CHAPTER 5

Impact of Race, Ethnicity, and Culture on the Expression and Assessment of Psychopathology

L. KEVIN CHAPMAN, RYAN C. T. DELAPP, and MONNICA T. WILLIAMS

This chapter provides an overview and framework for understanding race, ethnicity, and culture as factors that affect adult psychopathology. Of primary interest are the assessment and treatment of psychopathology that integrates culturally salient values, ideologies, and behaviors into the mental health care of ethnic minorities. Moreover, the chapter is organized into two sections. In the first section, we present a model that highlights relevant multicultural factors that should be considered when working with ethnic minorities. The second section provides a discussion of how to effectively apply the knowledge of these multicultural factors when assessing or treating individuals with diverse ethnic backgrounds. Ultimately, the main objective of this chapter is to encourage mental health professionals to acknowledge the impact of race, ethnicity, and culture on adult psychopathology in order to optimize the efficaciousness of mental health services provided to ethnic minority individuals.

The existing literature has clearly demonstrated the importance of multicultural competency in the assessment and treatment of ethnic minorities. In particular, the relevance of ethnicity (or "a voluntaristic self-identification with a group culture, identified in terms of language, religion, marriage patterns and real or imaginary origins"; Bradby, 2012, p. 955) in adult psychopathology has been substantiated by evidence identifying disparities in prevalence rates, symptom presentation, and severity, as well as mental health service utilization across diverse ethnic groups. For example, Himle et al. (2009) found that most anxiety disorders (with the exception of post-traumatic stress disorder [PTSD]) were more prevalent among non-Hispanic Whites than among African Americans and Caribbean Blacks. However, despite their lower prevalence rates, researchers reported that African Americans and Caribbean Blacks experienced anxiety disorders that were greater in severity and more functionally impairing, which demonstrates how experiences with mental illness can vary by ethnicity. Moreover, ethnicity has been implicated as a differentiating factor in the diagnosis and treatment of schizophrenia (Fabrega et al., 1994; Cara et al., 2012).

These studies highlight the susceptibility of misdiagnosed schizophrenia in African American patients due to the tendency for African Americans to endorse more psychotic symptoms during diagnostic assessments. As a result, Gara et al. (2012) emphasize the importance of culturally sensitive diagnostic assessment tools by explaining how an inability to effectively discriminate schizophrenia and schizoaffective disorders can lead to poor treatment outcomes. Additionally, the relevance of ethnicity in adult psychopathology is bolstered by the findings of Alegria et al. (2007), who used data from the National Latino and Asian Study (NLAAS) to identify factors that influence the treatment-seeking behaviors of Latino individuals. Specifically, researchers found that age of migration, Latino ethnicity (e.g., Mexican, Puerto Rican), birth origin (e.g., U.S.-born, foreign-born), primary language spoken, and years of residency in the United States were all influential factors in the use of mental health services and the satisfaction with care received. Most notably, these findings highlight the impact of varied immigration statuses on the perspectives that ethnic minority individuals bring to the mental health arena. Overall, the aforementioned studies clearly underscore the need for multicultural competency in mental health professionals given that one’s self-identification with an ethnic heritage has proven to be a vital differentiating factor in the presentation of symptoms and treatment outcomes across diverse adult samples.

RELEVANCE OF ETHNIC IDENTITY AND ACCULTURATION IN ADULT PSYCHOPATHOLOGY

An understanding of the interaction between multicultural factors (e.g., ethnic identity, acculturation) and sociocultural factors (e.g., socioeconomic status, life stress) in ethnic minority patients has become undeniably germane to providing these individuals with effective mental health care. Prior to learning “how” to integrate the understanding of this interaction within assessment, diagnostic, and treatment practices, mental health professionals must possess the knowledge of “what” multicultural factors exist. Inasmuch, Carter, Sbrocco, and Carter (1996) proposed a theoretical model that acknowledges the role of ethnicity, or a “shared culture and lifestyle,” as a pivotal underlying construct in the epidemiology, symptom expression, and treatment of psychopathology in ethnic minority individuals (p. 456). Though initially created to explain variations of anxiety disorders in African Americans, the Carter et al. (1996) model can be utilized to more broadly understand the relationship between ethnicity and adult psychopathology by comprehending the salience of ethnic identity and acculturation in all ethnic minorities.

In particular, ethnic identity is a multifarious construct characterized by how people develop and maintain a sense of belonging to their ethnic heritage (Roberts et al., 1999). Important factors influencing a person’s ethnic identity include whether they personally identify as a member of an ethnic group, their sentiments and evaluations of the ethnic group, their self-perception of their group membership, their knowledge and commitment to the group, and their ethnic-related behaviors and practices (Burnett-Ziegler, Bohnert, & Ilgen, 2013). Extant literature has provided several models explaining the developmental stages of ethnic identity (Cross, 1978; Cross & Vandiver, 2001; Marcia et al., 1993; Phinney, 1989). Collectively, each model describes identity shifts between ethnic ambivalence (lack of interest or pride in one’s ethnic background), ethnic exploration (curiosity in one’s ethnic background potentially accompanied by a devaluing of other ethnic heritages), and multicultural acceptance (integration of commitment to one’s ethnic background which supports the idea that acceptance) typically mechanisms, experts (Chavez-Korvell, Bei Walker, Fields, Broo, Wong, and Turkheim not ubiquitous and re not Appel, and Lee (2015) of major depressive c of adult samples. Research lower likelihood of among Chinese Am sample. Though the findings, along with enhenc a strong sen culturally specific st an individual’s focus that the stage of eth attenuate the bufferi et al., 2013).

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to one’s ethnic background and an appreciation for other ethnic heritages). Evidence supports the idea that individuals high in ethnic identity (i.e., closer to multicultural acceptance) typically have higher levels of self-esteem, develop more protective coping mechanisms, experience more optimism, and report less psychological symptoms (Chavez-Korvell, Benson-Florez, Rendon, & Farias, 2014; Roberts et al., 1999; Smith, Walker, Fields, Brookins, & Seay, 1999; McMahon & Watts, 2002; Williams, Chapman, Wong, and Turkheimer, 2012). Notably, the protective nature of a strong ethnic identity is not ubiquitous and may vary across ethnic minority groups. For example, Ai, Nicadao, Appel, and Lee (2015) compared the relationships between ethnic identity and diagnosis of major depressive disorder (MDD) among Chinese, Filipino, and Vietnamese American adult samples. Researchers found that higher levels of ethnic identity were related to lower likelihood of MDD among Filipino Americans and higher likelihood of MDD among Chinese Americans. Ethnic identity was unrelated to MDD in the Vietnamese sample. Though the buffering effects of ethnic identity are evident for some, such findings, along with other research (Yip, Gee, & Takeuchi, 2008), suggest that experiencing a strong sense of belonging to a native heritage can amplify the impact of culturally specific stressors (e.g., discrimination, social inequalities), thereby enhancing an individual’s focus on their differences from majority culture. Past literature has found that the stage of ethnic identity development, age, and level of perceived stress can attenuate the buffering influence of high ethnic identity (see review by Burnett-Ziegler et al., 2013).

Another relevant construct implicated in the Carter et al. (1996) model is acculturation, traditionally defined as the extent to which ethnic minorities adopt the values and participate in the traditional activities of mainstream culture. Recent re-conceptualizations of the acculturation process utilize a multidimensional perspective where ethnic minorities must reconcile discrepancies in their identity (the salience of one’s ethnic versus national identity), value system (individualism versus collectivism), language proficiency, cultural attitudes and knowledge, as well as cultural practices (Park & Rubin, 2012; Schwartz et al., 2013; Yoon et al., 2013).

