Effect of Discrimination on Mental Health Service Utilization Among Chinese Americans

| Michael S. Spencer, PhD, MSSW, and Juan Chen, MSW

Low utilization of mental health services by Asian Americans/Pacific Islanders is well documented.[1–7] Nationally, Asian American/ Pacific Islander populations are 3 times less likely than White populations to use available mental health services.[8] Data from the Chinese American Epidemiology Study (CAPES) indicated that only 17% of Chinese Americans who experienced problems with emotions, anxiety, drugs, alcohol, or mental health in the past 6 months sought care.[9] Less than 6% of these patients saw mental health professionals, 4% saw medical doctors, and 8% saw a minister or priest.

Barriers to service utilization are often conceptualized as issues of availability and access. The supplement to the surgeon general's report on mental health states that nearly half of the Asian American/Pacific Islander population's low utilization of mental health services is attributable to lack of English proficiency and a shortage of providers who possess appropriate language skills.[10] Accessibility of mental health services to Asian Americans/Pacific Islanders has been found to be associated with health insurance coverage—21% of all Asian Americans/ Pacific Islanders lack health insurance. Twenty percent of Chinese Americans lack health insurance, and only 13% of Chinese Americans with family incomes below 200% of the federal poverty level have Medicaid coverage (compared with 24% of Whites in the same income bracket).[10,11]

Family and extended family serve as an active support system and a source of help for psychological problems. The family unit and the extended family serve an important function in taking collective responsibility to care for an emotionally impaired member.[13] When a family is unable to resolve the problem, it may turn to outside help within the ethnic community, consulting indigenous healers, community elders, and physicians for assistance.[12,13] Although these support systems are

Objectives. We examined the association between discrimination and mental health service use among a representative sample of Chinese Americans.

Methods. Our data were derived from the 2-wave Chinese American Psychiatric Epidemiological Survey, a strata-cluster survey conducted in 1993 and 1994 in a western American city.

Results. Language-based discrimination was associated with higher levels of use of informal services and seeking help from friends and relatives for emotional problems. Negative attitudes toward professional mental health services were associated with greater use of informal services.

Conclusions. The findings suggest that language-based discrimination influences patterns of mental health service use among Chinese Americans. Implications for service providers and policymakers are discussed. (*Am J Public Health.* 2004;94:809–814)

certain to play an important role in maintaining Asian American/Pacific Islanders' well-being, use of such informal support systems may result in delay in seeking professional treatment until symptoms become severe and unmanageable. Studies of community mental health centers, county mental health systems, and student psychiatric clinics have found that Asian Americans/Pacific Islanders who use mental health services tend to be more severely ill than Whites who use the same services.[7,14–17]

Cultural and social contexts shape the mental health of ethnic minorities and influence the types of mental health services they use; racism and discrimination are facets of the social context that are ever present in the lives of racial/ethnic minorities.[10,18–24] History is fraught with examples of policies and practices that have systematically discriminated against Asian Americans/Pacific Islanders (e.g., the Chinese Exclusion Act of 1882, the Immigration Act of 1917, the Tydings–McDuffie Act of 1934, Executive Order 90666 in 1942). Past abuses and the perceived mistreatment of racial and ethnic minorities by medical and mental health professionals may precipitate mistrust of service providers. Although mistrust has been hypothesized to represent a major barrier to the receipt of mental health treatment by racial/ethnic minorities, very lit-

tle empirical evidence is available to document.[10] Studies that have examined the relation between discrimination and mental health service use have found that higher proportions of African Americans and Latinos than of Whites felt that a doctor or health provider had judged them unfairly or treated them with disrespect because of their race or ethnic background. Clinician bias and stereotyping also play a role in mistrust and subsequent service utilization in minorities.[25–27] Takeuchi, Mokuau, and Chun noted that one of the difficulties of establishing culturally responsive mental health services for Asian Americans/ Pacific Islanders is a lack of congruence between the characteristics of the mental health system and the characteristics of the minority group culture; assessment instruments, agency policies, clinicians, and practices do not address the concerns or take into account the special needs of minority clients.[28] Uba identified the following barriers to mental health service utilization for Asian Americans/Pacific Islanders: (1) racial and cultural biases (culturally inappropriate services, differential receipt of services compared with Whites, a history of institutional discrimination and insensitivity, a feeling of being unwelcome, and suspicion of the service delivery system); (2) conflicts between the epistemological underpinnings and characteristics of "Western" psychotherapy

and the personality syndromes, values, expectations, and interpersonal styles of Asian Americans/Pacific Islanders; (3) Asian/Pacific Islander cultural attitudes toward seeking help and perceptions of the usefulness of such help; (4) language barriers; (5) a shortage of bilingual and culturally sensitive service providers; and (6) lack of knowledge of existing services.[29] Thus, although evidence for an association between discrimination and mental health service use is scant, there is general agreement in the literature that such discrimination is an area of concern and requires further research.

