Overview of Cultural Diversity and Mental Health Services

The U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations. Racial and ethnic minority groups are generally considered to be underserved by the mental health services system (Neighbors et al., 1992; Takeuchi & Uehara, 1996; Center for Mental Health Services [CMHS], 1998). A constellation of barriers deters ethnic and racial minority group members from seeking treatment, and if individual members of groups succeed in accessing services, their treatment may be inappropriate to meet their needs.

Awareness of the problem dates back to the 1960s and 1970s, with the rise of the civil rights and community mental health movements (Rogler et al., 1987) and with successive waves of immigration from Central America, the Caribbean, and Asia (Takeuchi & Uehara, 1996). These historical forces spurred greater recognition of the problems that minority groups confront in relation to mental health services.

Research documents that many members of minority groups fear, or feel ill at ease with, the mental health system (Lin et al., 1982; Sussman et al., 1987; Scheffler & Miller, 1991). These groups experience it as the product of white, European culture, shaped by research primarily on white, European populations. They may find only clinicians who represent a white middle-class orientation, with its cultural values and beliefs, as well as its biases, misconceptions, and stereotypes of other cultures.

Research and clinical practice have propelled advocates and mental health professionals to press for “linguistically and culturally competent services” to improve utilization and effectiveness of treatment for different cultures. Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems (CMHS, 1998). Without culturally competent services, the failure to serve racial and ethnic minority groups adequately is expected to worsen, given the huge demographic growth in these populations predicted over the next decades (Takeuchi & Uehara, 1996; CMHS, 1998; Snowden, 1999).

This section of the chapter amplifies these major conclusions. It explains the confluence of clinical, cultural, organizational, and financial reasons for minority groups being underserved by the mental health system. The first task, however, is to explain which ethnic and racial groups constitute underserved populations, to describe their changing demographics, and to define the term “culture” and its consequences for the mental health system.

Introduction to Cultural Diversity and Demographics

The Federal government officially designates four major racial or ethnic minority groups in the United States: African American (black), Asian/Pacific Islander, Hispanic American (Latino), and Native American/American Indian/Alaska Native/Native Hawaiian (referred to subsequently
as “American Indians”) (CMHS, 1998). There are many other racial or ethnic minorities and considerable diversity within each of the four groupings listed above. The representation of the four officially designated groups in the U.S. population in 1999 is as follows: African Americans constitute the largest group, at 12.8 percent of the U.S. population; followed by Hispanics (11.4 percent), Asian/Pacific Islanders (4.0 percent), and American Indians (0.9 percent) (U.S. Census Bureau, 1999). Hispanic Americans are among the fastest-growing groups. Because their population growth outpaces that of African Americans, they are projected to be the predominant minority group (24.5 percent of the U.S. population) by the year 2050 (CMHS, 1998).

Racial and ethnic populations differ from one another and from the larger society with respect to culture. The term “culture” is used loosely to denote a common heritage and set of beliefs, norms, and values. The cultures with which members of minority racial and ethnic groups identify often are markedly different from industrial societies of the West. The phrase “cultural identity” specifies a reference group—an identifiable social entity with whom a person identifies and to whom he or she looks for standards of behavior (Cooper & Denner, 1998). Of course, within any given group, an individual’s cultural identity may also involve language, country of origin, acculturation,2 gender, age, class, religious/spiritual beliefs, sexual orientation, and physical disabilities (Lu et al., 1995). Many people have multiple ethnic or cultural identities.

The historical experiences of ethnic and minority groups in the United States are reflected in differences in economic, social, and political status. The most measurable difference relates to income. Many racial and ethnic minority groups have limited financial resources. In 1994, families from these groups were at least three times as likely as white families to have incomes placing them below the Federally established poverty line. The disparity is even greater when considering extreme poverty—family incomes at a level less than half of the poverty threshold—and is also large when considering children and older persons (O’Hare, 1996). Although some Asian Americans are somewhat better off financially than other minority groups, they still are more than one and a half times more likely than whites to live in poverty. Poverty disproportionately affects minority women and their children (Miranda & Green, 1999). The effects of poverty are compounded by differences in total value of accumulated assets, or total wealth (O’Hare et al., 1991).

Lower socioeconomic status—in terms of income, education, and occupation—has been strongly linked to mental illness. It has been known for decades that people in the lowest socioeconomic strata are about two and a half times more likely than those in the highest strata to have a mental disorder (Holzer et al., 1986; Regier et al., 1993b). The reasons for the association between lower socioeconomic status and mental illness are not well understood. It may be that a combination of greater stress in the lives of the poor and greater vulnerability to a variety of stressors leads to some mental disorders, such as depression. Poor women, for example, experience more frequent, threatening, and uncontrollable life events than do members of the population at large (Belle, 1990). It also may be that the impairments associated with mental disorders lead to lower socioeconomic status (McLeod & Kessler, 1990; Dohrenwend, 1992; Regier et al., 1993b).

Cultural identity imparts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to, mental health services. These include coping styles and ties to family and community, discussed below.

**Coping Styles**

Cultural differences can be reflected in differences in preferred styles of coping with day-to-day problems. Consistent with a cultural emphasis on restraint, certain Asian American groups, for
example, encourage a tendency not to dwell on morbid or upsetting thoughts, believing that avoidance of troubling internal events is warranted more than recognition and outward expression (Leong & Lau, 1998). They have little willingness to behave in a fashion that might disrupt social harmony (Uba, 1994). Their emphasis on willpower is similar to the tendency documented among African Americans to minimize the significance of stress and, relatedly, to try to prevail in the face of adversity through increased striving (Broman, 1996).

Culturally rooted traditions of religious beliefs and practices carry important consequences for willingness to seek mental health services. In many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one’s commitment to a religious or spiritual system of belief and to engage in prescribed religious or spiritual forms of practice. African Americans (Broman, 1996) and a number of ethnic groups (Lu et al., 1995), when faced with personal difficulties, have been shown to seek guidance from religious figures.23

Many people of all racial and ethnic backgrounds believe that religion and spirituality favorably impact upon their lives and that well-being, good health, and religious commitment or faith are integrally intertwined (Taylor, 1986; Priest, 1991; Bacote, 1994; Pargament, 1997). Religion and spirituality are deemed important because they can provide comfort, joy, pleasure, and meaning to life as well as be means to deal with death, suffering, pain, injustice, tragedy, and stressful experiences in the life of an individual or family (Pargament, 1997). In the family/community-centered perception of mental illness held by Asians and Hispanics, religious organizations are viewed as an enhancement or substitute when the family is unable to cope or assist with the problem (Acosta et al., 1982; Comas-Diaz, 1989; Cook & Timberlake, 1989; Meadows, 1997).

Culture also imprints mental health by influencing whether and how individuals experience the discomfort associated with mental illness. When conveyed by tradition and sanctioned by cultural norms, characteristic modes of expressing suffering are sometimes called “idioms of distress” (Lu et al., 1995). Idioms of distress often reflect values and themes found in the societies in which they originate.

One of the most common idioms of distress is somatization, the expression of mental distress in terms of physical suffering. Somatization occurs widely and is believed to be especially prevalent among persons from a number of ethnic minority backgrounds (Lu et al., 1995). Epidemiological studies have confirmed that there are relatively high rates of somatization among African Americans (Zhang & Snowden, in press). Indeed, somatization resembles an African American folk disorder identified in ethnographic research and is linked to seeking treatment (Snowden, 1998).

A number of idioms of distress are well recognized as culture-bound syndromes and have been included in an appendix to DSM-IV. Among culture-bound syndromes found among some Latino psychiatric patients is ataque de nervios, a syndrome of “uncontrollable shouting, crying, trembling, and aggression typically triggered by a stressful event involving family. . . ” (Lu et al., 1995, p. 489). A Japanese culture-bound syndrome has appeared in that country’s clinical modification of ICD-10 (WHO International Classification of Diseases, 10th edition, 1993). Taijin kyofusho is an intense fear that one’s body or bodily functions give offense to others. Culture-bound syndromes sometimes reflect comprehensive systems of belief, typically emphasizing a need for a balance between opposing forces (e.g., yin/yang, “hot-cold” theory) or the power of supernatural forces (Cheung & Snowden, 1990). Belief in indigenous disorders and adherence to culturally rooted coping practices are more common among older adults and among persons who are less acculturated. It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes.
Family and Community as Resources

Ties to family and community, especially strong in African, Latino, Asian, and Native American communities, are forged by cultural tradition and by the current and historical need to assist arriving immigrants, to provide a sanctuary against discrimination practiced by the larger society, and to provide a sense of belonging and affirming a centrally held cultural or ethnic identity.

Among Mexican-Americans (del Pinal & Singer, 1997) and Asian Americans (Lee, 1998) relatively high rates of marriage and low rates of divorce, along with a greater tendency to live in extended family households, indicate an orientation toward family. Family solidarity has been invoked to explain relatively low rates among minority groups of placing older people in nursing homes (Short et al., 1994).

The relative economic success of Chinese, Japanese, and Korean Americans has been attributed to family and communal bonds of association (Fukuyama, 1995). Community organizations and networks established in the United States include rotating credit associations based on lineage, surname, or region of origin. These organizations and networks facilitate the startup of small businesses.

There is evidence of an African American tradition of voluntary organizations and clubs often having political, economic, and social functions and affiliation with religious organizations (Milburn & Bowman, 1991). African Americans and other racial and ethnic minority groups have drawn upon an extended family tradition in which material and emotional resources are brought to bear from a number of linked households. According to this literature, there is “(a) a high degree of geographical propinquity; (b) a strong sense of family and familial obligation; (c) fluidity of household boundaries, with greater willingness to absorb relatives, both real and fictive, adult and minor, if need arises; (d) frequent interaction with relatives; (e) frequent extended family get-togethers for special occasions and holidays; and (f) a system of mutual aid” (Hatchett & Jackson, 1993, p. 92).

Families play an important role in providing support to individuals with mental health problems. A strong sense of family loyalty means that, despite feelings of stigma and shame, families are an early and important source of assistance in efforts to cope, and that minority families may expect to continue to be involved in the treatment of a mentally ill member (Uba, 1994). Among Mexican American families, researchers have found lower levels of expressed emotion and lower levels of relapse (Karno et al., 1987). Other investigators have demonstrated an association between family warmth and a reduced likelihood of relapse (Lopez et al., in press).

