CHAPTER

3

Understanding Cultural Influences on Mental Health

Tolerance, inter-cultural dialogue and respect for diversity are more essential than ever in a world where peoples are becoming more and more closely interconnected.—**Kofi Annan (Former Secretary-General of the United Nations, 1938–Present)**

"Culture consists of such symbolic vehicles of meaning, including beliefs, ritual practices, art forms, and ceremonies, as well as informal cultural practices such as language, gossip, story, and rituals of daily life" (Swidler, 1986). Culture permeates almost every aspect of one's life, from everyday issues such as clothing choices, music, and the food we eat, to deeper cultural values such as parenting, family relationships, and how we take care of the elderly. Moreover, culture affects us in both conscious and unconscious ways (eg, our exploration or lack of understanding of our ethnic identity, or how we conceptualize and perceive stigma toward mental illness). In order to become proficient at culturally adapting psychotherapy, practitioners and clinical scientists need to have a basic and foundational understanding of how culture influences health and mental health processes.

This chapter provides a conceptual framework and overview for how to think about cultural influences on mental health (CIMH). In doing so, I introduce the CIMH model, a practical and conceptual paradigm for improving cultural understanding and awareness (Hwang, Myers, Abe-Kim, & Ting, 2008). This framework was created to help practitioners and clinical researchers go beyond simplistic and stereotyped ways of thinking about culture by focusing on insightful understanding of the cultural complexities, and clinical realities of the ways in which culture permeates and affects multiple and interrelated mental health processes. This model was designed to help those in the mental health field understand cultural influences in a comprehensive and systematic manner. Expanding upon the original conceptualization of the CIMH model, I argue that culture permeates and affects several core domains of the illness process, including (1) etiology and causes of illness, (2) cultural meanings and norms regarding mental illness, (3) expression and communication of distress, (4) diagnostic and assessment issues, (5) the prevalence of psychiatric disorders, (6) help-seeking pathways and coping styles, (7) treatment and intervention issues, and (8) policy and funding issues. In addition, these domains systematically impact and influence one another—leading to interactive connectedness and natural pathways of interrelatedness.

For example, people of different ethnic backgrounds may experience different amounts or types of stress, which in turn increases risk for developing psychiatric disorders. Conversely, people from different cultural backgrounds may also evidence different support systems and cultural protective factors. In addition, differences in cultural norms and stigma toward mental illness can affect problem definition, recognition, focus, and interpretation of physical and psychological symptoms. Cultural differences in the expression of distress (eg, emotional distress or physical symptoms) and which symptoms a patient reports to their health and mental health care providers can influence diagnostic accuracy. This in turn impacts our ability to reliably estimate the prevalence and incidence (ie, first onset) of psychiatric disorders.

What people believe to be the causes of their problems (eg, bodily problems causing depression or depression causing physical health problems) also plays a role in where they seek help (eg, primary care or mental health facility), and one's confidence in the treatment provided (eg, belief that talk therapy is effective vs feeling like talking about problems makes one feel worse). If cultural issues influence the accuracy of diagnosis (eg, patients coming into treatment reporting physical symptoms and denying mental symptoms), our understanding of the prevalence of problems in various communities may be severely underestimated. This is problematic because

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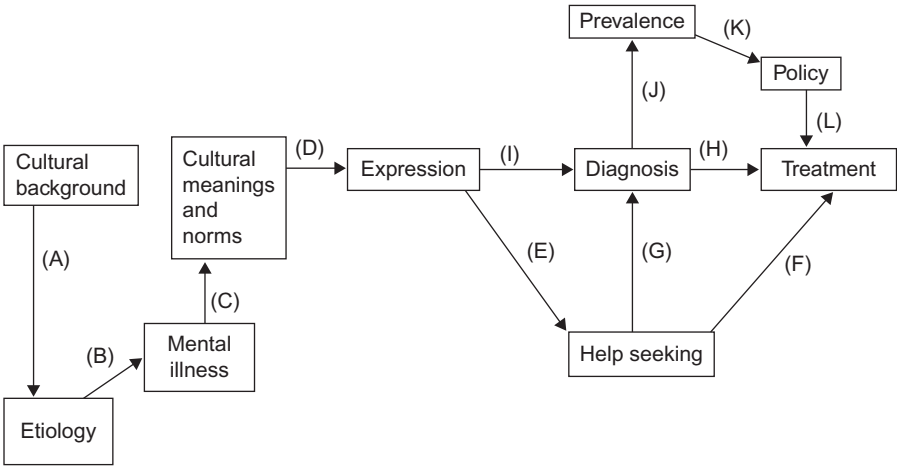

FIGURE 3.1 The Cultural Influences on Mental Health (CIMH) Model. *Source: Reproduced from Hwang et al. (2008). Elsevier, Clinical Psychology Review.*

funding and policy issues are influenced by what we know to be the magnitude of various health and mental health problems. Our understanding of the prevalence of problems influences the prioritization, development, and implementation of evidence-based interventions for diverse communities. See Fig. 3.1 for illustrative examples of these interrelated pathways.

Because of the multitude of ways that culture can influence mental health processes, these domains are not meant to be all-inclusive. Rather, they serve as starting points for understanding the most prominent ways cultural influences can manifest themselves. These domains are clearly and logically related. The pathways begin with the development and conceptualization of mental illness, which subsequently has a significant impact on how illnesses are expressed, where and whether people seek help, the types of treatments provided, and the effectiveness of said treatments.

For example, if a client from an Asian heritage background experiences acculturative stress from immigration, this can lead to the development of depression. Because mental illness is highly stigmatized and because psychotherapy does not exist in many Asian heritage countries, the client may delay help-seeking or not seek mental health treatment. Or, they may also seek help from friends and family, traditional healers, and religious institutions. Moreover, the client may express and experience distress somatically—thus leading them to seek help through primary care rather than mental health services. If primary care physicians are less proficient in conducting mental health screenings and are less aware of the importance of conducting mental health screenings for Asian heritage populations (because of underreporting due to stigma and somatic ways of expressing mental distress), they may not appropriately diagnose the clients or refer them to specialty mental health care. If the client is eventually referred to mental health services, their condition may be extremely severe because they delayed seeking help. This has important implications for prognosis, treatment effectiveness, and length of time needed for symptom remission. If clients do not experience treatments as helpful, they may be less engaged and drop out of treatment prematurely. This is problematic because treatment progress and the rate of symptom change are greatly affected by the severity of clinical problems at point of entry—which is delayed for many clients of Asian heritage descent.

As previously mentioned, the CIMH was initially developed to go beyond the general and simplistic notion that culture matters. The CIMH framework serves as a central piece in improving one's cultural lens for examining and understanding culture's broad and specific influence on mental health processes. Understanding these complicated interrelationships is a prerequisite for cultural competency and the ability to culturally adapt psychotherapy for diverse populations. In order to be culturally competent and learn how to effectively modify therapy for people of different backgrounds, one must first develop a sophisticated way of thinking about these complicated issues and develop cultural insight and awareness. Although no one model can adequately capture the complexities involved in addressing cultural issues, the CIMH model is important because it sets the stage and provides a solid foundation for identifying and targeting potential areas for prevention and treatment for individuals and communities. The CIMH model serves as an illustrative roadmap that helps those wanting and needing to improve their cultural awareness visualize the dynamic and interactive complexities involved in understanding CIMH. Below, I frame the discussion of culture's impact on each of the CIMH domains by highlighting the intricate pathways and interrelationships. I also discuss the evidence-base that informs our understanding of these domains and pathways.

UNDERSTANDING CULTURE-UNIVERSAL AND CULTURE-SPECIFIC PHENOMENA

Before delving into the major domains and pathways of the CIMH model, it is important to understand the concepts of etic and emic. In the mental health field, the terms etic and emic have been used to differentiate culture-universal and culture-specific phenomena. Specifically, what issues cut across all groups, and what issues are specific to certain populations. I have previously defined and elaborated upon the origins of these words in the encyclopedia of cross-cultural psychology (Hwang & Ting, 2013a, 2013b). The origins of the words etic and emic were historically coined by the linguistic anthropologist Kenneth Pike in 1954, and had a distinctively different meaning than how it is used in the mental health field today.

The term etic originates from the word "phonetic," and originally referred to units of sound that are not distinctive to a particular language. As such, etic refers to culture-universal sounds that might appear in multiple languages. In the context of studying culture, etic first referred to the outsider's account or perspective (Pike, 1954). Classically, this was exemplified by the White researcher observing and studying indigenous cultures around the world. However, there was a problematic assumption of neutrality and that the outsider's viewpoint was more objective, and as a result, conferred greater advantages. This assumption was ethnocentric, and led to many erroneous assumptions about White culture as representing universal truths and being the standard for which other groups are compared. Specifically, this instilled the practice of comparing all diverse populations with White or European culture, which resulted in an ethnocentric, monocular, and cross-cultural framework bias.

The term emic was originally derived from the word "phonemic," and refers to the units of sound that are distinctive to a particular language, or sounds that are culture- or language-specific. Since this initial conceptualization, these terms have been defined, modified, and used in diverse ways by different disciplines and fields of study. Emic refers to the insider's account or perspective (Pike, 1954), which was traditionally seen as being more subjective and culture-specific. The goal of the emic perspective was to fully understand the culture through deep anthropological understanding and full immersion. In doing so, the framework became less cross-cultural or comparative, and focused more on ethnic-specific studies and understanding the culture from its own perspectives. The emic researcher was an active participant, and would interact and collaborate with the members of the culture of interest. However, because White anthropological researchers often stood out among indigenous peoples, participatory biases may have influenced the conclusions that were made. The emic approach was intended to better understand the beliefs, customs, and values of the groups being studied. Etic and emic approaches can be somewhat likened to present-day cross-cultural comparisons versus ethnic studies.

In the field of psychology, the terms etic and emic took on different meanings. French (1963) was the first researcher to refer to the distinction between etic and emic approaches, and Berry (1969) was among the first to utilize these terms when conducting cross-cultural psychological research (Berry, 1989). These terms were then used to distinguish between culture-universal phenomena (etic) versus culture-specific phenomena (emic) (Hwang & Ting, 2013a, 2013b; Sue & Sue, 2003). There is merit to both emic and etic approaches. Utilizing both viewpoints together confers the advantage of understanding and taking into account cultural similarities (culture-universal etics) and differences (culture-specific emics). This is advantageous because it helps mental health practitioners understand which issues and phenomena cut across cultures, and how specific ethnocultural groups express and manifest certain issues in culture-specific ways. Specifically, it helps us understand which issues apply to all humans, and that culture-universal phenomena can be exhibited in culture-specific ways.