The purpose of this study was to examine the association between discrimination and mental health service utilization; we controlled for demographic characteristics, socioeconomic status, psychological stress, immigration status, and traditional barriers to services related to access and attitudes. In addition to formal and informal mental health services, seeking help from friends and relatives was also included as a mental health service outcome. It was hypothesized that discrimination would be associated with less use of formal services, greater use of informal services, and increased incidences of seeking help from friends and relatives.

METHODS

Sample

The data for this study were taken from the 2-wave CAPES. The CAPES is the largest psychiatric epidemiological study of an Asian American/Pacific Islander group to have obtained *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition,*[30] diagnoses for all participants. The CAPES is a strata-cluster survey conducted in 1993–1994 in the greater Los Angeles area. The survey's probability sample of 1747 Chinese American households is representative of the general Chinese American population residing in the area. We designed the 3-stage sampling procedure to (1) select tracts from the 1652 census tracts in Los Angeles County, which were cross-stratified by the percentage of Chinese American households in census tracts, the median income for Asian American/Pacific Islander households in tracts, and the racial/ethnic percentage in the tracts; (2) ran-

domly select 12 blocks within each of the tracts; and (3) randomly select 4 households within each of the blocks. Selection in the first 2 stages was designed with probabilities proportional to size, such that even though selection probabilities varied within each stage, the ultimate selection probabilities were the same for all Chinese households (see Takeuchi et al.[31] for details).

The sample for the current study consisted of 1503 adults interviewed in both waves of the survey. Combining the 2 waves allowed us to maximize the incidence of lifetime psychiatric disorder and mental health service use among the sample. Wave 2 measured discrimination, whereas wave 1 measured lifetime incidence of psychiatric disorders and service use. A total of 244 respondents who were interviewed in only 1 wave were excluded from the sample. However, no significant differences in the demographic characteristics examined in the study were found between the 244 respondents excluded and the 1503 respondents that composed the final sample.

Procedures

Bilingual interviewers, fluent in English and in Mandarin or Cantonese, were recruited for this study. Whenever possible, interviewers were recruited from areas close to the sampled census tract; this close proximity helped ensure familiarity with the neighborhoods. The interviewers were lay interviewers with at least some college education.

The interviews were conducted in English, Mandarin, or Cantonese, depending on the respondent's language preference, and lasted approximately 90 minutes. Eligible individuals included Chinese Americans aged 18 to 65 years in 1993 who resided in Los Angeles County. One eligible person within each eligible household was randomly selected for the interview.[32] Of the eligible respondents, 1747 interviews were completed in the first wave, which resulted in an 82% response rate. In the second wave, 1503 interviews were completed out of the 1747 respondents in the first wave.

Measures

Psychiatric disorder. The major diagnostic instrument used in the CAPES was the University of Michigan version of the Composite International Diagnostic Interview.[31] The

Composite International Diagnostic Interview is a structured interview schedule based primarily on the National Institute of Mental Health Diagnostic Interview Schedule and designed to be used by trained interviewers who are nonclinicians. Computer algorithms are used to construct clinical diagnoses based on the responses to the Composite International Diagnostic Interview. The CAPES focuses on major psychiatric disorders, including affective disorders, anxiety disorders, and alcohol and drug abuse or dependence. In the current study, we limited our analyses to affective disorders and anxiety disorders. The psychiatric disorder variable was generated by combining both lifetime and 12-month rates (any disorder) of agoraphobia, major depressive episode, dysthymia, generalized anxiety disorder, panic disorder, simple phobia, and social phobia from both waves of the CAPES. A dummy variable was computed to indicate presence of any of these lifetime disorders.