According to a meta-analysis of 325 studies about the relationship between acculturation and mental health, Yoon et al. (2013) found that mainstream language proficiency was negatively associated with negative mental health, whereas endorsing an ethnic identity was positively related to positive mental health. Most importantly, these findings demonstrate how complex the relationship between acculturation and psychopathology can be, which emphasizes the need for mental health professionals to consider the relevance of each acculturation dimension (e.g., identity, language, value system, behaviors) when working with ethnic minorities. Furthermore, the acculturative stress of integrating disparities in ethnic and mainstream culture across these dimensions can result in difficulties adapting to mainstream culture and/or perceived rejection from one’s native heritage (Schwartz et al., 2013), which has been associated with psychopathology in ethnic minority adults (e.g., more eating-disorder symptoms (Van Diest, Tartakovsky, Stachon, Pettit, & Perez, 2013) and greater levels of depression (Ai et al., 2015; Driscoll & Torres, 2013; Jaggers & MacNeil, 2015; Park & Rubin, 2012). When confronted with such cultural disparities, extant literature has identified biculturalism, or the ability for ethnic minorities to effectively integrate elements of two cultural streams, as one of the most protective acculturation statuses against negative health outcomes (Schwartz et al., 2013). For example, Wei et al. (2010) found that high levels of bicultural competence (or the ability to navigate between two groups without undermining one’s cultural identity) among ethnic minority college students were protective against depressive symptoms despite experiencing high levels of minority stress.
Alternative acculturative statuses include strongly adhering to the mainstream culture and devaluing native heritage (assimilation), strongly adhering to the native heritage and devaluing the mainstream culture (separation), and exhibiting little interest in adhering to either cultural stream (marginalization; see Matsunga, Hecht, Elek, & N diarrhea, 2010; Yoon et al., 2013). Overall, the existing literature has yielded inconclusive findings clarifying the impact of acculturation on the mental health of ethnic minorities (see Concepcion, Kohatsu, & Yeh, 2013), which has been accredited to the multiple definitions of acculturation (e.g., time since immigration, language fluency, acculturation status) and examining this construct in few ethnic minority groups (Burnett-Zeigler et al., 2013; Yoon et al., 2013).

Aside from knowing of ethnic identity and acculturation, mental health professionals must also understand how these constructs interact to influence the psychopathology expressed in many ethnic minority individuals (Yoon et al., 2013). In referencing the Carter et al. (1996) model, African Americans who maintain a strong ethnic identity and are highly assimilated in the dominant culture are believed to endorse traditional beliefs of mainstream society (e.g., individualism) and exhibit symptom presentations consistent with the current diagnostic nomenclature. Notably, it is theorized that these individuals may feel conflicted by being acculturated to believe psychological treatment is effective while embodying a mistrust of societal systems in mainstream culture as a result of historically significant cultural experiences (e.g., perceived discrimination from individuals of the dominant culture). Similarly, Carter et al. (1996) conceptualized that African Americans low in ethnic identity and highly assimilated will exhibit a traditional symptom presentation, but will be more willing to seek, persist through, and benefit from traditional treatment practices. In contrast, individuals high in ethnic identity who strongly de-identify with mainstream culture (separation acculturation status) represent a subset of ethnic minorities who may display unique symptom presentations and utilize culturally specific explanations for their symptoms, thereby resulting in a greater likelihood of misdiagnosed psychopathology. Further, these individuals are theorized to be less likely to seek treatment due to mistrust in and/or a limited knowledge of mental health care.

Although there is a dearth of literature devoted to examining the additive impact of ethnic identity and acculturation on adult psychopathology (Chae & Foley, 2010), several studies provide evidence supporting the broad application of the Carter et al. (1996) model across diverse ethnic minority groups. Burnett-Zeigler et al. (2013) examined the relationship among ethnic identity, acculturation, and the lifetime prevalence of mental illness and substance use in African American, Latino, and Asian samples. Results indicated that higher levels of ethnic identity, and not higher acculturation, were related to decreased lifetime prevalence of psychiatric illness and substance use for each minority group. Notably, higher acculturation (e.g., use of English language or social preference for individuals not in ethnic group) was associated with increased prevalence of depression in African Americans and Hispanics, increased bipolar diagnoses in Hispanics, and increased anxiety disorder diagnoses for all minority groups. Regarding substance use, higher acculturation was related to increased lifetime prevalence of alcohol and drug use among the Hispanic and Asian sample. These findings suggest that having a strong sense of pride and belonging to an ethnic heritage is protective; however, nondominant individuals who are unable to maintain cultural ties with their native heritage (e.g., first language, relationships with members of ethnic group) may be more susceptible to negative health outcomes.

Nascent literature has provided a more specific understanding of the interaction between these two constructs by utilizing acculturation statuses (e.g., integration, assimilation, separation, and marginalization; see Takac, 2015). Researchers have examined the impact of acculturation on health outcomes among minority individuals, with studies focusing on various conditions such as mental health, physical health, and health behaviors. For example, a study by Yoon et al. (2013) found that higher levels of acculturation were associated with better mental health outcomes among Korean Americans. Similarly, a study by Guo et al. (2010) found that higher levels of acculturation were associated with better physical health outcomes among Chinese Americans.

Relevance

Although an understanding of the role of acculturation in ethnic identity is important to explain some of the unique experiences of ethnic minority individuals, it is essential to consider the impact of socioeconomic status (SES) on health outcomes. Ethnic minority individuals who have lower SES are at a greater risk for negative health outcomes due to systemic barriers and discrimination. Researchers have examined the relationship between SES and health outcomes among ethnic minority individuals, with studies focusing on various conditions such as mental health, physical health, and health behaviors. For example, a study by Yoon et al. (2013) found that higher levels of acculturation were associated with better mental health outcomes among Korean Americans. Similarly, a study by Guo et al. (2010) found that higher levels of acculturation were associated with better physical health outcomes among Chinese Americans.
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**RELEVANCE OF SOCIOCULTURAL FACTORS IN ADULT PSYCHOPATHOLOGY**

Although an understanding of the aforementioned constructs is essential, it is equally important to examine the impact of other sociocultural variables that also exert a considerable degree of influence over the symptom presentation and treatment outcomes of ethnic minorities. Although extant literature has identified myriad variables that impact minority mental health, the current chapter solely focuses on socioeconomic status (SES), stressful life events, and age cohort, which were each identified by the Carter et al. (1996) model as important contributors to the mental health of ethnic minorities.

Researchers propose that SES can provide a more precise understanding of the relationship between ethnicity and adult psychopathology by focusing on the specific environmental elements that characterize each social class. Past literature has shown that high SES is related to better health outcomes. One study by Shen and Takeuchi (2001), examining the relationship between acculturation, SES, and depression in Chinese Americans, found that SES was a better indicator of depressive symptoms than acculturation and that high-SES individuals (i.e., high educational attainment and increased income) had better mental health outcome (i.e., fewer depressive symptoms) compared with low-SES individuals. These findings suggest that it is through the variance in SES and related variables (e.g., perceptions of stress, social support, and physical health) that acculturation may impact the mental health of nondominant individuals (Shen & Takeuchi, 2001). By contrast, nascent literature has begun to propose that the association between social class and mental health is much more complex in that evidence has supported that low-SES and/or foreign-born individuals are not automatically guaranteed poor health outcomes (John, de Castro, Martin, Duran, & Takeuchi, 2012). Rather, it has also been shown that middle class status may be associated with higher rates of affective disorders relative to lower and high classes (Prins, Bates, Keyes, & Muntaner, 2015). Given such findings, it suggests that mental health professionals should acknowledge the detrimental as well as the protective elements of one's social class.

