Cross-Cultural Barriers to Mental Health Services in the United States

By Frederick T. L. Leong, Ph.D., and Zornitsa Kalibatseva

Editor's note: Getting treatment for a mental illness can be difficult for any American—and more than half of all adults in the country will experience a mental illness during their lives. But for members of ethnic and racial minority groups, the road to treatment is often blocked by cultural views of mental illness and therapy, lack of insurance and access to appropriate care, and a critical deficiency of studies pertaining to nonwhite populations. Significant, national changes to the mental health field must be made in order for proper care to be widely available and accepted.

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On November 9, 2004, a 36-year-old Chinese American woman was found dead in her car in Los Gatos, California, with a self-inflicted gunshot wound to her head. On April 16, 2007, a 23-year-old Korean American college student in Virginia also shot himself. While these two cases are among the 5.4 per 100,000 suicides committed annually by Asian Americans,[1] they are actually two of the most high-profile cases involving Asian Americans. The 36-year-old woman was Iris Chang, author of *The Rape of Nanking: The Forgotten Holocaust of World War II* and *The Chinese in America.* She committed suicide after a bout of depression for which she briefly sought psychiatric help. The Korean American college student was Seung-Hui Cho; he killed 32 people at Virginia Tech before committing suicide. Cho also had brief contact with the mental health system, consisting of two phone calls and one in-person visit to the Cook Counseling Center on campus as well as a short stay at the Carilion St. Albans Hospital psychiatric ward. Both Chang and Cho had prematurely terminated their contact with mental health professionals.

On a daily basis, racial and ethnic minority members in the United States are not getting the help that they need. In this article we seek to discuss some of the barriers, cultural and otherwise, that prevent their access to care, and to provide some recommendations for solutions. We do not intend to imply that white European Americans do not have similar mental health problems, but only that the evidence suggests that racial and ethnic minorities in the United States are more likely to underutilize mental health services and prematurely terminate treatment despite their continued need for it.[2]

Mental illness is the most prevalent health problem in the United States. The statistics are staggering: one in ten children[3] and one in four adults[4] suffer from mental illness in this country. According to the National Comorbidity Survey, 57.4 percent of U.S. adults are estimated to have experienced some form of diagnosable mental illness in their lifetime.[5] And mental illness can be costly. Among the major medical conditions in the United States, mental disorders contribute to the highest number of lost years of life due to premature mortality and disability.[6] Furthermore, nearly three-quarters of the individuals with disabilities related to mental illness are unemployed, and 15 percent of those diagnosed with schizophrenia, bipolar disorder, or depression are homeless.[7]

During the last several decades researchers have been investigating ways to improve our mental health system, addressing such questions as: How do Americans deal with their emotional problems? Who seeks help when, why, and under what circumstances?[8] These questions first

gained national attention in 1978, when President Jimmy Carter established the President's Commission on Mental Health.[9] The commission urged that particular attention be paid to the needs and problems of racial and ethnic minorities and recommended policy changes that would result in better serving the needs of these vulnerable populations.

Twenty years later, *Mental Health: A Report of the Surgeon General* was issued.[3] According to the report, close to 15 percent of U.S. adults seek mental health services in a given year; more recent estimates are not available. But mental health service delivery systems can often be complicated, and clients may encounter a variety of barriers in their attempt to access services. Financial concerns and social stigma are among the most frequent deterrents to receiving appropriate care. Some of the barriers to receiving services have been associated with the discrepancy between optimally effective treatments recommended by research and the actual services provided in practice settings.[3]

Overall, the surgeon general's report on mental health provided hope for people with mental disorders by laying out evidence and recommendations for prevention and treatment. It emphasized challenging the social stigma and myths surrounding mental illness and psychological treatments. In response to the severity of the mental health disparities for racial and ethnic minorities, the surgeon general commissioned a supplement to the mental health report. *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* indicated that ethnic and racial minorities experience a disproportionately higher burden from unmet mental health needs.[2] The report accentuated the necessity of considering cultural differences when studying ways to alleviate mental health disparities among ethnic and racial minorities. The supplement probed deeper into mental health disparities affecting racial and ethnic minorities by reviewing the extant scientific literature in order to accomplish the following three objectives: (a) to better understand the nature and extent of mental health disparities, (b) to present the evidence on the need for mental health services and the provision of services to meet that need, and (c) to document promising directions toward the elimination of mental health disparities and the promotion of mental health.