Mental health service utilization. Three dummy variables were computed to measure the dependent variables in our analyses: use of formal services, use of informal services, and seeking help from friends or relatives. Use of formal mental health services was assessed with a dummy variable for which 1 indicated ever having sought help for problems with emotions, nerves, drugs, alcohol, or mental health by going to "a psychiatrist or other mental health specialist at a health or family clinic"; "a psychiatrist, psychologist, social worker, or counselor in private practice"; "a medical doctor in private practice (except for a psychiatrist) or any medical person at a health plan or a primary care clinic"; "a mental health center"; "a psychiatric outpatient clinic at a general hospital or university hospital"; "an outpatient clinic in a psychiatric hospital"; "an outpatient clinic in a Veterans Administration hospital"; "a hospital emergency room"; "a family service, child counseling, or social service agency"; "someone at a self-help group like Alcoholics Anonymous"; or "[by going to] a community program like a crisis center or [by calling] a hotline number." Use of informal services was assessed with a dummy variable for which 1 indicated ever having gone to either "a minister or a priest—including a priest in a Taoist or Buddhist temple" or "a spiritualist, herbalist, or fortune-teller." Seeking help from friends or

relatives was assessed with a dummy variable in which 1 indicated ever having gone to a friend or relative for help. Use of formal services, use of informal services, and seeking help from friends or relatives are not mutually exclusive; thus, separate logit models were analyzed for each dependent variable.

Discrimination. We used 2 dummy variables to assess discrimination. The first variable measured race discrimination, with 1 indicating having ever been treated unfairly or badly because of one's race or ethnicity. The second variable assessed language discrimination, with 1 indicating having ever been treated unfairly or badly because "you speak a different language or you speak with an accent." Discrimination was measured only in the second wave of the CAPES.

Demographics and socioeconomic status. We assigned age (in years), gender (1=female), and marital status (reference group=married) as sociodemographic control variables in the analyses. Education and income were the measures of socioeconomic status. Education was divided into 3 categories: grades 0 through 11, high school, and some college and above. Income was measured as total household income during the previous year. Income was divided into 4 categories based on the percentage distribution of the sample. Household size (the number of persons living in the household) was included in all analyses that involved income, because the meaning of a given level of income is related to the number of persons living in the household.

Stress. Two general indicators of stress were used: negative life events and daily hassles. The life-events measure was a dummy variable, with 1 indicating any lifetime experience with items from an inventory of 10 traumatic events (combat experience; life-threatening accident; involvement in a natural disaster; witnessing someone being badly injured or killed; being raped; being sexually molested; being physically attacked or assaulted; being physically abused as a child; being neglected as a child; and being threatened with a weapon) or any experience in the past 12 months with items from an inventory of 10 negative experiences (a close friendship breakup; a long separation from a loved one; being robbed or burglarized; having a driver's license suspended; suing somebody; being sued by somebody;

having serious trouble with the police or the law; having serious ongoing tension conflicts or arguments with close relatives; having any close friends or close relatives die; having friends or relatives have a major life crisis) reported in either wave. Daily hassles measure chronic stress. Our scale captured the intensity of the following experiences (from a list of 16 items) in day-to-day life: difficulties with friends; not enough time for family; problems with children; problems with aging parents; not seeing enough people; friends or relatives too far away; social obligations; and concerns about accidents, auto maintenance, physical conditions of the neighborhood, traffic, prejudice and discrimination from others, news events, noise, crime, or pollution.

Immigration status. Immigration status was assessed with 2 variables: age at immigration and length of time in the United States. We recoded the age at immigration and length of time in the US from continuous variables to categorical variables with 3 values to avoid the possible misspecification of a linear relation between these variables and the log–odds ratios of the dependent variables in our logit models.

Barriers to service utilization. Three variables were computed to measure barriers to service utilization: attitudes, accessibility, and medical insurance status. Attitudes were assessed by calculating the mean score of 3 items: "Treatment for problems with emotions, nerves, drugs, alcohol, or mental health does not help"; "These problems will get better by themselves"; and "When seeking help in these problems, one should be concerned about what others might think." The higher the score, the more negative the attitudes toward services. Accessibility was assessed by using the mean score of 3 accessibility measures: "Treatment of problems with emotions, nerves, drugs, alcohol, or mental health takes too much time"; "It is too expensive to seek treatment for these problems"; and "I do not know where to seek help for these problems." The higher the score, the more difficult the accessibility. Although typically defined as an issue of access, having medical insurance was assessed separately (with a dummy variable, 1 indicating having medical insurance) because of previous studies that have shown medical insurance to be a significant indicator of service use.