Also, the Carter et al. (1996) model identifies stressful life events as a contributor to the variability in the psychopathology of ethnic minorities. Though a comprehensive understanding of the multiple forms of stress (e.g., violence exposures, neighborhood context,
poverty, etc) is beyond the scope of this chapter, extant literature pinpoints race/ethnic-based stress as influential to the mental health of ethnic minority individuals. In particular, Greer (2011) describes racism as “complex systems of privilege and power, which ultimately serve to threaten and/or exclude racial and ethnic minorities from access to societal resources and other civil liberties” (p. 215). As a result of such racial/ethnic injustice, many ethnic minorities are subjected to damaging race/ethnic-focused attitudinal appraisals (i.e., prejudice), race/ethnic-focused assumptions (i.e., stereotypes), and unjust treatment based upon their race/ethnicity (Greer, 2011).

Past studies have indicated that exposure to such race/ethnic-based experiences are strong indicators of mental health outcomes across diverse ethnic minority groups [e.g., discrimination was related to increased lifetime prevalence of generalized anxiety disorder in African Americans (Soto, Dawson-Andoh, & BeLue, 2011) and perceived discrimination was associated with increased anxiety, affective, substance abuse disorders among African Americans, Hispanic Americans, and Asian Americans (Chou, Asnaani, & Hofmann, 2011)]. Notably, empirical evidence suggests that perceived discrimination may be particularly salient to African American clients, given that several studies have found that African Americans endorse greater degrees of perceived discrimination in comparison to other ethnic minority groups in the United States (Cokley, Hall-Clark, & Hicks, 2011; Donovan et al., 2013). Overall, when utilizing ethnic identity and acculturation to gain insight into the culturally specific worldviews of nondominant individuals, it is imperative that mental health professionals also examine the occurrence and impact of race/ethnic-based stressors on the psychopathology of ethnic minorities.

Finally, the Carter et al. (1996) model discusses the relevance of age cohort in the manifestation of psychopathology in ethnic minorities. The evolution of the “social, economic, and political climate” in the United States has yielded diverse experiences across generations of ethnic minorities in this country, thereby impacting the meaning of ethnicity for each generation (Carter et al., 1996, p. 460). In the context of each ethnic group, there are different historical details separating each generation; however, the impact of age cohort on psychopathology remains a relevant consideration. In general, existing literature has implicated intergenerational disparities in perceived racial discrimination (Yip et al., 2008), ethnic identity (Yip et al., 2008), acculturation status (Buscemi, Williams, Tappen, & Blais, 2012), and lifetime prevalence of psychiatric illness (Breslau et al., 2006) across the adult lifespan. One study particularly relevant to this chapter’s discussion of the Carter et al. (1996) model examined the protective and/or exacerbating nature of ethnic identity in the relationship between racial discrimination and psychological distress in Asian adults (Yip et al., 2008). Results indicated that ethnic identity appeared to buffer the negative impact of racial discrimination on the psychological distress for adults aged 41–50 years, yet exacerbate the effects of racial discrimination for adults aged 31–40 years and 51 and older. In an attempt to explain these findings, Yip et al. (2008) theorize that the former age cohort is more likely to have a stable lifestyle with more coping mechanisms for stress, whereas the latter age cohorts may characterize adults who are in the exploration phase of their ethnic identity, which, therefore, heightens their sensitivity to being unfairly treated on the basis of their race/ethnicity. Furthermore, the parent–child relationship is another important way that intergenerational differences can impact adult psychopathology, especially for immigrant families (Kim, 2011; Vu & Rook, 2012).

In a study examining intergenerational acculturation conflict and depressive symptoms among Korean American parents, Kim (2011) found that greater discrepancies in cultural values between parent and child (greater intergenerational conflict) were related to increased parenthood than in fathers' (e.g., to be a "wet nurse" incongruously withively, such finding culturally specific minorities.

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**Expression of Psychopathology**

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to increased parental depressive symptoms—an association more pronounced in mothers than in fathers. It was proposed that the cultural expectations of the Korean mother (e.g., to be a “wise and benevolent” primary caregiver) was conflicted by an incongruence with the value system of mainstream culture (Kim, 2011, p. 691). Collectively, such findings provide evidence that the Carter et al. (1996) model elucidates culturally specific considerations for psychological distress among diverse ethnic minorities.

EXPRESSION/ASSESSMENT OF PSYCHOPATHOLOGY

Aside from the administration of culturally sensitive assessment tools to aid in the accurate diagnosis of psychopathology among ethnic minority patients, the current literature has implicated cultural factors endemic to ethnic groups that may influence the expression of their symptomology. The following section presents a general overview of how factors, such as stigma surrounding mental illness and perceived discrimination, impact various forms of symptom expression among non-Western and Western ethnic groups.

Expression of Psychopathology Differs Across Cultural Groups

It is often unclear how symptom profiles may differ between ethnic groups when typical research studies use structured instruments, based on an a priori set of questions believed to exemplify the disorder under investigation. Measures based on Western notions of prototypical symptoms will fail to capture cultural differences in the expression of all disorders. Thus, variations in symptom patterns are often overlooked or misunderstood. Such misunderstandings affect how we, in turn, conceptualize even seemingly well-defined disorders. The DSM-5 recognizes several cultural concepts of distress or mental disorders that are generally limited to specific cultural groups for certain dysfunctional and/or distressing behaviors, experiences, and observations (American Psychiatric Association, 2013).

Many culture-bound syndromes are likely unrecognized variations of common Western ailments. For example, susto is a folk illness seen in many Latin American and Native American communities that is attributed to having an extremely frightening experience. Although it is historically translated as “soul loss,” a closer meaning to this may actually be loss of “vital force,” as the soul is typically not thought to have actually left the body until death (Glazer, Baer, Weller, García de Alba, & Liebowitz, 2004). People afflicted with susto may have symptoms that include nervousness, loss of appetite, insomnia, listlessness, despondency, involuntary muscle tics, and diarrhea. The symptoms of susto are actually quite similar to PTSD, which includes anxiety, avoidance, dissociation, jumpiness, sleep disturbances, and depression. Loss of “vital force” could resemble the fatigue and anhedonia, which may be a part of depressive symptoms within PTSD. Additionally, feeling as if one’s soul has been lost may be an idiom of distress for dissociation. Therefore, the concept of susto as a culture-bound syndrome may be better conceptualized as a culture-specific description of PTSD itself.