President Bush established the President's New Freedom Commission on Mental Health in 2002 to recommend policies for adoption by federal, state, and local governments to better coordinate and take advantage of existing mental health services. The commission's findings, similar to those of previous studies, revealed the existence of unmet needs and barriers to

receiving mental health services and noted the prevalence of mental disorders across all populations, regardless of age, race, ethnicity, or gender. The commission recommended setting six specific goals to transform the existing mental health system: (1) understanding that mental health is essential to overall health, (2) providing consumer- and family-driven mental health care, (3) eliminating disparities, (4) providing early detection, assessment, and treatment, (5) incorporating research findings into practice, and (6) using technology in mental health care and information access.[10]

Despite decades of research and at least three national policy studies and associated recommendations, the perennial and intractable problems of inadequate mental health services and mental health disparities for ethnic and racial minorities have remained. The twin problems of underutilization of mental health services and premature treatment termination among racial and ethnic minorities persist to this day. If those problems are to be solved, significant changes to the mental health field must be made.

Barriers to Treatment

Acculturation—the process by which members of a minority group (immigrants or ethnic minorities) change their behaviors and attitudes to resemble those of the host or majority group—is a major factor related to barriers to seeking mental health services among racial and ethnic minorities and often may transcend gender and social class. In general, research shows that individuals who have low levels of acculturation may perceive more barriers to seeking help. Cross-cultural barriers to seeking help can be classified in four categories: cognitive, affective, value orientation, and physical or structural.[11]

<u>Cognitive Barriers</u>

People's conceptions of the nature, causes, and cures of mental illness are culturally influenced.[11] In some Asian cultures, for example, there may be no distinction between physical and psychological problems because "the psyche and soma" are seen as a whole. However, the dominant Western conceptualization of mental health relies on the notion of Cartesian dualism, which views the mind and the body as separate entities. This difference in the conceptualization of mental illness may explain why some Asian Americans experience psychological distress in somatic terms and seek help from medical doctors for their psychological problems. While

primary care physicians are essential in recognizing and diagnosing mental illness and can provide pharmacotherapy to their clients, they can rarely provide psychotherapy. Therefore, it may be challenging for primary care physicians to address problems such as stigma, underutilization of therapy, and premature termination.

The way people think about cure is also influenced by culture. Among Asian, Hispanic, and African Americans, it is often believed that a mental illness can be treated or overcome through willpower, heroic stoicism, and avoidance of morbid thoughts rather than by seeking external, professional psychological help.[12] For example, a classic study suggested that Asian Americans were more likely than Caucasian Americans to believe that mental health was enhanced by exercising self-control and avoiding morbid thoughts. Conversely, traditional psychoanalysis considers the avoidance of morbid thoughts to be a repressive mechanism that is harmful to the individual's mental health. Therefore, the authors recommended incorporating cultural concepts and values before deciding whether a particular behavior was deviant.[13]

Affective Barriers

Even when a person acknowledges psychological distress, other barriers may exist that prevent him or her from seeking mental health services. The willingness to report problems may be influenced by perceptions of stigma and shame. Among ethnic and racial minorities, in comparison to the majority group, mental illness may be even more stigmatized. An important barrier related to stigma that is often researched among Asian Americans is the concern for "loss of face." The construct of "face" is defined as a social image that is projected by a person to be in accordance with socially approved attributes and functions for the purpose of maintaining group cohesion.[14] Since the family name and "face" are very important, Asian Americans may decide to protect the family's reputation by not openly seeking help even though they may be having psychological difficulties.

Another obstruction is the mistrust that some members of ethnic and racial minority groups may have with regard to the mental health system because of the way the psychology field has treated certain groups. Studies have shown that the likelihood of misdiagnosis is greater for African American clients than for their Caucasian counterparts as a result of cultural insensitivity among the treating clinicians and the invalidity of diagnostic instruments that were standardized with predominantly Caucasian samples.[15] Furthermore, certain branches of

psychology have historically applied the genetic deficit model (the idea that the genetic background of racial minorities is deficient and results in poor performance) when interpreting observed racial differences in psychological assessments, most notably intelligence quotient tests, while minimizing the impact of social-environmental factors, such as inequalities in access to quality education and health care, history of racism and discrimination, and socioeconomic class differences.[16]

Value Orientation Barriers

Cultural values shape our emotional expressions and communication styles, which are particularly relevant to psychotherapy. For racial and ethnic groups, that tend to be oriented more toward collectivistic values, like Hispanics and Asians, the process of psychotherapy may seem foreign. It focuses largely on an individual's internal thoughts and feelings and requires open verbal communication about intimate issues with a person who is not a family member or part of a trusted in-group. In collectivistic cultures, group members are usually encouraged to prioritize collectivistic goals over self-directed aspirations, and bringing attention to individual needs is often construed as being selfish. The disclosure of personal problems or family dysfunctions to strangers (like psychotherapists) is highly discouraged in collectivistic cultures, especially in cultures that place a strong emphasis on maintaining group harmony and firm in-group versus out-group boundaries. Therefore, the traditional model of psychotherapy may not be perceived as an appealing or relevant form of help for individuals with a collectivistic value orientation.[11]

