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Chapter 2 Culture Counts: The Influence of Culture and Society on Mental Health

Introduction

To better understand what happens inside the clinical setting, this chapter looks outside. It reveals the diverse effects of culture and society on mental health, mental illness, and mental health services. This understanding is key to developing mental health services that are more responsive to the cultural and social contexts of racial and ethnic minorities.

With a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting. It can account for minor variations in how people communicate their symptoms and which ones they report. Some aspects of culture may also underlie *culture-bound syndromes* - sets of symptoms much more common in some societies than in others. More often, culture bears on whether people even seek help in the first place, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental illness. Culture also influences the *meanings* that people impart to their illness. Consumers of mental health services, whose cultures vary both between and within groups, naturally carry this diversity directly to the service setting.

The cultures of the clinician and the service system also factor into the clinical equation. Those cultures most visibly shape the interaction with the mental health consumer through diagnosis, treatment, and organization and financing of services. It is all too easy to lose sight of the importance of culture - until one leaves the country. Travelers from the United States, while visiting some distant frontier, may find themselves stranded in miscommunications and seemingly unorthodox treatments if they seek care for a sudden deterioration in their mental health.

Health and mental health care in the United States are embedded in Western science and medicine, which emphasize scientific inquiry and objective evidence. The self-correcting features of modern science - new methods, peer review, and openness to scrutiny through publication in professional journals - ensure that as knowledge is developed, it builds on, refines, and often replaces older theories and discoveries. The achievements of Western medicine have become the cornerstone of health care worldwide.

What follows are numerous examples of the ways in which culture influences mental health, mental illness, and mental health services. This chapter is meant to be illustrative, not exhaustive. It looks at the culture of the patient, the culture of the clinician, and the specialty in which the clinician works. With respect to the context of mental health services, the chapter deals with the organization, delivery, and financing of services, as well as with broader social issues - racism, discrimination, and poverty - which affect mental health.

Culture refers to a groups shared set of beliefs, norms, and values (Chapter 1). Because common social groupings (e.g., people who share a religion, youth who participate in the same sport, or adults trained in the same profession) have their own cultures, this chapter has separate sections on the culture of the patient as well as the culture of the clinician. Where cultural influences end and larger societal influences begin, there are contours not easily demarcated by social scientists. This chapter takes a broad view about the importance of both culture and society, yet recognizes that they overlap in ways that are difficult to disentangle through research.

What becomes clear is that culture and social contexts, while not the only determinants, shape the mental health of minorities and alter the types of mental health services they use. Cultural misunderstandings between patient and clinician, clinician bias, and the fragmentation of mental health services deter minorities from accessing and utilizing care and prevent them from receiving appropriate care. These possibilities intensify with the demographic trends highlighted at the end of the chapter.

Culture of the Patient

The culture of the patient, also known as the consumer of mental health services, influences many aspects of mental health, mental illness, and patterns of health care utilization. One important cautionary note, however, is that general statements about cultural characteristics of a given group may invite stereotyping of individuals

based on their appearance or affiliation. Because there is usually more diversity within a population than there is between populations (e.g., in terms of level of acculturation, age, income, health status, and social class), information in the following sections should not be treated as stereotypes to be broadly applied to any individual member of a racial, ethnic, or cultural group.

Symptoms, Presentation, and Meaning

The symptoms of mental disorders are found worldwide. They cluster into discrete disorders that are real and disabling (U.S. Department of Health and Human Services [DHHS], 1999). As noted in Chapter 1, mental disorders are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 1994). Schizophrenia, bipolar disorder, panic disorder, obsessive compulsive disorder, depression, and other disorders have similar and recognizable symptoms throughout the world (Weissman et al., 1994, 1996, 1997, 1998). Culture-bound syndromes, which appear to be distinctive to certain ethnic groups, are the exception to this general statement. Research has not yet determined whether culture-bound syndromes are distinct ¹ from established mental disorders, are variants of them, or whether *both* mental disorders and culture-bound syndromes reflect different ways in which the cultural and social environment interacts with genes to shape illness (Chapter 1).

One way in which culture affects mental illness is through how patients describe (or present) their symptoms to their clinicians. There are some well recognized differences in symptom presentation across cultures. The previous chapter described ethnic variation in symptoms of somatization, the expression of distress through one or more physical (somatic) symptoms (Box 1-3). Asian patients, for example, are more likely to report their somatic symptoms, such as dizziness, while not reporting their emotional symptoms. Yet, when questioned further, they do acknowledge having emotional symptoms (Lin & Cheung, 1999). This finding supports the view that patients in different cultures tend to selectively express or present symptoms in culturally acceptable ways (Kleinman, 1977, 1988).

Cultures also vary with respect to the *meaning* they impart to illness, their way of making sense of the subjective experience of illness and distress (Kleinman, 1988). The meaning of an illness refers to deep-seated attitudes and beliefs a culture holds about whether an illness is "real" or "imagined," whether it is of the body or the mind (or both), whether it warrants sympathy, how much stigma surrounds it, what might cause it, and what type of person might succumb to it. Cultural meanings of illness have real consequences in terms of whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help (mental health specialist, primary care provider, clergy, and/or traditional healer), the pathways they take to get services, and how well they fare in treatment. The consequences can be grave - extreme distress, disability, and possibly, suicide - when people with severe mental illness do not receive appropriate treatment.

Causation and Prevalence

Cultural and social factors contribute to the causation of mental illness, yet that contribution varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any one of these major factors can be stronger or weaker depending on the disorder (DHHS, 1999).

The prevalence of schizophrenia, for example, is similar throughout the world (about 1 percent of the population), according to the *International Pilot Study on Schizophrenia*, which examined over 1,300 people in 10 countries (World Health Organization [WHO], 1973). International studies using similarly rigorous research methodology have extended the WHO's findings to two other disorders: The lifetime prevalence of bipolar disorder (0.3-1.5%) and panic disorder (0.4-2.9%) were shown to be relatively consistent across parts of Asia, Europe, and North America (Weissman et al., 1994, 1996, 1997, 1998). The global consistency in symptoms and prevalence of these disorders, combined with results of family and molecular genetic studies, indicates that they have high heritability (genetic contribution to the variation of a disease in a population) (National Institute of Mental Health [NIMH], 1998). In other words, it seems that culture and societal factors play a more sub-ordinate role in causation of these disorders.

Cultural and social context weigh more heavily in causation of depression. In the same international studies cited above, prevalence rates for major depression varied from 2 to 19 percent across countries (Weissman et al., 1996). Family and molecular biology studies also indicate less heritability for major depression than for bipolar disorder and schizophrenia (NIMH, 1998). Taken together, the evidence points to social and cultural factors, including exposure to poverty and violence, playing a greater role in the onset of major depression. *In this context, it is important to note that poverty, violence, and other stressful social environments are not unique to any part of the globe, nor are the symptoms and manifestations they produce. However, factors often linked to race or ethnicity, such as socioeconomic status or country of origin can increase the likelihood of exposure to*

these types of stressors.

Cultural and social factors have the most direct role in the causation of post-traumatic stress disorder (PTSD). PTSD is a mental disorder caused by exposure to severe trauma, such as genocide, war combat, torture, or the extreme threat of death or serious injury (APA, 1994). These traumatic experiences are associated with the later development of a longstanding pattern of symptoms accompanied by biological changes (Yehuda, 2000). Traumatic experiences are particularly common for certain populations, such as U.S. combat veterans, inner-city residents, and immigrants from countries in turmoil. Studies described in the chapters on Asian Americans and Hispanic Americans reveal alarming rates of PTSD in communities with a high degree of pre-immigration exposure to trauma (Chapters 5 and 6). For example, in some samples, up to 70 percent of refugees from Vietnam, Cambodia, and Laos met diagnostic criteria for PTSD. By contrast, studies of the U.S. population as a whole find PTSD to have a prevalence of about 4 percent (DHHS, 1999).

Suicide rates vary greatly across countries, as well as across U.S. ethnic sub-groups (Moscicki, 1995). Suicide rates among males in the United States are highest for American Indians and Alaska Natives (Kachur et al., 1995). Rates are lowest for African American women (Kachur et al., 1995). The reasons for the wide divergence in rates are not well understood, but they are likely influenced by variations in the social and cultural contexts for each subgroup (van Heeringen et al., 2000; Ji et al., 2001).