Interestingly, Latin American folk treatments for the disorder include elements of exposure-based therapies for PTSD (e.g., Williams, Cahill, & Foa, 2010). During the treatment ritual, the individual afflicted with susto must recount their terrifying experience while lying on the axis of a crucifix on the floor. Fresh herbs are swept over the afflicted individual’s body while the folk healer says a series of healing prayers (Gillette, 2013). If the first session is not effective, the process is repeated every third day until the
patient is recovered. This repeated recounting process is a critical active ingredient in prolonged exposure and cognitive processing therapy, both highly effective treatments for PTSD, which likely accounts for some of the effectiveness of this folk remedy. Sugar, water, and tea may also be used to treat symptoms of chronic susto (Glazer et al., 2004), and in fact herbs used in traditional Mexican medicine have been found to possess anxiolytic effects (Herrera-Ruiz et al., 2011). In terms of conventional treatment for susto, because it is a folk illness, with roots deep in the Hispanic culture, patients may not believe they can be cured by modern methods, and therefore may be less likely to seek mental health care and less likely to believe they can be helped by Western treatments (Gillette, 2013). However, it is worth noting that effective folk remedies for susto have been available for centuries, whereas modern psychological treatments like prolonged exposure were developed relatively recently.

Another example of the connection between DSM disorders and culture-bound syndromes can be seen in the enigmatic ailment called koro. Though uncommon in Western cultures, koro is characterized by anxiety over the possibility of one’s genitalia receding into the body, resulting in infertility or death (Chowdhury, 1990). To prevent any envisioned shrinkage or retraction of the genitals, a koro sufferer will perform certain behaviors (i.e., pulling of genitals, spiritual rituals, securing genitals to prevent retraction) intended to reduce or eliminate this risk. Obsessive-compulsive disorder (OCD) is characterized by distressing and typically implausible obsessions, with compulsions designed to reduce the anxiety caused by the obsessions. Davis, Steevers, Tervilliger, and Williams (2012) note the possibility that koro is simply a form of OCD, as an alternative to the current conceptualization as a culture-bound syndrome or cultural concept of distress. The most salient feature of koro concerns the anxiety surrounding the retraction and shrinkage of genitalia. The degree to which this distress can impair the daily functioning of those with koro has marked similarities to the construct of obsessions in OCD. This, coupled with the improbability of one’s genitalia actually receding into one’s body for good, makes it possible to categorize this fear as an implausible obsession.

Sexual obsessions are extremely common in OCD worldwide (Williams & Steevers, 2015), but these types of thoughts are considered taboo or embarrassing in most cultures. Thus, the stigma and shame attached to the experience of sexual symptoms of OCD are exceptionally distressing (Glazer, Wetterneck, Singh, & Williams, 2015). Furthermore, Bernstein and Gaw (1990) note that sexual identity questions and conflicting feelings about sexuality are common in the experience of koro. Similarly, approximately 10% of treatment-seeking OCD patients report concerns about their sexual identity as a main concern (Williams & Farris, 2011). In OCD, these worries often manifest as fears of experiencing a change in sexual orientation, which is strikingly similar to the worries reported to underlie many cases of koro. Finally, koro has been shown to respond well to behavioral psychotherapy and medications like selective serotonin reuptake inhibitors (SSRIs; Buckle, Chuah, Fones, & Wong, 2007). These same treatments have long been the preferred method of treatment for OCD and its subtypes. Thus, koro is likely simply a cultural variant of OCD.

Although listed in the DSM-5 as a cultural concept of distress, neurasthenia, or shenjing shuijia, is currently a recognized mental disorder in the World Health Organization’s International Classification of Diseases (ICD-10) and in the Chinese Classification of Mental Disorders. Traditional Chinese medicine describes shenjing shuijia as a depletion of vital energy and reduced functioning in critical internal organs. The Chinese Classification of Mental Disorders considers it a mental disorder that may include weakness, emotional symptoms, excitement symptoms, tension-induced pain, and sleep disturbances. Neuropsychiatric illnesses, such as depression, anxiety, and personality disorders, may also be associated with neurasthenia.

Expression of Psychiatric Illnesses

African Americans are not just more prone to mental illness; they are also more likely to experience psychological distress and depression in their daily lives. According to a study by the National Institute of Mental Health, African Americans are twice as likely to experience depression and anxiety compared to whites. Despite this, African Americans are less likely to seek mental health care, and when they do, they are less likely to be diagnosed with depression.

The study found that African Americans were less likely to seek mental health care due to cultural beliefs and stigma. For example, some African Americans believe that mental illness is a sign of weakness or weakness of the will, and that seeking help is a sign of weakness. In addition, African Americans are more likely to experience discrimination in health care settings, which can lead to a reluctance to seek help for mental illness.

In conclusion, while African Americans are more likely to experience mental illness, they are less likely to seek help due to cultural beliefs and discrimination. This highlights the need for increased awareness and education about mental illness among African Americans and the importance of addressing discrimination in health care settings.
tive ingredient in effective treatments like remedy. Sugar, etc. (2004), found to possess analgesic properties for susto. Patients may not less likely to seek treatment for susto have symptoms like prolonged culture-bound unusual in the context of one's genitalia. To prevent this, Davis, Steever, 2012, found obsessive-compulsive symptoms in five major areas, including contamination and washing, sexual obsessions and reassurance, aggression and mental compulsions, symmetry and perfectionism, and doubt and checking. These dimensions are similar to findings of studies in primarily White samples. However, African Americans with OCD report more contamination symptoms and were twice as likely to report excessive concerns with animals compared with European Americans with OCD.

These notable cultural differences are consistent with findings among nonclinical samples (e.g., Thomas, Turkheimer, & Oltezmann, 2000). Williams and Turkheimer (2007) studied racial differences in OCD symptoms and found that a nonclinical sample of African Americans scored significantly higher on an animal attitude factor than European Americans, meaning they had greater concerns about animals, and it was determined that cultural factors explained this difference. It was hypothesized that the Western perspective of animals as pets is more socially acceptable among European Americans than other cultures which are more likely to regard animals as a source of food or vehicle for labor. Other cultural differences may relate to earlier practices such as the use of dogs as a means to hunt slaves or attack protesters during the Civil Rights era. This is consistent with recent work suggesting that African Americans may experience greater phobias of animals (Chapman et al., 2008). As such, cultural differences are plausible contributing factors for increased animal sensitivity among those with OCD. Fear of being misunderstood was also more frequently endorsed by African Americans with OCD (Williams et al., 2012). An obsessive need to be perfectly understood could be a unique finding for African Americans related to fears of appearing unintelligent, resulting in stereotype compensation—an intentional effort to present oneself in a counterstereotypical manner (Williams, Turkheimer, Magee, & Guterbock, 2008). Finally, one epidemiological study found that that OCD symptom severity was significantly correlated to racial discrimination but not other forms of discrimination, such as discrimination based on gender or sexual orientation.
PREVALENCE RATES MAY DIFFER FOR CULTURAL REASONS

Prevalence rates of various disorders may also differ for cultural reasons. For example, the National Survey of American Life (NSAL) conducted a comprehensive nationwide study of African American and Caribbean Blacks. They interviewed a large number of adults (n = 5,191) and adolescents (n = 1,170) in their homes, using professionally trained, ethnically matched interviewers. Their study was the first to examine the prevalence, age of onset, and gender differences in a number of mental disorders in a nationally representative Black sample (Taylor, Caldwell, Basen, Faison, & Jackson, 2007). Findings were consistent with previous research indicating that anorexia nervosa is rare among African Americans. In fact, not a single woman in the study met criteria for anorexia in the previous 12 months, and there were no reports of anorexia in Caribbean adults. These findings indicate that Black Americans are at lower risk of anorexia than their White counterparts. Likewise, a related study found that Hispanic and Asian American female adults experienced similarly low rates of anorexia nervosa (Franko, 2007). The authors of that study suggested that detection and barriers to treatment may be a factor in the lower rates, but there has been very little research focused on what cultural factors may differentially protect minorities from this disorder and yet promote it in European Americans.

