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"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),[20] 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,[21] gender, age, class, religious/spiritual beliefs, sexual orientation[22], 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.[24] 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).

African Americans are, as noted above, overrepresented in inpatient psychiatric care (Snowden, in press-b). Their rate of utilization of psychiatric inpatient care is about *double* that of whites (Snowden & Cheung, 1990). This difference is even higher than would be expected on the basis of prevalence estimates. Overrepresentation is found in hospitals of all types except private psychiatric hospitals.[25] While difficult to explain definitively, the problem of overrepresentation in psychiatric hospitals appears more rooted in poverty, attitudes about seeking help, and a lack of community support than in clinician bias in diagnosis and overt racism, which also have been implicated (Snowden, in press-b). This line of reasoning posits that poverty, disinclination to seek help, and lack of health and mental health services deemed appropriate, and responsive, as well as community support, are major contributors to delays by African Americans in seeking treatment until symptoms become so severe that they warrant inpatient care.

Finally, African Americans are more likely than whites to use the emergency room for mental health problems (Snowden, in press-a). Their overreliance on emergency care for mental health problems is an extension of their overreliance on emergency care for other health problems. The practice of using the emergency room for routine care is generally attributed to a lack of health care providers in the community willing to offer routine treatment to people without insurance (Snowden, in press-a).

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 [26] side 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.

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[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).