals declared at the onset of treatment; when the treatment meets the needs of the individual client; when negative transferences are actively confronted, when therapeutic experiences lead to increments in self-acceptance and self-respect; and when the therapist takes an interest in the client as a person, avoiding creation of a caricature of good human relationships by persisting without basic interest and commitment (Strupp & Binder, 1984). It is very likely that these essential ingredients may also operate in the psychotherapy of the Asian client. The purpose of the literature on culturally sensitive therapy is to delineate differences in cultural values, how these differences may be expressed, and how different values may be misconstrued and misinterpreted. Awareness on these levels is crucial for facilitating a genuine understanding and affection between the therapist and client who are culturally different.

Indigenous Psychotherapies

Another route for understanding the effective ingredients for psychotherapy with cultural minorities is to examine the indigenous psychotherapies

of the culture in question. Reynolds (1980) offers descriptions of five forms of therapy indigenous to Japan, that is, interventions built on basic Japanese social precepts, reflecting Japanese attitudes toward life and living. These are Morita (named after its founder), Naikan (*nai* meaning inner, *kan* meaning observation), Shadan (isolation), Seiza (*sei* meaning quiet, *za* meaning sitting), and Zen (derived from the Chinese *ch'an* meaning meditation) therapies. Reynolds, attempting to synthesize the common aspects of these therapies, states that these therapies treat the flux in emotional and physical being. They treat the flow of awareness directly, accept suffering as a integral part of life to be accommodated rather than eliminated, they do not recognize the Western distinction between mind and body, and they are based on a Buddhist premise that people are basically good; they are only in need of education to achieve a better state of mind. Reynolds further describes that happiness is not a goal for Japanese therapy, contrary to the American obsession with it, the right to the pursuit of which is even guaranteed in the U.S. Constitution (Reynolds, 1980, p. 104). These therapies seek to resocialize unhappiness, which is viewed as obsession with self-centered concerns, in favor of behaving as a mature adult who is more loving and giving. The vehicle for resocialization is isolation, not talk, which hones inner focus and acceptance by releasing the grip of resentment over "what ought to be but isn't" or "what might have been but wasn't." In many of these therapies the theme of obligation also serves as the resocializing cognitive content.

DeVos (1980), in his afterward to Reynolds' book, notes that these therapies are predicated to some degree on the expression of gratitude. He suggests that American society's overemphasis on the individual produces alienation in its youth, resentment about family dysfunction or inadequacy, and resistance to self-discipline. The Japanese therapies attempt to capitalize on the important role of gratitude and shame through self-discipline. These therapies attempt to reconcile the individual to the "legitimate functioning of parents" based on the belief that resentment occurs when one is unable to release any feeling of gratitude toward another person. DeVos observes that in contrast, many Western therapies are predicated on rejecting or challenging the functioning of parents and their competence. He conjectures that Japanese will continue to reject psychoanalysis because delving into the unconscious and making connection with rage at unmet needs and incompetence in parents will threaten family cohesion. By the same token, Japanese therapies may be poorly suited for American clients, who seek to change their lot in life and do not want reconciliation with occupational or family roles.

The brief comparison of indigenous Japanese therapies and Western therapeutic models illustrates some fundamental differences in treatment technique that necessarily emanate from social philosophy. Precisely because therapy is a socializing agent that takes its direction from societal values, it in turn fosters change that the cultural environment will tolerate

and accept. In the case of Asian women, this function of indigenous forms of therapy is disastrous. Focusing on gratitude and fate in life likely serves social harmony at the expense of women's emotional health. The Buddhist ethic on this matter appears to neglect that a great portion of female suffering is not in the nature of life, but in the nature of male domination. As such, is this aspect of women's suffering still legitimate? In cultural systems, both Asian and Western—that advocate and perpetuate suppression of women, women will not be healthy. Yet, acknowledging the value of healthy women will demand a change in society such that the contribution of women be seen as equal to that of men. In this sense, the Western goal of individuation may be to some extent appropriate and necessary. However, encouraging this type of social change will have to be accomplished deftly. Other Asian societies likely have interventions aimed at alleviating what we as Westerners identify as emotional distress. Examination of these indigenous practices will likely help illuminate who is oppressed, how, and the route for change.