Another way in which culture may impact psychopathology can be found in the frequencies of specific symptoms within a disorder. For example, Chapman and colleagues (Chapman et al., 2008, 2011) found that both African American college students (2008) and African American adults from the community (2011) reported more animal and social fears than did their European American counterparts. These results indicate the need for further exploration of cultural factors and their impact on psychopathology.

STIGMA AND SOMATIZATION OF DISTRESS ACROSS CULTURES

Although there is a general tendency toward somatization across all cultures, ethnic minority individuals in the United States appear more likely to express psychological distress through bodily symptoms for two primary reasons: (1) as compared with European Americans, there is a higher level of stigma associated with mental illness and, therefore, physical symptoms are more socially acceptable; and (2) there is more holistic conceptualization of the person, and, therefore, less of a distinction between mind and body among ethnic minorities (USDHHS, 2001).

For many groups there is considerable stigma attached to being afflicted by mental illness, and thus clients from these groups may be more comfortable reporting physical symptoms over affective and cognitive symptoms. One study of African Americans found that concerns about stigma prompted most mental health care consumers to initially avoid or delay treatment, and once in treatment, they commonly faced stigmatizing reactions from others (Alvidrez, Snowden, & Kaiser, 2008). Hunter and Schmidt (2010) developed a model that incorporates stigma, racism, and somatization into the expression of anxiety in African Americans. The emphasis on physical illnesses over mental illness in African American communities is thought to be related to physical explanations of somatic symptoms of anxiety, including attributing these to conditions like cardiovascular disease, and subsequent help-seeking oriented to these explanations. In particular, anxiety disorders among African Americans are likely to include both fears related to minority status and catastrophic interpretations of somatic symptoms. They propose that these differences, because of their implications for measurement and diagnosis, can explain cultural differences.

Western models of mental health are regarded as having many common mental health issues. For example, many cultural traditions hold that the mind and body are connected, and the salience of the body's sensations and experiences is recognized.

SPIRITUALITY AND RELIGION

Spirituality and religion are important factors that may influence mental health and thus affect treatment outcomes. In the United States, many people identify with a particular religious affiliation. For example, the American Psychological Association's Office of Religion and Research Center, which focuses on research related to spirituality and religion, has been active in promoting greater understanding of how religious beliefs and practices influence mental health and well-being. Devout or orthodox individuals often have strong beliefs about the role of their faith in their lives and thus may be more inclined to seek guidance from religious leaders or other spiritual community members in times of stress or crisis.

Over the past several decades, research on the relationship between religion and mental health has been extensive. The link between religious involvement and mental health has been well documented. For example, religious involvement has been associated with reduced symptoms of depression and anxiety, greater emotional well-being, and improved overall mental health. This relationship is thought to be mediated by factors such as social support, greater sense of community, and a sense of purpose and meaning in life.

RACISM AND DISCRIMINATION

As previously noted, discrimination is a common phenomenon in many cultural groups around the world. This includes various populations such as African Americans, Latinos, Native Americans, Asian Americans, and lesbian, gay, bisexual, and transgender individuals. Discrimination can have a significant impact on mental health, leading to increased stress, anxiety, and depression. Understanding the role of discrimination in mental health outcomes is critical for designing effective interventions.

However, cultural factors also play a significant role in mental health. Cultural norms, beliefs, and practices can influence how mental health issues are perceived, diagnosed, and treated. For example, cultural beliefs about the mind-body relationship can affect how patients present their symptoms and how providers respond to them. Understanding these cultural factors is crucial for developing culturally competent mental health services.
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Western models of health and illness often depict a fragmented representation of the person to conceptualize mental and physical processes. For example the mind and body are regarded as separate (called dualism), and then the mind is even further divided in many common models (e.g., psychodynamic personality model of id, ego, and superego; cognitive behavioral therapy’s affective, behavioral, and cognitive components). However, many cultures do not make a distinction between the mind and body. Additionally, many cultural traditions recognize the spirit as an integral part of the person, inseparable from the mind and body (e.g., Parham, 2002). Thus, omitting this component will reduce the salience of the treatment in such clients.

SPIRITUALITY AND RELIGION

Spirituality and religious beliefs can be the most important facets of a person’s identity, and thus appreciating spiritual and religious diversity is essential to multicultural competency. In the United States, 89% of adults say they believe in God, 77% have a religious affiliation, and 53% say their beliefs are very important to their lives (Pew Research Center, 2015). When help is sought, clients typically look for someone who shares the same values. Thus, therapists will be viewed as more credible in the community if they are competent in religious/spiritual issues.

Devout or orthodox members of most religious traditions tend to have negative perceptions of the mental health professions, distrust therapists, and under-utilize mental health services. This is in part because traditionally the field of psychology has been hostile toward religion. Psychologists are more secular and less religious than the population at large, and therapists have tended to reject organized religious involvement; thus, there is a religiosity gap between mental health providers and the US majority. As a result, building trust may be challenging when working with devout clients, and, in such cases, learning about a client’s religious tradition is essential to building rapport. At the very least, it is essential for therapists to avoid interventions that conflict with normative religious beliefs, and at best therapists can incorporate a client’s religious practices into treatment. Therapists need to be able to understand individuals and their beliefs within their cultural context (Richards, Keller, & Smith, 2004).

Over the past few years, an uneasy truce has developed between psychology and religion. This is due in part to new research that shows the important role of religion in mental health and well-being. For example, meditation and prayer are correlated with reduced blood pressure and pulse, lower endocrine activity, and lower metabolism. Religious involvement has also been shown to buffer against emotional difficulties, such as depression and anger. Thus a variety of psychological and spiritual interventions may be appropriate with religious clients, depending on the client, the nature of the problem, and the therapist’s religious knowledge.

RACISM AND DISCRIMINATION

As previously noted, the experience of being a stigmatized ethnoracial minority is a common phenomenon across cultures, with profound implications for mental health. This includes visible minorities in the United States and Canada, as well as ethnic and cultural groups in other countries, such as Blacks in the United Kingdom, Turks in Germany, and the Dalit in India. Many studies have established a link between
discrimination and mental health outcomes. In the United States, African Americans experience the greatest amount of racial discrimination, followed by Asian Americans and Hispanic Americans (Chou et al., 2012). Perceived discrimination has been found to be negatively correlated with mental health, and the effects seem to be strongest (most detrimental) for Asian Americans, followed by Hispanic Americans, followed by African Americans (Coley et al., 2011).

In addition to overall psychological distress, racism and discrimination have been associated with several specific mental health problems, including stress (Clark, Anderson, Clark, & Williams, 1999), depression (Banks & Kohn-Wood, 2007; Torres, Driscoll, & Burrow, 2010), anxiety (Hunter & Schmidt, 2010), binge drinking (Blume, Lovato, Thyken, & Denny, 2012), PTSD (Pieterse, Todd, Neville, & Carter, 2012), and psychosis (Berger & Sarnyai, 2015). A strong, positive ethnic identity has been shown to be a potential protective factor against psychopathology among minorities (e.g., Williams, Chapman, et al., 2012), except when discriminatory events are severe (Chae, Lincoln, & Jackson, 2011). Failure to understand the role of racism and discrimination limits our understanding of mental health in stigmatized people groups.