Epidemiology and Utilization of Services

One of the best ways to identify whether a minority group has problems accessing mental health services is to examine their utilization of services in relation to their need for services. As noted previously, a limitation of contemporary mental health knowledge is the lack of standard measures of “need for treatment” and culturally appropriate assessment tools. Minority group members’ needs, as measured indirectly by their prevalence of mental illness in relation to the U.S. population, should be proportional to their utilization, as measured by their representation in the treatment population. These comparisons turn out to be exceedingly complicated by inadequate understanding of the prevalence of mental disorders among minority groups in the United States. Nationwide studies conducted many years ago overlooked institutional populations, which are disproportionately represented by minority groups. Treatment utilization
information on minority groups in relation to whites is more plentiful, yet, a clear understanding of health seeking behavior in various cultures is lacking.

The following paragraphs reveal that disparities abound in treatment utilization: some minority groups are underrepresented in the outpatient treatment population while, at the same time, overrepresented in the inpatient population. Possible explanations for the differences in utilization are discussed in a later section.

African Americans

The prevalence of mental disorders is estimated to be higher among African Americans than among whites (Regier et al., 1993a). This difference does not appear to be due to intrinsic differences between the races; rather, it appears to be due to socioeconomic differences. When socioeconomic factors are taken into account, the prevalence difference disappears. That is, the socioeconomic status-adjusted rates of mental disorder among African Americans turn out to be the same as those of whites. In other words, it is the lower socioeconomic status of African Americans that places them at higher risk for mental disorders (Regier et al., 1993a).

African Americans are underrepresented in some outpatient treatment populations, but overrepresented in public inpatient psychiatric care in relation to whites (Snowden & Cheung, 1990; Snowden, in press-b). Their underrepresentation in outpatient treatment varies according to setting, type of provider, and source of payment. The racial gap between African Americans and whites in utilization is smallest, if not nonexistent, in community-based programs and in treatment financed by public sources, especially Medicaid (Snowden, 1998) and among older people (Padgett et al., 1995). The underrepresentation is largest in privately financed care, especially individual outpatient practice, paid for either by fee-for-service arrangements or managed care. As a result, underrepresentation in the outpatient setting occurs more among working and middle-class African Americans, who are privately insured, than among the poor. This suggests that socioeconomic standing alone cannot explain the problem of underutilization (Snowden, 1998).

Asian Americans/Pacific Islanders
The prevalence of mental illness among Asian Americans is difficult to determine for methodological reasons (i.e., population sampling). Although some studies suggest higher rates of mental illness, there is wide variance across different groups of Asian Americans (Takeuchi & Uehara, 1996). It is not well known how applicable DSM-IV diagnostic criteria are to culturally specific symptom expression and culture-bound syndromes. With respect to treatment-seeking behavior, Asian Americans are distinguished by extremely low levels at which specialty treatment is sought for mental health problems (Leong & Lau, 1998). Asian Americans have proven less likely than whites, African Americans, and Hispanic Americans to seek care. One national sample revealed that Asian Americans were only a quarter as likely as whites, and half as likely as African Americans and Hispanic Americans, to have sought outpatient treatment (Snowden, in press-a). Asian Americans/Pacific Islanders are less likely than whites to be psychiatric inpatients (Snowden & Cheung, 1990). The reasons for the underutilization of services include the stigma and loss of face over mental health problems, limited English proficiency among some Asian immigrants, different cultural explanations for the problems, and the inability to find culturally competent services. These phenomena are more pronounced for recent immigrants (Sue et al., 1994).

**Hispanic Americans**

Several epidemiological studies revealed few differences between Hispanic Americans and whites in lifetime rates of mental illness (Robins & Regier, 1991; Vega & Kolody, 1998). A recent study of Mexican Americans in Fresno County, California, found that Mexican Americans born in the United States had rates of mental disorders similar to those of other U.S. citizens, whereas immigrants born in Mexico had lower rates (Vega et al., 1998a). A large study conducted in Puerto Rico reported similar rates of mental disorders among residents of that island, compared with those of citizens of the mainland United States (Canino et al., 1987).

Although rates of mental illness may be similar to whites in general, the prevalence of particular mental health problems, the manifestation of symptoms, and help-seeking behaviors within Hispanic subgroups need attention and further research. For instance, the prevalence of depressive symptomatology is higher in Hispanic women (46%) than men (almost 20%); yet, the known risk factors do not totally explain the gender difference (Vega et al., 1998a; Zunzunegui et al., 1998). Several studies indicate that Puerto Rican and Mexican American women with depressive symptomatology are underrepresented in mental health services and overrepresented in general medical services (Hough et al., 1987; Sue et al., 1991, 1994; Duran, 1995; Jimenez et al., 1997).

**Native Americans**

American Indians/Alaska Natives have, like Asian Americans and Pacific Islanders, been studied in few epidemiological surveys of mental health and mental disorders. The indications are that depression is a significant problem in many American Indian/Alaska Native communities (Nelson et al., 1992). One study of a Northwest Indian village found rates of DSM-III-R affective disorder that were notably higher than rates reported from national epidemiological studies (Kinzie et al., 1992). Alcohol abuse and dependence appear also to be especially problematic, occurring at perhaps twice the rate of occurrence found in any other population group. Relatedly, suicide occurs at alarmingly high levels. (Indian Health Service, 1997). Among Native American veterans, post-traumatic stress disorder has been identified as especially prevalent in relation to whites (Manson, 1998). In terms of patterns of utilization, Native Americans are overrepresented in psychiatric inpatient care in relation to whites, with the exception of private psychiatric hospitals (Snowden & Cheung, 1990; Snowden, in press-b).
Barriers to the Receipt of Treatment

The underrepresentation in outpatient treatment of racial and ethnic minority groups appears to be the result of cultural differences as well as financial, organizational, and diagnostic factors. The service system has not been designed to respond to the cultural and linguistic needs presented by many racial and ethnic minorities. What is unresolved are the relative contribution and significance of each factor for distinct minority groups.

Help-Seeking Behavior

Among adults, the evidence is considerable that persons from minority backgrounds are less likely than are whites to seek outpatient treatment in the specialty mental health sector (Sussman et al., 1987; Gallo et al., 1995; Leong & Lau, 1998; Snowden, 1998; Vega et al., 1998a, 1998b; Zhang et al., 1998). This is not the case for emergency department care, from which African Americans are more likely than whites to seek care for mental health problems, as noted above. Language, like economic and accessibility differences, can play an important role in why people from other cultures do not seek treatment (Hunt, 1984; Comas-Diaz, 1989; Cook & Timberlake, 1989; Taylor, 1989).

Mistrust

The reasons why racial and ethnic minority groups are less apt to seek help appear to be best studied among African Americans. By comparison with whites, African Americans are more likely to give the following reasons for not seeking professional help in the face of depression: lack of time, fear of hospitalization, and fear of treatment (Sussman et al., 1987). Mistrust among African Americans may stem from their experiences of segregation, racism, and discrimination (Primm et al., 1996; Priest, 1991). African Americans have experienced racist slights in their contacts with the mental health system, called “microinsults” by Pierce (1992). Some of these concerns are justified on the basis of research, cited below, revealing clinician bias in overdiagnosis of schizophrenia and underdiagnosis of depression among African Americans.

Lack of trust is likely to operate among other minority groups, according to research about their attitudes toward government-operated institutions rather than toward mental health treatment per se. This is particularly pronounced for immigrant families with relatives who may be undocumented, and hence they are less likely to trust authorities for fear of being reported and having the family member deported. People from El Salvador and Argentina who have experienced imprisonment or watched the government murder family members and engage in other atrocities may have an especially strong mistrust of any governmental authority (Garcia & Rodriguez, 1989). Within the Asian community, previous refugee experiences of groups such as Vietnamese, Indochinese, and Cambodian immigrants parallel those experienced by Salvadoran and Argentine immigrants. They, too, experienced imprisonment, death of family members or friends, physical abuse, and assault, as well as new stresses upon arriving in the United States (Cook & Timberlake, 1989; Mollica, 1989).

American Indians’ past experience in this country also imparted lack of trust of government. Those living on Indian reservations are particularly fearful of sharing any information with white clinicians employed by the government. As with African Americans, the historical relationship of forced control, segregation, racism, and discrimination has affected their ability to trust a white majority population (Herring, 1994; Thompson, 1997).
Stigma

The stigma of mental illness is another factor preventing African Americans from seeking treatment, but not at a rate significantly different from that of whites. Both African American and white groups report that embarrassment hinders them from seeking treatment (Sussman et al., 1987). In general, African Americans tend to deny the threat of mental illness and strive to overcome mental health problems through self-reliance and determination (Snowden, 1998). Stigma, denial, and self-reliance are likely explanations why other minority groups do not seek treatment, but their contribution has not been evaluated empirically, owing in part to the difficulty of conducting this type of research. One of the few studies of Asian Americans identified the barriers of stigma, suspiciousness, and a lack of awareness about the availability of services (Uba, 1994). Cultural factors tend to encourage the use of family, traditional healers, and informal sources of care rather than treatment-seeking behavior, as noted earlier.

Cost

Cost is yet another factor discouraging utilization of mental health services (Chapter 6). Minority persons are less likely than whites to have private health insurance, but this factor alone may have little bearing on access. Public sources of insurance and publicly supported treatment programs fill some of the gap. Even among working class and middle-class African Americans who have private health insurance, there is underrepresentation of African Americans in outpatient treatment (Snowden, 1998). Yet studies focusing only on poor women, most of whom were members of minority groups, have found cost and lack of insurance to be barriers to treatment (Miranda & Green, 1999). The discrepancies in findings suggest that much research remains to be performed on the relative importance of cost, cultural, and organizational barriers, and poverty and income limitations across the spectrum of racial and ethnic and minority groups.

Clinician Bias

Advocates and experts alike have asserted that bias in clinician judgment is one of the reasons for overutilization of inpatient treatment by African Americans. Bias in clinician judgment is thought to be reflected in overdiagnosis or misdiagnosis of mental disorders. Since diagnosis is heavily reliant on behavioral signs and patients’ reporting of the symptoms, rather than on laboratory tests, clinician judgment plays an enormous role in the diagnosis of mental disorders. The strongest evidence of clinician bias is apparent for African Americans with schizophrenia and depression. Several studies found that African Americans were more likely than were whites to be diagnosed with schizophrenia, yet less likely to be diagnosed with depression (Snowden & Cheung, 1990; Hu et al., 1991; Lawson et al., 1994).