Let me take a moment to deconstruct these terms and give practical examples of how to utilize them when understanding CIMH. This is important because these terms and their definitions tend to be somewhat esoteric and opaque—resulting in ambiguity for those trying to utilize them in a practical way. One way to think about etic is to imagine that there are culture-universal phenomena that all human beings and culture groups engage in (Hwang & Ting, 2013a, 2013b). For example, all societies have traditions and celebrations (eg, holidays, celebrating birth, mourning death), methods and styles of communication (eg, verbal and nonverbal, and direct and indirect), and norms for appropriate human behavior (eg, committing crimes is bad and being a contributing member of society is good). The manner in which different societies and cultures carry out and express these various culture-universal phenomena varies from culture to culture, which refers to the emics.

For example, all human societies have some method of celebrating the birth of a child and for mourning the loss of a loved one. The specific methods for celebrating birth and death may be very different across cultures. For example, in Western cultures, funerals tend to be one day and dressing in black is very common place. In some Asian heritage cultures, funeral rituals can last many days depending on when somebody was born, their astrological sign, and mourning may involve burning paper money and paper-made objects so that the deceased

can take with them to the afterlife. Another culture-universal (etic) phenomenon is that in all cultures, there are customs for dating and marriage. The culture-specific (emic) manner in which this is carried out can vary quite a bit. For example, in many Asian heritage cultures arranged marriages can be quite commonplace. In many Western cultures, arranged marriages have fallen out of favor and methods of meeting significant others have changed as well, with many people finding relationships through online dating. It is important to remember that culture is different from race and ethnicity. Cultures are constantly changing and evolving. Cultural adaptations are not ethnic or racial adaptations and are focused on individualizing and tailoring services for culture, not race.

In regards to clinical issues, all cultures (etic) experience some form of sadness or depression. However, the emic, or how psychiatric illness such as depression is labeled and experienced or phenomenologically expressed, can vary (Hwang & Ting, 2013a, 2013b). For example, the majority of the Chinese population uses the term and diagnosis of neurasthenia instead of the term major depression. Neurasthenia is a more somatic expression of depression, and is included as a cultural idiom of distress, or culture-bound syndrome in the DSM (American Psychiatric Association, 1994, 2000). In addition, there may be cultural differences in the use of verbal versus nonverbal expression of distress, or in the directness or indirectness of how people communicate. Neurasthenia and somatic issues are discussed in greater detail later in this chapter.

In regards to research perspectives, an emic approach takes more of an ethnic studies approach and is less concerned about comparing one group to another. Specifically, it studies the culture for what it is, and tries to do so by taking on the cultural lens of those being studied. As mentioned before, the comparative or cross-cultural approach has historically been ethnocentrically biased, and utilized the lens or assumption that White cultures are the primary comparison group, deeming them the normative frame of reference.

In terms of assessment or questionnaire development, an emic approach would try to develop questionnaires that tap into the constructs of sadness and depression from the bottom up; whereas, an etic approach would try to apply instruments developed in one culture to other cultures (eg, utilizing the Beck Depression Inventory to assess depression across multiple groups). Since most psychiatric and psychological assessment measures have been developed on White American or European populations, to assume that they are reliable and valid in other cultures is problematic—unless they are rigorously tested and normed for other groups. Similarly, treatments that are developed and tested on one population do not necessarily generalize to other populations. It is important to empirically test evidence-based practices to ensure that they have cross-cultural validity and generalizability in terms of client engagement and outcomes.

Ideally, an integrative and potentially interactive emic–etic approach would be the best methodology for fully understanding cultural similarities, as well as comparing cultural differences. Knowledge gained from utilizing a combined approach would contribute to a culture-universal and specific psychological science, and help reduce ethnocentric biases that tend to affect cross-cultural research as well as clinical practice. For the rest of this chapter, I will focus on discussing how culture influences various mental health processes. I will review the CIMH model and also continue to highlight etic and emic phenomena. This book utilizes an integrative ethnic studies, comparative, and integrative approach to highlighting interesting cultural impacts on mental health.

THE CULTURAL INFLUENCES ON MENTAL HEALTH (CIMH) MODEL

Cultural Issues in the Etiology and Causes of Illness

At a basic level, we know that people from different cultural backgrounds experience different types and magnitudes of stressors and problems that potentially exacerbate the risk for mental illness. This is illustrated by Pathways A & B in Fig. 3.1. For instance, ethnic minorities in the United States (US) experience a number of stressors that White or European Americans face to a lesser degree (eg, many ethnic minorities have experiences with racism and discrimination). Conversely, many people of color also do not benefit from White privilege. In addition, many immigrant groups experience immigration stressors that nonimmigrants do not face. Examples of immigrant stressors include traumatic refugee experiences and acculturative stress (eg, linguistic stressors, difficulties finding employment, problems with housing, pressures to assimilate, separation from family, and acculturation-related intergenerational family problems).

Acculturation and Adaptation Stressors

Many refugees escape to other countries having experienced a variety of traumatic experiences that the majority of Americans do not face. These include genocide, war, violence, famine, and political persecution

(Gong-Guy, Cravens, & Patterson, 1991; Williams & Berry, 1991). Differential experiences with specific types and amounts of stress increase risk for developing posttraumatic stress disorder (PTSD) and depression. The rates of these illnesses are higher among Southeast Asian, African, Bosnian, and Kurdish refugees because of the traumas they have experienced (Chung & Kagawa-Singer, 1993; Hirschowitz & Orkin, 1997; Kinzie et al., 1990; Kroll, Habenicht, Mackenzie, & Yang, 1989; Sundquist, Johansson, DeMarinis, Johansson, & Sundquist, 2005; Sudelin-Wahlsten, Ahmad, & Knorring, 2001). No matter what a person's cultural background, exposure to trauma exacerbates risk, a culture-universal (etic) phenomenon. The emic, or the culture-specific stresses that people from different cultural backgrounds experience may vary in type and amount across groups (eg, we know that refugees experience disproportionate trauma exposure and burden compared with nonrefugees) (Gong-Guy et al., 1991; Williams & Berry, 1991).

In addition to immigrants, other ethnic minority groups such as Native Americans also suffer from intergenerational transmission of trauma burden that accumulated from hundreds of years of oppression and genocide. The psychiatric consequences of this today are a higher rate of alcohol and substance abuse, depression and PTSD, and exposure to violence compared to most other groups living in the US (National Center for Injury Prevention and Control, 2002; Walters & Simoni, 1999). At a basic level, understanding of etic and emic experiences is important because it provides targets for culturally adapting psychotherapy and services for specific populations. Addressing culture-specific issues is one of the domains of the Psychotherapy Adaptation and Modification Framework (PAMF) and is one of the most easily identified areas for adapting treatments.

After refugees and nonrefugee immigrants arrive in their host countries, they may experience immigration stressors that exacerbate previous traumas and/or that increase the difficulty of healthy and successful transitions. Specifically, they may experience culture-specific (emic) acculturative stressors that are prominent in the culture of migration. Acculturative stress, defined as the stress related to transitioning and adapting to a new environment (eg, linguistic difficulties, pressures to assimilate, separation from family, experiences with discrimination, and acculturation-related intergenerational family conflicts) refers to adaptation stressors that can increase risk for mental health problems (Berry, 1998; Berry & Sam, 1997; Hwang & Ting, 2008). For refugees who had little time or few resources to prepare before leaving their country of origins, acculturative stressors can compound their difficulties and exacerbate the deleterious effects of acute trauma exposure and forced migration. In addition, there have been a number of studies showing that acculturative stress increases the risk for a variety of health and mental health problems (Berry, 1998; Goater et al., 1999; Hovey, 2000; Hwang & Ting, 2008; Jarvis, 1998; King et al., 2005; Myers & Rodriguez, 2003; Oh, Koeske, & Sales, 2002; Organista, Organista, & Kuraski, 2003; Schrier, van de Wetering, Mulder, & Selten, 2001; Vega & Rumbaut, 1991; Veling et al., 2006; Williams & Berry, 1991). The degree to which acculturative stresses are likely to have a negative impact partially depends on a number of pre−post migration factors. These include educational status, linguistic ability, refugee status, access to thriving ethnic neighborhoods in the host country, and support networks available (Williams & Berry, 1991).

Immigrants are also faced with cultural assimilation issues that can increase risk for a plethora of problems. Cultural assimilation, or the process of gradually taking on the characteristics of a new environment (Berry, 1998), can further increase risk for health and mental health problems, especially if the prevalence of those problems in the host country are higher than in their countries of origin—a phenomenon similar to regressing to the mean rates of illness in the host country because a person is exposed to the same risk factors over time. This is known as the epidemiological paradox or the cultural assimilation hypothesis.

The longer people live in a country, the more they are exposed to country-specific stressors and problems. Moreover, they begin to lose culturally protective factors, such as social support and connection to extended family networks. Although the empirical evidence has not been able to delineate exactly why this is happening, increased risk is likely due to exposure to culturally unfamiliar stressors, accumulated stress burden, environmental and neighborhood context issues, loss and attenuation of culturally protective factors, limited social and financial mobility, and experiences with racism and discrimination. This can apply to other contextual issues such as diet. For example, the fast food industry has increased the obesity rate of people in this country, which also affects immigrants as they begin eating fast food at a higher rate when they arrive because it is cheap, convenient, and previously less available in their countries of origin.

In regards to mental and physical health problems, there is a growing body of research supporting the cultural assimilation hypothesis, indicating that US-born Latinos evidence higher rates than foreign-born Latinos for a variety of problems (Escobar, Nervi, & Gara, 2000; Ortega, Rosenheck, Alegria, & Desai, 2000). Chinese Americans also evidence similar cultural assimilation-related risk for psychiatric disorders such as major depression (Hwang, Chun, Takeuchi, Myers, & Siddarth, 2005). Even for disorders such as schizophrenia, which is believed to be more biologically mediated and similar across groups, a number of studies have found higher

rates among African immigrants, Afro Caribbeans, Asians, Surinamese, Netherland Antillians, Moroccans, and other immigrants than Whites in Great Britain and the Netherlands—indicating that immigration and acculturative stress can increase the risk for mental health problems (Goater et al., 1999; Jarvis, 1998; King et al., 2005; Schrier et al., 2001; Veling et al., 2006).

Family Relationships

Social factors, such as familial relationships, serve as important risk and protective factors for all people, but may also affect ethnic minority families or those from collectivistic cultural orientations differently than White Americans or those from individualistic family backgrounds. For example, research examining expressed emotions for White Americans suffering from schizophrenia has found that negative family interactions involving criticism increase the chances of relapse after returning home after hospitalization. However, emotional distance and lack of warmth played a stronger role than emotionally negative family interactions in predicting relapse for Mexican American families (López et al., 2004). This is another example of how culture influences mental health. Specifically, well-documented psychological phenomena that have been found among White Americans may not have the same debilitating effect for other groups (eg, expressed emotional criticism). Furthermore, other variables may play a more significant role (eg, emotional distancing and lack of warmth and caring). Importantly, clinical interventionists may need to target different mechanisms and causal risk factors when working with people from different backgrounds (eg, reducing criticism in White families for those recovering from schizophrenia, and increasing emotional warmth and familial interconnectedness when working with Mexican American families). Targeting risk factors versus increasing culturally protective factors may have differential importance for different groups, and they also have a differential impact on outcomes.