Even though there are similarities and differences in the distribution of certain mental disorders across populations, the United States has an aggregate rate of about 20 percent of adults and children with diagnosable mental disorders (DHHS, 1999; Table 1-1). As noted in Chapter 1, this aggregate rate for the population as a whole does not have sufficient representation from most minority groups to permit comparisons between whites and other ethnic groups. The rates of mental disorder are not sufficiently studied in many smaller ethnic groups to permit firm conclusions about overall prevalence; however, several epidemiological studies of ethnic populations, supported by the NIMH, are currently in progress (Chapter 7). Until more definitive findings are available, *this Supplement concludes, on the basis of smaller studies, that overall prevalence rates for mental disorders in the United States are similar across minority and majority populations.* As noted in Chapter 1, this general conclusion applies to racial and ethnic minority populations living in the community, because high-need subgroups are not well captured in community household surveys.

Family Factors

Many features of family life have a bearing on mental health and mental illness. Starting with etiology, Chapter 1 highlighted that family factors can protect against, or contribute to, the risk of developing a mental illness. For example, supportive families and good sibling relationships can protect against the onset of mental illness. On the other hand, a family environment marked by severe marital discord, overcrowding, and social disadvantage can contribute to the onset of mental illness. Conditions such as child abuse, neglect, and sexual abuse also place children at risk for mental disorders and suicide (Brown et al., 1999; Dinwiddie et al., 2000).

Family risk and protective factors for mental illness vary across ethnic groups. But research has not yet reached the point of identifying whether the variation across ethnic groups is a result of that group's culture, its social class and relationship to the broader society, or individual features of family members.

One of the most developed lines of research on family factors and mental illness deals with relapse in schizophrenia. The first studies, conducted in Great Britain, found that people with schizophrenia who returned from hospitalizations to live with family members who expressed criticism, hostility, or emotional involvement (called *high expressed emotion*) were more likely to relapse than were those who returned to family members who expressed lower levels of negative emotion (Leff & Vaughn, 1985; Kavanaugh, 1992; Bebbington & Kuipers, 1994; Lopez & Guarnaccia, 2000). Later studies extended this line of research to Mexican American samples. These studies reconceptualized the role of family as a dynamic interaction between patients and their families, rather than as static family characteristics (Jenkins, Kleinman, & Good, 1991; Jenkins, 1993). Using this approach, a study comparing Mexican American and white families found that different types of interactions predicted relapse. For the Mexican American families, interactions featuring distance or lack of warmth predicted relapse for the individual with schizophrenia better than interactions featuring criticism. For whites, the converse was true (Lopez et al., 1998). This example, while not necessarily generalizable to other Hispanic groups, suggests avenues by which other culturally based family differences may be related to the course of mental illness.

Coping Styles

Culture relates to how people cope with everyday problems and more extreme types of adversity. Some Asian American groups, for example, tend not to dwell on upsetting thoughts, thinking that reticence or avoidance is better than outward expression. They place a higher emphasis on suppression of affect (Hsu, 1971; Kleinman, 1977, with some tending first to rely on themselves to cope with distress (Narikiyo & Kameoka, 1992). African

Americans tend to take an active approach in facing personal problems, rather than avoiding them (Broman, 1996). They are more inclined than whites to depend on handling distress on their own (Sussman et al., 1987). They also appear to rely more on spirituality to help them cope with adversity and symptoms of mental illness (Broman, 1996; Cooper-Patrick et al., 1997; Neighbors et al., 1998).

Few doubt the importance of culture in fostering different ways of coping, but research is sparse. One of the few, yet well developed lines of research on coping styles comes from comparisons of children living in Thailand versus America. Thailand's largely Buddhist religion and culture encourage self-control, emotional restraint, and social inhibition. In a recent study, Thai children were two times more likely than American children to report reliance on covert coping methods such as "not talking back," than on overt coping methods such as "screaming" and "running away" (McCarty et al., 1999). Other studies by these investigators established that different coping styles are associated with different types and degrees of problem behaviors in children (Weisz et al., 1997).

The studies noted here suggest that better understanding of coping styles among racial and ethnic minorities has implications for the promotion of mental health, the prevention of mental illness, and the nature and severity of mental health problems.

Treatment Seeking

It is well documented that racial and ethnic minorities in the United States are less likely than whites to seek mental health treatment, which largely accounts for their under-representation in most mental health services (Sussman et al., 1987; Kessler et al., 1996; Vega et al., 1998; Zhang et al., 1998). Treatment seeking denotes the pathways taken to reach treatment and the types of treatments sought (Rogler & Cortes, 1993). The pathways are the sequence of contacts and their duration once someone (or their family) recognizes their distress as a health problem.

Research indicates that some minority groups are more likely than whites to delay seeking treatment until symptoms are more severe (See Chapters 3 & 5). Further, racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists (Gallo et al., 1995; Chun et al., 1996; Zhang et al., 1998). Instead, studies indicate that minorities turn more often to primary care (Cooper-Patrick et al., 1999a; see later section on *Primary Care*). They also turn to informal sources of care such as clergy, traditional healers, and family and friends (Neighbors & Jackson, 1984; Peifer et al., 2000). In particular, American Indians and Alaska Natives often rely on traditional healers, who frequently work side-by-side with formal providers in tribal mental health programs (Chapter 4). African Americans often rely on ministers, who may play various mental health roles as counselor, diagnostician, or referral agent (Levin, 1986). The extent to which minority groups rely on informal sources in lieu of, or in addition to, formal mental health services in primary or specialty care is not well studied.

When they use mental health services, Some African Americans prefer therapists of the same race or ethnicity. This preference has encouraged the development of ethnic-specific programs that match patients to therapists of the same culture or ethnicity (Sue, 1998). Many African Americans also prefer counseling to drug therapy (Dwight-Johnson et al., 2000). Their concerns revolve around side effects, effectiveness, and addiction potential of medications (Cooper-Patrick et al., 1997).

The fundamental question raised by this line of research is: Why are many racial and ethnic minorities less inclined than whites to seek mental health treatment? Certainly, the constellation of barriers deterring whites also operates to various degrees for minorities - cost, fragmentation of services, and the societal stigma on mental illness (DHHS, 1999). But there are extra barriers deterring racial and ethnic minorities such as mistrust and limited English proficiency.

Mistrust

Mistrust was identified by the SGR as a major barrier to the receipt of mental health treatment by racial and ethnic minorities (DHHS, 1999). Mistrust is widely accepted as pervasive among minorities, yet there is surprisingly little empirical research to document it (Cooper-Patrick et al., 1999). One of the few studies on this topic looked at African Americans and whites surveyed in the early 1980s in a national study known as the Epidemiologic Catchment Area (ECA) study. This study found that African Americans with major depression were more likely to cite their fears of hospitalization and of treatment as reasons for not seeking mental health treatment. For instance, almost half of African Americans, as opposed to 20 percent of whites, reported being afraid of mental health treatment (Sussman et al., 1987).

What are the reasons behind the lack of trust? Mistrust of clinicians by minorities arises, in the broadest sense, from historical persecution and from present-day struggles with racism and discrimination. It also arises from documented abuses and perceived mistreatment, both in the past and more recently, by medical and mental

health professionals Neal-Barnett & Smith, 1997; see later section on "Clinician Bias and Stereotyping");). A recent survey conducted for the Kaiser Family Foundation (Brown et al., 1999) found that 12 percent of African Americans and 15 percent of Latinos, in comparison with 1 percent of whites, felt that a doctor or health provider judged them unfairly or treated them with disrespect because of their race or ethnic background. Even stronger ethnic differences were reported in the Commonwealth Fund Minority Health Survey: It found that 43 percent of African Americans and 28 percent of Latinos, in comparison with 5 percent of whites, felt that a health care provider treated them badly because of their race or ethnic background (LaVeist et al., 2000). Mistrust of mental health professionals is exploited by present day antipsychiatry groups that target the African American community with incendiary material about purported abuses and mistreatment (Bell, 1996).

Mistrustful attitudes also may be commonplace among other groups. While insufficiently studied, mistrust toward health care providers can be inferred from a group's attitudes toward government-operated institutions. Immigrants and refugees from many regions of the world, including Central and South America and Southeast Asia, feel extreme mistrust of government, based on atrocities committed in their country of origin and on fear of deportation by U.S. authorities. Similarly, many American Indians and Alaska Natives are mistrustful of health care institutions; this dates back through centuries of legalized discrimination and segregation, as discussed in Chapter 4.

Stigma

Stigma was portrayed by the SGR as the "most formidable obstacle to future progress in the arena of mental illness and health" (DHHS, 1999). It refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999).