Special Topics in Psychotherapy for Asian American Women

Domestic Violence

Asian Americans have a reputation for low rates of domestic violence. Several authors have remarked on this reputation, speculating that while rates of reporting are low, the correspondence to actual occurrence is unknown. This may be a result of the underutilization of public services by Asian Americans, inadequate access to mental health services, inadequacy of available mental health services, or other culturally related factors (Ho, 1990; Rimonte 1989; Eng, 1986; Root et al., 1986).

A number of factors affect both the occurrence of domestic violence and individual and cultural perspectives on it. Sexism in the culture, power differentials between men and women, women's access to alternatives and self-sufficiency, cultural views of physical violence, racism extant in the culture, attitudes toward marriage or partnership, as well as a host of other variables too numerous to discuss fully here constitute some of these factors. However, the cultural context in which the domestic violence occurs should not become cause for mental health professionals to determine that it is unwise to intervene. Though violence against women is tolerated to different degrees across cultures, I advocate intervention in violent situations against women or children, regardless of cultural norms. Rather, cultural context is important to understanding the proper routes for intervention that may not be apparent from the perspective of the cultural stranger.

To illustrate examples of cultural variation regarding use of physical violence, Ho's (1990) research on four populations of Southeast Asian refugees in the United States will be summarized. Her data show how

certain cultural consistencies may be expressed differently across ethnicities. Using a culturally sensitive method and allowing expression in the respondents' native language, she found that among the Laotians, Khmers, Vietnamese, and Southeast Asian Chinese, male domination over females prevailed across all four groups even though the degree to which men may exercise this power varied across groups. Regarding power balance between men and women, the Chinese men reported giving wives the illusion of some influence by agreeing with them, but in actuality the final authority remained with the men. While the Chinese respondents reported instances of subtle exercise of male domination, Vietnamese men described a more overt sense of ownership about their wives and their domination was more overt. Ho cited examples of male prerogative such as intolerance of wives refusing sexual overtures and expectations that wives would tolerate their extramarital sexual activity. By comparison to Vietnamese women, Laotian and Khmer women were dominated to an even greater extent, as illustrated by a word in Khmer meaning that women "stay in the shadows and in the home" (Ho, 1990, p. 141). Laotian women reported similar proscriptions for behavior and both groups reported that males enforce a cultural intolerance for refusal of sex to a husband for any reason.

Attitudes toward physical violence are often evident in the power dynamics between men and women, as well as in the expression of discipline toward children. Ho (1990) investigated this correspondence in her study, finding that all four groups endorsed physical punishment as an acceptable form of discipline. All groups had clear definitions of locations on the child's body that were acceptable sites for hitting, and clear senses of whether implements for hitting were appropriate, at what level of disobedience hitting was appropriate, and the role of anger in hitting. Variations emerged across groups however: Ho suggested that physical punishment appeared less acceptable among the Southeast Chinese than among the other groups. Nevertheless, she was careful to point out that this attitude may not reduce the occurrence of physical punishment in actual practice.

Regarding violence against wives, Chinese men and women reported attitudes least tolerant of domestic violence yet estimated that 20% to 30% of marriages resulted in some form of male violence toward wives. Vietnamese women and men were reported to be more tolerant of physical violence, citing occasional hitting or hitting when out of control as expectable. In contrast, Khmer and Laotians expressed the highest tolerance, reporting that domestic violence is common. In view of even these few examples, it is hard to believe that in a general context of Asian cultural tolerance for spousal violence, under the especially stressful conditions of immigration, or under the different yet substantial stresses of minority life, that domestic violence is as infrequent as public statistics imply.

Several populations of Asian and Asian American women are at particular risk for domestic violence, including women who are immigrants or

refugees. The losses these women are forced to confront compound the struggle to respond to unfamiliar demands and expectations (Rimonte, 1989). When these women are subjected to rejection in the new community, their cultural training facilitates feelings of personal failure and social incompetence. Depression is therefore a primary liability for these women, and often their indigenous culture has no acceptable label or explanation for these feelings. Refugee women are at risk both within their cultural contexts, and especially in the context of their displacement as refugees. Similarly, Asian wives of U.S. military men are at special risk because of their displaced status, lack of familiarity with American norms, and their isolation from other members of their cultural or ethnic group.