Analyses

We applied weights to the sample data to adjust for demographic variables, nonresponse rates, and differential probability of selection within the household. Both weighted and unweighted descriptive statistics are included in Table 1. In subsequent analyses, only weighted data were used. To test our hypothesis that discrimination is associated with mental health service use, we used binomial logistics regressions to examine the association between 3 types of service use (use of formal services, use of informal services, and help seeking from friends or relatives) and discrimination. We included lifetime incidence of psychiatric disorder, demographic characteristics, socioeconomic status, stress indicators, immigration status, and barriers to service use in our logistic regression models. The weighted maximum likelihood method was used to estimate the parameters and standard errors from which Wald F statistics, probability levels, and odds ratios were calculated. We assessed statistical significance as a *P* level of .05.

RESULTS

Table 1 shows the descriptive statistics for the sample. Among 1503 respondents, 20.5% had ever experienced an episode of at least 1 of the major psychiatric disorders investigated. Rates were 9.5% for ever having used a formal service agency, 11.3% for ever having used informal services, and 24.2% for ever having sought help from friends and relatives. About 18% of the respondents reported having been treated badly or unfairly because of their racial/ethnic status and 13% reported such treatment because they speak a different language or speak with an accent.

Table 2 presents results of the logit model for service utilization. Lifetime incidence of a psychiatric disorder showed strong and consistent associations with all of the following: use of formal services, use of informal services, and help seeking from friends or relatives. Not surprisingly, the association between having a psychiatric disorder and use of formal services was the strongest. Individuals who had ever experienced a psychiatric disorder were 3.2 times more likely to have used formal mental health services than were individuals who had never experienced a psy-

TABLE 1—Characteristics (Unweighted and Weighted) of Chinese Americans: Chinese American Psychiatric Epidemiological Survey, 1993–1994

	Mean (SD)		No. (%)	
	Unweighted	Weighted	Unweighted	Weighted
Psychiatric disorder			308 (20.5)	308.0 (20.5)
Service use				
Formal service use			143 (9.5)	123.2 (8.2)
Informal service use			170 (11.3)	135.7 (9.0)
Friends and relatives			364 (24.2)	329.8 (21.9)
Discrimination				
Race discrimination			269 (17.9)	251.8 (16.8)
Language discrimination			195 (13.0)	178.7 (11.9)
Age, y	40.1 (11.8)	39.6 (12.6)		
Female			788 (52.4)	745.2 (49.6)
Marital status				
Single			359 (23.9)	408.8 (27.2)
SDW			113 (7.5)	79.6 (5.3)
Married[a]			1028 (68.5)	1011.2 (67.4)
Education				
Grades 0–8			288 (19.2)	326.2 (21.7)
High school or GED			277 (18.5)	297.5 (19.8)
Some college[a]			936 (62.3)	877.9 (58.5)
Household income, $				
0–12 499			217 (14.4)	204.6 (13.6)
12 500–24 999			416 (27.7)	469.0 (31.2)
25 000–49 999			443 (29.5)	460.1 (30.6)
≥ 50 000[a]			427 (28.4)	369.2 (24.6)
Household size, no. persons	2.8 (1.5)	2.8 (1.6)		
Stress indicators				
Life events			1044 (69.5)	990.3 (65.9)
Daily hassles	1.1 (0.5)	1.1 (0.5)		
Age at immigration, y	26.1 (13.3)	26.3 (14.1)		
0–20[a]			476 (31.7)	524.1 (34.9)
21–40			815 (54.3)	736.2 (49.0)
41–65			211 (14.1)	241.8 (16.1)
Length in US, y	13.7 (9.3)	13.0 (8.9)		
≤ 5			214 (14.3)	231.5 (15.4)
> 5–≤ 10			347 (23.1)	374.3 (24.9)
> 10			941 (62.6)	896.5 (59.7)
Barriers				
Attitudes	1.7 (0.6)	1.7 (0.6)		
Access	2.7 (0.8)	2.8 (0.8)		
Medical insurance			1041 (69.3)	983.6 (65.5)

Note. SDW = separated, divorced, widowed; GED = Graduate Equivalency Diploma.
[a]Reference group.