Stigma is widespread in the United States and other Western nations Bhugra, 1989; Brockington et al., 1993 and in Asian nations (Ng, 1997. In response to societal stigma, people with mental problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment Sussman et al., 1987; Wahl, 1999. Stigma also lowers their access to resources and opportunities, such as housing and employment, and leads to diminished self-esteem and greater isolation and hopelessness Penn & Martin, 1998; Corrigan & Penn, 1999. Stigma can also be against family members; this damages the consumer's self-esteem and family relationships (Wahl & Harman, 1989). In some Asian cultures, stigma is so extreme that mental illness is thought to reflect poorly on family lineage and thereby diminishes marriage and economic prospects for other family members as well Sue & Morishima, 1982; Ng, 1997).

Stigma is such a major problem that the very topic itself poses a challenge to research. Researchers have to contend with people's reluctance to disclose attitudes often deemed socially unacceptable. How stigma varies by culture can be studied from two perspectives. One perspective is that of the targets of stigma, i.e., the people with symptoms: If they are members of a racial or ethnic minority, are they more likely than whites to experience stigma? The other perspective is that of the public in their attitudes toward people with mental illness: Are members of each racial or ethnic minority group more likely than whites to hold stigmatizing attitudes toward mental illness? The answers to these cross-cultural questions are far from definitive, but there are some interesting clues from research.

Turning first to those who experience symptoms, one of the few cross-cultural studies questioned Asian Americans living in Los Angeles. The findings were eye-opening: Only 12 percent of Asians would mention their mental health problems to a friend or relative (versus 25 percent of whites). A meager 4 percent of Asians would seek help from a psychiatrist or specialist (versus 26 percent of whites). And only 3 percent of Asians would seek help from a physician (versus 13 percent of whites). The study concluded that stigma was pervasive and pronounced for Asian Americans in Los Angeles (Zhang et al., 1998).

Turning to the question of public attitudes toward mental illness, the largest and most detailed study of stigma in the United States was performed in 1996 as part of the General Social Survey, a respected, nationally representative survey being conducted by the National Opinion Research Center since the 1970s. In this study, a representative sample was asked in personal interviews to respond to different vignettes depicting people with mental illness. The respondents generally viewed people with mental illness as dangerous and less competent to handle their own affairs, with their harshest judgments reserved for people with schizophrenia and substance use disorders. Interestingly, neither the ethnicity of the respondent, nor the ethnicity of the person portrayed in the vignette, seemed to influence the degree of stigma (Pescosolido et al., 1999).

By contrast, another large, nationally representative study found a different relationship between race, ethnicity, and attitudes towards patients with mental illness. Asian and Hispanic Americans saw them as more dangerous than did whites. Although having contact with individuals with mental illness helped to reduce stigma for whites, it did not for African Americans. American Indians, on the other hand, held attitudes similar to whites (Whaley, 1997).

Taken together, these results suggest that minorities hold similar, and in some cases stronger, stigmatizing

attitudes toward mental illness than do whites. Societal stigma keeps minorities from seeking needed mental health care, much as it does for whites. Stigma is so potent that it not only affects the self-esteem of people with mental illness, but also that of family members. The bottom line is that stigma does deter major segments of the population, majority and minority alike, from seeking help. It bears repeating that a majority of *all* people with diagnosable mental disorders do not get treatment (DHHS, 1999).

Immigration

Migration, a stressful life event, can influence mental health. Often called acculturative stress, it occurs during the process of adapting to a new culture (Berry et al., 1987). Refugees who leave their homelands because of extreme threat from political forces tend to experience more trauma, more undesirable change, and less control over the events that define their exits than do voluntary immigrants Rumbaut, 1985; Meinhardt et al., 1986.

The psychological stress associated with immigration tends to be concentrated in the first three years after arrival in the United States (Vega & Rumbaut, 1991). According to studies of Southeast Asian refugees, an initial euphoria often characterizes the first year following migration, followed by a strong disenchantment and demoralization reaction during the second year. The third year includes a gradual return to well-being and satisfaction (Rumbaut, 1985, 1989). This U-shaped curve has been observed in Cubans and Eastern Europeans (Portes & Rumbaut, 1990). Similarly, Ying (1988) finds that Chinese immigrants who have been in the United States less than one year have fewer symptoms of distress than those residing here for several years. Korean American immigrants have been found to have the highest levels of depressive symptoms in the one to two years following immigration; after three years, these symptoms remit (Huh & Kim, 1988).

Although immigration can bring stress and subsequent psychological distress, research results do not suggest that immigration *per se* results in higher rates of mental disorders (e.g., Vega et al., 1998). However, as described in the chapters on Asian Americans and Latinos, the traumas experienced by adults and children from war-torn countries before and after immigrating to the United States seem to result in high rates of post-traumatic stress disorder (PTSD) among these populations.

Overall Health Status

The burden of illness in the United States is higher in racial and ethnic minorities than whites. The National Institutes of Health (NIH) recently reported that compared with the majority populations, U.S. minority populations have shorter overall life expectancies and higher rates of cardiovascular disease, cancer, infant mortality, birth defects, asthma, diabetes, stroke, adverse consequences of substance abuse, and sexually transmitted diseases DHHS, 2000; NIH, 2000. The list of illnesses is overpoweringly long.

Disparities in health status have led to high-profile research and policy initiatives. One long-standing policy initiative is *Healthy People*, a comprehensive set of national health objectives issued every decade by the Department of Health and Human Services. The most recent is *Healthy People 2010*, which contains both well defined objectives for reducing health disparities and the means for monitoring progress (DHHS, 2000).

Higher rates of physical (somatic) disorders among racial and ethnic minorities hold significant implications for mental health. For example, minority individuals who do not have mental disorders are at higher risk for developing problems such as depression and anxiety because chronic physical illness is a risk factor for mental disorders DHHS, 1999; see also earlier section. Moreover, individuals from racial and ethnic minority groups who *already* have both a mental and a physical disorder (known as comorbidity) are more likely to have their mental disorder missed or misdiagnosed, owing to competing demands on primary care providers who are preoccupied with the treatment of the somatic disorder Borowsky, et al., 2000; Rost et al., 2000. Even if their mental disorder is recognized and treated, people with comorbid disorders are saddled by more drug interactions and side effects, given their higher usage of medications. Finally, people with comorbid disorders are much more likely to be unemployed and disabled, compared with people who have a single disability (Druss et al., 2000).

Thus, poor somatic health takes a toll on mental health. And it is probable that some of the mental health disparities described in this Supplement are linked to the poorer somatic health status of racial and ethnic minorities. The interrelationships between mind and body are inescapably evident.

Culture of the Clinician

As noted earlier, a group of professionals can be said to have a "culture" in the sense that they have a shared set of beliefs, norms, and values. This culture is reflected in the jargon members of a group use, in the orientation and emphasis in their textbooks, and in their mindset, or way of looking at the world.

Health professionals in the United States, and the institutions in which they train and practice, are rooted in Western medicine. The culture of Western medicine, launched in ancient Greece, emphasizes the primacy of the human body in disease. ² Further, Western medicine emphasizes the acquisition of knowledge through scientific

and empirical methods, which hold objectivity paramount. Through these methods, Western medicine strives to uncover universal truths about disease, its causation, diagnosis, and treatment.

Around 1900, Western medicine started to conceptualize disease as affected by social, as well as by biological phenomena. Its scope began to incorporate wider questions of income, lifestyle, diet, employment, and family structure, thereby ushering in the broader field of public health [Porter, 1997](#); see also [Chapter 1](#).

Mental health professionals trace their roots to Western medicine and, more particularly, to two major European milestones - the first forms of biological psychiatry in the mid-19th century and the advent of psychotherapy (or "talk therapy") near the end of that century ([Shorter, 1997](#)). The earliest forms of biological psychiatry primed the path for more than a century of advances in pharmacological therapy, or drug treatment, for mental illness. The original psychotherapy, known as psychoanalysis, was founded in Vienna by Sigmund Freud. While many forms of psychotherapy are available today, with vastly different orientations, all emphasize verbal communication between patient and therapist as the basis of treatment. Today's treatments for specific mental disorders also may combine pharmacological therapy and psychotherapy; this approach is known as multimodal therapy. These two types of treatment and the intellectual and scientific traditions that galvanized their development are an outgrowth of Western medicine.