Focusing specifically on the link between racism and PTSD can help us to understand how Eurocentric models may sometimes be inadequate for identifying distress in minority populations. The criteria for a PTSD diagnosis implies that a traumatizing event must involve a threat to an individual's physical well-being. Although this description may address many forms of ethnocentrically motivated traumatic events, it does not take into account how ongoing lower levels of racism that can lead to a general sense of distress and uncontrollability (Carter, 2007). These experiences, though they may not be physical in nature, attack the individual's identity and force the person to re-experience traumas associated with their culture's history (Helms, Nicholas, & Green, 2010).

Previous editions of the DSM recognized racism as trauma only when an individual met criteria for PTSD in relation to a discrete racist event. This is problematic given that many minorities experience cumulative experiences of racism as traumatic, with a discrete event acting as "the last straw," triggering trauma reactions (Carter, 2007). Thus, current conceptualizations of trauma as a discrete horrific event may be limiting for minorities. Recent changes to the DSM may open the door for wider recognition of racism-related trauma. It is now within criteria that a person can have PTSD from learning about a traumatic event involving a close friend or family member, or if a person is repeatedly exposed to details about trauma (APA, 2013). This could encompass trauma resulting from ongoing racial stressors (Malcoun, Williams, & Bahojb Nouri, 2014).

Moreover, existing PTSD measures aimed at identifying an index trauma fail to include racism among listed choice response options, leaving such events to be reported as "other" or made to fit into an existing category that may not fully capture the nature of the trauma (e.g., physical assault). This can be problematic since minorities may be reluctant to report experiences of racism to European American therapists (Carter, 2007), who comprise the majority of mental health clinicians in the United States. Minority clients also may not link current PTSD symptoms to a single experience of racism if their symptoms relate to cumulative experiences of discrimination.

Bryant-Davis and Ocampo (2005) noted the similar courses of psychopathology between rape victims and victims of racism. Similar to rape victims, race-related trauma victims may respond with dissociation or shock, which can prevent them from responding to the incident in a functional manner. Victims may then feel shame and self-blame because they were unable to respond or defend themselves, which may lead to self-blame or self-destructive behaviors (Bryant-Davis & Ocampo, 2005). In the same investigation, a parallel was drawn between race-related trauma victims and victims of domestic violence. In both situations, victims are likely to experience feelings of worthlessness and loss of control over their lives.

Language and Symptom

Another influence on the expression of PTSD is the language in which symptoms are reported. For example, Díaz et al. (2001) found that Hispanic Americans are more likely to report symptoms related to PTSD when using bilingual English-Spanish language than when using solely English. This is particularly important in situations where individuals are not fluent in English, as this may affect the accuracy of diagnoses and treatment planning.

As the US continues to become a more ethnically diverse country, understanding the impact of race and ethnicity on mental health is crucial. This requires a cultural approach to treatment and therapy, which can enhance the success of interventions for diverse populations.
African Americans and Asian Americans have been found to experience the strongest (most internalized) dissonance. Despite this, African Americans and Asian Americans have been found to experience the strongest (most internalized) dissonance.

Language and Symptom Expression

Another influence on symptom expression is the language used by clinician and client. For example, Diaz et al. (2009) examined the influence of language in the diagnosis of major mental disorders. A total of 259 bilingual Latino, monolingual English-speaking Latino, and European American adults with a history of MDD or psychotic symptoms were compared using structured interviews. Compared with European Americans and monolingual English-speaking Latinos, bilingual Latinos had significantly higher rates of diagnosed MDD and significantly lower levels of mania. No significant differences were found between monolingual English-speaking Latinos and European Americans. Between the three study groups, there was no significant difference in level of functioning, psychotic symptoms, or severity of depression. The authors concluded that the diagnostic process is affected by the combination of culture and language, notably being bilingual English/Spanish speaking. Thus, there appears to be an important effect of language on the report and diagnosis of psychopathology (Malgady & Constantino, 1998).

Treatment Issues

As the USA continues to diversify, the understanding of the role of culture, race, and ethnicity in treatment remains paramount and is essential to culturally proficient work with ethnic minority patients. In the following section, a discussion of how such factors can influence various domains of the treatment process (e.g., therapeutic alliance, clinical judgments, and client perspectives) is presented. It is worth noting that the following treatment considerations are not comprehensive, but rather a general overview of how acknowledging the impact of certain cultural factors when working with ethnic minority patients can enhance the efficiency and effectiveness of treatment.

Clinician and Client Interplay

As noted in the previous edition, ethnic minority clients report feeling more comfortable discussing psychological problems with someone of the same ethnic background (for review, see Chapman, DeLapp, & Williams, 2014; Jackson et al., 2004), and they may answer questions about symptoms differently when this match is present (e.g., Williams & Turkheimer, 2008). Ethnic minority clients may perceive their counseling experience to be more effective when they are ethnically matched (Lee, Sutton, France, & Uhlemann, 1983), and non-Hispanic White clients may feel more comfortable with someone of the same ethnic group (Davis, Williams, & Chapman, 2011). Matching has been shown to strengthen the therapeutic alliance and improve retention (Flicker et al., 2008). However, cultural matching is not always possible due to a lack of availability of a clinician of the same ethnicity as the client, and it may not be desirable from the client’s perspective (e.g., could be perceived as “forced segregation”; Pole, Gone, & Kulkarni, 2008). Moreover, cross-cultural understanding of the client–therapist relationship may be enhanced by examining dynamics and issues surrounding race. Thus, cross-cultural training is essential for all clinicians (Miller et al., 2015).

Cultural traditions vary in relation to the manner in which clinicians are regarded. Many consider therapists as authority figures and will feel uncomfortable challenging or
disagreeing with their clinician. For example, when a Japanese client enters a consulting room, it is common for the client to just sit very tensely in front of the therapist and calmly answer questions. Japanese clients typically want to perform ideally, and this is reflected in therapist–client relationship. Clients tell the therapist their issues, and then just wait for the therapist to analyze them. Clients expect the therapist to tell them what to do. From a Western viewpoint, this can be seen as dependent, but it is actually a way for Japanese people to show respect by giving power to those in authority. Non-Hispanic White therapists can find it difficult to work with Japanese clients if the therapist is not aware of the power dynamics within the Japanese culture. When the Japanese utilize psychotherapy services, they generally apply Japanese methods of forming relationships, creating a hierarchical relationship between client and therapist. A Japanese client was assessed by a Western therapist without this understanding and the therapist believed the client had no sense of self, describing the client as passive, needy, and repressed. Japanese clients sometimes feel helpless and this might be misinterpreted as playing a victim role. However, from the client’s view, it is considered culturally appropriate (Nipoda, 2002). This example also illustrates how cultures differ in terms of what they consider to be the role of the therapist or healer. For example, within the Afrocentric framework, the essence of all things is spiritual. The spirit is energy and life force in each person, which constitutes a self-healing power. Thus, therapy becomes a process or vehicle in which individuals are helped to access their own self-healing power (Parham, 2002).