In addition to problems of overdiagnosis or misdiagnosis, there may well be a problem of underdiagnosis among minority groups, such as Asian Americans, who are seen as “problem-free” (Takeuchi & Uehara, 1996). The presence and extent of this type of clinician bias are not known and need to be investigated.

Improving Treatment for Minority Groups

The previous paragraphs have documented underutilization of treatment, less help-seeking behavior, inappropriate diagnosis, and other problems that have beset racial and ethnic minority groups with respect to mental health treatment. This kind of evidence has fueled the widespread perception of mental health treatment as being uninviting, inappropriate, or not as effective for
minority groups as for whites. The Schizophrenia Patient Outcome Research Team demonstrated that African Americans were less likely than others to have received treatment that conformed to recommended practices (Lehman & Steinwachs, 1998). Inferior treatment outcomes are widely assumed but are difficult to prove, especially because of sampling, questionnaire, and other design issues, as well as problems in studying patients who drop out of treatment after one session or who otherwise terminate prematurely. In a classic study, 50 percent of Asian Americans versus 30 percent of whites dropped out of treatment early (Sue & McKinney, 1975). However, the disparity in dropout rates may have abated more recently (O’Sullivan et al., 1989; Snowden et al., 1989). One of the few studies of clinical outcomes, a pre- versus post-treatment study, found that African Americans fared more poorly than did other minority groups treated as outpatients in the Los Angeles area (Sue et al., 1991). Earlier studies from the 1970s and 1980s had given inconsistent results (Sue et al., 1991).

**Ethnopsychopharmacology**

There is mounting awareness that ethnic and cultural influences can alter an individual’s responses to medications (pharmacotherapies). The relatively new field of ethnopsychopharmacology investigates cultural variations and differences that influence the effectiveness of pharmacotherapies used in the mental health field. These differences are both genetic and psychosocial in nature. They range from genetic variations in drug metabolism to cultural practices that affect diet, medication adherence, placebo effect, and simultaneous use of traditional and alternative healing methods (Lin et al., 1997). Just a few examples are provided to illustrate ethnic and racial differences.

Pharmacotherapies given by mouth usually enter the circulation after absorption from the stomach. From the circulation they are distributed throughout the body (including the brain for psychoactive drugs) and then metabolized, usually in the liver, before they are cleared and eliminated from the body (Brody, 1994). The rate of metabolism affects the amount of the drug in the circulation. A slow rate of metabolism leaves more drug in the circulation. Too much drug in the circulation typically leads to heightened side effects. A fast rate of metabolism, on the other hand, leaves less drug in the circulation. Too little drug in the circulation reduces its effectiveness.

There is wide racial and ethnic variation in drug metabolism. This is due to genetic variations in drug-metabolizing enzymes (which are responsible for breaking down drugs in the liver). These genetic variations alter the activity of several drug-metabolizing enzymes. Each drug-metabolizing enzyme normally breaks down not just one type of pharmacotherapy, but usually several types. Since most of the ethnic variation comes in the form of inactivation or reduction in activity in the enzymes, the result is higher amounts of medication in the blood, triggering untoward side effects.

For example, 33 percent of African Americans and 37 percent of Asians are slow metabolizers of several antipsychotic medications and antidepressants (such as tricyclic antidepressants and selective serotonin reuptake inhibitors) (Lin et al., 1997). This awareness should lead to more cautious prescribing practices, which usually entail starting patients at lower doses in the beginning of treatment. Unfortunately, just the opposite typically had been the case with African American patients and antipsychotic drugs. Clinicians in psychiatric emergency services prescribed more oral doses and more injections of antipsychotic medications to African American patients (Segel et al., 1996). The combination of slow metabolism and overmedication of antipsychotic drugs in African Americans can yield very uncomfortable extrapyramidal side effects.
effects (Lin et al., 1997). These are the kinds of experiences that likely contribute to the mistrust of mental health services reported among African Americans (Sussman et al., 1987).

Psychosocial factors also can play an important role in ethnic variation. Compliance with dosing may be hindered by communication difficulties; side effects can be misinterpreted or carry different connotations; some groups may be more responsive to placebo treatment; and reliance on psychoactive traditional and alternative healing methods (such as medicinal plants and herbs) may result in interactions with prescribed pharmacotherapies. The result could be greater side effects and enhanced or reduced effectiveness of the pharmacotherapy, depending on the agents involved and their concentrations (Lin et al., 1997). Greater awareness of ethnopsychopharmacology is expected to improve treatment effectiveness for racial and ethnic minorities. More research is needed on this topic across racial and ethnic groups.

20 The term “Latino(a)” refers to all persons of Mexican, Puerto Rican, Cuban, or other Central and South American or Spanish origin (CMHS, 1998).

21 Acculturation refers to the “social distance” separating members of an ethnic or racial group from the wider society in areas of beliefs and values and primary group relations (work, social clubs, family, friends) (Gordon, 1964). Greater acculturation thus reflects greater adoption of mainstream beliefs and practices and entry into primary group relations.

22 Research is emerging on the importance of tailoring services to the special needs of gay, lesbian, and bisexual mental health service users (Cabaj & Stein, 1996).

23 Of the 15 percent of the U.S. population that use mental health services in a given year, about 2.8 percent receive care only from members of the clergy (Larson et al., 1988).

24 In spring 2000, survey field work begins on an NIMH-funded study of the prevalence of mental disorders, mental health symptoms, and related functional impairments in African Americans, Caribbean blacks, and non-Hispanic whites. The study will examine the effects of psychosocial factors and race-associated stress on mental health, and how coping resources and strategies influence that impact. The study will provide a database on mental health, mental disorders, and ethnicity and race. James Jackson, Ph.D., University of Michigan, is principal investigator.

25 African Americans are overrepresented among persons undergoing involuntary civil commitment (Snowden, in press-b).

26 Dystonia (brief or prolonged contraction of muscles), akathisia (an urge to move about constantly), or parkinsonism (tremor and rigidity) (Perry et al., 1997).

Diversity & Cultural Competence

Two recent events have made the need for “cultural competence”—understanding the specific cultural, language, social and economic nuances of particular people and families—more important than ever. One is the civil rights movement that began in the 1950s, in which African Americans, women, gays and lesbians, people with disabilities and other minority groups alerted the country to their distinct identities and long histories of oppression. The other is the growing number of new immigrants to this country, who bring with them unique cultural, language,
religious, and political backgrounds. Histories of internal displacement within their own
countries, torture, political oppression, and extreme poverty abound among immigrant
communities. Melding these backgrounds with the history, experiences, and expectations of U.S.
born ethnic and diverse populations creates both challenges and opportunities for social workers.

It is fair to say that both helping professionals and society at large have a long way to go to gain
cultural competence. Fortunately, social workers represent a group of service providers with a
longstanding history of understanding both people’s differences and the impact of social
injustices on their well being. Today, many social workers are adding cultural competence to
these already existing strengths and values, making them particularly well-equipped to deliver
culturally competent care. Many schools of social work now include curricula on cultural
competence, and the National Association of Social Workers recently developed standards that
require social workers to strive to deliver culturally competent services to their increasingly
diverse clientele.

It is no exaggeration to say that a culturally competent provider can mean the difference between
a person “making it” or “falling through the cracks.” Here is an extreme example. Latina social
worker Josie has a brother with schizophrenia who speaks only Spanish. When her brother failed
to receive culturally competent care over a 20-year period, he was hospitalized 162 times. When
he finally did receive culturally competent care, he was hospitalized only once in 15 years.

Language differences affect both majority and minority populations. For example, a refugee
from war-torn Bosnia doesn’t understand English, and he lacks both material and financial
resources. If he doesn’t get help, he faces many potential dangers that result from poverty and an
inability to access the system. A social worker trained in culturally competent care connects him
with a range of social services—the traditional assistance provided by social workers. In
addition, she introduces him to a group of other Bosnians who have undergone similar
experiences thus, providing an added support that she’s aware of because of her extra training.

Another example of how a culturally competent social worker can have an impact on people’s
lives is in the area of international adoptions. Social workers trained in cultural competence can
help adoptive parents understand their adopted child’s cultural heritage and create activities to
keep the child’s culture alive. Adding this dimension to the child’s assimilation can foster the
younger’s sense of identity and make the adoption experience a smoother and happier one for
both parents and child.
For Asian Americans, families are their primary source of support; thusly, they tend to keep
problems inside the family rather than sharing them with others. A social worker who is
culturally competent will therefore provide brief, task-oriented therapy that respects their privacy
and helps them achieve concrete goals, instead of providing traditional Western-style therapy
that is more individualistic and analytical. Similarly, African Americans often come from
backgrounds that include extended-family bonds and a strong, community-oriented spiritual life.
Trained social workers will make sure these cultural realities become an integral part of therapy
by often times including other family members in therapy.

Culturally competent services are needed beyond race and ethnicity. Culturally competent social
workers are also better able to address issues of gender and help persons with disabilities, older
adults, gays, lesbians, bisexuals, and transgender people. A working knowledge of these groups’
cultures and values helps social workers tailor care so it is effective and appropriate for their
clients’ needs.
It can be persuasively argued that effective care is impossible without a working knowledge and understanding of a person’s or group’s culture and background. As we move into an ever more pluralistic and multicultural society, social workers are among those best-equipped to deliver that care and to empower people from all backgrounds to lead connected, healthy lives.

http://www.naswdc.org/pressroom/features/issue/diversity.asp

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**Mental Health Care for African Americans**

**Current Status**

**Geographic Distribution**

In spite of the Great Migration to the North, a large African American population remained in the South, and in recent years, a significant return migration has taken place. Today, 53 percent of all blacks live in the South. Another 37 percent live in the Northeast and Midwest, mostly in metropolitan areas. About 10 percent of all blacks live in the West (U.S. Census Bureau, 2001; see Figure 3-1). Nationally, 15 percent live in rural areas, compared to 23 percent of whites and 25 percent of Americans overall (Rural Policy Research Institute, 1997).

Many African Americans still live in segregated neighborhoods (Massey & Denton, 1993), and poor African Americans tend to live among other African Americans who are poor. Poor neighborhoods have few resources, a disadvantage reflected in high unemployment rates, homelessness, crime, and substance abuse (Wilson, 1987). Children and youth in these environments are often exposed to violence, and they are more likely to suffer the loss of a loved one, to be victimized, to attend substandard schools, to suffer from abuse and neglect, and to encounter too few opportunities for safe, organized recreation and other constructive outlets (National Research Council, 1993). Personal vulnerabilities are exacerbated by problems at the community level, beyond the sphere of individual control.