Chao (1994) also challenged etic or culture-universal conceptualizations that all groups utilize the same parenting styles and/or that specific parenting styles have the same effect across cultures. Specifically, Baumrind (1966) originally conceptualized parenting styles as falling into certain categories that were assumed to be culture-universal (eg, authoritative, authoritarian, and permissive parenting styles)—with certain parenting styles assumed to be related to positive outcomes and others to negative outcomes. The assumption that psychological phenomena discovered and researched on White populations apply universally to other groups is an overgeneralization that needs to be scientifically tested. Moreover, utilizing an etic approach and applying Western conceptualizations to other groups is a very different process than developing conceptualizations from an emic (culture-specific) ground-up approach.

Chao's (1994) study found that Chinese American parents tended to be more "authoritarian," but unlike research on White American children's academic performance where authoritarian parenting negatively affected school results, Chinese American children whose parents utilized authoritarian parenting had children who still performed well in school. In addition, Chao also proposed a culture-specific (emic) style of Chinese parenting called "child training" or "xiaoxun" (pronounced as Xiàoxùn in Mandarin Chinese—孝訓), which is based on Chinese notions of filial piety. Chao's research on "Xiaoxun" has found that it better explains Chinese child–parent relations and outcomes than predominant Western conceptualizations of parenting.

In addition to different parenting styles, immigrant Asian and Latino heritage populations are also exposed to unique family stressors that White Americans do not face. Previously, I discussed how acculturative stress can increase risk for a variety of problems. There is also a specific literature that examines how parent–child acculturation gaps can increase risk for family problems (Farver, Narang, & Bhadha, 2002; Gil & Vega, 1996; Kwak, 2003; Rosenthal, Ranieri, & Klimidis, 1996; Sluzki, 1979; Ying, 1999) and/or exacerbate psychological problems (Costigan & Dokis, 2006; Crane, Ngai, Larson, & Hafen, 2005; Hwang, 2006; Hwang & Wood, 2009; Hwang, Wood, & Fujimoto, 2010). However, despite the fact that every immigrant family evidences some degree of an acculturation gap, it is important to note that not every immigrant family develops problems. This indicates that other more proximal mechanisms that increase risks are involved and can be targeted for prevention and intervention purposes.

For example, Hwang (2006) proposed the theory of Acculturative Family Distancing (AFD). The construct of AFD is composed of two dimensions, a breakdown of communication and an increase in incongruent cultural values between parents and children. AFD was hypothesized to increase risk for psychiatric problems, and is mediated through family conflict. Specifically, AFD increases risk for family conflict, which in turn increases risk for psychological difficulties. It is not difficult to imagine that parent–child relationships can be influenced by communication difficulties (eg, differential fluency in English and heritage languages, as well as differences in verbal/nonverbal and direct/indirect communication styles). Moreover, family members growing up in different cultural environments can lead to the adoption of different values and discrepant viewpoints (eg, differences in cultural norms regarding family roles and responsibilities, dating, and academic and career choices). AFD has

been empirically shown to increase risk for depression by increasing family conflict among Asian American and Latino college students (Hwang & Wood, 2009). Moreover, AFD has also been shown to increase risk for depression among Chinese American high school students and their mothers, even after controlling for the effect of the more distal notion of the acculturation gap (Hwang et al., 2010).

Racism and Discrimination

Ethnic minorities' experiences with racism are emic (culture-specific) stressors that many White or European Americans typically do not face. Experiences with racial discrimination (whether overt, covert, or perceived) are emotionally detrimental to the individual, often leaving people with feelings of anger, disempowerment, fear, loss of control, and helplessness. Moreover, actual and perceived discrimination are significant stressors that negatively impact health and mental health (Clark, Anderson, Clark, & Williams, 1999; Krieger, Sidney, & Coakley, 1998). Minorities and people of color often report negative experiences with racism and discrimination (Clark et al., 1999; Kessler, Mickelson, & Williams, 1999; Williams, 1996). Ethnic and racial discrimination continue to be highly prevalent around the world, with many people holding stereotypes and believing that ethnic minorities and people of color are dangerous, lazy, less intelligent, and so forth (Davis & Smith, 1990). Recent reports also indicate that ethnic and racial discrimination not only result in economic disadvantages for many ethnic minorities, but also persist in healthcare systems, affecting the type of treatments offered, and playing significant roles in exacerbating and perpetuating health disparities (Smedley, Stith, & Nelson, 2003).

The other side of the racism coin is the less understood, but highly significant, phenomenon known as White privilege. In addition to being the target of racism, we now know that ethnic minorities are less likely to benefit from a number of institutional privileges available to Whites (McIntosh, 1989; Rothenberg, 2005). In discussing White privilege, McIntosh (1998) notes in her seminal essay that "[she] was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance in my group" (p. 31). White privilege confers a number of significant advantages to White people that are denied to people of color. The majority of people do not like to think about themselves as being privileged. They like to think that all of their accomplishments and successes are due to their hard work and diligence—and are less likely to consider the advantages they received because of their color of skin, gender, and other privileges.

From early on, we are taught that the US is a meritocracy and that there is an equal playing field with an equal chance of success if you work hard and persevere. However, the truth is, everybody is born into a different set of circumstances and into families with different amounts and types of resources. These advantages are transferred from generation to generation through inheritance, social connections, insider knowledge, and educational and vocational opportunities. Advantages that are conferred by race and gender boost people's competitive potentials and protect them from stressful experiences or other priorities that may detract from their success (eg, worries about finances, safety, crime, and drugs that are more prevalent in lower-income neighborhoods).

Racism has a cumulative impact across generations, as does White privilege. Imagine the financial potential that has been lost for people of color as they experienced institutionalized racism and the taking of human and financial resources during conquest, imperialism, slavery, and colonization. In addition, imagine the amount of privileges and financial and human capital accumulated by White people throughout history that were transferred from one generation to the next. If a therapist is not able to recognize and understand these issues, they will not be able to effectively work with clientele of color, some of whom struggle with feeling that many doors are closed to them because of their race. White privilege not only reduces the amount of stressful experiences that White Americans face, but also serves as a protective factor and increases their resources for anticipating and coping with adversity relative to persons of color. Chin, Cho, Kang, and Wu (1996) note that:

> For many people of color, racism has decreased the amount and value of economic, social, and cultural capital inherited from our ancestors. Not only did we receive less material wealth, we also received less "insider knowledge" and fewer social contacts so instrumental to one's educational and professional advancement. The fact that runners today might compete on more equal "footing" does nothing to change this fact … even if you are individually innocent of any racial discrimination, do you still enjoy its illicit fruits? After all, discrimination (by others) has shrunk your pool of competitors for admissions, public contracting, and jobs. (pp. 3, 5)

Asian heritage populations are often stereotyped as not having any problems and as being protected from experiences with discrimination and racism, which is simply untrue (Wu, 2003). There are a number of articles that have examined the impact of discrimination and racism on the mental health of Asian Americans. For example, Hwang and Goto (2008, 2009) documented how experiences with perceived discrimination increased risk for higher psychological distress, suicidal ideation, state anxiety, trait anxiety, and depression for Asian American

and Latino college students. There are also many other resources that document the negative impact of racism and discrimination on Asian heritage populations that I do not have space to cover in this book.

However, there are a number of websites that discuss and report upon the ongoing discriminatory acts that occur in the everyday lives of Asian Americans in the US. For example, https://angryasianman.com is a popular website used to raise awareness of modern-day racism and discriminatory acts. In addition, a very popular character is Angry Little Asian Girl (http://www.facebook.com/AngryLittleAsianGirl or http://www.angryasiangirlsunited.tumblr.com), which has been used to discuss a number of social and racial issues through various comic characters. In conjunction with academic publications, popular websites such as these help document the various forms of racism and discrimination that still occur and greatly affect Asian heritage populations. They range from more overt acts (eg, Asian Americans committing suicide because of bullying in schools or in the military), to more covert issues (such as the "glass or bamboo ceiling"—or how Asian Americans are prevented from moving to higher positions despite their educational status), to internalized racism (eg, being racist toward oneself and one's own people because of racial self-hatred, which is often unconscious and goes unrecognized).

In addition to discrimination and privilege, stereotypes also have a well-documented effect on self-esteem, academics, identity, and emotional well-being. Even when stereotypes are so-called "positive," they can still have a deleterious effect. For example, Asian heritage populations are often stereotyped as the "model minority." The purpose of this book is not to get into debunking the model minority myth, as there are many resources that address this issue effectively. Nevertheless, imagine what it feels like if you are unable to get good grades or match the stereotypes that others believe about you. This can have a detrimental impact on your self-efficacy and perception of self-worth. For those who are able to work hard and achieve, their efforts are often not recognized or dismissed because they are "supposed to be that way"—failing to recognize that their success is because of their hard work. Research shows that the "model minority" stereotype has many detrimental effects on a person's mental health.

When working with Asian heritage populations, practitioners need to be prepared to understand and address these issues. Unfortunately, few graduate training programs provide training on how to address experiences with discrimination and other culture-specific stressors in psychotherapy. As a result, therapists fail to effectively address these important issues in treatment, especially with Asian heritage populations who are often not seen or prioritized as a "minority." This is evident in many research reports where African Americans and Latinos are included, but Asian heritage populations are not. By highlighting and bringing attention to the importance and salience of ethnocultural issues, hopefully mental health training programs will begin to incorporate and train practitioners to address these issues effectively in therapy.

Socioeconomic Status

Social economic status (SES) is another significant stressor and issue that many ethnic minority and international groups face. However, these issues are often misunderstood. For example, some Asian American groups (predominantly Southeast Asians), African Americans, Latino Americans, and Native Americans evidence a higher burden of poverty in the US than White Americans (Proctor & Dalaker, 2003). This is a topical issue that is salient and can be targeted when culturally adapting therapy. For example, addressing neighborhood context, lack of educational resources, gangs, drugs, and financial stress can easily be incorporated into individual or group therapy workshops that target specific populations.

Some find it surprising that ethnic minorities do not evidence even higher rates of mental dysfunction compared to White Americans (Chernoff, 2002), especially given the high rates of poverty and the cumulative impact of racism and discrimination over generations. Positive coping resources (eg, kinship, spirituality, ethnic pride, collective unity) may serve as a culturally protective factor that helps preserve the mental health of ethnic minority communities (Chernoff, 2002). Nevertheless, these issues take a toll and may account for the disproportionate burden of medical problems and morbidity in many diverse populations.