To say that physicians or mental health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the interrelationship among body, mind, and environment, informed by knowledge acquired through the scientific method. It also means that clinicians view symptoms, diagnoses, and treatments in a manner that sometimes diverges from their patients. "[Clinicians'] conceptions of disease and [their] responses to it unquestionably show the imprint of [a] particular culture, especially its individualist and activist therapeutic mentality," writes sociologist of medicine [Paul Starr \(1982\)](#).

Because of the professional culture of the clinician, some degree of distance between clinician and patient always exists, regardless of the ethnicity of each ([Burkett, 1991](#)). Clinicians also bring to the therapeutic setting their own personal cultures [Hunt, 1995](#); [Porter, 1997](#). Thus, when clinician and patient do not come from the same ethnic or cultural background, there is greater potential for cultural differences to emerge. Clinicians may be more likely to ignore symptoms that the patient deems important, or less likely to understand the patient's fears, concerns, and needs. The clinician and the patient also may harbor different assumptions about what a clinician is supposed to do, how a patient should act, what causes the illness, and what treatments are available. For these reasons, *DSM-IV* exhorts clinicians to understand how their relationship with the patient is affected by cultural differences ([Chapter 1](#)).

Communication

The emphasis on verbal communication is a distinguishing feature of the mental health field. The diagnosis and treatment of mental disorders depend to a large extent on verbal communication between patient and clinician about symptoms, their nature, intensity, and impact on functioning ([Chapter 1](#)). While many mental health professionals strive to deliver treatment that is sensitive to the culture of the patient, problems can occur.

The emphasis on verbal communication yields greater potential for miscommunication when clinician and patient come from different cultural backgrounds, even if they speak the same language. Overt and subtle forms of miscommunication and misunderstanding can lead to misdiagnosis, conflicts over treatment, and poor adherence to a treatment plan. But when patient and clinician do not speak the same language, these problems intensify. The importance of cross-cultural communication in establishing trusting relationships between clinician and patient is just beginning to be explored through research in family practice ([Cooper-Patrick et al., 1999](#)) and mental health (see later section on "[Culturally Competent Services](#)").

Primary Care

Primary care is a critical portal to mental health treatment for ethnic and racial minorities. Minorities are more likely to seek help in primary care as opposed to specialty care, and cross-cultural problems may surface in either setting ([Cooper-Patrick et al., 1999](#)). Primary care providers, particularly under the constraints of managed care, may not have the time or capacity to recognize and diagnose mental disorders or to treat them adequately, especially if patients have co-existing physical disorders ([Rost et al., 2000](#)). Some estimates suggest that about one-third to one-half of patients with mental disorders go undiagnosed in primary care settings [Higgins, 1994](#); [Williams et al., 1999](#). Minority patients are among those at greatest risk of nondetection of mental disorders in primary care ([Borowsky et al., 2000](#)). Missed or incorrect diagnoses carry severe consequences if patients are given inappropriate or possibly harmful treatments, while their underlying mental disorder is left untreated.

Clinician Bias and Stereotyping

Misdiagnosis also can arise from clinician bias and stereotyping of ethnic and racial minorities. Clinicians often reflect the attitudes and discriminatory practices of their society (Whaley, 1998). This institutional racism was evident over a century ago with the establishment of a separate, completely segregated mental hospital in Virginia for African American patients (Prudhomme & Musto, 1973). While racism and discrimination have certainly diminished over time, there are traces today which are manifest in less overt medical practices concerning diagnosis, treatment, prescribing medications, and referrals (Giles et al., 1995; Shiefer, Escarce, & Schulman, 2000). One study from the mental health field found that African American youth were four times more likely than whites to be physically restrained after acting in similarly aggressive ways, suggesting that racial stereotypes of blacks as violent motivated the professional judgment to have them restrained (Bond et al., 1988). Another study found that white therapists rated a videotape of an African American client with depression more negatively than they did a white patient with identical symptoms (Jenkins-Hall & Sacco, 1991).

There is ample documentation provided in Chapter 3 that African American patients are subject to overdiagnosis of schizophrenia. African Americans are also underdiagnosed for bipolar disorder (Bell et al., 1980, 1981; Mukherjee, et al., 1983, depression, and, possibly, anxiety (Neal-Barnett & Smith, 1997; Baker & Bell, 1999; Borowsky et al., 2000). The problems extend beyond African Americans. Widely held stereotypes of Asian Americans as "problem free" may prompt clinicians to overlook their mental health problems (Takeuchi & Uehara, 1996).

The following chapters of this Supplement each cover diagnostic errors and inappropriate treatment in greater detail. They also address the extent to which each racial or ethnic minority group utilizes services or receives treatment in conformance with treatment guidelines developed from controlled clinical trials. For example, minority patients are less likely than whites to receive the best available treatments for depression and anxiety (Wang et al., 2000; Young et al., 2001).

To infer a role for bias and stereotyping by clinicians does not prove that it is actually occurring, nor does it indicate the extent to which it explains disparities in mental health services. Some of the racial and ethnic disparities described in this Supplement are likely the result of racism³ and discrimination by white clinicians; however, the limited research on this topic suggests that the issue is more complex. A large study of cardiac patients could not attribute African Americans' lower utilization of a cardiac procedure to the race of the physician. Lower utilization by African American versus white patients was independent of whether patients were treated by white or black physicians (Chen et al., 2001). The study authors suggested the possibility that institutional factors and attitudes that were common to black and white physicians contributed to lower rates of utilization by black patients. Some have suggested that what appears to be racial bias by clinicians might instead reflect biases of their socioeconomic status or their professional culture (Epstein & Ayanian, 2001). These biases, whether intentional or unintentional, may be more powerful influences on care than the influence of the clinician's own race or ethnicity.

Culture, Society, and Mental Health Services

Every society influences mental health treatment by how it organizes, delivers, and pays for mental health services. In the United States, services are financed and delivered in vastly different ways than in other nations. That organization was shaped by and reflects a unique set of historical, economic, political, and social forces, which were summarized in the SGR (DHHS, 1999). The mental health service system is a fragmented patchwork, often referred to as the "*de facto* mental health system" because of its lack of a single set of organizing principles (Regier et al., 1993). While this hybrid system serves a range of functions for many people, it has not successfully addressed the problem that people with the most complex needs and the fewest financial resources often find it difficult to use. This problem is magnified for minority groups. To understand the obstacles that minorities face, this section provides background on mental health service settings, financing, and the concept of culturally competent services.

Service Settings and Sectors

Mental health services are provided by numerous types of practitioners in a diverse array of environments, variously called settings and sectors. Settings range from home and community to institutions, and sectors include public or private primary care and specialty care. This section provides a broad overview of mental health services, patterns of use, and trends in financing. Interested readers are referred to the SGR, which covers these topics in greater detail.

The burgeoning types of community services available today stand in sharp contrast to the institutional orientation of the past. Propelled by reform movements, advocacy, and the advent of managed care, today's best mental health services extend beyond diagnosis and treatment to cover prevention and the fulfillment of broader needs, including housing and employment. Services are formal (provided by professionals) or informal (provided by lay volunteers). The most fundamental shift has been in the setting for service delivery, from the institution to

the community.

There are four major sectors for receiving mental health care:

1. The specialty mental health sector is designed solely for the provision of mental health services. It refers to mental hospitals, residential treatment facilities, and psychiatric units of general hospitals. It also refers to specialized agencies and programs in the community, such as community mental health centers, day treatment programs, and rehabilitation programs. Within these settings, services are furnished by specialized mental health professionals, such as psychologists, psychiatric nurses, psychiatrists, and psychiatric social workers;
2. The general medical and primary care sector offers a comprehensive range of health care services including, but not limited to, mental health services. Primary care physicians, nurse practitioners, internists, and pediatricians are the general types of professionals who practice in a range of settings that include clinics, offices, community health centers, and hospitals;
3. The human services sector is made up of social welfare (housing, transportation, and employment), criminal justice, educational, religious, and charitable services. These services are delivered in a full range of settings - home, community, and institutions;
4. The voluntary support network refers to self-help groups and organizations devoted to education, communication, and support. Services provided by the voluntary support network are largely found in the community. Typically informal in nature, they often help patients and families increase knowledge, reduce feelings of isolation, obtain referrals to formal treatment, and cope with mental health problems and illnesses.

Consumers can exercise choice in treatment largely because of the range of effective treatments for mental illness and the diversity of settings and sectors in which these treatments are offered. Consumers can choose, too, between distinct treatment modalities, such as psychotherapy, counseling, pharmacotherapy (medications), or rehabilitation. For severe mental illnesses, however, all types are usually essential, as are delivery systems to integrate their services (DHHS, 1999).