![Figure 3-1](image.png)

*Figure 3-1 illustrates the African American population by region, based on data from Census.*
2000. It shows that the majority of African Americans live in the South, 19% live in the Midwest, 18% in the Northeast, and 10% in the West.

On the other hand, not all African American communities are distressed. Like other well functioning communities, stronger African American communities (both rich and poor) possess cohesion and informal mechanisms of social control, sometimes called collective efficacy. Evidence indicates that collective efficacy can counteract the effects of disabling social and economic conditions (Sampson et al., 1997). It also forms the foundation for community-building efforts (Bell & Fink, 2000).

**Family Structure**

In 2000, there were approximately 9 million African American families in the United States. On average, African American families are larger than white families; (65% versus 54% of families had three or more members), but smaller than families from other racial and ethnic minority groups (76% had three or more members). On the other hand, many African American children grow up in homes with only one parent. Only 38 percent were living in 2-parent families compared to 69% of all children in the United States. For children who lived with one parent, African Americans were more likely to live with their mothers than were U.S. children overall (92% versus 69%)(U.S. Census Bureau, 2001c).

Those who study African American life have argued that these trends are offset by an extended family orientation that calls for mutual material and emotional support (Hatchett & Jackson, 1993). This perspective has found wide acceptance and is reflected in policies such as family foster care, where children and youth removed from their homes are placed with relatives. African Americans participate extensively in family foster care in numbers proportional to their representation in foster care in general (Berrick et al., 1994; Landsverk et al., 1996; Altshuler, 1998).

Increasingly, however, researchers have discovered gaps and limitations in extended family support. Analyzing data from the National Survey of Families and Households, a large, community survey, Roschelle (1997) demonstrated that African American women were more likely than other women to provide assistance with child care and household tasks, but were less likely to receive such assistance in return. Respondents reported during in-depth interviews that levels of intergenerational support provided to teen mothers had waned (McDonald & Armstrong, 2001). They further indicated that several factors, including the youth of many grandmothers and the burden of problems brought on by urban poverty, had undermined supportive traditions.

**Education**

African Americans have shown an upward trend in educational attainment throughout the latter half of the 20th century. By 1997, there was no longer a gap in high school graduation rates between African Americans and whites. The number of African Americans enrolled in college in 1998 was 50 percent higher than the number enrolled a decade earlier. By 2000, 79 percent of African Americans age 25 and over had earned at least a high school diploma and 17 percent had attained a bachelor’s or graduate degree. These rates are in comparison to 84% and 26%, respectively, for Americans overall (U.S. Census Bureau, 2001c).
Income

When considered in aggregate, African Americans are relatively poor. In 1999, about 22 percent of African American families had incomes below the poverty line ($17,029 for a family of 4 in 1999) but only 10 percent of all U.S. families did (U.S. Census Bureau, 2001c). The difference in poverty rates has shrunk over the past decade, however, and the socioeconomic distribution of African Americans has become increasingly complex.

At one end of the income spectrum, the official poverty rate may understate the true extent of African American poverty. African Americans are more likely than whites to live in severe poverty, with incomes at or below 50 percent of the poverty threshold; the African American rate of severe poverty is more than three times the white rate. Children and youth are especially affected; while the national poverty rate for U.S. children is nearly 20 percent, almost 37 percent of African Americans 18 and younger live in poor families (U.S. Census Bureau, 1999b). There is considerable turnover in the poverty population. Most of the poor move out of poverty over time but are replaced by others. African Americans move in and out of poverty, but their periods of poverty tend to last longer, making African Americans more likely than whites to suffer from long-term poverty (O'Hare, 1996).

African American families fall well below white families on an important measure of aggregate financial resources: total wealth. Net worth, the value of assets minus liabilities, is a useful indicator. The median net worth of whites is about 10 times that of blacks (U.S. Census Bureau, 1999a). This wide disparity reflects limited African American family assets, lower rates of home ownership, limited savings, and few investments (O'Hare et al., 1991). Because most are descendants of deeply impoverished rural agricultural workers, many contemporary African Americans can expect to borrow only modest sums from relatives and can expect only small inheritances. Most African Americans have little financial cushion to absorb the impact of the social, legal, or health-related adversity that often accompanies mental illness.

African American poverty is associated with family structure. Despite historical patterns to the contrary and a slight reduction in recent years, African American children in particular, are especially likely to live in single-parent, mother-only families. This pattern reflects relatively low and declining marriage rates; the number of never-married African American adults almost equals the number of those who are married. Taking cohabitation into account reduces, but does not eliminate differences in the domestic partnership rates of African Americans versus other groups (Statistical Abstract of the United States, 1999).

The disparity in poverty rates affects older adults as well. Older African Americans are almost three times as likely as whites to be poor. The poverty rate among single African American women living alone or with non-relatives is very high (Ruiz, 1995). Older African American women are far more numerous than older African American men because of different mortality rates.

While many African Americans live in poverty, many others have joined the middle class. Between 1967 and 1997, African Americans benefited from a 31 per-cent boost in their real median household income, a raise that contrasts with an 18 percent increase for whites (U.S. Census Bureau, 1998). Nearly a quarter of all African Americans had incomes greater than $50,000 in 1997, and the median income of African Americans living in married-couple households was 87 percent that of comparable whites. Almost 32 percent of African Americans lived in the suburbs (Ternstrom & Ternstrom, 1997).
Thus, in socioeconomic terms, the African American population has become polarized. Many
African Americans are very poor and sometimes suffer an added burden from living in
impoverished communities. African Americans, poor and nonpoor alike, possess relatively few
financial assets. However, a large and increasing number of African Americans—more than once
expected—have taken up well-earned positions in the middle class.

Physical Health Status

As a group, African Americans bear a disproportionate burden of health problems (DHHS,
2000a). Mortality rates until age 85 are higher for blacks than for whites (National Center for
Health Statistics, 1996). Disparities in morbidity, too, are pronounced. The African American
rate of:

- diabetes is more than three times that of whites;
- heart disease is more than 40 percent higher than that of whites;
- prostate cancer is more than double that of whites;
- HIV/AIDS is more than seven times that of whites (In the past decade, deaths due to
  HIV/AIDS have increased dramatically in the African American population, and this
disease is now one of the top five causes of death for this group.);
- breast cancer is higher than it is for whites, even though African American women are
  more likely to receive mammography screening than are white women (DHHS, 2000a);
- infant mortality is twice that of whites.

The disparity in infant mortality rates, which are considered sensitive indicators of a population's
health status, is particularly stark. It is not entirely accounted for by socioeconomic factors.
Although infant mortality tends to decrease with maternal education, the most educated black
women have infant mortality rates that exceed those of the least educated white women (DHHS,
1998).

High rates of African American HIV/AIDS pose special challenges related to mental health. HIV
infection can lead to mental impairment, from minor cognitive disorder to full-blown dementia,
as well as precipitate the onset of mood disorders or psychosis. Opportunistic infections, use of
psychoactive substances associated with HIV infection, and adverse effects from treatment can
gravely compromise mental functioning (McDaniel et al., 1997).

Disparities in access to appropriate health care partially explain the differences in health status.
In 1996, about 76 percent of whites had an office-based usual point of care, which facilitates
preventive and primary care treatment. This compared to only 64 percent of African Americans
(Kass et al., 1999). Only 10 percent of African Americans, versus 12 percent of other Americans,
made a visit to an outpatient physician in 1997; African Americans made 26 percent fewer
annual visits than whites. African Americans are especially likely to obtain health care from
hospital outpatient and emergency departments. In 1997, African Americans made about 22
percent of emergency department visits (U.S. Census Bureau, 1999b). As will be shown in the
next section, the pattern of mental health treatment for African Americans is characterized by
low rates of out-patient care and high rates of emergency care.
Mental Health Care for African Americans

Historical Context

The overwhelming majority of today's African American population traces its ancestry to the slave trade from Africa. Over a period of about 200 years, millions of Africans are estimated to have been kidnapped or purchased and then brought to the Western Hemisphere.

Ships delivered them to the Colonies and later to the United States (Curtin, 1969). Legally, they were considered chattel—personal property of their owners. By the early 1800s, most Northern States had taken steps to end slavery, where it played only a limited economic role, but slavery continued in the South until the Emancipation Proclamation in 1863 and passage of the 13th Amendment to the U.S. Constitution in 1865 (Healey, 1995).

The 14th Amendment (1868) extended citizenship to African Americans and forbade the States from taking away civil rights; the 15th Amendment (1870) prohibited disfranchisement on the basis of race. However, these advances did not eliminate the subjugation of African Americans. The right to vote, supposedly assured by the 15th Amendment, was systematically denied through poll taxes, literacy tests, grandfather clauses, and other exclusionary practices. Racial segregation prevailed. Many Southern State governments passed laws that became known as Jim Crow laws or "black codes," which reinforced informal customs that separated the races in public places, and perpetuated an inferior status for African Americans.

The economy of the South remained heavily agricultural, and most people were poor. Exploited and con-signed to the bottom of the economic ladder, most African Americans toiled as sharecroppers. They rented land and paid for it by forfeiting most, if not all, of their harvested crops. Some worked as agricultural laborers and were paid rock-bottom wages. With very low, irregular incomes and little opportunity for betterment, African Americans continued to live in poverty. They were kept dependent and uneducated, with limited horizons (Thernstrom & Thernstrom, 1997).

As late as 1910, 89 percent of all blacks lived in legalized subservience and deep poverty in the rural South. When World War I interrupted the supply of cheap labor provided by European immigrants, African Americans began to migrate to the industrialized cities of the North in the Great Migration. As Southern agriculture became mechanized, and as the need for industrial workers in Midwestern and Northeastern States increased, African Americans moved north in even greater numbers. Following World War II, blacks began to migrate to selected urban centers in the West, mostly in California.