In addition, there are complex research methodology and issues with statistical biases that affect the understanding of the true relationship between race and socioeconomic status. For example, Betancourt and López (1993) note that the prevalence of depressive symptoms was found to be higher among Latinos than White Americans in a study conducted by Frerichs, Aneshensel, and Clark (1981). At face value, the results seem to suggest evidence of ethnic differences; however, this effect may be overestimated. Specifically, when SES was statistically controlled for in the analyses, the ethnic effect disappeared and SES became the most important predictor of depression. Because of the strong relationship between ethnicity and SES (in statistical terms they are highly correlated and share a lot of variance), both variables need to be included in statistical analyses in order to improve accuracy.

However, this overlap also effectively limits our ability to disaggregate shared variability (shared variance is typically thrown out of statistical models, and the nonshared variance portion may not truly represent the contribution of ethnicity or SES). For illustrative purposes and simplified for conceptual understanding, if ethnicity and SES are correlated at 0.80, then the remainder of the nonshared variability (0.20) represents so little of each of these variables that it no longer sufficiently reflects their global and unique contributions. Ensuring that there is sufficient representation of all SES levels for an ethnic group and understanding these complex interrelationships can help reduce these biases to ensure that more valid conclusions are drawn (Betancourt & López, 1993). Given the disproportionate number of ethnic minorities in the lower SES stratum, understanding and addressing these types of issues is also important in culturally adapting therapy and providing effective interventions that target salient issues in diverse communities.

Culture Norms, Beliefs About Mental Illness and Cultural Differences in Expression of Distress

The cultural background of an individual results in exposure to different etiological factors that increase the likelihood for developing mental illness. A person's cultural background also influences the definitions and sociocultural meanings of illness, which is also one of the six cultural adaptation domains of the PAMF. These meanings are shaped by cultural norms, beliefs, and values. Ultimately, they serve as a filter to shape the manner in which distress is expressed, as illustrated by Pathways C & D. It is important to note that though the prevalence of various types of disorders can vary across populations, people from all around the world experience mental illness (USDHHS, 2001). In addition, the manifestation of such difficulties and how they are communicated and expressed can be quite different. For example, people may differ in the amount of information they want to share. Some may openly talk about their problems while others may conceal the difficulties they face (Hwang, 2006). This can be influenced by cultural norms, and beliefs such as stigma regarding mental illness. Moreover, there may be differences in communication styles (eg, how direct and indirect people communicate, whether communication is expressed verbally or nonverbally, and the extent to which people focus on their emotional experiences or their somatic/bodily symptomatology) (Hwang, 2006). Addressing communication and expression differences is also one of the six domains of the PAMF.

Expressions of distress and the phenomenological experience of psychological symptoms can vary quite a bit by age, gender, and cultural background (Kleinman, 1978; Marsella, 1980). For instance, the sociocultural environment may act as a contextual backdrop and influence cultural conceptions of illness (eg, how do you define a mental illness vs a stressful experience), symptom recognition and tolerance (eg, whether one recognizes or ignores symptoms, or tolerates them by not focusing on them and placing their attentional focus elsewhere), the manner in which mental illness is communicated (eg, directly, indirectly, or not at all), and how people in that cultural group perceive and attribute social meaning to an illness (eg, someone with a mental illness is crazy, weak, suffering, or sick) (Hwang, 2008).

Etic (culture-universal phenomena) and emic (culture-specific phenomena) distinctions are also important to make when considering cultural differences in the expression of distress (Fischer, Jome, & Atkinson, 1998; Sue, 1983). For example, the etic perspective assumes that all people express depression in similar ways and that our diagnostic criteria can be applied without significant cultural bias to people from all backgrounds. For instance, there is a common etic assumption that the core symptoms of most mental illnesses are similar across cultures. However, we know that this is incorrect, and a culture-specific (emic) perspective also needs to be considered.

Contrary to the etic assumption, an emic perspective would argue that both universal forms of depressive symptoms (ie, criterial symptoms) and cultural variability in symptom expression (eg, emic) simultaneously affect the manifestation of illness expression (Fischer et al., 1998; Sue, 1983). An emic perspective would argue that there may be some core similarities, but there may also be variability in how people from different backgrounds express their distress and emphasize certain types of symptoms (eg, differences in the loading of affective, cognitive, and somatic complaints). For example, an emic perspective might hypothesize that depression can be associated with more than just the nine symptoms that are currently part of the major depression diagnosis. Among many Asian heritage populations, somatic symptoms (eg, headaches, stomachaches, and gastrointestinal problems) are often symptoms of depression but are not currently included in the US Diagnostic Statistical Manual (DSM) or the International Classification of Disease (ICD) (American Psychiatric Association, 2000; World Health Organization, 1992).

Somatic symptoms are often associated with lower stigma and tend to be more prevalent among collectivistic cultures where stigma toward psychiatric illness is often higher than in individualistic cultures. An emic perspective might argue that while there may be culture-universal disorders and expressions of psychiatric illness, there may also be culture-specific disorders that typically only manifest themselves in certain groups. These culture-specific idioms of distress are known as culture-bound syndromes, and a small portion of them are included in the appendix of the DSM (American Psychiatric Association, 1994, 2013; Levine & Gaw, 1995).

Somatization: The Expression of Psychological Distress Through Bodily Means

Somatization refers to the tendency to express, experience, and communicate psychological distress through physical means (Katon, Ries, & Kleinman, 1984). This is an area that has greater potential for cultural variability. "Soma" stems from the Greek word for body, and "ation" or the derivative "ization" is a suffix that refers to an action, process, or the result which leads to a certain state or quality. Somatization is a normative process and people from all across the world experience both mental and physical symptoms of psychological distress. Although most mental illnesses have emotional, cognitive, and somatic components, the relative weighting of emotional, cognitive, and somatic experiences may be different across cultures. This weighting can be influenced by the sociocultural meanings of illness, cultural values, individual and social stigma, social response to symptomatology, and the mind–body focus of traditional healing systems and indigenous medicines.

Western conceptualizations of mental illness often focus on the mind or "psyche," which is self-evident given the labels of psychological problems and psychiatric illness. Nevertheless, if you look at each and every diagnosis in the DSM, you will notice that every illness has a significant somatic component. For example, four out of the nine symptoms of major depression are somatic in nature (eg, fatigue, sleeping difficulties, changes in appetite or weight, feeling slow, down, or restless). Another example would be generalized anxiety disorder (GAD). In order to meet the criteria for a GAD diagnosis, in addition to excess worry, a person needs evidence of three out of six symptoms. However, when you examine the symptoms of GAD, you will find that four out of six are somatic in nature (eg, feelings of restlessness, fatigue, muscle tension, and sleep disturbance). If one were to take a purely symptomatic approach to defining an illness, it would seem that generalized anxiety has more somatic symptoms than "mental" symptoms. Some may question whether Western culture overemphasizes the psyche, and underemphasizes the somatic, thereby increasing stigma and beliefs that those who are mentally ill are "crazy." Helping patients understand that psychiatric disorders are not necessarily "mental" only, can be an important cultural adaptation that helps reduce the stigma toward mental illness. Given the constitution of physical and mental symptoms associated with psychiatric or psychological illness, it is curious why we do not call them psychosomatic illness—which could potentially decrease the stigma associated with being mentally ill.

Somatization can have many social meanings and psychological purposes (Kirmayer & Young, 1998). The expression of distress through somatic or psychological ways can be influenced by social feedback and response. For example, if a person were to say that they are feeling depressed, those from cultures where mental illness is highly stigmatized and misunderstood might respond by saying, "stop being so weak and lazy," "toughen up," or "there's nothing wrong with you, just get over it." Psychological expression of distress in certain cultures can result in criticism and negative feedback. Because collectivistic cultures tend to stigmatize psychiatric illness, it makes sense that those from collectivistic backgrounds are hesitant to express their emotional and psychological difficulties to others.

In contrast, if a person from a collectivistic background expresses that they do not feel physically well to other members from the same culture (eg, headaches, bodily pain, and gastrointestinal difficulties), their social environment might respond with concern, ask if they need anything, or suggest that they take time off of work or school and see a doctor. Cultural differences in response to different types of symptoms suggest that somatization is not just a physical symptom, but also a form of communication and a way in which social support is elicited (Chun, Enomoto, & Sue, 1996). Somatic expression of distress may elicit empathy and help rally support from social networks (eg, the belief that this person has a real medical problem and needs help).

Illnesses are dynamic in that they represent complex social constructs that are influenced by social norms and complex social feedback interactions between the person and their social environment (Chun et al., 1996). Some may consider that somatization can also be a nonspecific amplification of psychological distress (eg, a spillover effect or stress reaction response that cannot be contained or expressed only through the psyche). In some cultures, attribution of interpersonal distress to physical causes may also initially protect patients from feeling

negative emotions or worry. It can also reduce feelings of shame, weakness, and loss of control. Shifting the focus to physical and bodily symptoms can also help protect an individual from feeling stigmatized and help reduce social blame for being "weak" or "lazy."

There are many types of somatic symptoms, which can affect multiple physical domains—the most prevalent of which include: pain (eg, headaches), fatigue (eg, feeling tired, difficulty sleeping), gastrointestinal problems (eg, stomach pain, diarrhea, bloating), cardiopulmonary symptoms (eg, chest pain, heart palpitations, shortness of breath), and neurological difficulties (eg, dizziness, muscle weakness, movement difficulties). When individuals experience a number of somatic symptoms, they may be diagnosed with what was called a somatoform disorder in the DSM-IV or a somatic symptom and related disorder in the DSM-5 (American Psychiatric Association, 2000, 2013). The DSM-5 includes a number of somatic symptoms and other related disorders category that includes diagnoses such as somatic symptom disorder, hypochondriasis, and illness anxiety disorder, pain disorder, conversion disorder, and psychological factors affecting other medical conditions and factitious disorders (American Psychiatric Association, 2013).

Somatic symptom disorders are often characterized by two distinct features: vague or exaggerated physical symptoms and a chronic course and history of symptoms that lasts for more than 2 years. Somatic symptoms and disorders are also highly comorbid with other psychiatric disorders (at a rate estimated over 50%). These other disorders may include mood disorders, anxiety disorders, personality disorders, or substance abuse disorder. Some have further differentiated somatization into two types: "presenting somatization," the somatic presentation of a psychiatric disorder, versus "functional somatization," a high level of medically unexplained symptoms that are more characteristic of a somatoform disorder (Kirmayer & Robbins, 1991). However, aside from health psychologists and those who work in medical settings, the general practitioner may be less aware or may not commonly utilize these diagnoses.