Consumer preferences cannot necessarily be inferred from the types of treatment they actually use because costs, reimbursement, or availability of services - rather than preferences - may drive their utilization. For example, minority patients who wish to see mental health professionals of similar racial or ethnic backgrounds may often find it difficult or impossible, because most mental health practitioners are white. Because there are only 1.5 American Indian/Alaska Native psychiatrists per 100,000 American Indians/Alaska Natives in this country, and only 2.0 Hispanic psychiatrists per 100,000 Hispanics, the chance of an ethnic match between Native or Hispanic American patient and provider is highly unlikely (Manderscheid & Henderson, 1999).

Financing of Mental Health Services and Managed Care

Mental health services are financed from many funding streams that originate in the public and private sectors. In 1996, slightly more than half of the \$69 billion in mental health spending was by public payers, including Medicaid and Medicare. The remainder came mostly from either private insurance (27%) or out-of-pocket payments (17%) by patients and their families (DHHS, 1999).

One of the most significant changes affecting both privately and publicly funded services has been the striking shift to managed care. Relatively uncommon two decades ago, managed care in some form now covers the majority of Americans, regardless of whether their care is paid for through the public or the private sector (Levit & Lundy, 1998). The term "managed care" technically refers to a variety of mechanisms for organizing, delivering, and paying for health services. It is attractive to purchasers because it holds the promise of containing costs, increasing access to care, improving coordination of care, promoting evidence-based quality care, and emphasizing prevention. Attainment of these goals for all racial and ethnic groups is difficult to verify through research because of the breathtaking pace of change in the health care marketplace. Study in this area is also challenging because claims data are closely held by private companies and thus are often unavailable to researchers, and because insurers and providers often do not collect information about ethnicity or race (Fraser, 1997).

Almost 72 percent of Americans with health insurance in 1999 were enrolled in managed *behavioral* health organizations for mental or addictive disorders (OPEN MINDS, 1999). Managed care has far-reaching implications for mental health services in terms of access, utilization, and quality, yet there has been only a limited body of research on its effectiveness in these areas (DHHS, 1999).

Through lower costs, managed care was expected to boost access to care, which is especially critical for racial and ethnic minorities. However, there is preliminary evidence that managed care is perceived by some racial and ethnic minorities as imposing more barriers to treatment than does fee-for-service care (Scholle & Kelleher, 1997);

Provan & Carle, 2000. Yet, improved access alone will not eliminate disparities (Chapter 3). Other compelling factors curtail utilization of services by racial and ethnic minorities, and they need to be addressed to reduce the gap between minorities and whites (Chapter 7).

In terms of quality of care, the SGR noted ongoing efforts within behavioral health care to develop quality reporting systems. It also pointed out that existing incentives within and outside managed care do not encourage an emphasis on quality of care (DHHS, 1999). While the SGR concluded that there is little direct evidence of problems with quality in well implemented managed care programs, it cautioned that "the risk for more impaired populations and children remains a serious concern."

Finally, managed care has been coupled with legislative proposals to impose parity in financing of mental health services. Intended to reverse decades of inequity, parity seeks coverage for mental health services on a par with that for somatic (physical) illness. Managed care's potential to control costs through various management strategies that prevent overuse of services makes parity more economically feasible (DHHS, 1999). Studies described in the SGR found negligible cost increases under existing parity programs within several States. Further, several studies have shown that racial and ethnic disparities in access to health care and in treatment outcomes are reduced or eliminated under equal access systems such as the Department of Defense health care system Optenberg et al., 1995; Taylor et al., 1997, the VA medical system for some disease conditions, and in some health maintenance organizations Tambor et al., 1994; Martin, Shelby, & Zhang, 1995; Clancy & Franks, 1997.

Evidence-Based Treatment and Minorities

The SGR documented a comprehensive range of effective treatments for many mental disorders (DHHS, 1999). These evidence-based treatments rely on consistent scientific evidence, from controlled clinical trials, that they significantly improve patients' outcomes (Drake et al., 2001). Despite strong and consistent evidence of efficacy, the SGR spotlighted the problem that evidence-based treatments are not being translated into community settings and are not being provided to everyone who comes in for care.

Many reasons have been cited as underlying the gap between research and practice. The most significant are practitioners' lack of knowledge of research results, the lag time between reporting of results and their translation into the practice setting, and the cost of introducing innovative services into health systems, most of which are operating within a highly competitive marketplace. There are also fundamental differences in the health characteristics of patients studied in academic settings where the research is conducted versus practice settings where patients are much more heterogeneous and often disabled by more than one disorder (DHHS, 1999).

The gap between research and practice is even worse for racial and ethnic minorities. Problems span both research and practice settings. A special analysis performed for this Supplement reveals that controlled clinical trials used to generate professional treatment guidelines did not conduct specific analyses for any minority group (See Appendix A for complete analysis). Controlled clinical trials offer the highest level of scientific rigor for establishing that a given treatment works.

Several professional associations and government agencies have formulated treatment guidelines or evidence-based reports on treatment outcomes for certain disorders on the basis of consistent scientific evidence, across multiple controlled clinical trials. Since 1986, nearly 10,000 participants have been included in randomized clinical trials evaluating the efficacy of treatments for bipolar disorder, major depression, schizophrenia, and attention-deficit/hyperactivity disorder. However, for nearly half of these participants (4,991), no information on race or ethnicity is available.⁴ For another 7 percent of participants (N = 656), studies only reported the designation "non-white," without indicating a specific minority group. For the remaining 47 percent of participants (N = 4,335), Table 2-1 shows the breakdown by ethnicity. *In all clinical trials reporting data on ethnicity, very few minorities were included and not a single study analyzed the efficacy of the treatment by ethnicity or race.*⁵ A similar conclusion was reached by the American Psychological Association in a careful analysis of all empirically validated psychotherapies: "We know of no psychotherapy treatment research that meets basic criteria important for demonstrating treatment efficacy for ethnic minority populations..." (Chambless et al., 1996).

The failure to conduct ethnic-specific analyses in clinical research is a problem that must be addressed the health characteristics of patients (Chapter 7). This problem is not unique to the mental health field; it affects all areas of health research. In 1993, Congress passed legislation creating the National Institute of Health's Office of Research on Minority Health to increase the representation of minorities in all aspects of biomedical and behavioral research (National Institutes of Health, 2001). In November 2000, the Minority Health Disparities Research and Education Act elevated the Office of Research on Minority Health to the National Center on Minority Health and Health Disparities. This gave NIH increased programmatic and budget authority for research on minority health issues and health disparities. The law also promotes more training and education of health professionals, the evaluation of data collection systems, and a national public awareness campaign.

Even though the treatment guidelines are extrapolated from largely white populations, they are, as a matter of public health prudence, the best available treatments for everyone, regardless of race or ethnicity. Yet evidence suggests that in clinical practice settings, minorities are less likely than whites to receive treatment that adheres to treatment guidelines (Chapters 3-6; see also Lehman & Steinwachs, 1998; Sclar et al., 1999; Blazer et al., 2000; Young et al., 2001). *Existing treatment guidelines should be used for all people with mental disorders, regardless of ethnicity or race.* But to be most effective, treatments need to be tailored and delivered appropriately for individuals according to age, gender, race, ethnicity, and culture (DHHS, 1999).

Culturally Competent Services

The last four decades have witnessed tremendous changes in mental health service delivery. The civil rights movement, the expansion of mental health services into the community, and the demographic shift toward greater population diversity led to a growing awareness of inadequacies of the mental health system in meeting the needs of ethnic and racial minorities Rogler et al., 1987; Takeuchi & Uehara, 1996. Research documented huge variations in utilization between minorities and whites, and it began to uncover the influence of culture on mental health and mental illness Snowden & Cheung, 1990; Sue et al., 1991. Major differences were found in some manifestations of mental disorders, idioms for communicating distress, and patterns of help-seeking. The natural outgrowth of research and public awareness was self-examination by the mental health field and the advent of consumer and family advocacy. As noted in Chapter 1, major recognition was given to the importance of culture in the assessment of mental illness with the publication of the "Outline for Culture Formulation" in DSM-IV (APA, 1994).