Segregation continued until the early 1950s. Then in 1954, in Brown v. Board of Education, the Supreme Court declared racially segregated education unconstitutional. In the 1960s, a protest movement arose. Led by the 1964 Nobel laureate, the Rev. Dr. Martin Luther King, Jr., activists confronted and sought to overturn segregationist practices, often at considerable peril. New legislation followed. The Civil Rights Act of 1964 prohibited both segregation in public accommodations and discrimination in education and employment. The Voting Rights Act, passed in 1965, suspended the use of voter qualification tests.
While the African American experience in the United States is rife with episodes of subjugation and displacement, it is also characterized by extraordinary individual and collective strengths that have enabled many African Americans to survive and do well, often against enormous odds. Through mutual affiliation, loyalty, and resourcefulness, African Americans have developed adaptive beliefs, traditions, and practices. Today, their levels of religious commitment are striking: Almost 85 percent of African Americans have described themselves as "fairly religious" or "very religious" (Taylor & Chatters, 1991), and prayer is among their most common coping responses. Another preferred coping strategy is not to shrink from problems, but to confront them (Broman, 1996). Yet another successful coping strategy is the tradition of turning for aid to significant others in the community, especially family, friends, neighbors, voluntary associations, and religious figures. This strategy has evolved from the historical African American experience of having to rely on each other, often for their very survival (Milburn & Bowman, 1991; Hatchett & Jackson, 1993).

African Americans have also developed a capacity to downplay stereotypical negative judgments about their behavior and to rely on the beliefs and behavior of other African Americans as a frame of reference (Crocker & Major, 1989). For this reason, at least in part, most African Americans do not suffer from low self-esteem (Gray-Little & Hafdahl, 2000). African Americans have a collective identity and perceive themselves as having a significant sphere of collectively defined interests. Such psychological and social frameworks have enabled many African Americans to overcome adversity and sustain a high degree of mental health.

What it means to be African American, belonging to a certain race, can no longer be taken for granted. As noted in Chapter 1, racial classification based on genetic origins is of questionable scientific legitimacy and of limited utility as a basis for understanding complex social phenomena (Yee et al., 1993). Still, the category "African American" provides a basis for social classification. African Americans are recognized by their physical features and are treated accordingly. Many African Americans identify as African American; they share a social identity and outlook (Frable, 1997; Cooper & Denner, 1998). Scholars have defined and measured aspects of this sense of racial identity: its salience, its centrality to the sense of self, the regard others hold for African Americans, what African Americans believe about the regard others hold for them, and beliefs about the role and status of African Americans (Sellers et al., 1998).

http://www.mentalhealth.org/cre/ch3_historical_context.asp

Mental Health Care for Asian Americans and Pacific Islanders

Current Status

Asian Americans and Pacific Islanders represent very diverse populations in terms of ethnicity, language, culture, education, income level, English proficiency, and sociopolitical experience. Although cultural ties exist among the different AA/PI communities, it is important to recognize the differences among the groups.

Geographic Distribution

Asian Americans and Pacific Islanders are heavily concentrated in the western United States; more than half of this group (54%) lived in the West in 2000 (U.S Census Bureau, 2001b).
However, a good number of AA/PIs also live in the South. Guam was under U.S. Navy control from the time it was acquired during the Spanish American War in 1898 until its transfer to the Office of Insular Affairs in 1950. American Samoa was ceded to the United States in 1900 and transferred to the Office of Insular Affairs in 1951. In 1947, the United Nations grouped the Northern Mariana Islands, the Marshall Islands, and the Caroline Islands into the Trust Territory of the Pacific Islands. Authority over these islands was given to the U.S. Secretary of the Interior in 1951. The Northern Mariana Islands became a U.S. Commonwealth in 1976. In 1986, the Republic of the Marshall Islands and the Federated States of Micronesia became sovereign states and now maintain relations with the United States through the Department of State. In 1994, Palau joined the freely associated States.

Until recently, the Secretary of the Interior held broad authority over these islands, but the people living there now have their own elected legislatures and governors. Today the U.S.-Associated Pacific Basin jurisdictions remain as freely associated States affiliated with the (17%) and Northeast (18%). A growing number of AA/PIs live in the Midwest (11%). One reason for this distribution is that some Asian Americans are descendants of the Chinese laborers who came in the mid-1800s to work on the transcontinental railroad. Other Asian Americans are descendants of the Japanese immigrants who came to California in the late 19th and early 20th centuries. Since 1965, when Asians began arriving in greater numbers, more entered the United States through New York as well as California. According to 1997 data, 37 percent of all Asian Americans and Pacific Islanders lived in California, 10 percent lived in New York, and 7 percent lived in Hawaii (Population Reference Bureau, 1999).

The largest proportion of nearly every major Asian American ethnic group lives in California. The 1990 census showed that three-fifths of Chinese Americans lived in California or New York, while about two-thirds of Filipinos and Japanese lived in California and Hawaii. Asian Indian (or South Asians) and Korean populations are somewhat less concentrated geographically, although large communities have emerged in a handful of States, including Illinois, New Jersey, and Texas, as well as California and New York. Approximately 75 percent of Pacific Islanders lived in Hawaii and California. Southeast Asians are distributed in a different pattern because of Federal resettlement programs that created pockets of Southeast Asian refugees in a few States. Nearly two-fifths of the Hmong population, for example, lived in Minnesota and Wisconsin in 1990. One-tenth of Vietnamese Americans live in Texas—the largest concentration of Vietnamese Americans outside of California (Population Reference Bureau, 1999). The overwhelming majority (96%) of Asian Americans and Pacific Islanders live in metropolitan areas (U.S. Census Bureau, 2001b).

Family Structure

Compared with white Americans and African Americans, AA/PIs are more likely to live in households that are comprised exclusively of family members, an arrangement referred to as “family households.” In 2000, family households made up 75 percent of Asian American households, compared to 67 percent of non-Hispanic white and African American households (U.S. Census Bureau, 2001b). Asian Americans also have a relatively low percentage of female-headed households (13%), which is comparable to the rate for white Americans but much lower than the rates for other groups. Asian Indian, Chinese, Korean, and Japanese Americans all tend to have lower percentages of female-headed households, from 7 to 13 percent, while Vietnamese, Filipinos, and other Southeast Asians each have a rate of 18 percent (Lee, 1998). Pacific Islanders have larger families than most Asian Americans and other Americans. Pacific Islander family size averages 4.1 persons, compared to 3.8 for Asian American families and 3.2 for all American families (U.S. Census Bureau, 1990).
While subgroup differences exist, Asian Americans tend to wait longer to have children and to have fewer children than other major ethnic groups. Only 6 percent of all live births occur to Asian American women under the age of 20 years. This is strikingly different from the percentages for white Americans (10%), African Americans (23%), and Latinos (18%) (Lee, 1998). Fertility rate data suggest that the AA/PI population will change, and that some ethnic group numbers will decrease over time. The fertility rates of Chinese American women (1.4 children per woman) and Japanese American women (1.1) are lower than the replacement level of 2.1 (the number of children needed for a generation to replace itself). Among Southeast Asian Americans, however, women have high fertility rates and tend to have children at earlier ages than Chinese and Japanese Americans (Lee, 1998). If fertility becomes a more dominant factor than immigration, the proportion of Southeast Asian Americans can be expected to rise compared to that of Chinese and Japanese Americans.

**Education**

On average, Asian Americans have attained more education than any other ethnic group in the United States. In 2000, 44 percent of Asian Americans age 25 years or older had a college or professional degree, whereas only 28 percent of the white population had achieved that level of education (U.S. Census Bureau, 2001b). According to 1997 data, 58 percent of Americans who descended from natives of the Indian subcontinent (India, Pakistan, Bangladesh, and Sri Lanka) had under-graduate, graduate, or professional degrees.

Some groups of AA/PIs did not have high educational attainment, however. In 1990, only 12 percent of Hawaiians and 10 percent of non-Hawaiian Pacific Islanders had achieved a bachelor’s degree or more. Furthermore, almost two-thirds of Cambodians, Hmong, and Laotians had not completed high school. Many of these Southeast Asians were not able to complete school, but their offspring are clearly taking advantage of the academic opportunities in the United States. In 1990, 49 percent of Vietnamese, 45 percent of Cambodian, 32 percent of Hmong, and 26 percent of Laotians between the ages of 18 and 24 years were enrolled in college.

**Income**

Three factors are important to note when examining the income characteristics of AA/PIs. First, there are substantial ethnic group differences in average income. Second, it is important to control for family size because AA/PIs tend to have large extended families. Finally, in some groups, income averages may disguise the bimodal income distribution within a population.

In 1998, the per capita income of AA/PIs was $18,709, compared to $22,952 for non-Hispanic whites. The average family income for AA/PIs tends to be higher than the national average. About one-third of Asian American and Pacific Islander families had incomes of $75,000 or more, compared with 29 percent for non-Hispanic white families. However, because Asian families often include extended family members, per capita income (i.e., income per each member of the family) is highest for whites, followed by Asian Americans.

Approximately 25 percent of the Asian Indian population had household incomes that exceeded $75,000, while less than 5 percent of the Cambodian, Hmong, and Laotian populations had similar household incomes.

In 1990, for which detailed information on specific AA/PI groups is available, approximately 14 percent of all Asian Americans were living in poverty. Again, variations in poverty rates were
Physical Health Status

The small number of studies that report health status by different subgroups limits an examination of overall physical health among Asian Americans and Pacific Islanders. While administrative data and health surveys include AA/PIs as a category, more often than not they do not have adequate comparable data for specific ethnic subgroups. Accordingly, an overall assessment of the AA/PI ethnic category leads to simple but misleading conclusions.

When it is reported that Asian Americans and Pacific Islanders have lower death rates attributable to cancer and heart disease than other minority groups, some might be misled and conclude that AA/PIs enjoy better health than other groups in the United States. However, when subgroup data are available, more accurate statements about the health profile of AA/PIs can be made (Zane, et al., 1994). For example, Native Hawaiian men have higher rates of lung cancer than white men do, and the incidence of cervical cancer among Vietnamese women in the United States is more than five times greater than that among white women (Kuo & Porter, 1998). While coronary heart disease and stroke kill nearly as many Americans as all other diseases combined, mortality from heart disease for Asian Americans and Pacific Islanders is 40 percent lower than that for whites.

http://www.mentalhealth.org/cre/ch5_current_status.asp

Mental Health Care for Hispanic Americans

Historical Context

To place the growth of the Latino population in context, it is important to review some of the historical events that have brought Latinos to the United States. Although the Spanish language and cultural influence form a bond among most Hispanics, many key differences among the four main Latino groups are related to the circumstances of their migration.