Western definitions of somatization can be different from those of other cultures. For example, in regards to Western diagnostic systems, the hallmark or general definition of somatization is unexplained physical symptoms that are present when a medical condition is not. Somatization can also occur when a medical condition is present, but the severity and range of symptoms cannot be fully explained by the physical illness. The somatic symptoms must cause significant distress or impairment. Somatization is often not intentionally produced, as would be the case with malingering. Specifically, patients with medically unexplained symptoms are a diverse group, and most are not motivated by a conscious or unconscious desire to adopt a sick role. It is important to know that somatization and somatoform disorders are quite common. For example, studies have found that the majority of primary care patients evidence medically unexplained physical symptoms, and that somatizing patients generate medical costs that are several times higher than those of nonsomatizing patients (Katon et al., 1984; Smith, Monson, & Ray, 1986). Indeed, the healthcare costs associated with somatization are a large burden for the healthcare system.

There is some evidence to support that Asian heritage populations tend to somatize more than those from Western cultural backgrounds, which places a greater emphasis on talking about problems and expressing oneself verbally and emotionally (Chun et al., 1996). This is an important point and has implications not only for culturally adapting therapy, but also for the detection and diagnosis of mental illness, as well as where Asian heritage populations seek help. For example, when comparing Chinese and American psychiatric patients with depressive syndromes, Kleinman (1977) found that 88% of Chinese patients compared to 20% of US patients did not present affective complaints and reported only somatic complaints. In Taiwan, nearly 70% of psychiatric outpatients presented with predominantly somatic complaints at their first visit (Tseng, 1975).

Chun et al. (1996) note that somatization may be more prevalent among Asian heritage populations because open displays of emotional distress are discouraged, which may be due to differences in value orientation, as well as strong stigma associated with mental illness. Displaying psychological symptoms of depression may be perceived as characteristic of personal or emotional weakness. As a result, Asians may deny, suppress, or repress the experience and expression of emotions. This is not to say that Asians and Asian Americans do not experience psychologically related depressive emotions per se. Instead, there may be cultural differences in selective attention (eg, amount of focus on the mind vs body), ordering of such foci (eg, focusing on somatic symptoms first because this is more culturally acceptable and less stigmatized than acknowledging cognitive and emotional symptoms), and/or willingness to express distress based on what is culturally appropriate or accepted (eg, greater stigma associated with mental illness and/or differences in divulging problems to people outside of the family). Cultural stigma surrounding mental illness likely plays a large role in how people express their distress and whether they are willing to seek treatment.

Although Chinese patients may initially report more somatic symptoms and suppress or ignore emotional symptoms, this does not mean that they do not experience emotional and cognitive symptoms (Cheung, 1982;

Cheung & Lau, 1982). In fact, clinical experience tells us that after developing a good therapeutic relationship, Chinese patients begin to feel more comfortable expressing more cognitive and affective symptoms. In addition, studies have found that although some patients were more likely to focus on physical complaints when they initially came into treatment, they were fully aware of and capable of expressing feelings and talking about the social problems that had brought them into treatment once a strong patient–therapist relationship had developed (Cheung, 1982; Cheung & Lau, 1982).

There may even be linguistic differences in the language available to describe, interpret, and communicate one's problems. For example, in Native American culture, words for many Western conceptualizations of illness such as depression and anxiety do not exist (Manson, Shore, & Bloom, 1985). In examining ethnic differences in the clinical presentation of depression, Myers et al. (2002) found that even after controlling for SES and severity of distress, African American and Latina women who were depressed reported more somatic complaints than White American women. Greater somatic manifestations among many ethnic groups may be associated with philosophical or cultural underpinnings that emphasize an integrated or holistic mind–body–spirit experience (Hwang, Wood, Lin, & Cheung, 2006). This can be seen in Traditional Chinese Medicine (TCM) where the mind and body are treated as one, inseparable, and is a balance of yin (negative) and yang (positive) energies. Moreover, in some Latino groups somatic disturbances take the form of chest pains, heart palpitations, and gas (Escobar, Burnam, Karno, & Forsythe, 1987); whereas, in some African and South Asians groups it is sometimes expressed through burning of the hands and feet, and the sensation of worms in the head or the crawling of ants under the skin (American Psychiatric Association, 1994; USDHHS, 2001).

Culture-Bound Syndromes

In addition to somatic expressions of distress, those working with diverse populations also need to be aware of and address culture-bound syndromes, some of which are included in Appendix I of the DSM-IV (American Psychiatric Association, 2000) and Appendix III (the Glossary of Cultural Concepts of Distress) in DSM-5 (American Psychiatric Association, 2013). Culture-bound syndromes have been defined as culture-specific idioms of distress that form recognized symptom patterns and have distinct clinical characteristics, symptom constellations, and social meanings (American Psychiatric Association, 2000; Levine & Gaw, 1995). Culture-bound symptoms have been documented in many different cultures within the US and around the world. They are commonly known as cultural manifestations of distress that tend to be more emic than etic.

Two of the most-researched culture-bound syndromes include ataque de nervios and neurasthenia. Ataque de nervios, often characterized as a form of panic attack among Latinos, is associated with feelings of being out of control due to stressful events that relate to family difficulties (American Psychiatric Association, 2000). Unlike traditional panic attacks, it is not associated with the hallmark symptoms of acute fear or apprehension. Other symptoms include trembling, uncontrollable shouting or crying, somatic feelings of heat rising through the chest to the head, dissociative experiences, seizure-like fainting episodes, and aggressive behavior (American Psychiatric Association, 2000). Recent evidence suggests that although a portion of those diagnosed with ataque de nervios also meet criteria for panic disorder, the majority of subjects with ataque de nervios do not, which suggests that ataque de nervios is a unique construct (Lewis-Fernandez et al., 2002). Key features that distinguish ataque de nervios from panic disorder include a more rapid onset of attack, being preceded by an upsetting event in one's life, and greater fears of losing control, going crazy, depersonalization, sweating, and/or dizziness (Lewis-Fernandez et al., 2002; Liebowitz, Salmán, Jusino, & Garfinkel, 1994).

Neurasthenia (NT), or "shenjing shuairuo" (pronounced as shénjīngshuāiruò, "神經衰弱") in Mandarin Chinese, is commonly referred to as a Chinese form of depression, and is characterized by two highly overlapping symptom domains including increased fatigue after mental effort (eg, poor concentration, increased distractibility, inefficient thinking) or physical weakness or exhaustion that is accompanied by physical pains and inability to relax (eg, headaches, dizziness, sleep difficulties, gastrointestinal problems, anhedonia, and bodily pain) (Organization, 1992). This diagnosis continues to be used in China and is included in the Chinese Classification of Mental Disorders, Second Edition-Revised and Third Edition (Chinese Medical Association and Nanjing Medical University, 1995; Chinese Psychiatric Society, 2001). However, it is considered to be a culture-bound syndrome (eg, a culture-specific emic) by the West (American Psychiatric Association, 2000, 2013).

Nevertheless, neurasthenia tends to be more highly prevalent than major depression in China, as well as among Chinese Americans in the US (Weissman et al., 1996; Zheng et al., 1997). There continues to be controversy about whether neurasthenia is merely major depression with a cultural label or whether it is a distinct

diagnostic entity. For example, Kleinman (1982) found that 87% of psychiatric patients diagnosed with NT in a Chinese clinic could be differently diagnosed with major depression in a Western clinic. However, these results are likely to be biased because those seeking help in China do so as a last resort, and therefore are likely to have more severe symptoms. Greater clinical severity is associated with less variability in the expression of distress. Clinical populations are also less representative than the general population. In contrast, a recent epidemiological study of Chinese Americans in Los Angeles found that 78% of those diagnosed with neurasthenia did not meet criteria for major depression or an anxiety disorder, with the prevalence rate of neurasthenia being as high as that of major depression (Zheng et al., 1997). This study indicates that neurasthenia is a diagnostically distinct entity, and may be a more valid research study than Kleinman's because it includes a randomly selected nonpsychiatric help-seeking population.

Many other culture-bound syndromes have also been documented (Levine & Gaw, 1995). Unfortunately, there is less empirical research to help us understand these syndromes, which affect people from all around the world. In regards to Asian heritage populations, a number of culture-bound disorders have been identified including, Amok among Malaysians (a frenzied dissociative state that affects groups), Shin-Byung among Koreans (anxiety, somatic complaints, dissociation, and possession), Dhat among Asian Indians (hypochondriasis and anxiety about loss of semen—also known as Shen-Kui in Chinese), Taijin Kyofusho among Japanese (similar to social phobia but focused on fear of embarrassing others with one's body parts and odors), Qi-gong induced psychosis among the Chinese (psychotic episodes associated with misbalanced Qi or energy), Hwabyung among Koreans (an anger sickness associated with somatic symptoms, depression, and maltreatment of women), and a number of syndromes (eg, Koro) associated with fear of the penis shrinking into the body that are present in many different Asian, African, and some European heritage cultures (American Psychological Association, 1994; Levine & Gaw, 1995).

It is important to note that there is a clear link between cultural definitions of mental illness and how people express their problems. Even common disorders, such as eating disorders, can be misconstrued as culture-universal etics, rather than being culture-specific emics. Specifically, for many cultures around the world, eating disorders did not exist until the birth of mass media, globalization, and internationalization. Many international and developing countries simply did not value being thin, or there were economic reasons such as food shortages and poverty that would preclude the development of eating disorders. Therefore, eating disorders, such as anorexia nervosa and bulimia, could be seen as Western culture-bound syndromes "emics"—that rapidly spread through mass media and became culture-universal "etics" (Banks, 1992; Keel & Klump, 2003). This speaks to the pathoplasticity, or malleability and changing nature of psychiatric problems, as well as how they are expressed and influenced by culture.

How Cultural Differences in Conceptualization of Illness and Expression of Distress Influence Help-Seeking Patterns

The manner in which a person expresses their psychological distress and conceptualizes the sociocultural meaning of illness can have a significant impact on help-seeking patterns and pathways. Kleinman (1978, 1988) introduced the notion of the explanatory model of illness, which is defined as how a patient perceives, understands, experiences, identifies, and explains the causes of their illness to themselves and to others. How a patient understands and experiences an illness is embedded within a social context, and is influenced by societal norms as well as cultural mores (Pathway C). Understanding how to address the (1) communication and expression and (2) illness and treatment beliefs domains of the PAMF can help improve the client−therapist relationship domain, which is also targeted as an area of cultural adaptation.

When both the practitioner and client are from the same cultural system, it is more likely that they will have matching explanatory models. However, when there is a mismatch between the patient and clinician explanatory models, the cultural and clinical realities of what is perceived to be wrong, what caused the problem, and what type of treatment is most appropriate may be incongruent. Explanatory models of illness also influence how societies label and diagnose diseases. Diagnostic labels provide meaning, and also socially sanction and define the cultural sick role for the patient by legitimizing their illness experiences and providing useful information about possible etiology, course, and treatment for their problems.