### Role of Stereotypes, Biases, and the Clinician’s Culture

Although most clinicians are now receiving some multicultural education in their training programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009), practical skills for working with members of specific minority groups are often not included. When clinicians and researchers lack the needed skills and education for effective cross-cultural interactions, they may rely on a color-blind approach. Color-blindness is the ideology that different ethnic groups should all be treated the same, regardless of cultural differences (Terwilliger, Bach, Bryan, & Williams, 2013). Minorities are often treated as if they lack characteristics that make them different from the dominant majority. Although the intent of color-blindness is to promote fairness, it often causes confusion and can paradoxically increase prejudice (e.g., Richeson & Nussbaum, 2004). When the idea of “treating everyone the same” is proposed, it is typically from the perspective of the dominant majority, implying that clients should be treated as if they were culturally non-Hispanic Whites (Terwilliger et al., 2013).

From a clinical standpoint, color-blindness could result in negative consequences for an ethnic minority client if a therapist were to suggest that the client engage in behaviors that are generally considered adaptive within European American psychological tradition but which may in fact be culturally incongruent outside of that tradition. For example, a therapist may encourage an adult client to move out of the parents’ home and find his or her own apartment to assert autonomy. But in more collectivist cultures, it may be abnormal for unmarried children to move out. Thus such an event could potentially result in a family crisis, conflict, and loss of needed emotional support. The goal, therefore, is not to treat participants as if they were European American, but as they should be treated based on the norms and customs of their particular culture. This approach, called multiculturalism, embraces the differences, strengths, and uniqueness of each cultural group (Terwilliger et al., 2013; Williams, Tellawi, Wetterneck, & Chapman, 2013).

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### Culture as an Inter

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Another issue of which clinicians must be aware concerns preconceived notions about clients based solely on ethnic group membership, or pathological stereotypes (Williams, Gooden, & Davis, 2012). These are generalizations about people used as a means of explaining and justifying differences between groups and thereby using these differences to oppress the “out-group.” Social status or group position determines the content of stereotypes, and not actual personal characteristics of group members (Jost & Banaji, 1994). Groups that have fewer social and economic advantages will be stereotyped in a way that seemingly explains disparities, such as lower employment or higher illiteracy rates. Although disadvantaged group members may have greater difficulty finding a job due to in-group favoritism, discrimination, and institutional racism, the disadvantaged group member is characterized as unmotivated (could have found a job if he looked hard enough), unintelligent (not smart enough to have that job), lazy (would rather take handouts than work), and criminal (will steal rather than work) (Williams, Gooden, & Davis, 2012).

It is important to understand that pathological stereotypes about cultural groups are unfair and inaccurate. Furthermore, all members of a society are affected by the negative social messages that espouse these stereotypes, casting disadvantaged groups in a negative light (Devine & Elliott, 1995). When we uncritically accept these negative messages, racism follows, even from professionals who mean well. This can lead to harmful, discriminatory behaviors toward clients, which may be conscious or unconscious, and overt or covert.

Perhaps the most common act of discrimination by clinicians is what is termed as microaggression (Sue et al., 2007). A microaggression is a brief, everyday exchange that sends denigrating messages to a target simply because they belong to a racial minority group. Microaggressions are often unconsciously delivered in the form of slights or subtle dismissive behaviors. The target of a microaggression is often forced to ascertain whether another individual did in fact, perpetrate a discriminatory act. This attributional ambiguity is inherently stressful and is different from an overt discriminatory act, which is more easily identified and explained. As such, the influence of racial microaggressions on stress and anxiety may lie in the uncertainty generated from such interactions (Torres, Driscoll, & Burrow, 2010). One study found that racial microaggressions directed against African American clients was predictive of a weaker therapeutic alliance with White therapists. This, in turn, predicted lower ratings of general competence and multicultural counseling competence, and, unsurprisingly, lower counseling satisfaction ratings. Racial microaggressions had a significant indirect effect on client ratings of the counseling competence of White counselors through the therapeutic working alliance (Constantine, 2007).

It is important to understand that microaggressions can be particularly harmful to vulnerable clients, who may already feel stigmatized and exposed even attempting therapy. Minority clients may find it difficult to respond to such remarks in counseling situations due to self-doubt and power dynamics. These problems contribute to feelings of distance from the therapist, unwillingness to disclose sensitive information, and early termination from treatment. Thus, clients may be unable to overcome the condition for which they sought help due to undesirable therapist factors. The degree of harm therapists may cause in this manner is unknown and likely underestimated (Constantine, 2007).

**CULTURE AS AN INTEGRAL PART OF ASSESSMENT**

Americans are socialized not to acknowledge race and ethnicity, due in part to concerns of appearing biased or racist (Gaertner & Dovidio, 2005). However, this avoidance
contributes to difficulty in recognizing, discussing, and adapting to cultural differences (Terwilliger et al., 2013). Many European American therapists are uncomfortable discussing race in cross-racial therapeutic dyads (Knox et al., 2003). However, therapists actually have more success working cross-culturally when they address differences directly. Raising the issue of race early in the therapeutic relationship conveys cultural sensitivity and may address clients’ concerns about a racially different counselor. When counselors communicate their own cultural background and acknowledge their client’s cultural values, clients are more likely to see their counselor as credible and feel more relaxed in therapy (Owen, Tao, Leach, & Rodolfa, 2011). Culturally competent counselors are aware of how their own cultural backgrounds and experiences influence their attitudes and values surrounding psychological processes, and this recognition enables them to better access the client’s needs (Delsignore et al., 2010).

Thus, it is important that clinicians understand culture-specific differences, which can range from amount of eye contact to specific idioms of psychological distress. Mental health professionals must make culture an integral part of each assessment, as it influences patterns of communication between clinician and patient and subsequent diagnostic and treatment outcomes (Alarcón et al., 2009). There are too many different groups for any one person to have an in-depth understanding of all, so clinicians should at least receive training specific to the ethnoracial groups most commonly served, and seek additional information and consultation when confronted with clients from completely foreign cultures.

In its ongoing effort to more widely recognize cultural context, the DSM-5 now includes a cultural formulation interview guide designed to help clinicians assess cultural factors influencing client perspectives on their symptoms and treatment options. It includes questions about client background in terms of culture, race, ethnicity, religion and geographical origin. The interview facilitates the process for individuals to describe distress in their own words and then relate this to how others, who may not share their culture, see their difficulties. This gives the clinician a more comprehensive basis for diagnosis and care, and may be a good starting point for those clinicians working with ethnically different clients.

MISTRUST OF MEDICAL INSTITUTIONS AND ESTABLISHMENT

According to the US Surgeon General, “research documents that many members of minority groups fear, or feel ill at ease, with the mental health system” (NIH, 1999). African Americans have greater distrust of the medical establishment and mental health care, many believing that medical institutions hold racist attitudes (Gamble, 1993; Whaley, 2001). Negative perceptions may be rooted in historical abuses of slaves, who were often used to test and perfect medical procedures before they were attempted on Whites (Gamble, 1997).

The most well-known example of such abuses is The Tuskegee Study of Untreated Syphilis in the African American Male. This is the longest nontherapeutic experiment on human beings in medical history. Begun in 1932 by the United States Public Health Service (USPHS), the study was designed to determine the natural course of untreated syphilis in 400 African American men in Tuskegee, Alabama. The research subjects, who had syphilis when they were enrolled in the study, were matched against 200 uninfected subjects who served as controls (Heintzelman, 2003).

The subjects were recruited with misleading promises of “special free treatment,” which were actually spinal taps done without anesthesia to study the neurological effects of syphilis, and they were enrolled without informed consent. The subjects were denied antibiotic therapy when treatment for the disease subjects from obtaining it.