Interventions: Techniques and Considerations

Rimonte (1989) outlines the need for intervention to help the battered Asian woman see herself as a victim, learn to speak, and learn to act. Due to the cultural acceptance of domestic violence, in combination with cultural expectations and socialization that women learn to suffer with dignity, the battered Asian woman may not perceive herself as a victim. Her culture (e.g., Confucian values) may even encourage the acceptance of battering, as fate to be tolerated rather than changed. Yet, without some understanding of herself as a victim, there will be little impetus for creating change or understanding that change is possible. The counselor, as the agent of change, is likely to have little power if her family cannot be mobilized as advocates for her. Learning to speak (give voice to complaint) is, again, culturally proscribed; in fact, in some Asian cultures, silence is a specific way of communicating, especially of pain or anger. Through silence, these feelings are communicated without jeopardizing the family or its harmony. Yet, in domestically violent families the sanctity of the family must be challenged, and this cannot be done without breaking the code of silence. Learning to act on rights and legal privileges requires information, emotional support, and a level of assertiveness that likely surpasses much of what has been required or allowed the woman in the past. Choosing independence from the batterer has serious consequences for the minority woman. The mental health counselor should prepare the woman for these eventualities. Though there is no research on the occurrence of battered woman's syndrome (BWS) and how it is expressed in minority cultures, it seems that the symptom complex identified as BWS is very consistent with culturally prescribed behavior for many Asian women under many circumstances. Because of this similarity, BWS in Asian and Asian American women may be hard to detect.

In addition to the individual orientation that must be established in order for an intervention to occur, Ho (1990) suggests using the community, family, and social pressure as potent forces aiding intervention. Ho advocates capitalizing on Asian values concerning obedience to authority and hierarchy. Use of police intervention is reportedly very effective (Dao, 1988) and the general respect conferred on law and order facilitates compliance to court-mandated treatment and education. Ho (1990) also suggests that by mobilizing the process of shaming by family elders and community, the batterer may be confronted and the cultural imperative that the battered woman have loyalty to her husband can be superseded. Use of translators in treatment may be advised, but caution is recommended because of situations in which translators have editorialized on the communication, interjecting their own opinions about domestic violence, which are not necessarily helpful to the treatment (Ho, 1990; Dao, 1988; Kanuha, Chapter 15, this volume).

Similar to domestic violence, rape and incest occur but may not be interpreted as victimization, may be subsumed under male prerogative, and reporting may be inhibited by Asian values concerning shame and personal failure. Many of the intervention strategies outlined above may also apply to situations in which rape or incest must be addressed. Asian women most likely to have experienced sexual victimization are recent refugees of war, recent immigrants, and wives of servicemen. Although there is much more that can be said on this topic, the literature is sparse. There is probably a great deal to be learned from individual women, and thus these culturally taboo questions must be raised in treatment, thoroughly assessed, and culturally appropriate interventions must be attempted.

Lesbians

The topic of lesbians of color deserves special attention because the belief commonly held, as a result of sexist stereotypes and efforts by most communities of color to deny their existence, is that there are no lesbian women of color. Kanuha (1990) observes that lesbians' relative invisibility, which continues to characterize communities of color, relates to the adherence by communities of color to the use of sexism as a force for ensuring the control of women. She states that visibility of lesbians in their respective communities of color threatens the institutionalization of male domination, and that lesbians are perceived as betrayers of the community because of their perceived nonparticipation in the perpetuation of the race. The "triple jeopardy" of racism, sexism, and homophobia that faces lesbians of color essentially means there is no safe place, no place to belong, whether in the majority or minority community. Often as a result of this condition, violence occurs, further complicating the feelings of shame, guilt, and fear. For a complete analysis of the multiple oppressions lesbians of color face, Kanuha (1990) provides a feminist conceptualization as well as recommendations for intervention for abusers and victims of lesbian battering. Pamela H. (1989) deals more specifically with Asian lesbians, speaking more broadly about issues related to acceptance of self and by community. Both provide perspectives on the effects of cultural rejection by both the minority and the majority community.

CONCLUSIONS

The aim of this chapter has been to continue the trend, only recently begun, to break down monolithic treatment of Asians and Asian Americans as a single racial and ethnic group. In attempting to encourage a heterogeneous perspective that reflects the richness and complexity of Asian cultures both abroad and in the United States, the enormity of the task became apparent. Consequently, there is much in the chapter that has been neglected. The hope is to stir an awakening for the need to research more diligently and specifically the individual context with which we are faced when we deal with Asian and Asian American women. The second aim is to face the task of speaking directly to the needs and conditions of Asian women in a way that enhances what little has already been done, and in a way that encourages more analysis and experience. Asian women, if they are to be viewed in their true contexts, would virtually fill volumes.

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