The discrepancy between Western mental health treatment (eg, psychotherapy and psychiatric medications) and the cultural beliefs of people from different backgrounds is especially relevant to Asian heritage populations.

As a result, great care needs to be taken when evaluating problem development, identifying a diagnosis, and prescribing an appropriate and effective treatment. Practitioners need to be cognizant of cultural differences in expression of distress as well as selective attention to culturally sanctioned symptoms (eg, the reporting of somatic vs psychological and emotional symptoms). This is important because the discrepancy between cultural beliefs and methods of treatment can influence patient engagement, client satisfaction, treatment compliance, and can lead to premature treatment failure.

As a result, cultural meanings of illness and how they are labeled or diagnosed are two factors that are also likely to influence the manner in which distress is expressed (Pathway D), whether they are accurately diagnosed (Pathway I), beliefs about treatment effectiveness (Pathway H), and where people seek help (Pathway E). Where one seeks help influences how problems are diagnosed (Pathway G) and the types of treatment offered (Pathway F). For example, the manner in which one experiences his/her illness and expresses his/her distress is embedded in a larger cultural milieu. This ultimately affects the "who, why, when, and how," and whether people seek help to cope with problems as illustrated by Pathway E. Those who believe their problems are psychological might seek help from a psychologist. Those who believe their problems are somatic in nature, or are ashamed because of high stigma associated with mental illness, may choose to seek help from a primary care physician (Hwang et al., 2006). There is some research to suggest that ethnic minorities may be more likely to seek psychiatric help from their primary care physician than mental health practitioners, but that primary care doctors are at greater risk for not detecting mental health problems among various ethnic minority groups (Borowsky et al., 2000). Training medical professionals to conduct brief psychiatric screenings and to be cognizant of these cultural differences in help-seeking pathways may help with early problem identification and referral to mental health care. Otherwise, many people from non-Western cultural backgrounds may not receive the help they sorely need.

For many ethnic minorities, an additional choice has to be made, and that whether to seek help from a formal source (eg, psychiatrist or physician), or whether to seek help from more indigenous or informal sources of treatment that they may be more familiar with, have greater access to, and have more confidence in (eg, TCM, herbal treatment, or religious prayer). Although use of alternative therapies is popular among US citizens in general, research has found that ethnic minority groups are more likely to turn to indigenous or complementary treatments for physical and mental health care (Barnes, Powell-Griner, McFann, & Nahin, 2004; Becerra & Inlehart, 1995; Eisenberg et al., 1998; Koss-Chioino, 2000). Nevertheless, more work needs to be done on understanding the interactive relationship between cultural beliefs about the causes of illness and where one seeks helps. Furthermore, better coordination between Western health and mental health services and indigenous and alternative healthcare services (eg, herbal medicine, prayer, and TCM) can help ensure that more people get the help that they need. Collaborative relationships can also help increase patient "buy-in," psychoeducation, and confidence in treatments offered.

For example, there is a growing body of research documenting different beliefs about the causes of mental illness. Bangladeshis and African-Caribbeans living in the UK were found to be the more likely to cite supernatural reasons for the causes of schizophrenia; whereas, Whites more frequently cited biological reasons (McCabe & Priebe, 2004). Research has also found that depressed Chinese Americans who seek psychiatric help in primary care rarely spontaneously report upon their depressed mood, with only 10% of patients labeling their illness as a psychiatric condition (Yeung, Chang, Gresham, Nierenberg, & Fava, 2004). Most of the patients sought help from primary care, lay help, and used alternative treatments, and only 3.5% sought help from a mental health professional.

Religion may also act as a powerful coping resource and method of dealing with life problems for many groups (George, Larson, Koenig, & McCullough, 2000). Many Asian heritage populations utilize religion as a powerful way to reduce stress and find meaning and value from difficult experiences. Some have converted to Western religions and attend Western churches; whereas, others continue to believe in their heritage religions (eg, Buddhism, Taoism, Shintoism, Hinduism, Jainism, and Sikhism). Similarly, many ethnic minority groups, such as African Americans, also utilize religious coping and prayer to deal with adversity, even more so than White Americans (Conway, 1985). African Americans also report having greater satisfaction with their religious coping efforts and feel more connected to God (McAuley, Pecchioni, & Grant, 2000; Myers & Hwang, 2004). Better integration and collaboration between mental health services and religious organizations may help facilitate appropriate referrals as well as provide multiple methods for dealing with life stressors.

Collaboration with traditional or indigenous healers, alternative and complementary medicine, and religious organizations can be especially important, particularly since most people suffering from a mental illness do not receive or seek treatment (USDHHS, 1999). Ethnic minorities are also less likely to have access to and use mental health service than Whites, with many groups evidencing delayed help-seeking (Cheung & Snowden, 1990; Robins & Regier, 1991; Snowden & Cheung, 1990; Sussman, Robins, & Earls, 1987; Swartz et al., 1998). The

underutilization of mental health services by minorities is likely the result of a combination of factors, including: culture-related beliefs about mental illness, stigma, and economic barriers. Two common examples of economic barriers that prevent minorities from utilizing mental health services are lack of insurance and higher rates of poverty (US Department of Health and Human Services, 2001).

For example, African Americans, Native Americans, Latino Americans, and some Asian American groups have a much higher rate of poverty and are less likely to be insured than White Americans (Brown, Ojeda, Wyn, & Levan, 2000; Proctor & Dalaker, 2003). Lack of insurance and financial barriers have been found to be related to lower help-seeking rates among ethnic minorities (Abe-Kim, Takeuchi, & Hwang, 2002; Chin, Takeuchi, & Suh, 2000). Nevertheless, financial and insurance barriers are not sufficient explanations for why ethnic minorities utilize mental health services at a lower rate. Studies have found that even when health insurance plans do cover mental health services or when sociodemographic and need variables are controlled for in statistical models, there does not seem to be as great an increase in help-seeking among ethnic minorities compared to Whites (Padgett, Struening, Andrews, & Pittman, 1995; Swartz et al., 1998).

Therefore, the most salient factor that leads to underutilization of mental health services is cultural stigma toward mental illness. Stigma is one of the most formidable obstacles to seeking and accessing care (USDHHS, 1999). Unfortunately, there is very little research conducted on the relationship between stigma and help-seeking. Moreover, there is little comparative research examining the prevalence of mental illness stigma among different ethnic groups. Nevertheless, we know that stigma toward mental illnesses is a worldwide phenomenon and operates by motivating the general public to reject, avoid, fear, and discriminate against those with mental illnesses (Corrigan, 2004). As a result, those with mental illnesses may feel stigma, shame, conceal their problems for fear of being labeled, and delay or never seek help. For example, Ng (1997) pointed out that stigma is such a powerful factor in Asian heritage cultures that it not only reflects badly upon the one who is ill, but it also diminishes the economic and marriage value for a person as well as the value of his/her family. Because of the strong stigma toward mental illness in various cultural groups, mental illness is often equated with being "crazy" or "weak." Community interventions that focus on public health education and decreasing stigma within those communities and clinical populations are sorely needed.

Our ability to provide culturally competent and effective care is not only related to effectively training White or European American therapists, but also associated with the shortage of ethnic minority and linguistically proficient staff available. The shortage of mental health professionals who come from diverse backgrounds and the limited availability of services available in various ethnic languages is a significant barrier that restricts minorities from receiving effective care. This shortage of ethnic minority practitioners is especially problematic because research suggests that many ethnic minorities would prefer an ethnic-matched provider (USDHHS, 2001). This may be due to beliefs that someone from a similar cultural background will not only be able to understand them better, but will also be more effective in meeting their needs. For Asian heritage populations, ethnic and linguistic matches may be even more important, especially given the large proportion of recent immigrants and heightened linguistic needs of those communities. In addition, there are greater differences between Asian and Western cultures, than between various other minority groups in the US.

It is problematic that many practitioners would prefer to refer their ethnic clients to other therapists, and often feel less confident in their ability to deal competently with people of color. However, oftentimes there is nobody to refer them to—thus leaving many diverse populations feeling like there is nowhere to go for help. This underscores the notion that all mental health practitioners need to be trained to be culturally competent in order to meet the needs of the diverse clientele that we treat in the US, as well as in other countries.

A preference for an ethnic client–therapist match may also be associated with the racism and discrimination that historically marginalized groups have experienced. For example, overall, African Americans have a greater fear and misunderstanding of mental health services compared to White Americans (Clark et al., 1999; Keating & Robertson, 2004). Mistrust of mental health providers was cited as a major barrier to receiving mental health treatment by some ethnic minority groups (USDHHS, 1999). Summary reports in the US and England have also found that some ethnic minorities lack confidence in the mental health care system and feel that they have been mistreated and/or discriminated against by providers in the system (Smedley et al., 2003; US Department of Health and Human Services, 2001).

However, there can also be a preference for ethnic mismatch when it comes to being treated by White American practitioners. For example, when I have conducted cultural competency training, various supervisors and therapists have often told me that some ethnic minorities prefer to see White American therapists. Specifically, because of stereotypes and internalized racism, some patients possess a cultural misconception that White therapists are smarter and better than ethnic therapists. Others believe that ethnic therapists push them

harder, while White therapists are more emotionally supportive. More research about these issues is needed. Whether these perceptions are true or not, we need to better understand the client perceptions of treatment providers from different cultural backgrounds and how it impacts the treatment process.

Reducing the impact of racism and addressing social inequalities that act as barriers to care needs to be properly addressed if we are to improve care for ethnic minorities. In summarizing the apparent failure of England's mental health system in treating ethnic minorities over the past 20 years, Fernando (2005) notes that ethnic minorities are more often than Whites to be diagnosed as schizophrenic, compulsorily detained in hospitals, admitted as offender patients, held by the police for observation for mental illness, transferred to locked wards from open wards when they are patients in hospitals, given high doses of medication when they are hospital patients, and are less likely to be referred for psychotherapy when suffering from a mental illness. Keating (2000) underscores that antiracist perspectives and proper staff training are critical in fighting provider racist ideas, institutional racism, and discriminatory practices. Until these issues are adequately addressed, social inequalities, fear of discrimination, and dissatisfaction with services will continue to act as barriers that negatively impact minority populations from receiving the care they need.

Help-Seeking, Diagnoses, and Their Relation to Treatment

From whom a person seeks help is likely to have an impact on the type and quality of treatment provided, whether those interventions are evidence-based, and the effectiveness of the treatments engaging the patient and reducing symptoms (Pathway F). Practitioners from different help-seeking sources such as primary care, mental health services, and indigenous medicines may conceptualize problems in different ways and differentially diagnose patients (Pathway G). They are also likely to provide different types of treatments because their training backgrounds and ideologies for understanding and approaching problems vary, thus influencing outcomes (Pathway H). As a result, the who, when, why, how, and if one seeks help have important implications, especially if people delay help-seeking until their problems become intolerably worse, which tends to be a big problem among Asian heritage populations.