Mexicans have been U.S. residents longer than any other Hispanic subgroup. After the Mexican War (1846–1848), when the United States took over large territories from Texas to California, the country gained many Mexican citizens who chose to remain in their “new” U.S. communities. The considerable economic, social, and political instability during the Mexican Revolution (1910–1917) contributed to the growth of the Mexican population in the United States. Economic pressures and wars have propelled subsequent waves of migration. Both push factors (economic hardships in Mexico) and pull factors (the need for laborers in the United States) have affected the flow. The sheer numbers of people who have come to the United States—well over 7 million—as well as the fact that many arrive “unauthorized” (without documentation) distinguishes Mexican immigration (U.S. Census Bureau, 2000d).
Puerto Ricans began arriving in large numbers on the U.S. mainland after World War II as Puerto Rico’s population increased. High unemployment among displaced agricultural workers on the island also led to large-scale emigration to the mainland United States that continued through the 1950s and 1960s. In the 1980s, the migration pattern became more circular as many Puerto Ricans chose to return to the island. One distinctive characteristic of Puerto Rican migration is that the second Organic Act, or Jones Act, of 1917 granted Puerto Ricans U.S. citizenship.

Although Cubans came to the United States in the second half of the 19th century and in the early part of the 20th century, the greatest influx of Cuban immigrants began after Fidel Castro overthrew the Fulgencio Batista government in 1959. First, an elite group of Cubans came, but emigration continued with balseros, people who make the dangerous crossing to the United States by makeshift watercraft (Bernal & Shapiro, 1996). Some of these immigrants, such as the educated professionals who came to the United States during the early phase of Cuban migration, have become well established, whereas others who arrived with few economic resources are less so. Unlike immigrants from several other countries, many Cubans have gained access to citizenship and Federal support through their status as political refugees (Cattan, 1993).

Central Americans are the newest Latino subgroup in the United States. Many Central Americans fled their countries por la situacion, a phrase that refers to the political terror and atrocities in their homelands (Farias, 1994; Jenkins, 1991; Suarez-Orozco, 1990). Although the specific social, historical, and political contexts differ in El Salvador, Guatemala, and Nicaragua, conflicts in those countries led to a significant emigration of their citizens. About 21 percent of foreign-born Central Americans arrived in the United States between 1970 and 1979, and the bulk (about 70%) arrived between 1980 and 1990 (Farias, 1994).

The circumstances that caused various Hispanic groups to migrate greatly influence their experience in the United States. Cubans fled a Communist government, and, as a result, the U.S. Government has provided support through refugee or entrant status, work permits (Gil & Vega, 1996), and citizenship. More than half (51%) of Cuban immigrants have become U.S. citizens, compared to only 15 percent of Mexican immigrants (U.S. Census Bureau, 1998). Puerto Ricans, whether born on the mainland or in Puerto Rico, are by definition U.S. citizens and, as a result, have access to government-sponsored support services.

In contrast, many Central American immigrants are not recognized as political refugees, despite the fact that the war-related trauma and terror that preceded their immigration may place them at high risk for post-traumatic stress disorder (PTSD) and may make adjustment to their new home more difficult. Many Latinos who arrive without proper documentation have difficulty obtaining jobs or advancing in them and live with the chronic fear of deportation. Finally, many Mexicans, Puerto Ricans, Central Americans, and recent Cuban immigrants come as unskilled laborers or displaced agricultural workers who lack the social and economic resources to ease their adjustment.

Multicultural Assessment. ERIC Digest.

Assessment includes the use of various techniques to make an evaluation; multicultural assessment refers to the cultural context in which the assessment is conducted, namely one in which people of differing cultures interact. One can argue that all assessments are conducted and interpreted within some cultural context, but only recently have the cultural assumptions
underlying such assessments been acknowledged (Sue & Sue, 1990). The fields of counseling and therapy traditionally have relied heavily upon the use of assessment techniques to gather information about clients in order to indicate appropriate directions for treatment. Measures to assess personality, cognitive abilities, interests, and other psychological constructs have been utilized in a variety of different counseling and education settings. Although many of the measures most widely used have established reliability and validity only within White racial samples, these measures often are used inappropriately and unethically with populations from different cultures.

This digest identifies four common misuses of assessments in multicultural contexts, describes some of the ways in which multicultural assessments can be improved, and suggests topics for future research in the area of multicultural assessment.

**COMMON MISUSES OF ASSESSMENTS IN MULTICULTURAL CONTEXTS**

1. "Assuming that labeling something solves the problem."

   Sedlacek (in press, a) has called this the "Quest for the Golden Label" problem. Using new terms (e.g., multicultural, diversity) does not mean we are doing anything operationally different with our measures. Westbrook and Sedlacek (1991) found that although labels for nontraditional populations had changed over forty years, the groups being discussed were still those without power who were being discriminated against in the system.

2. "Using measures normed on White populations to assess non-White people."

   Sedlacek (in press, a) discussed what he called the "Three Musketeers" problem, namely that developing a single measure with equal validity for all is often the goal of test developers. However, if different people have different cultural and racial experiences and present their abilities differently, it is unlikely that a single measure could be developed that would work equally well for all.

3. "Ignoring the cultural assumptions that go into the creation of assessment devices."

   Helms (1992) argued that cognitive ability measures are commonly developed from an unacknowledged Eurocentric perspective. Until there is more thought given to the context in which tests are developed, work comparing different racial and cultural groups using those measures will be spurious.

4. "Not considering the implications of the use of measures with clients from various racial and cultural groups."

   Professionals may not be adequately trained in determining which measures are appropriate to use with particular clients or groups. Sedlacek (in press, a) has called this the "I'm OK, you're not" problem in that very few professionals receive adequate training in both instrument development and an appreciation of multicultural issues.
SUGGESTIONS FOR IMPROVING MULTICULTURAL ASSESSMENTS

1. "Concentrate on empirical and operational definitions of groups, not just labels."

Sedlacek (in press, b) has suggested that if members of a group receive prejudice and present their abilities in nontraditional ways, they can be considered "multicultural." He suggested the use of measures of racial attitudes and noncognitive variables in making this determination.

2. "Identify measures specifically designed for multicultural groups."

Sabnani and Ponterotto (1992) provided a critique of "racial/ethnic minority-specific" instruments and made recommendations for their use in different assessment contexts. Prediger (1993), in a compilation of multicultural assessment standards for counselors developed for the American Counseling Association, recommended that a determination be made that the assessment instrument was designed for use with a particular population before it is used.

3. "Encourage the consideration of cultural factors in the earliest conceptual stages of instrument development."

Helms (1992) called this a "culturalist perspective" in assessment. Sedlacek (in press, a) noted a lack of developmental multicultural thinking as new instruments are developed. Multicultural groups are usually "throw ins" after the fact to see how their test results compare with those of the population on which the test was normed. He called this the "Horizontal Research" problem in developing assessment measures.

4. "Increase opportunities for an exchange of information between those with quantitative training in instrument development and those with an interest and expertise in multicultural issues."

Currently there is little overlap in these two groups. Helms (1992) felt it was important not to assume that there are enough professionals of color to do this work. Many individuals from majority racial and cultural groups will need to develop such measures as well. Conventions, workshops, coauthored articles, and curricular reform in graduate programs are but a few examples of what could be done.

TOPICS FOR FUTURE RESEARCH ON MULTICULTURAL ASSESSMENT

Research on the validity and reliability of measures for specific multicultural groups is needed (Helms, 1992; Sabnani & Ponterotto, 1992). This includes studies of attributes that may be more important for multicultural groups than for others. Noncognitive variables, such as handling racism or having support of a cultural or racial group, have been shown to be particularly useful for members of nontraditional groups and should be studied further. Additional research on the utility of defining nontraditional groups broadly to include diversity based on age, physical disability, sexual orientation, etc. (Sedlacek, in press, a), or to concentrate on the major racial and cultural groups, e.g., African Americans, American Indians, Asian Americans, and Hispanics; (Sue, Arredondo, & McDavis, 1992) should be conducted.
SUMMARY

More valid assessments for multicultural populations would help counseling professionals better serve their clients and improve the lives of many people whose backgrounds and experiences may differ from those of White clients. Four common misuses of assessments in multicultural contexts were presented here, as were ways to counteract those misuses. Concentrating on empirical and operational definitions of multicultural groups rather than relabeling was the first suggestion discussed. Using measures specifically designed for multicultural groups was recommended as the best solution to the problem of using instruments normed on White populations. Developing new measures from a "culturalist perspective" was the recommended way to counter a lack of multicultural thinking in instrument development. Creating more opportunities to bring together those with training in instrument development and those with multicultural interests was seen as a way to improve the quality of multicultural assessments by professionals.