Among the demographic and socioeconomic status variables examined, gender was found to be associated with use of informal services and help seeking from friends or relatives. Compared with men, women were 1.52 times more likely to use an informal service and 1.83 times more likely to seek help from friends or relatives. No significant difference existed between women and men in seeking formal service. Age was associated with help seeking from friends or relatives; the older the respondents, the less likely they were to seek help from friends or relatives. Single individuals were less likely to use informal services compared with their married counterparts. People with less education were less likely to seek help from friends or relatives. Although there is a weak association between income and service use, this association was complex and may have been confounded by the correlation among income, ever having had a psychiatric disorder, and having medical insurance.

Among stress variables, life events were associated with all of the following: use of formal services, use of informal services, and help seeking from friends or relatives. Daily hassles were associated only with help seeking from friends or relatives. Among the variables measuring immigration status, length of time in the United States was associated with use of formal services; respondents who had lived in the United States for more than 10 years were more likely to use formal services.

With regard to accessibility and attitudinal barriers, attitudes were associated with use of informal services. The more negative the attitudes held toward formal mental health services, the more likely respondents were to use informal services. Accessibility was negatively associated with use of formal services and help seeking from friends or relatives. The more difficult it was to access formal services, the less likely individuals were to use those services or to seek help from friends and relatives. Having medical insurance was associated with use of formal services and with help seeking from friends or relatives. Individuals with medical insurance were more likely to use formal mental health services, whereas people without medical insurance were more likely to seek help from friends or relatives.

chiatric disorder. Having experienced unfair or bad treatment because of one's race/ethnicity was not related to service use; however, respondents who reported experiencing unfair or bad treatment because they speak a different language or speak with an accent were 2.2 times more likely to use informal services and 2.4 times more likely to seek help from friends or relatives relative to respondents who did not report such treatment.

TABLE 2—Logistic Regression Models of Mental Health Service Utilization Among Chinese Americans: Chinese American Psychiatric Epidemiological Survey, 1993–1994

	Coefficient (Odds Ratio)		
	Formal Services	Informal Services	Friends or Relatives
Psychiatric disorder	1.16† (3.18)	0.64*** (1.91)	0.56*** (1.76)
Discrimination			
Race discrimination	–0.34 (0.71)	0.18 (1.20)	–0.45* (0.64)
Language discrimination	0.42 (1.52)	0.79** (2.20)	0.89† (2.42)
Age, y	–0.01 (0.99)	–0.02 (0.98)	–0.03*** (0.97)
Female gender	0.09 (1.10)	0.42** (1.52)	0.61† (1.83)
Marital status			
Single	–0.17 (0.84)	–0.75** (0.47)	–0.42 (0.66)
SDW	0.38 (1.46)	0.39 (1.48)	0.35 (1.41)
Married[a]			
Education			
Grades 0–8	0.19 (1.21)	–0.41 (0.66)	–0.90† (0.41)
High school or GED	0.41 (1.50)	–0.14 (0.87)	–0.34* (0.71)
Some college[a]			
Household income, $			
0–12 499	0.52 (1.68)	–0.31 (0.73)	0.01 (1.01)
12 500–24 999	0.17 (1.19)	–0.62** (0.54)	–0.15 (0.86)
25 000–49 999	0.11 (1.12)	–0.07 (0.94)	0.17 (1.19)
≥ 50 000[a]			
Household size, no. persons	–0.06 (0.94)	–0.12 (0.89)	–0.04 (0.96)
Stress indicators			
Life events	0.60** (1.83)	0.67*** (1.95)	0.42*** (1.52)
Daily hassles	0.27 (1.31)	0.29 (1.34)	0.46*** (1.58)
Age at immigration, y			
0–20[a]			
21–40	–0.06 (0.94)	0.45 (1.57)	–0.24 (0.79)
41–56	0.20 (1.22)	0.12 (1.13)	–0.36 (0.70)
Length in US, y			
≤ 5	–0.64* (0.52)	0.06 (1.06)	0.06 (1.06)
> 5–≤ 10	–0.64** (0.53)	–0.31 (0.73)	–0.05 (0.95)
> 10[a]			
Barriers			
Attitudes	0.19 (1.21)	0.52† (1.68)	0.10 (1.10)
Access	–0.36*** (0.70)	–0.20 (0.82)	–0.40† (0.67)
Medical insurance	0.54** (1.71)	0.10 (1.10)	–0.36** (0.70)
Constant	–2.93	–2.61	0.23

Note. SDW = separated, divorced, widowed; GED = Graduate Equivalency Diploma.
*$P \leq .10$; **$P \leq .05$; ***$P \leq .01$; †$P \leq .001$.
[a]Reference group.