Overall, research suggests that ethnic minorities evidence higher levels of mental illness burden and disability, and are less likely to have access to and receive quality health and mental health services than White Americans (Smedley et al., 2003; US Department of Health and Human Services, 2001). They are also more likely to drop out of treatment prematurely, and evidence worse treatment outcomes (Smedley et al., 2003; US Department of Health and Human Services, 2001). Improving mental health services for Asian Americans is an extremely important issue because mental illness and its treatment are highly stigmatized, resulting in lower help-seeking rates (Bui & Takeuchi, 1992; Chen, Sullivan, Lu, & Shibusawa, 2003; Hu, Snowden, Jerrell, & Nguyen, 1991; Snowden & Cheung, 1990; Sue, 1977; Sue, Fujino, Hu, & Takeuchi, Zane, 1991) and greater psychiatric impairment when help is sought (Chen et al., 2003; Lin & Lin, 1978; Sue, 1977; Sue & Sue, 1987). Moreover, naturalistic outcome studies indicate that Asian Americans evidence lower treatment satisfaction and worse outcomes (Sue, 1977; Zane, Enomoto, & Chun, 1994). In regards to premature treatment dropout, the evidence is mixed, but some studies found that Asian Americans are more likely to drop out prematurely when compared to White Americans (Sue, 1977; Zane et al., 1994), and other studies finding that their greater illness severity is also associated with greater need to stay in treatment and, as a result, is associated with lower dropout rates and a higher average length of stay (Chen et al., 2003; Sue et al., 1991).

Stigma toward mental illness and its treatment are a huge problem among Asian heritage populations (Ng, 1997; Uba, 1994). This is especially problematic because treating more severely ill clients is much more difficult and takes much more time. As a result, they may be less responsive to treatment and also less confident in treatment because they are less likely to feel significantly better in the short term due to their initial clinical severity. Utilizing and coordinating between psychiatric medication and psychotherapy can potentially help improve outcomes. Because Asian heritage populations often delay help-seeking until their problems get intolerably worse, they are often more treatment-resistant. This occurs because of the clinical cultural interaction between stigma and unfamiliarity with therapy. When a patient is more clinically severe, they may also be less capable of fully participating and engaging in therapy. More efforts need to be placed on early prevention and psychoeducation. For example, it is much easier to treat cancer in its early stages than to introduce clinical interventions near the end stages. Greater efforts need to be placed on breaking down common cultural stereotypes and misperceptions regarding mental illness and its treatment.

As previously mentioned, coordination of care between various types of healthcare providers and alternative sources of care is also especially important, especially since we know that ethnic minorities are more likely than White Americans to not only utilize complementary and alternative medicines, but also seek help at these resources before considering psychological or psychiatric care (Barnes et al., 2004; Becerra & Inlehart, 1995; Eisenberg et al., 1998; Koss-Chioino, 2000). Seldom do practitioners from various professions that have different theoretical underpinnings cross paths and collaborate. This is quite unfortunate because even simple coordination efforts, such as basic referrals and placing help-seeking resources (eg, educational brochures and pamphlets) in clinics can be beneficial.

Because we know that some ethnic minorities of Asian heritage populations delay help-seeking and as a result are more likely to be severely ill at point of entry or have been recently hospitalized (Breaux & Ryujin, 1999; Hu et al., 1991; Snowden & Cheung, 1990; Sue & Sue, 1987; Sue, 1977), greater effort should be made to ensure that their initial contact with the clinic or a service provider is culturally sensitive and effective. A major part of cultural competency is to ensure that clients are appropriately oriented to mental health services. Therapy or treatment orientation is one of the domains of the PAMF. Therapy orientations can help decrease stigma and misperceptions, while at the same time increasing client comfort and understanding of treatment. This is especially important since research suggests that treating patients in a more culturally sensitive manner (ie, providing client–therapist ethnic matching and being treated at ethnic-specific services) can reduce premature treatment dropouts (Flaskerud & Liu, 1991; Sue et al., 1991; Takeuchi, Sue, & Yeh, 1995). Moreover, among English-speaking Asian Americans, the benefits of being treated in a treatment center that specializes in cultural competency outweigh the positive effects of being matched with an ethnically similar therapist (Takeuchi et al., 1995). This suggests that training therapists to be culturally competent and developing culturally effective interventions can serve as a form of quality improvement. It can be even more important than client–therapist ethnic match and should be a top priority in improving care. Training practitioners how to properly orient clients to therapy can be a concrete cultural adaptation strategy that can be easily rendered.

The American Psychological Association (APA) recently published "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (American Psychological Association, 2003), emphasizing the importance of taking culture into account when providing mental health services. However, although these guidelines reinforce the idea that culture and diversity need to be effectively addressed, these guidelines are largely aspirational because they do little to help practitioners understand what to do and what to say to improve their cultural competence or how to culturally adapt and modify services. Many professionals who want and need to be culturally competent understand that culture matters, but continue to struggle with actual skills implementation.

Although, there is a body of research that links cultural competence with therapists feeling more confident and effective in treating ethnic minority clientele, there continues to be little research that directly ties cultural competence to actual therapy outcomes. Also, there is a lack of research that examines the mechanisms and specific aspects of cultural competency that facilitate treatment progress. This is especially problematic because an integration of theory, clinical insight, and empirical findings are needed in order to improve cultural competency training and to better inform our efforts for culturally competent care. Specifically, training programs could target the active ingredients that make cultural competency effective—but these factors have yet to be thoroughly understood by researchers. Obviously, more resources need to be committed to this very worthy endeavor.

The underrepresentation of ethnic minorities in treatment outcome research is especially problematic since recent reports indicate that ethnic minorities have for the most part been left out of the US APA's initiative to establish, define, and validate empirically supported treatments. For example, the US Surgeon General's report indicates that out of the 9266 participants involved in the efficacy studies forming the major treatment guidelines for depression, bipolar disorder, schizophrenia, and ADHD, only 561 participants were African American, 99 were Latino, 11 were Asian Americans or Pacific Islanders, and none were Native Americans or Alaskan Natives. To make the assumption that as-is treatments (or nonculturally adapted treatments) work just as effectively with ethnic minorities is presumptuous and ethnocentric. Although there is a growing body of literature documenting that psychotherapeutic treatments work with some minority groups, there continues to be a dearth of research especially when it comes to empirically based treatments (Miranda et al., 2005). Moreover, different ethnic groups may evidence differential outcomes to as-is therapies. This may depend on how identified they are with White American culture, as well as their own cultural heritage. In addition, just because some groups respond to as-is treatments, it does not mean that they would not benefit from culturally adapted services, especially since the goal of such treatments is to tailor and individualize care for clients.

Because many mental health professionals need and want to be more culturally competent, further research and training that help practitioners understand and actualize these much needed but hard to render skills would be very beneficial. Cultural adaptations are especially important because therapeutic concepts may be culturally foreign to those who have had little exposure to mental illness. This is especially the case for Asian heritage populations where mental illness can be especially stigmatizing (Hwang, 2006; Hwang, Saenz, & Aguirre, 1995). Although the core healing elements of many therapies may generalize across cultures, packaging treatments to better fit with patient needs is integral to improving patient satisfaction, engagement, compliance, and outcome—thus reducing treatment failure. It is important to remember that it is not the responsibility of mentally ill patients to adjust to the requirements of treatment approaches that may be culturally incongruent or dystonic. Instead, our mental health care services are responsible for providing services that are culturally tailored and effective, no matter the ethnocultural backgrounds of their clients. Mental health services need to be culturally effective and provided in a form that is easily understood and accepted by consumers. Cultural competency in providing effective care is a necessity rather than a luxury, and much more work needs to be done on improving our cultural effectiveness.

How Cultural Differences in the Expression of Distress Influence Diagnostic Accuracy and Affect Prevalence Estimates for Mental Illness

Cultural differences in the expression of distress can have a significant impact on practitioners being able to accurately diagnose and assess problems. For example, if practitioners are not aware of cultural differences in the phenomenology of distress, they may assume that clients who report somatic complaints are not suffering from mental illness and only have physical health problems. This results in patients not getting the care that they sorely need. Practitioners may not know to conscientiously explore psychological and emotional issues if the client initially refrains from talking about these symptoms, or denies them while continuing to suffer silently. Clients may be more likely to divulge their emotional struggles to a practitioner after they get to know each other. Therefore, practitioners may get differential responses at different times of inquiry, and should keep this in mind and not be hesitant to re-ask the same question at different times during treatment. Understanding these issues can help reinforce when treating Asian heritage populations.

The ability to consider cultural differences in expression of distress impacts diagnostic accuracy and ultimately influences our ability to have an accurate understanding of the true prevalence rate of psychiatric problems, as illustrated by Pathway J. In addition to individual practitioner effectiveness in diagnosing problems, we also need to develop culturally effective assessment instruments that can be used in research studies. Standards and norms need to be developed so that results can be properly interpreted. At a practical level, accurate diagnostic assessment instruments are needed because they help practitioners refer patients to appropriate providers, are needed in billing and insurance companies, help us track treatment outcomes and change over time, serve as important tools for assessing remission, and help with early detection and recurrence of an illness so that appropriate prevention strategies can be initiated.

When working with Asian heritage populations, diagnostic and assessment practices can be especially challenging because of cultural differences in the manifestation, presentation, and concealment of problems (Pathway I). Current diagnostic systems and methods, which are based on Western conceptualizations of mental illness, may therefore be less accurate in diagnosing those from different cultural backgrounds. In fact, there is much literature documenting the fact that ethnic minorities are more likely to be misdiagnosed than White Americans (Fernando, 2005; Smedley et al., 2003; US Department of Health and Human Services, 2001). Culturally effective instruments can help us better understand true symptom changes in clinical trials, as well as allow for comparative prevalence studies across different populations. Marsella, Kaplan, and Suarez (2002) recommend utilizing the following considerations when addressing these issues: (1) appropriate items and questions, including the use of idioms of distress; (2) opportunities to index frequency, severity, and duration of symptoms, since groups vary in their reporting within certain modes; (3) establishment of culturally relevant baselines in symptom parameters; (4) sensitivity to the mode and context of response (ie, self-report, interview, translation issues); (5) awareness of normal behavior patterns; and (6) symptom scales should be normed and factor-analyzed for specific cultural groups. Taking cultural considerations into account can help reduce diagnostic error.