## CULTURAL CHARACTERISTICS COMPARISON MATRIX*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Euro-American</th>
<th>Hispanic/Latino</th>
<th>Asian</th>
<th>African-American</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religion</strong></td>
<td>Predominantly Christian (Protestant and Catholic), viewed as the exclusive route to an afterlife.</td>
<td>Primarily Catholic. Community churches and priests strongly influential in Hispanic day to day life. Our Lady of Guadalupe, patron saint, and Virgin Mary central.</td>
<td>Confucianism, Taoism, Buddhism, Ancestor worship, Catholic</td>
<td>Christianity (Protestant), Islam, African Methodist Episcopal Church (AME), Ancient tribal worship of spirits of nature and past elders. Higher % &quot;churched&quot; than mainstream.</td>
</tr>
<tr>
<td><strong>Family Structure</strong></td>
<td>Individual superior to family. Independence and competition fostered. Democracy in families.</td>
<td>Family is superior to individual. Service to family takes precedence over all other concerns, activities. Interdependence and cooperation supported among families. Eldest son has more authority than younger siblings.</td>
<td>Family superior to individual, elders honored, eldest son has more authority and responsibility than young siblings. Welfare, harmony and reputation of family supported by members. Male infants valued over females.</td>
<td>Family superior to individual, &quot;family&quot; may include non-blood-related individuals</td>
</tr>
<tr>
<td><strong>Gender Roles</strong></td>
<td>Contemporary view egalitarian, older view was of male dominance</td>
<td>Patriarchal family structure, matriarchal servitude</td>
<td>Male superior to female</td>
<td>Elders held in high esteem, male assumed to be &quot;head of household&quot;, sometimes even if not present.</td>
</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
<td>Based on traditional, structured, male dominated relationship</td>
<td>Parent-child relationship more important than marital relationship</td>
<td>Parent-child relationship more important than marital relationship</td>
<td>Authoritarian child rearing practices</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Concrete, direct, low-context</td>
<td>Spanish language is common tie among Hispanics; literacy cannot be assumed based on language fluency. High context, numerous dialects, some Indian.</td>
<td>Conflict to be avoided; many dialects No eye contact with speaking with a person of high position/power, mild delay in responding</td>
<td>Highly dependent on context; situation determines, seen as part of identity and roots, emotionally expressiveness often mistaken for anger and threat. Asking questions at first meeting intrusive.</td>
</tr>
<tr>
<td><strong>Decorum &amp; Discipline</strong></td>
<td>Control of emotions is important. Limited physical contact.</td>
<td>Female pre-marital virginity important. Negative emotions such as anger, aggression not acceptable</td>
<td>“Saving face” is of paramount importance</td>
<td>Males must constantly prove manhood to achieve respect.</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>Health and healing based on science. Disease may be caused by &quot;evil spirits&quot;. Catholic Holy Water used to ward off evil spirits.</td>
<td>Determined by socio-economic class; natural faith healers, spiritualists, massage.</td>
<td>Based on &quot;yin&quot; and &quot;yin&quot; (balance), diet, spirituality; shamans important to health.</td>
<td>Varies widely dependent on income and education. Southern African Americans holistic; herbal, food. Poor dependent on ER, absent insurance. Some believe in &quot;sins of the fathers&quot;.</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>K-12 minimally expected</td>
<td>Stereotype of lack of interest in educ. Is erroneous. Schools communicate poorly with Latino families; education is valued as route to improvement. Amer. Educ. System is low-context, causing conflict, withdrawal.</td>
<td>Teachers held in high esteem. Gaining education a responsibility to family, education brings honor to family</td>
<td>Education is promise of better life, socio-economic class-dependent, elementary level children often &quot;shy&quot; or &quot;quiet&quot;, fear of reprisal; church is teacher of morals, leadership, responsibility, community bonds</td>
</tr>
<tr>
<td><strong>Time Perceptions</strong></td>
<td>Schedule-oriented, time is money, valuable</td>
<td>Time less important than current pursuit.</td>
<td>Typically early or on time out of respect for others’ time.</td>
<td>More oriented to situation (here and now) rather than schedule. Exact times not important.</td>
</tr>
</tbody>
</table>

*These characteristics are generalized, and do not necessarily apply to all members of a culture. ©2004 Jerry M. Hatfield
Hispanic Cultural Values #1: Family

I have recently been asked, "What are the values within the Hispanic community?" This gave me quite a bit to think about. Is there a common thread and belief that identifies Hispanics or that all Hispanics can identify with? Is there a certain thinking that permeates the Hispanic community? Can you almost classify what it means to be Hispanic? Is that a stereotypical way of thinking of a certain group of people? One simple question gave birth to a diluge of other questions that probed deeply into the real reason I actually write these articles. What is it about Hispanics that makes us feel that bond amongst ourselves and that pride in our race that we carry like a flag for the whole world to see. Why is it that our nations are more brotherly towards each other for the most part and our citizens embrace each other and fill in as family when we are separated from our carnales? Yes, I think there are a certain set of values in the Hispanic community that sets us apart. Almost like a recipe, you take a little of this and a little of that and you combine it in the right setting and you have the perfect ingredients for what I would call the values of the Hispanic Culture.

Before I outline exactly what I believe some of those Hispanic values are, let me add to this a precursor. Not everyone is the same. Within each race there are individuals who hold values that are theirs alone and apart from the mainstream thought and value system of those who surround them, share their lives and even of those who have reared them. That is what makes Human's so unique, that we are able to grow up within a certain set and still choose to change or adopt a differing approach or value system than that which was taught us. To be sure we do have instinct, yet we are not ruled by it. So as I write this please bare in mind that what I am writting about is the values that the Hispanic Community holds as important in general, leaving room for the individual the freedom to disagree these guidelines as it were. If you were to sit amongst a grouping of Hispanics, no matter the country of origin, I think they would all find these values to be a common ground for conversation and most could agree upon.

Family by far is the most valued part of any Hispanic's life I have ever met. When I say this I mean that in a very differnt way then anyone outside the Hispanic family would understand it. To this end I will explain what I mean by the statement of family being most valued. Beginning with growing up, as a young Hispanic, we do not look forward to the life ahead of us with thoughts of ourselves outside the family. We are not independant of the family unit. To the contrary, what are you without your family? To another race you are yourself, to the Hispanic, you are nothing. Everything you go through as you are growing up is shared with some member of the family. Children grow up hanging out with their brothers, sisters, and cousins as friends. There is no need to go out by yourself and leave the younger ones at home as if they are a burden. Of course there are the times when you spend alone, but most of the time you spend it enjoying company of your family. The love and treasuring that takes place in the Hispanic family I have never seen in any other family setting. The way in which your mother and father relate to you is different also. There is a respect that is demanded from children towards their elders. Your parents care for you, provide for you and protect you. Growing up you know that nothing is more important in their lives than you. No matter how busy the parents are, their is always time for the children. No matter what happens in life, one thing most children of Hispanic families grow up
with, it is the essential knowledge that your parents and all the other adults in the family as well have always put you first.

In return for this type of acceptance and love, an individual who grows up in this type of family always feels the reciprocal toward their parents as well as other children in the family. I do not know of too many Hispanic families where the children feel anomosity towards their younger siblings. Even when a new baby in brought into the family, the older children are very much a part of the family every step of the way. Many are the times that I see children in other families with the "mine" disease as I like to call it. Boundaries for this that and the other thing permeate the non-Hispanic family. Personal boundaries covering your personal desires that is. The boundaries do not seem to be lined out to cover protecting those in the family or does it go towards including them. It always puzzles me as to why a couple would have children, and I suppose I think more of women as I am a woman myself, if they are always complaining about the children and always looking to find a babysitter, time for themselves and seem to be constantly thinking of how much better it was and will be without the kids around. The lives of some people seems too busy to allow time for family. Time is scheduled so tightly and no flexiblty is there. There is a career, gym, sports, friends, church, shopping, movies, family gatherings and the list just goes on and on. Then there are the toys: boats, motorbikes, race cars, classic cars, sporting goods, hiking, traveling, skiing... I tell you it boggles the mind. Even the day of rest is scheduled. I used to live in an area that was predominantly non-Hispanic and I tell you I was tired just listening to the parents go on and on about their schedule, and non of that even included the kids. Is it any wonder why people have to ask me what the value system of Hispanics are? Why we aren't at too many of those multiple functions as we are too busy relaxing after work with our family and friends enjoying the peace and comfort of family and home. I think for the most part we are absent from the scene by choice. Yes the very first Value a Hispanic has I would have to say is family. They are you hopes, dreams, support, strength, cheerleaders. Family loves you when no one else will. When all has failed you, as a Hispanic Family will never fail you. They give you roots, identity, acceptance, devotion, promise, passion, drive and life. Yes Family is life. The very seed of each of us does not rest in who we perceive ourselves to be but from the seed of generations known as genetics that gifts, curses, equips and carves out who we are and who we will be. After all, if you are not Hispanic by birth you can never change that. And if you are Hispanic by birth, you can never change that. Then again, who would want to be anywhere but in a Hispanic family?

http://www.bellaonline.com/articles/art31982.asp

Rebecca M. Cuevas De Caissie

Hispanic Values #2: Respect

When I think of the values that all Hispanics I have met hold as important respect would be up at the top of the list. To the average Hispanic, respect is a very important quality and value in our lives. Many times I have heard remarks used to describe Hispanics such as those that follow: hard working, honest, loyal, wearing their heart on their sleeve, dedicated, family oriented and many other positive and highly desirable qualities. Let me say up front that though these qualities are spoken in a very stereotypical manner, I find it flattering that enough of those who are from
my race are of this caliber that we carry this reputation as a people. There are those Hispanics, naturally, that are far from this ideal. But the fact remains that many many Hispanics do carry the values that lead them to live out their lives in a manner that gives all Hispanics the reputation for being of this class of people.

Once there was a time when Hispanics began immigrating into Anglo communities, and the value system that Hispanics held was looked down upon and misunderstood. But let it be said that the value system that many Anglo's carry has never been envied by Hispanics either. To say the least it is the tension that builds in the lives of Hispanics living and growing up in Anglo communities that creates a great deal of confusion in young Hispanic lives. The values of Hispanic families are sorely tested and there is a great fight to maintain the level of dedication and respect that the individual Hispanic value system teaches. I have for the most part found that many Anglo's conversely moves into and thrive in Hispanic communities with a lesser degree of stress on their family and in fact benefit from the influences that the value system of the Hispanic family holds.

So how does respect factor into the values and how do Hispanics interpret respect? You might think that it is the same as the way in which Anglo or African Americans interpret respect but then you would be very wrong and very far from understanding Hispanic values.

Respect for Hispanics begins with ones self. How one treats ones self and how you carry yourself. If you respect yourself you will naturally to Hispanics be a person of high integrity. It will show in how you treat others around you, how you preform your work, whom your friends are, where you go and the way in which you present yourself. Let me go a step further and explain each of these statements in turn. If you truly have self respect the way you treat others will be that which gives respect and demands it in return. In my experience many people misunderstand fear as respect when in fact it is not the same. Also many other minority races misunderstand power as respect and it also is not the same.

Respect is a value that stems from understanding your self worth and treating yourself accordingly based on this understanding and appreciation. It will be reflected upon those around you as once you can see you self worth then you will be free to see that of others also. It will effect everything about you from how you live your private life to how you live your public life. When you have a true and high level of respect as is the value of the Hispanic culture, your private life and your public life will be very compatible and there will be very little that you would have to hide or be ashamed for others to know. Part of this value comes from the way the family works together. Your elders as a child do not live a separate life from you as a child but live the life of an adult in which you are ushered into adulthood by the members of your family as opposed to finding your way into adulthood on your own as is the case in many other cultures. In this way you begin to understand how to hold yourself up in a respectful manner and understand that respect comes from certain boundaries that you place on yourself and on those around you. Boundaries that include your family in a very close and personal manner. Respect for yourself also comes from knowing who you are and what your belief system is as well as being comfortable taking a stand for what you believe.