DISCUSSION

This study investigated the association between discrimination and mental health service utilization among Chinese Americans. Our findings suggest that discrimination is associated with greater use of informal services and with help seeking from friends or relatives, but not with use of formal services. The study hypothesis that language-based and racial/ethnic discrimination are associated with patterns of service utilization were only partially supported. Although racial/ethnic discrimination was not significantly associated with service use, discrimination resulting from speaking a different language and having an accent was an important stressor that can influence the types of services individuals may use. These findings support bilingual and bicultural services as a means for providing culturally sensitive services to Chinese Americans who may have experienced discrimination resulting from lack of English-language proficiency.

Our findings also underscore the differential effects of barriers on use of formal services, use of informal services, and seeking help from friends or relatives. Negative attitudes toward formal services are associated with greater use of informal services. To help counteract these attitudes, formal service agencies could establish collaborative partnerships with informal service providers in the area and refer clients to them when necessary. Efforts to combine traditional healing methods with evidence-based practices should also be examined. To date, almost no research has been done on empirically supported interventions for Chinese Americans. Providers of formal services can also capitalize on the common practice of seeking help from friends and relatives by encouraging and supporting positive social networks through new and existing community-based support groups. Such groups might be developed around specific interest areas, such as cooking, gardening, walking, or games.

Our findings also show that individuals with medical insurance are more likely to seek formal services, whereas individuals without medical insurance are more likely to seek help from friends or relatives. In addition to health care reform making mental health services readily available to all individuals, more multilingual education is needed regarding the availability of Medicaid; increased funding also is needed for community-based agencies that serve new immigrant populations and the uninsured.

The limitations of this study must be noted. First, the instrument used to measure perceived discrimination did not assess discrimination in multiple other areas of life or gather information on the frequency of exposure over the life course. Development of measures of discrimination is in its infancy, and continued research in this area is needed (see Krieger[33] for discussion). Although we used longitudinal

data, because we combined prevalence rates across 2 waves in computing our study variables, we could not identify causal relations between the independent variables and our dependent variables. For example, individuals may have possessed negative attitudes toward service use before the study because of negative past experiences with formal services. By combining the 2-wave data, we cannot establish temporal ordering and thus cannot attribute a causal relationship between our study variables. Second, although the CAPES study focuses exclusively on Chinese Americans, more diversity exists within this ethnic category than has been examined in our analyses. For example, Chinese Americans who immigrate to the United States may have come from different sociopolitical environments—such as mainland China, Taiwan, Hong Kong, and Southeast Asian countries—and therefore may show differences in patterns of service utilization. Further research should investigate in more depth the heterogeneity of Chinese Americans and should pay more attention to how stress, acculturation, and accessibility or attitudinal barriers combine with other factors in additive or interactive ways to affect Chinese American individuals' mental health status and service utilization. ■

About the Authors

Michael S. Spencer is with the School of Social Work, University of Michigan, Ann Arbor. Juan Chen is a doctoral student in social work and political science at the University of Michigan.

Requests for reprints should be sent to Michael S. Spencer, School of Social Work, University of Michigan, 1080 S University Ave, Ann Arbor, MI 48109-1106 (e-mail: spencerm@umich.edu).

This article was accepted May 6, 2003.

Human Participant Protection

No protocol approval was needed for this study.

References

1. Cheung FK, Snowden LR. Community mental health and ethnic minority populations. *Community Ment Health J.* 1990;26:277–292.

2. Yamashiro G, Matsuoka JK. Help-seeking among Asian and Pacific Americans: a multiperspective analysis. *Soc Work.* 1997;42:176–186.

3. Sue S, Morishima JK, eds. *The Mental Health of Asian Americans.* San Francisco, Calif: Jossey-Bass; 1982.

4. Cheung FK. The use of mental health services by ethnic minorities. In: Myers HF, Wohlforo P, Guzman LP, Echemendia RJ, eds. *Ethnic Minority Perspectives on Clinical Training and Services in Psychology.* Washington, DC: American Psychological Association; 1991:23–31.