Another innovation was to take stock of the mental health treatment setting. This setting is arguably unique in terms of its strong reliance on language, communication, and trust between patients and providers. Key elements of therapeutic success depend on rapport and on the clinicians' understanding of patients' cultural identity, social supports, self-esteem, and reticence about treatment due to societal stigma. Advocates, practitioners, and policymakers, driven by widespread awareness of treatment inadequacies for minorities, began to press for a new treatment approach: the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values. This approach to service delivery, often referred to as cultural competence, has been promoted largely on the basis of humanistic values and intuitive sensibility rather than empirical evidence. Nevertheless, substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these groups will improve utilization and outcomes.

Cultural competence underscores the recognition of patients' cultures and then develops a set of skills, knowledge, and policies to deliver effective treatments (Sue & Sue, 1999). Underlying cultural competence is the conviction that services tailored to culture would be more inviting, would encourage minorities to get treatment, and would improve their outcome once in treatment. Cultural competence represents a fundamental shift in ethnic and race relations (Sue et al., 1998). The term *competence* places the responsibility on mental health services organizations and practitioners - most of whom are white (Peterson et al., 1996) - and challenges them to deliver culturally appropriate services. Yet the participation of consumers, families, and communities helping service systems design and carry out culturally appropriate services is also essential (Chapter 7).

Many models of cultural competence have been proposed. One of the most frequently cited models was developed in the context of care for children and adolescents with serious emotional disturbance (Cross et al., 1989). At the Federal level, efforts have begun to operationalize cultural competence for applied behavioral healthcare settings (CMHS, 2000). Though these and many other models have been proposed, few if any have been subject to empirical test. No empirical data are yet available as to what the key ingredients of cultural competence are and what influence, if any, they have on clinical outcomes for racial and ethnic minorities e.g., Sue & Zane, 1987; Ramirez, 1991; Pedersen & Ivey, 1993; Ridley et al., 1994; Lopez, 1997; Szapocznik et al. 1997; Falicov, 1998; Koss-Chioino & Vargas, 1999; Sue & Sue, 1999. A common theme across models of cultural competence, however, is that they make treatment effectiveness for a culturally diverse clientele the responsibility of the system, not of the people seeking treatment.

Later chapters of this Supplement describe the findings to date in relation to each ethnic or racial group. The main point is that cultural competence is more than the sum of its parts: It is a broad-based approach to transform the organization and delivery of all mental health services to meet the diverse needs of all patients.

Medications and Minorities

The introductory chapter of this Supplement emphasized the overall genetic similarities across ethnic groups and noted that while there may be some genetic polymorphisms that show mean differences between groups, these variations cannot be used to distinguish one population from another. Observed group differences are outweighed by shared genetic variation and may be correlates of lifestyle rather than genetic factors (Paabo, 2001). For example, researchers are finding some racial and ethnic differences in response to a heart medication (Exner et

al., 2001) that appear to reflect both genetic and environmental factors. It is nevertheless reasonable to assume that medications for mental disorders, in the absence of data to the contrary, are as effective for racial and ethnic minority groups as they are for whites.

Therefore, this Supplement encourages people with mental illness, regardless of race or ethnicity, to take advantage of scientific advances and seek effective pharmacological treatments for mental illness. As part of the standard practice of delivering medicine, clinicians always need to individualize therapies according to the age, gender, culture, ethnicity, and other life circumstances of the patient.

There is a growing body of research on subtle genetic differences in how medications are metabolized across certain ethnic populations. Similarly, this body of research also focuses on how lifestyles that are more common to a given ethnic group affect drug metabolism. Lifestyle factors include diet, rates of smoking, alcohol consumption, and use of alternative or complementary treatments. These factors can interact with drugs to alter their safety or effectiveness.

The relatively new field known as ethnopsychopharmacology investigates ethnic variations that affect medication dosing and other aspects of pharmacology. Most research in this field has focused on gene polymorphisms (DNA variations) affecting drug metabolizing enzymes. After drugs are taken by mouth, they enter the blood and are circulated to the liver, where they are metabolized by enzymes (proteins encoded by genes). Certain genetic variations affecting the functions of these enzymes are more common to particular racial or ethnic groups. The variations can affect the pace of drug metabolism: A faster rate of metabolism leaves less drug in the circulation, whereas a slower rate allows more drug to be recirculated to other parts of the body. For example, African Americans and Asians are, on average, more likely than whites to be slow metabolizers of several medications for psychosis and depression (Lin et al., 1997). Clinicians who are unaware of these differences may inadvertently prescribe doses that are too high for minority patients by giving them the dose normally prescribed for whites. This would lead to more medication side effects, patient nonadherence, and possibly greater risk of long-term, severe side effects such as tardive dyskinesia (Lin et al., 1997; Lin & Cheung, 1999).

A key point is that this area of research looks for frequency differences across populations, rather than between individuals. For example, one research study reported on population frequencies for a polymorphism linked to the breakdown of neurotransmitters. It found the particular polymorphism in 15 to 31 percent of East Asians, compared with 7 to 40 percent of Africans, and 33 to 62 percent of Europeans and Southwest Asians (Palmatier et al., 1999). It is important to note that these differences become apparent across populations, but do not apply to an individual seeking treatment (unless the clinician has specific knowledge about that person's genetic makeup, or genotype, or their medication blood levels). The concern about applying research regarding ethnically based differences in population frequencies of gene polymorphisms is that it will lead to stereotyping and racial profiling of individuals based on their physical appearance (Schwartz, 2001). For any individual, genetic variation in response to medications cannot be inferred from racial or ethnic group membership alone.

Racism, Discrimination, and Mental Health

Since its inception, America has struggled with its handling of matters related to race, ethnicity, and immigration. The histories of each racial and ethnic minority group attest to long periods of legalized discrimination - and more subtle forms of discrimination - within U.S. borders (Takaki, 1993). Ancestors of many of today's African Americans were forcibly brought to the United States as slaves. The Indian Removal Act of 1830 forced American Indians off their land and onto reservations in remote areas of the country that lacked natural resources and economic opportunities. The Chinese Exclusion Act of 1882 barred immigration from China to the U.S. and denied citizenship to Chinese Americans until it was repealed in 1952. Over 100,000 Japanese Americans were unconstitutionally incarcerated during World War II, yet none was ever shown to be disloyal. Many Mexican Americans, Puerto Ricans, and Pacific Islanders became U.S. citizens through conquest, not choice. Although racial and ethnic minorities cannot lay claim to being the sole recipients of maltreatment in the United States, legally sanctioned discrimination and exclusion of racial and ethnic minorities have been the rule, rather than the exception, for much of the history of this country. Each of the later chapters of this Supplement describes some of the key historical events that helped shape the contemporary mental health status of each group.

Racism and discrimination are umbrella terms referring to beliefs, attitudes, and practices that denigrate individuals or groups because of phenotypic characteristics (e.g., skin color and facial features) or ethnic group affiliation. Despite improvements over the last three decades, research continues to document racial discrimination in housing rentals and sales (Yinger, 1995) and in hiring practices (Kirschenman & Neckerman, 1991). Racism and discrimination also have been documented in the administration of medical care. They are manifest, for example, in fewer diagnostic and treatment procedures for African Americans versus whites (Giles et al., 1995; Shieffer et al., 2000). More generally, racism and discrimination take forms from demeaning daily insults to more severe events, such as hate crimes and other violence (Krieger et al., 1999). Racism and discrimination can be perpetrated by institutions or individuals, acting intentionally or unintentionally.

Public attitudes underlying discriminatory practices have been studied in several national surveys conducted over many decades. One of the most respected and nationally representative surveys is the General Social Survey, which in 1990 found that a significant percentage of whites held disparaging stereotypes of African Americans, Hispanics, and Asians. The most extreme findings were that 40 to 56 percent of whites endorsed the view that African Americans and Hispanics "prefer to live off welfare" and "are prone to violence" (Davis & Smith, 1990).

Minority groups commonly report experiences with racism and discrimination, and they consider these experiences to be stressful (Clark et al., 1999). In a national probability sample of minority groups and whites, African Americans and Hispanic Americans reported experiencing higher overall levels of global stress than did whites (Williams, 2000). The differences were greatest for two specific types: financial stress and stress from racial bias. Asian Americans also reported higher overall levels of stress and higher levels of stress from racial bias, but sampling methods did not permit statistical comparisons with other groups. American Indians and Alaska Natives were not studied (Williams, 2000).

Recent studies link the experience of racism to poorer mental and physical health. For example, racial inequalities may be the primary cause of differences in reported quality of life between African Americans and whites (Hughes & Thomas, 1998). Experiences of racism have been linked with hypertension among African Americans (Krieger & Sidney, 1996; Krieger et al., 1999). A study of African Americans found perceived discrimination to be associated with psychological distress, lower well-being, self-reported ill health, and number of days confined to bed (Williams et al., 1997; Ren et al., 1999).