After respect for ones self would be respect for your family. In the Spanish culture it is said that if you do not respect your parents then you do not respect yourself. What this means is that the manner in which other races relate and talk to their elders shows a great lack of respect for them. This is one of the key ways in which our culture is so very different from others. The way in which you treat and talk to the elders in your family says alot to a Hispanic about how you value yourself. How you let others talk to the elders in your family also says alot about your level of self respect. How you treat and care for those who are younger than you speaks alot to your
values to Hispanics. In many races where respect, and mainly self respect, the way in which younger family members are treated is cruel and harsh. Older brothers and sisters are allowed to treat their siblings cruelly and to taunt and tease them and the elders in the family only stop the torture when it bothers them without consideration for the child who is really the victim. The bonds that bind a Hispanic family are very well grounded in respect for ones self and the reflection there of onto the rest of the family.

From that bases, the value of respect that a Hispanic person holds will effect the way in which they operate in all areas of their life. The value for ones self will drive you to be a better worker and to seek to promote oneself in whatever profession the individual in working in. That is the main key to why so many Hispanics come to America and now Canada and do so well in settling in and making a good life for themselves. There is a drive that supersedes what others see in you. It is the level of respect one holds for himself that will drive him to persist when faced with daunting odds. To respect who one is and ones heritage is a value that all Hispanics should have and many who come to this country maintain. It is that respect for who one is that keeps us in touch with our roots, heritage, customs and values. Values like true respect. The Webster definition of respect is a: high or special regard: ESTEEM b: the quality or state of being esteemed. 1 a: to consider worthy of high regard: ESTEEM b: to refrain from interfering with 2: to have reference to: CONCERN The definition for Regard is ATTENTION, CONSIDERATION: a protective interest: CARE. Based on the definition of respect, the value of respect would mean the treatment of yourself would reflect a different value system than that seen in many other races but is prevalent in the Hispanic race.

I think it is one of the main reasons why Hispanics are so welcome and contribute positively to the economy and community in which they move. I think it is the glue for our society that allows us to exist with other races and do so well while still not loosing who we are as a race. Our values start with self respect and builds from there, which is a gift given to us by our family, which was the first value and the greatest.

http://www.bellaonline.com/articles/art31981.asp

Notes on the film “GROWING UP HISPANIC”

In just 10 years, the United States Hispanic population jumped 58 percent, making it the largest minority group in the country. Today, 1 out of every 6 children in the United States is Hispanic, for a total of 12.3 million. Growing Up Hispanic examines the disparities that exist in healthcare for this segment of the population. The program travels inside the four largest Hispanic communities in the country: New York City, South Florida, southern Texas and southern California, to examine what is being done to combat the statistics surrounding Hispanics and healthcare, highlighting the steps some pediatricians, dentists, social workers and parents are taking to help children grow into healthy adolescents and adults.

Viewers will meet Raul Yzaguirre, president of La Raza, an organization dedicated to improving the lives of Hispanic people in America. Yzaguirre discusses three reasons behind the impressive growth of the Hispanic community in America, from inaccurate census counts to fertility levels to an increase in immigration.

Unfortunately, there is no safety in numbers. As the documentary explains, a disproportionate number of Latino children suffer from serious health problems like poor oral care and obesity. Hispanic boys and girls are the most overweight racial/ethnic group of U.S. children. Some experts blame genetics, culture, lifestyle and poverty. Many, like Dr. Francisco
Ramos-Gomez with University of California, believe the problems lie in the language barrier between physician and patient, education among immigrants and little or no insurance coverage.

_Growing Up Hispanic_ emphasizes the need for improved preventative medicine and social services within the Latino community. Hispanic doctors are encouraged to stay close to their people and heritage, and public education is seen as one of the keys to solving Hispanic health problems. Expert interviews and personal stories make _Growing Up Hispanic_ an insightful exploration into an epidemic plaguing America’s fastest growing ethnic group.

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**We are BORN that way**

A disturbing article appeared in the Wilkes-Barre, PA Times Leader on Sunday. It shows what happens when young gay men are pushed into believing their sexual orientation is a sin and that they can somehow change it.

Jeffrey Price, a gay young man age twenty, had been fighting his sexuality for a long time. Deep depression, two suicide attempts, and five stays in psychiatric wards marked his struggle, a reality not uncommon among gays his age. There was also a constant, driving fear that he let his father down. Jeff’s life ended in May of last year, cut short by what police described as "an accidental self-inflicted gunshot to the head."

As a fourteen-year old, Jeff explained to his parents that, "I like boys. I'm not really attracted to girls." His mother’s reaction was, "If you're trying to tell us you're gay honey, that doesn't change you as a person. You're still my son and you still have a beautiful heart. You're still the same person."

But Jeff’s father had a different take. He spent six years trying to comprehend Jeff’s homosexuality. He never told Jeff it didn’t matter. He said, “I don't hate you. I just don't understand it. I never will.” His dad had been in the military when being gay meant suffering beatings while superiors turned their heads,

At age fifteen, Jeff began attending the Back Mountain Harvest Assembly church, pastored by Rob Coscia. Jeff liked the man, opened up to him, turned to him for help in accepting himself for who he was. But the pastor believed that if a person didn’t want to be gay, they didn’t have to be gay and he told Jeff that with God’s help, he could change. As Jeff’s understanding of God strengthened, his displeasure with being homosexual grew.

Coscia told Jeff that he could help him rid his body of homosexuality and Jeff tried very hard to believe him. "I don't think God's plan was homosexuality in any way," Coscia told him after Jeff expressed a desire to deny his sexual orientation. “It's not like race, like you're born Caucasian or African-American. I let him know the he was not an aberration or a terrible person and God can do something about it."
Yet for all the spiritual guidance that came from Pastor Coscia, his inability to convert to a heterosexual was to Jeff just another form of failure. “Something’s wrong with me, but I don’t want to admit it,” he wrote in his journal. “I’m sorry I ever labeled myself as gay. Now it’s too hard to escape. I know if I start now at this young age I can become the man I’m supposed to be. The man that feels right. The man that has a family. But I want that with another man.”

Jeff swallowed a large amount of extra-strength painkillers at age 13, but threw them up later. “He had a lot of anger, but most of it came from himself, and being gay and not being able to do anything about it,” his mother said. “My son thought I was a hard-ass,” his father said. “You have your good days and your bad days. What father and son don’t see eye to eye sometimes? Yeah, I would have loved to have seen my son get married and have kids.” But Jeff felt that if his father couldn’t accept who he was, how could anyone else.

When he was in seventh grade, Jeff dated Amanda Maneval. They went to dances and their photo albums were filled with pictures of them. But Jeff confided to her that he was homosexual and the two stopped dating, although they remained friends.

Jeff fell in love with Shawn Bublo, a young man he had met at an after-care program for troubled kids when he was thirteen. After splitting up with Amanda, Jeff and Shawn entered into Jeff’s only attempt at a gay relationship. The pair dated for two years, until Jeff was sixteen. “After two years we weren’t the same people,” Shawn said. “He stopped going to church. He started getting mean upset a lot.” The two remained friends, however, and it was no secret that Jeff still loved Shawn.

At age seventeen, his parents knocked down Jeff’s bedroom door and found him laying on the floor, unconscious and mumbling incoherently. He had taken a handful of pills and barricaded himself in his room. He was rushed to Wilkes-Barre General Hospital, where doctors pumped his stomach. They saved his life. His suicide note read, “Please understand why I chose to die. I have suffered way too much. I would have suffered the rest of my life, so I had no choice at all...No matter what, no one could have helped. I was still gay and no one could change it.”

The last two years of his life saw changes in Jeff. In an effort to make new friends, he took up using marijuana, drinking, and hanging out with new people. It didn’t help. He still felt alone in a world where he wasn’t accepted for who he was.

Jeff’s poetry and journal became filled with obvious references to taking his own life. They were suicide notes written in short, broken sentences and grim stanzas. “Take away the pain, the tears, the longing and the fears.” A journal entry on May 16th read, “Wouldn’t it be nice to have someone miss me..."
Soon after that entry, Jeff visited his friend Shawn. He still had Shawn's picture on the TV in his bedroom. The two ran some errands. Shawn was the last person to see Jeff alive.

After Jeff’s death, his tragic end left friends and family still struggling for answers. His minister said, “Hopefully God used me to show Jeff God’s unconditional love. I just wish it didn’t have to come out this way.”

Shawn keeps pictures of him and Jeff on his computer to remember the fun they had as lovers and friends. “I don’t have as much fun with anyone else. I don’t even like clubs anymore. When I go, I just stand around and I’m bored. I just wish that somehow I could have helped him not be so down and out all the time.”

Amanda says she hopes to pay tribute to her lost friend by giving her first son the middle name of Jeffrey. “We were so good together, as friends and as a couple. There was such a strong bond.”

To Jeff’s mother, “It’s a devastating nightmare. He was a kind and compassionate person. I know how he died, but I’ll never know why.”

Jeff’s father is filled with regrets. He knows Jeff wasn’t a bad person because he was gay, he just never told him. He bowed his chin to his chest to hide his tears. He lifted his head up to reveal his red, watery eyes. “I just really miss him. At Jeff’s funeral the minister tried to talk to me. I said ‘I don’t think I believe in God right now. I feel like He let me down.”

This article doesn’t contain pictures. It doesn’t need to. The pictures of what happened to Jeffrey Price are there for all to see. It was a death that shouldn’t have happened. One that is all too familiar to most gay people. I thank Kris Wernowsky of the Wilkes-Barre Times Leader for giving birth to this article. It’s something every minister, priest, and pastor should think about before telling a gay person that they can change, that they weren’t born that way. It’s also something every straight person, especially parents of gay children, needs to understand so they can stop saying that gays have a choice concerning their lifestyle.

How many gay sons and daughters have to die before people will accept them for who they are and treat them like regular human beings?

http://www.bellaonline.com/ArticlesP/art28748.asp
III. Questions for Discussion

1. Explain the reasons for African-Americans’, Hispanics’, and Asians’ exclusion from the mental health treatment systems.

2. Explain how one’s values influence his participation in mental health care.

3. How do poverty and un- or underemployment contribute to mental health problems.

4. Explain how Asians’ coping mechanisms impact on their mental health care.

5. How would family culture influence African-Americans’, Hispanics’, and Asians’ participation in mental health treatment?

6. What are the common mistakes made in assessment of ethnic minority clients?

7. Why is infant mortality in African-Americans twice the rate of Caucasians?

8. Why is it not effective to prescribe the same dose of psychoactive medication to African-Americans as Caucasians?

9. Explain the role of the family and community in mental health care for ethnic minorities.

IV. Key Concepts

Hispanic
Asian and Pacific Islander
Latino
African-American
Gender role
Family structure
Gay
Homosexual
Lesbian
Transvestite
Transsexual
Bisexual