Accurate identification and classification of mental illness is an essential part of providing quality mental health care (Corey, Corey, & Callanan, 1993). Effective diagnoses can serve a number of functions, including properly identifying the problem, establishing the prevalence of illness in society, prescribing an appropriate treatment, and understanding the etiology, course, and prognosis of the illness. Moreover, the ability to accurately diagnose a problem helps us determine the prevalence of different illnesses and assess the public health needs of different populations. Inaccurate diagnosis severely impairs our ability to properly assess the prevalence of problems in different communities, which, in turn, impacts our understanding of the immediacy of the problem, and our ability to respond with policy efforts (Pathway K).

To provide a concrete example, we know that epidemiological studies assessing the rates of depression among Chinese and Chinese Americans have found lower rates of depression than the general US population (Chen et al., 1993; Hwu, Yeh, & Chang, 1989; Takeuchi et al., 1998; Yeh, Hwu, & Lin, 1995). Many of these studies find a prevalence of 2% or lower for the rate of depression in Asian heritage countries, which is unbelievably low (Weissman et al., 1996). However, community-based studies of Asian Americans have found higher rates of depressive symptoms among Asian Americans than White Americans (Abe & Zane, 1990; Kuo, 1984; Okazaki, 1997; Sue & Sue, 1987). Is this because Asians heritage populations are truly less depressed? Or is it because they exhibit a narrower range of symptoms, and consequently do not meet the five out of nine symptoms required to qualify for a diagnosis? If they only meet three or four of the five symptoms required, but evidence similar or greater severity in those symptoms or evidence equal or greater functional disability, should they not meet criteria for depression? Is this discrepancy due to methodological and/or reporting biases where some ethnic minorities may be less likely to reveal psychiatric difficulties to interviewers whom they do not personally know, but are willing to endorse experiencing a problem on a symptom checklist?

For example, in many collectivistic cultures, there is a high level of social stigma against psychiatric illness and many misperceptions and stereotypes (eg, having a mental illness means that a person is weak or crazy, and brings shame to the family). Epidemiological methods of randomly selecting people within households and asking them to reveal very private information may affect participation rates as well as how respondents answer questions (eg, giving negative ordinal responses). Specifically, even if respondents participate, they may not answer in open and honest ways because the research methodologies are seen as intrusive and culturally unacceptable, which can affect the accuracy of our prevalence estimates. For example, if a complete stranger calls for talks on the door of a person from an Asian heritage background asking if they hear voices or are thinking of killing themselves, most are likely to say no because of the high stigma toward mental illness. This results in an underestimate of the true prevalence rate for psychiatric disorders. In addition, if the people being studied do not label and experience their illness using Western terms, then the ability to accurately capture the prevalence rate is also affected.

In addition, should an individual not be diagnosed with depression if they do not meet full criteria, but evidence additional symptoms that are not included in the Western conceptualizations of depression (eg, somatic difficulties)? Should an individual be given a diagnosis of major depression if they do not meet diagnostic criteria, but do meet criteria for depressive culture-bound syndromes such as neurasthenia? Because healthcare insurance does not pay for services unless a diagnosis is provided, should individuals who evidence considerable illness burden but do not meet Western criteria for depression be excluded from coverage? Should culture-bound syndromes such as neurasthenia be covered by insurance? These and other culture-related questions need to be answered if we are to provide culturally appropriate and effective care. If left unattended, biases in diagnostic practices may lead to inaccurate assumptions about how prevalent problems are in diverse communities (Pathway J), and inappropriately influence funding and policy decisions (Pathway K), resulting in deficiencies in the type, quality, and amount of treatments provided (Pathways L).

When diagnosing those from different cultural backgrounds, practitioners must also be knowledgeable enough to understand whether symptoms and behaviors are culturally normative. This is another example of where cultural meanings and norms have a rippling effect and influence multiple components of the CIMH model. For example, Egeland, Hostetter, and Eshleman (1983) conducted an intriguing study pointing out how insufficient understanding of Amish cultural values and norms can easily lead to misdiagnosis of bipolar illness. Behaviors that would be considered a normative according to mainstream White American culture is significantly different from that of Amish culture. For example, criteria for mania (eg, grandiosity, excessive involvement, and reckless behavior) take on a very different meaning for the Amish. Specifically, driving a car, using machinery, dressing in nontraditional clothes, flirting with a married woman, smoking, taking vacations off season, and excessive telephone usage would be considered culturally nonnormative. If practitioners do not have a good understanding of the Amish culture, they may normalize such behaviors and minimize what would be considered manic symptoms in that cultural context.

In addition, it is also important to understand within-group differences for psychiatric risk. For example, among Chinese Americans, elderly Chinese American women have been found to have the highest rates of suicide when compared to other groups (Yamamoto, Chung, Nukariya et al., 1997; Yu, 1986). This information is useful because it helps with risk management, and provides a specific demographic indicator for high-risk, suicidal behavior. Another example would be African Americans between the ages of 20 and 29, and over age 65, evidencing a particularly high risk for major depression (Brown, Ahmed, Gary, & Milburn, 1995), as do African American women between the ages of 35 and 44 (Blazer, Kessler, McGonagle, & Swartz, 1994). Such information is useful because it identifies at-risk groups and prepares practitioners to assess for these problems. This would be analogous to physicians understanding specific demographic and ethnic indicators of risk when screening for physical illnesses such as diabetes, cancer, and HIV/AIDS. Unfortunately, for some groups (such as Native Americans), the cumulative effect of genocide and racial discrimination have had a devastating impact, which places the entire community at higher risk for a variety of psychiatric illness and substance abuse problems (Robin, Chester, & Goldman, 1996).

Meeting the Needs of Ethnic Minority and Immigrant Communities: Policy Implications

Culture affects many domains of mental health as delineated by the NIMH model. By now, I hope the reader has a good understanding of how culture influences basic mental health processes. Given that many of these cultural effects on mental health are interrelated and ultimately affect treatment and policy, addressing these issues and considering their policy implications is important for meeting the needs of diverse populations. Our current understanding of the prevalence of these problems, as well as our current healthcare system's ability to meet the needs of ethnic minorities or ethnic majorities in other countries, may not be sufficient. We have a lot of work to do in order to be fully prepared to meet the needs of various ethnic groups, reduce health disparities, and provide culturally competent and effective care.

Recent governmental reports reaffirm that racial and ethnic health disparities do exist, and that there may be biases in the healthcare system that influence whether people of differing backgrounds receive quality and equally effective mental health services (Smedley et al., 2003; USDHHS, 2001). Concrete plans that address short-term needs and plan for long-term systematic issues can help improve the outcomes of mental health services. Internationally, countries still need to figure out how to effectively provide mental health care (eg, adopting Western methods, culturally adapting mental health services, or developing and creating indigenous methods and systems that effectively address prevention and intervention efforts). This is especially important since a recent report from the World Health Organization (WHO) found that mental illness accounts for five of the top 10 leading causes of disability around the world, and accounts for 12–15% of disease burden worldwide (Murray & Lopez, 1996). Unfortunately, few national or international policies have been developed to address these global problems. For example, Shatkin and Belfer (2004) recently reviewed existing international policies across the world for child and adolescent mental health care. They found that only 18% of countries worldwide had an identifiable mental health policy, which is extremely low by any consideration. In addition, even though some policies may exist, they may not be very thorough or have an effective, well-funded implementation plan. Moreover, many of these countries also do not have the resources to develop indigenous systems of care or to create their own policies, and are often reliant on adopting Western strategies. If the US could help create culturally adapted and effective systems for treating diverse populations domestically, perhaps some of these culturally modified or adapted treatments could be utilized by international countries as a cost-saving strategy.

Patel, Saraceno, and Kleinman (2006) note that effective policies that help address international access to services need to be established. Specifically, it is unethical to continually deny effective, affordable care to those suffering from mental illness, especially when there is a growing body of research indicating that evidence-based treatments can be effective in ameliorating mental illness. Barriers such as international property rights agreements deny developing countries the right to produce generic versions of drugs (Patel et al., 2006). This results in unaffordable prices for brand-name drugs that are coveted by pharmaceutical companies to increase and retain profit margins. This is unfortunate because those in developing countries have fewer financial resources to pay for such high-priced drugs. Civil rights abuses including denial of basic rights, forced long-term residential treatment, treatment with older drugs with severe side effects, unsanitary conditions, and forced lockdowns of those who are mentally ill, also occur throughout the world and need to be addressed.

In addition to improving training and educational programs, policies that establish incentives for returning to one's country, are needed. Specifically, many countries experience what is called the "brain drain" phenomenon. For example, many of the higher educated people from other countries come to the US and stay, leaving a shortage of educated and highly trained professionals in their countries of origin. This is facilitated by US immigration laws which provide preferential treatment for those with higher education and professional skills. When referencing Asian countries, this is called the "Asian brain drain." Although many international undergraduate and graduate students also come here with the intent of returning home and helping develop their country's infrastructure and resources, many end up staying and do not return to their countries of origin.

In the US, the President's New Freedom Commission (2003) and the Institute of Medicine (Institute of Medicine & Wolfe, 2001) recommend that transformations in mental health delivery systems target six goals for improvement. These goals include: educating people so that they understand that mental health is essential to general health, ensuring mental health care is consumer- and family-driven, eliminating disparities in mental health services, offering early screening, making assessment accessible, establishing referral services, delivering quality mental health care, accelerating research, and using technology to access mental health care and information. These recommendations are surprisingly similar to targeted improvements in England (Beinecke, 2004). Some of the more successful multicultural services in the UK tend to employ a number of "good practices," including: using multicultural multidisciplinary teams, specific cultural sensitivity and antiracist practice trainings, antioppressive practices in establishing collaborative ties with communities, helping clients deal with racism, increasing the number of ethnic minority staff, improving the educational pipeline, linking psychological support to housing, providing advocacy to help clients deal with statutory services, integrating cultural spirituality and alternative treatments to psychotherapeutic services, and culturally adapting psychotherapy for clientele (Fernando, 2005). These effective practices could be applied to international services and a Global Alliance for Mental Health under the umbrella of the World Health Organization (Patel et al., 2006). However, for developing countries, critical economic and social problems may need to be addressed more immediately before many of these aspirational goals and changes can be implemented.

As mental health researchers, practitioners, and teachers, we bear the responsibility to improve our cultural awareness and competence. By developing a more sophisticated understanding of how culture systematically affects several interrelated areas of mental health domains, we position ourselves to better address the needs of diverse populations and provide culturally effective care. The CIMH conceptual framework was developed to help providers move beyond simplistic dyadic conceptualizations of cultural influences and to better understand the complexities involved in providing culturally competent and sensitive care. Moreover, the model provides concrete areas that can be targeted for cultural adaptation when providing culturally competent care. This model is offered as a basic framework for improving understanding about CIMH and its treatment. Although no model can encapsulate all of the complexities involved, the hope is that the CIMH model has helped improve your understanding of these complicated and interrelated issues so that professionals are equipped to work with diverse populations.

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