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LACK OF AWARENESS CAN

Evidence shows that previously. These include:

- Misuse of assessment tools
- Diagnostic criteria resulting in misdiagnosis
- Research findings not adequately interpreted
- Lack of adequate education about racial colorblindness
- Pathological stereotypes of racial clinician judgments
- Poor therapeutic outcomes agains...
cultural differences uncomfortable distress. However, therapists address differences convey cultural counselors. When their client's feel and more potent counselors influence their recognition enables distress, which can be relieved. Mental assessment, as it is and once counseling is a goal to describe may not share their experience with clients. From the DSM-5 now assess cultural treatment options. It ethnicity, religion individuals to describe may not share their experience for n rendering. working with many members of the "(NIH, 1999), and mental health slaves, abuses of slaves, were attempted.

Lack of awareness can result in misdiagnosis

Evidence shows that minorities are often misdiagnosed, due to the factors described previously. These include:

- Misuse of assessment instruments that are considered to be "gold standards."
- Diagnostic criteria based on Eurocentric observations and conceptualizations, resulting in missed or misunderstood symptoms.
- Research findings based on Eurocentric diagnostic criteria, providing less helpful information about psychopathology in non-White populations.
- Lack of adequate multicultural training for clinicians, often resulting in a problematic color-blind approach.
- Pathological stereotypes about members of specific cultural groups that affect clinician judgments.
- Poor therapeutic working alliance due to lack of cultural awareness and micro-aggressions against clients.

These problems are not simply academic, but result in substandard care, inappropriate treatments, and premature termination from treatment. In particular, African Americans are more often given the diagnosis of paranoid schizophrenia than non-Hispanic Whites with similar symptoms (Snowden & Fingitore, 2002). This could be due in part to misinterpretation by clinicians of "healthy cultural paranoia"—a defensive posture taken by African Americans when approaching a new situation that could involve racism or discrimination (Whaley, 2001). This paranoia is not completely unfounded given the reality of discrimination and racial tensions in the United States. Additionally, African Americans are more likely to be admitted as inpatients, even after controlling for severity of illness and demographic variables (Snowden, Hastings, & Alvidrez, 2009).
For Hispanic Americans the research results are mixed. Chui (1996) finds that Hispanics receive a diagnosis of schizophrenia less often than African Americans and non-Hispanic Whites, but they more often receive diagnoses of other mental illnesses. Solomon (1992) reports that more Puerto Ricans are diagnosed as schizophrenic than any other group, including other Hispanics. This could be due to the intersection of race and ethnicity, as many Puerto Ricans are both Black and Hispanic. Furthermore, when minorities are diagnosed with psychotic or affective disorders the conditions are more likely to be considered chronic rather than acute when compared with European Americans with the same diagnoses.

Likewise, assessments of dangerousness and potential for violence are overestimated for African American inpatients, in accordance with violent and criminal stereotypes (Good, 1996; Wood, Garb, Lilienfeld, & Nezworski, 2002). One result of this bias is the overmedication of Black psychiatric patients (Wood et al., 2002). This is compounded by the fact that African Americans, like many other ethnic minorities, metabolize antidepressants and antipsychotic medications more slowly than Whites and may be more sensitive to the medications. This higher sensitivity is manifested in a faster and higher rate of response and more severe side-effects, including delirium, when treated with doses commonly used for White patients (Munoz & Hilgenberg, 2006). Thus, African Americans may exhibit poorer medication compliance, which then may be misinterpreted as resistance to treatment.

Interestingly, Hispanic Americans are less likely to be medicated at all (Hodgkin, Volpe-Vartanian, & Alegria, 2007). Aside from limited health care access among Latino populations (Perez-Escamilla, 2010), another potential explanation could be a lack of adherence to medication throughout the course of mental illness (Hodgkin et al., 2007; Colby, Wang, Chhabra, & Pérez-Escamilla, 2012). In particular, Hodgkin et al. (2007) utilized data from the NLAAS and found that 18.9% of Hispanic Americans who discontinued antidepressant medication decided to do so without consulting a health professional. Researchers noted that proficiency in the English language, older age, being married, having insurance, and consistent visits to see a therapist were related to better antidepressant adherence in this sample.

African Americans are diagnosed less accurately than non-Hispanic Whites when they are suffering from depression and seen in primary care (Borowsky et al., 2000), or when they are seen for psychiatric evaluation in an emergency room (Strakowski et al., 1997). One study found that African Americans were less likely than Whites to receive an antidepressant when their depression was first diagnosed (27% vs. 44%), and among those who did receive antidepressant medications, African Americans were less likely to receive the newer SSRI medications than were the White patients (Melfi, Croghan, & Hanna, 2000).

In terms of substance abuse, 15% of the general population will abuse a substance in their lifetime and 4% will abuse a substance within 12 months (Kessler et al., 2005a; Kessler et al., 2005b). Negative social stereotypes dictate that drug users are largely Black and Hispanic. Most people are surprised to learn that African American youth are significantly less likely to use tobacco, alcohol or drugs than non-Hispanic Whites or Hispanic Americans (Centers for Disease Control, 2000). In fact, African Americans spend 25% less than Whites on alcohol (U.S. Department of Labor, 2002). The National Longitudinal Alcohol Epidemiological Survey (1996) indicated that Whites were more likely to use drugs over the lifetime but Blacks were more dependent than Whites, underscoring differential access to effective treatments (Grant, 1996). Blacks and Whites tend to abuse different drugs (e.g. crack vs. cocaine), and the drugs used by African Americans carry harsher penalties and are more likely to be the targets of law enforcement efforts.
enforcement efforts (e.g., Beckett, Nyrop, & Pfingst, 2006). Thus, institutionalized racism may play a role in drug abuse outcomes and access to treatment.

CONCLUSIONS

This chapter represents a charge to mental health professionals to fully consider and subsequently integrate racial, ethnic, and cultural variables into the assessment and treatment of ethnic minority individuals. The importance of such integration undoubtedly has a profound impact on several areas, including but not limited to the following: assessment, expression of psychopathology, diagnostic practices, mental health disparities, treatment outcome studies, continued dearth of ethnic minorities involved in research studies, and a continued paucity of researchers and practitioners of color. Explicit acknowledgment of inherent biases that we all possess and an understanding of the importance of incorporating cultural variables throughout all portions of our work with ethnic minority populations are important first steps to decreasing mental health disparities. Additionally, we continue to underscore the importance of reviewing the empirical literature as it pertains to ethnic minority populations since “all measures are not created equal.” Moreover, there continues to be a disconnect between much of our scientific training with regard to making decisions about assessment measures, how psychopathology is expressed in many ethnic minority individuals, which often deviates from “traditional” expressions, and our subsequent implementation of treatment. Spiritual identity is also essential to many ethnic minority individuals, and incorporating such variables into both the assessment and treatment process is essential. We are additionally emphasizing the importance of respecting (and sometimes incorporating when agreed upon by the client) and seeking assistance from traditional healers or spiritual elders into the treatment process.

Although significant strides have been made in the more recent empirical literature endemic to ethnic minority individuals, we as mental health professionals have to be increasingly cognizant of integrating identified cultural factors throughout all facets of our own work and in training the next generation. Ethnoracial minorities are currently 36.6% of the US population, and 50.4% of all births (U.S. Census Bureau, 2011, 2012), with non-Hispanic Whites projected to be a minority in the United States by 2050 (Nagayama Hall, 2001). Thus, much of the work that we have highlighted is vitally important to our cultural competence in the 21st century.

REFERENCES