5. Hu T-W, Snowden LR, Jerrell JM, Nguyen TD. Ethnic population in public mental health: services choice and level of use. *Am J Public Health.* 1991;81:1429–1434.

6. Lin K-M, Cheung F. Mental health issues for Asian Americans. *Psychiatr Serv.* 1999;50:774–780.

7. Bui K-VT, Takeuchi DT. Ethnic minority adolescents and the use of community mental health care services. *Am J Community Psychol.* 1992;20:403–417.

8. Matsuoka JK, Breux C, Ryujin DH. National utilization of mental health services by Asian Americans/ Pacific Islanders. *J Community Psychol.* 1997;25:141–145.

9. Young KNJ. *Help Seeking for Emotional/Psychological Problems Among Chinese Americans in the Los Angeles Area: An Examination of the Effects of Acculturation* [dissertation]. Los Angeles, Calif: University of California at Los Angeles; 1998.

10. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, Md: US Dept of Health and Human Services; 2001.

11. Brown ER, Ojeda VD, Wyn R, Levan R. *Racial and Ethnic Disparities in Access to Health Insurance and Health Care.* Los Angeles, Calif: University of California, Los Angeles, Center for Health Policy and Research and The Henry J. Kaiser Family Foundation; 2000.

12. Zhang AY, Snowden LR, Sue S. Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles Area. *J Community Psychol.* 1998;26:317–326.

13. Uba L. *Asian Americans: Personality Pattern, Identity, and Mental Health.* New York: Guilford Press; 1994.

14. Brown TR, Huang KH, Harris DE, Stein KM. Mental illness and the role of mental health facilities in Chinatown. In: Sue S, Wagner NN, eds. *Asian Americans: Psychological Perspectives.* Palo Alto, Calif: Science & Behavior Books; 1973:212–231.

15. Sue S. Community mental health services to minority groups: some optimism, some pessimism. *Am Psychol.* 1977;32:616–624.

16. Durvasula RS, Sue S. Severity of disturbance among Asian American outpatients. *Cult Divers Ment Health.* 1996;2:43–52.

17. Sue S, Sue DW. MMPI comparisons between Asian-American and non-Asian students utilizing a student health psychiatric clinic. *J Couns Psychol.* 1974;21:423–427.

18. Kessler RC, Mickelson KD, Williams DR. The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. *J Health Soc Behav.* 1999;40:208–230.

19. Krieger N. Racial and gender discrimination: risk factors for high blood pressure? *Soc Sci Med.* 1990;30:1273–1281.

20. Williams DR. Race and health: basic questions, emerging directions. *Ann Epidemiol.* 1997;7:322–333.

21. Williams DR, Spencer MS, Jackson JS. Race, stress, and physical health: the role of group identity. In: Contrada RJ, Ashmore RD, eds. *Self and Identity: Fundamental Issues.* New York, NY: Oxford University Press; 1998:71–100.

22. Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: socioeconomic status, stress, and discrimination. *Am J Health Psychol.* 1997;2:335–351.

23. Finch BK, Kolody B, Vega WA. Perceived discrimination and depression among Mexican-origin adults in California. *J Health Soc Behav.* 2000;41:295–313.

24. Murray VM, Brown PA, Brody GH, Cutrona CE, Simons RL. Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *J Marriage Fam.* 2001;63:915–926.

25. Abreu JM. Conscious and nonconscious African American stereotypes: impact on first impression and diagnostic ratings by therapists. *J Consult Clin Psychol.* 1999;67:387–393.

26. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academy Press; 2002.

27. Van Ryn M, Fu SS. Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? *Am J Public Health.* 2003;93:248–255.

28. Takeuchi DT, Mokuau N, Chun C-A. Mental health services for Asian Americans and Pacific Islanders. *J Ment Health Adm.* 1992;19:237–245.

29. Uba L. Meeting the mental health needs of Asian Americans: mainstream or segregated services. *Professional Psychol.* 1982;13:215–221.

30. *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition.* Washington, DC: American Psychiatric Association; 1987.

31. Takeuchi DT, Chung RC-Y, Lin K-M, et al. Lifetime and 12-month prevalence rates of major depressive episodes and dysthymia among Chinese Americans in Los Angeles. *Am J Psychiatry.* 1998;155:1407–1414.

32. Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry.* 1994;51:8–19.

33. Kieger N. Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: an ecosocial perspective. *Am J Public Health.* 2003;92:194–199.