A recent, nationally representative telephone survey looked more closely at two overall types of racism, their prevalence, and how they may differentially affect mental health (Kessler et al., 1999). One type of racism was termed "major discrimination" in reference to dramatic events like being "hassled by police" or "fired from a job." This form of discrimination was reported with a lifetime prevalence of 50 percent of African Americans, in contrast to 31 percent of whites. Major discrimination was associated with psychological distress and major depression in both groups. The other form of discrimination, termed "day-to-day perceived discrimination," was reported to be experienced "often" by almost 25 percent of African Americans and only 3 percent of whites. This form of discrimination was related to the development of distress and diagnoses of generalized anxiety and depression in African Americans and whites. The magnitude of the association between these two forms of discrimination and poorer mental health was similar to other commonly studied stressful life events, such as death of a loved one, divorce, or job loss.

While this line of research is largely focused on African Americans, there are a few studies of racism's impact on other racial and ethnic minorities. Perceived discrimination was linked to symptoms of depression in a large sample of 5,000 children of Asian, Latin American, and Caribbean immigrants (Rumbaut, 1994). Two recent studies found that perceived discrimination was highly related to depressive symptoms among adults of Mexican origin (Finch et al., 2000) and among Asians (Noh et al., 1999).

In summary, the findings indicate that racism and discrimination are clearly stressful events (see also Clark et al., 1999). Racism and discrimination adversely affect health and mental health, and they place minorities *at risk* for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention.

These and related findings have prompted researchers to ask how racism may jeopardize the mental health of minorities. Three general ways are proposed:

1. Racial stereotypes and negative images can be internalized, denigrating individuals' self-worth and adversely affecting their social and psychological functioning;
2. Racism and discrimination by societal institutions have resulted in minorities' lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health (see next section); and
3. Racism and discrimination are stressful events that can directly lead to psychological distress and physiological changes affecting mental health (Williams & Williams-Morris, 2000).

Poverty, Marginal Neighborhoods, and Community Violence

Poverty disproportionately affects racial and ethnic minorities. The overall rate of poverty in the United States, 12 percent in 1999, masks great variation. While 8 percent of whites are poor, rates are much higher among racial and ethnic minorities: 11 percent of Asian Americans and Pacific Islanders, 23 percent of Hispanic Americans, 24 percent of African Americans, and 26 percent of American Indians and Alaska Natives (U. S. Census Bureau, 1999). Measured another way, the per capita income for racial and ethnic minority groups is much lower than that for whites (Table 2-2).

Table 2-2 gives Per Capita Income averages by ethnicity in 1999.

For centuries, it has been known that people living in poverty, whatever their race or ethnicity, have the poorest overall health see reviews by Krieger, 1993; Adler et al., 1994; Yen & Syme, 1999. It comes as no surprise then that poverty is also linked to poorer mental health (Adler et al., 1994). Studies have consistently shown that people in the lowest strata of income, education, and occupation (known as socioeconomic status, or SES) are about two to three times more likely than those in the highest strata to have a mental disorder (Holzer et al., 1986; Regier et al., 1993; Muntaner et al., 1998). They also are more likely to have higher levels of psychological distress (Eaton & Muntaner, 1999).

Poverty in the United States has become concentrated in urban areas (Herbers, 1986). Poor neighborhoods have few resources and suffer from considerable distress and disadvantage in terms of high unemployment rates, homelessness, substance abuse, and crime. A disadvantaged community marked by economic and social flux, high turnover of residents, and low levels of supervision of teenagers and young adults creates an environment conducive to violence. Young racial and ethnic minority men from such environments are often perceived as being especially prone to violent behavior, and indeed they are disproportionately arrested for violent crimes. However, the recent Surgeon General's Report on Youth Violence cites self-reports of youth from both majority and minority populations *that indicate that differences in violent acts committed* may not be as large as arrest records suggest. The Report on Youth Violence concludes that race and ethnicity, considered in isolation from other life circumstances, shed little light on a given child's or adolescent's propensity for engaging in violence (DHHS, 2001).

Regardless of who is perpetrating violence, it disproportionately affects the lives of racial and ethnic minorities. The rate of victimization for crimes of violence is higher for African Americans than for any other ethnic or racial group (Maguire & Pastore, 1999). More than 40 percent of inner city young people have seen someone shot or stabbed (Schwab-Stone et al., 1995). Exposure to community violence, as victim or witness, leaves immediate and sometimes long-term effects on mental health, especially for youth (Bell & Jenkins, 1993; Gorman-Smith & Tolan, 1998; Miller et al., 1999).

How is poverty so clearly related to poorer mental health? This question can be answered in two ways. People who are poor are more likely to be exposed to stressful social environments (e.g., violence and unemployment) and to be cushioned less by social or material resources (Dohrenwend, 1973; McLeod & Kessler, 1990). In this way, poverty among whites and nonwhites is a risk factor for poor mental health. Also, having a mental disorder, such as schizophrenia, takes such a toll on individual functioning and productivity that it can lead to poverty. In this way, poverty is a consequence of mental illness (Dohrenwend et al., 1992). Both are plausible explanations for the robust relationship between poverty and mental illness (DHHS, 1999).

Scholars have debated whether low SES alone can explain cultural differences in health or health care utilization e.g. Lillie-Blanton et al., 1996; Williams, 1996; Stolley, 1999, 2000; LaVeist, 2000; Krieger, 2000. Most scholars agree that poverty and socioeconomic status do play a strong role, but the question is whether they play an exclusive role. The answer to this question is "no." Evidence contained within this Supplement is clearly contrary to the simple assertion that lower SES by itself explains ethnic and racial disparities. An excellent example is presented in Chapter 6. Mexican American immigrants to the United States, although quite impoverished, enjoy excellent mental health (Vega et al., 1998). In this study, immigrants' culture was interpreted as protecting them against the impact of poverty. In other studies of African Americans and Hispanics (cited in Chapters 3 and 6), more generous mental health coverage for minorities did not eliminate disparities in their utilization of mental health services. Minorities of the same SES as whites still used fewer mental health services, despite good access.

The debate separates poverty from other factors that might influence the outcome - such as experiences with racism, help-seeking behavior, or attitudes - as if they were isolated or independent from one another. In fact, poverty is caused in part by a historical legacy of racism and discrimination against minorities. And minority groups have developed coping skills to help them endure generations of poverty. In other words, poverty and other factors are overlapping and interdependent for different ethnic groups and different individuals. As but one example, the experience of poverty for immigrants who previously had been wealthy in their homeland cannot be equated with the experience of poverty for immigrants coming from economically disadvantaged backgrounds.

An important caveat in reviewing this evidence is that while most researchers measure and control for SES they do not carefully define and measure aspects of culture. Many studies report the ethnic or racial backgrounds of study participants as a shorthand for their culture, without systematically examining more specific information about their living circumstances, social class, attitudes, beliefs, and behavior. In the future, defining and measuring different aspects of culture will strengthen our understanding ethnic differences that occur, beyond those explained by poverty and socioeconomic status.

Demographic Trends

The United States is undergoing a major demographic transformation in racial and ethnic composition of its

population. In 1990, 23 percent of U.S. adults and 31 percent of children were from racial and ethnic minority groups (Hollmann, 1993). In 25 years, it is projected that about 40 percent of adults and 48 percent of children will be from racial and ethnic minority groups U.S. Census Bureau, 2000; Lewit & Baker, 1994. While these changes bring with them the enormous richness of diverse cultures, significant changes are needed in the mental health system to meet the associated challenges, a topic addressed in Chapter 7.

Diversity within Racial and Ethnic Groups

The four most recognized racial and ethnic minority groups are themselves quite diverse. For instance, Asian Americans and Pacific Islanders include at least 43 separate subgroups who speak over 100 languages. Hispanics are of Mexican, Puerto Rican, Cuban, Central and South American, or other Hispanic heritage (U.S. Census Bureau, 2000). American Indian/Alaskan Natives consist of more than 500 tribes with different cultural traditions, languages, and ancestry. Even among African Americans, diversity has recently increased as black immigrants arrive from the Caribbean, South America, and Africa. Some members of these subgroups have largely acculturated or assimilated into mainstream U.S. culture, whereas others speak English with difficulty and interact almost exclusively with members of their own ethnic group.

Growth Rates

African Americans had long been the country's largest ethnic minority group. However, over the past decade, they have grown by just 13 percent to 34.7 million people. In contrast, higher birth and immigration rates led Hispanics to grow by 56 percent, to 35.3 million people, while the whites grew just 1 percent from 209 million to 212 million. According to 2000 census figures, Hispanics have replaced African Americans as the second largest ethnic group after whites (U.S. Census Bureau, 2001).

Hispanics grew faster than any other ethnic minority group in terms of the actual number of individuals and the rate of population growth. The group with the second highest rate of population growth was Asian Americans, who in the 2000 census were counted separately from Native Hawaiians and Other Pacific Islanders. Because of immigration, the Asian American population grew 40.7 percent to 10.6 million people, and this growth is projected to continue throughout the century (U.S. Census Bureau, 2001).

American Indians and Alaska Natives surged between 38 and 50 percent over each of the decades from the 1960s through the 1980s. However, during the 1990s, the rate of growth was slightly slower (19%). Even so, the rate is still greater than that for the general population. One factor accounting for this higher-than-average growth rate is an increase in the number of people who now identify themselves as American Indian or Alaska Native. The current size of the American Indian and Alaska Native population is just under 1 percent of the total U.S. population, or about 2.5 million people. This number nearly doubles, however, when including individuals who identify as being American Indian and Alaska Native as well as one or more other races (U.S. Census Bureau, 2001).

The numbers of ethnic minority children and youth are increasing most rapidly. Between 1995 and 2015, the numbers of black youth are expected to increase by 19 percent, American Indian and Alaska Native youth by 17 percent, Hispanic youth by 59 percent, and Asian and Pacific Islander youth by 74 percent. During the same period, the white youth population is expected to increase by 3 percent (Snyder & Sickmund, 1999).

Geographic Distribution

Until the 1960s, American Indians, Asian Americans, and Hispanic Americans were geographically isolated. Before then, American Indians lived primarily on reservations to which the government assigned them. Few Asian Americans lived outside California, Hawaii, Washington, and New York City. Latinos resided primarily in the southwestern border States, New York City, and a few midwestern industrial cities (Harrison & Bennett, 1995).

Today, although they are not evenly distributed, members of each of the four major racial and ethnic minority groups reside throughout the United States. The western States are the most ethnically diverse in the United States, and they are home to many Latinos, Asian Americans, and American Indians. In the Midwest, which is less ethnically diverse, over 85 percent of the population is white, and most of the remainder is black. This proportion has remained relatively unchanged since the 1970s.

Although the Nation as a whole is becoming more ethnically diverse, this diversity remains relatively concentrated in a few States and large metropolitan areas. In general, minorities are more likely than whites to live in urban areas. In 1997, 88 percent of minorities lived in cities and their surrounding areas, compared to 77 percent of whites. American Indians/Alaska Natives and African Americans are the only minority groups with any considerable rural population. (U.S. Census Bureau, 1999).

Impact of Immigration Laws

During the last century, U.S. immigration laws alternately closed and opened the doors of immigration to different foreign populations. For example, the 1924 Immigration Act established the National Origins System, which restricted annual immigration from any foreign country to 2 percent of that country's population living in the United States, as counted in the census of 1890. Since most of the foreign-born counted in the 1890 census were from northern and western European countries, the 1924 Immigration Act reinforced patterns of white immigration and staved off immigration from other areas, including Asia, Latin America, and Africa.

Until the 1960s, approximately two-thirds of all legal immigrants to the United States were from Europe and Canada. The Immigration Act of 1965 replaced the National Origins System and allowed an annual immigration quota of 20,000 individuals from each country in the Eastern Hemisphere. The Act also gave preference to individuals in certain occupations. The effect was striking: Immigration from Asia skyrocketed from 6 percent of all immigrants in the 1950s to 37 percent by the 1980s. Yet another provision of the Act supported family reunification and gave preference to people with relatives in the United States, one factor behind the growth in immigration from Mexico and other Latin American countries (U.S. Census Bureau, 1999). Over this same period of time, the percentage of immigrants from Europe and Canada fell from 68 percent to 12 percent (U.S. Immigration and Naturalization Service, 1999).

In the past 20 years, immigration has led to a shift in the racial and ethnic composition of the United States not witnessed since the late 17th century, when black slaves became part of the labor force in the South (Muller, 1993). Though this wave of immigration is similar to the surge of immigration that occurred in the early part of this century, a critical difference is in the countries of origin. In the early 1900s, immigrants primarily came from Europe and Canada, while recent immigration is primarily from Asian and Latin American countries.

Overall, the racial and ethnic makeup of the United States has changed more rapidly since 1965 than during any other period in history. The reform in immigration policy in 1965, the increase in self-identification by ethnic minorities, and the slowing of the country's birth rates, especially among non-Hispanic white Americans, have all led to an increasing, and increasingly diverse, racial and ethnic minority population in the United States.

Conclusions

1. Culture influences many aspects of mental illness, including how patients from a given culture express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service utilization for racial and ethnic minorities, but they do play important roles.
2. Mental disorders are highly prevalent across all populations, regardless of race or ethnicity. Cultural and social factors contribute to the causation of mental illness, yet that contribution varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any one of these major factors can be stronger or weaker depending on the specific disorder.
3. Within the United States, overall rates of mental disorders for most minority groups are largely similar to those for whites. This general conclusion does not apply to vulnerable, high-need sub-groups, who have higher rates and are often not captured in community surveys. The overall rates of mental disorder for many smaller racial and ethnic groups, most notably American Indians, Alaska Natives, Asian Americans and Pacific Islanders are not sufficiently studied to permit definitive conclusions.
4. Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. Living in poverty has the most measurable impact on rates of mental illness. People in the lowest stratum of income, education, and occupation are about two to three times more likely than those in the highest stratum to have a mental disorder.
5. Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention.
6. Stigma discourages major segments of the population, majority and minority alike, from seeking help. Attitudes toward mental illness held by minorities are as unfavorable, or even more unfavorable, than attitudes held by whites.
7. Mistrust of mental health services is an important reason deterring minorities from seeking treatment. Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping. The extent to which clinician bias and stereotyping explain disparities in mental health services is not

known.

8. The cultures of ethnic and racial minorities alter the types of mental health services they use. Cultural misunderstandings or communication problems between patients and clinicians may prevent minorities from using services and receiving appropriate care.

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Footnotes

- 1 In medicine, each disease or disorder is considered mutually exclusive from another (WHO, 1992). Each disorder is presumed, but rarely proven, to have unique pathophysiology (Scadding, 1996).
- 2 In very general terms, most other healing systems throughout history conceived of sickness and health in the context of understanding relations of human beings to the cosmos, including planets, stars, mountains, rivers, deities, spirits, and ancestors (Porter 1997).
- 3 Defined in the next section of this chapter as "beliefs, attitudes, and practices that denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation...[which] can be perpetrated by institutions or individuals, acting intentionally or unintentionally."
- 4 Researchers may have collected this information but did not report it in their published studies.
- 5 One study of attention-deficit/hyperactivity disorder (AD/HD), the NIMH Multimodal Treatment Study of AD/HD, plans to conduct ethnic-specific analyses.
- 6 Perceived discrimination" is the term used by researchers in reference to the self-reports of individuals about being the target of discrimination or racism. The term is not meant to imply that racism did not take place.

Tables

Table 2-1. Ethnic Specific Analyses in Clinical Trials for Developing Evidence Based Treatment Guidelines

STUDIES	Total Number of Participants	NUMBER OF PARTICIPANTS FOR WHOM ETHNICITY IS REPORTED							Total Number of Ethnic Specific Analyses Conducted
		N (% of total sample)	White	Unspecified Non-White	Black	Hispanic	AA/PI	AI/AN	
Bipolar Disorder	921	305 (33%)	234	32	32	0	0	0	0
Schizophrenia	2813	2044 (73%)	1314	376	376	44	5	0	0
Depression	3860	1841 (48%)	1571	27	27	0	2	0	0
ADHD	1672	801 (48%)	545	126	126	55	4	0	0
Total	9266	4991 (54%)	3664	561	561	99	11	0	0

See Appendix A

Table 2-2: Per Capita Income by Ethnicity in 1999

	Per Capita Incomes
African Americans	\$14,397
Hispanic Americans	\$11,621
Asian Americans & Pacific Islanders	\$21,134
American Indians/Alaska Natives	Not Available
White Americans	\$24,109

Source: U.S. Census Bureau, Current Population Reports, Money Income in the U.S., 1999.

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