Physical and Structural Barriers

Physical barriers to seeking mental health services may be related more to social class than to culture. Some researchers have suggested that the lack of knowledge or awareness of available services stands out as one of the major reasons for underutilization. At the same time, racial and ethnic minorities encounter a number of structural barriers. In particular, mental health services may be unaffordable for individuals with a low socioeconomic status (SES). In addition, a lack of health insurance decreases the likelihood of using private providers for mental health care, as is the case with Latinos, who have the lowest rate of health insurance coverage.[17] Moreover, low SES clients may not be able to spend time seeking or receiving services because they need to work one or multiple jobs and/or take care of family members. Another physical

obstacle to mental health care access may be location. Many Native Americans, for example, live in rural or isolated areas that do not offer the needed services, and transportation can be a deterrent to seeking treatment if one does not have a car or needs to spend a long time traveling to receive services. Last but not least, low English proficiency of immigrants and the scarcity of bicultural and bilingual mental health professionals also act as a barrier to seeking help. Language difficulties can be particularly challenging for recent immigrants from Spanish-speaking and Asian countries, who may be less likely to enter and stay in treatment due to lack of understanding. However, it is difficult to separate the effect of low English proficiency from the influences of cultural values and acculturation because all of these factors are interrelated. For example, immigrants who live in an ethnic enclave where the primary spoken language is Spanish may be able to access mental health services easily in Spanish, but they may refuse to do so because of fear of being stigmatized.

Few research studies have explored the factors related to treatment dropout among ethnic and racial minorities, largely because of the costs and the resources associated with psychotherapy studies. But Stanley Sue and his colleagues at the University of California, Los Angeles, and the University of California, Santa Barbara, found that lack of accessibility to culturally appropriate services and the lack of bilingual and bicultural staff may relate to clients' decisions to initiate and continue treatment.[18] The ethnic match between therapist and client has been found to be especially effective in reducing premature termination and producing better outcomes with clients who do not speak English as their primary language. Other studies have shown that clients, especially Asian Americans, who received ethnic-specific mental health services had higher return rates and stayed in treatment longer. The relevance and credibility of the mental health treatment also plays an important role in retaining clients, since racial and ethnic minority clients may prefer a more directive and problem-solving approach that provides quick solutions and tangibly relieves the distress. Such an approach may differ from more traditional psychoanalytic techniques that rely on exploration and interpretation and take a less directive stance. In addition, a recent meta-analysis summarized findings from 76 studies and provided support for the effectiveness of culturally adapted interventions, especially when they targeted a specific group and were conducted in the clients' native language.[19]

Recommendations

Research

The majority of studies on this topic have examined attitudinal barriers to seeking help. The next logical step is to explore emotional barriers that will help us understand the actual process of seeking treatment among racial and ethnic minorities. Researchers also need to examine more closely how different culturally sensitive therapeutic models show incremental validity compared to traditional therapy in the retention of racial and ethnic minority clients.

We also face the problem of differential research infrastructure, which refers to the uneven rates of progress among subfields of psychology. There continues to be a substantially higher number of psychotherapy studies of predominantly white/European American samples than of African Americans, Hispanics, or Asian Americans. In fact, it was not until *A Supplement to Mental Health: A Report of the Surgeon General* was published in 2001 that health-care professionals started paying more attention to the significant ethnic minority mental health disparities and the critical knowledge gaps in those subfields.[2] Therefore, while we realize that the issue of differential research infrastructure will take a few decades to be resolved, we recommend that researchers attempt to close the gap by directing attention to underserved and understudied populations in the context of their existing research programs.

In addition, disparities exist in the student demographics of psychology training programs.[20] In 2006–2007, 34,957 European Americans were enrolled in full-time Ph.D. psychology programs, in comparison to 3,904 African Americans, 3,999 Hispanic Americans, and 3,145 Asian Americans.[21] While not all psychologists choose research topics related to their own racial and ethnic groups, the large discrepancy in enrollment numbers provides a general sense of the differential research infrastructure related to mainstream versus racial and ethnic minority psychology. In order to address this issue, we recommend the reinstitutionalization of funding for research and clinical training of ethnic and racial minority members (e.g., COR program, Minority Fellowship Program).

Policy

All three of the national policy reports have made important recommendations on how we need to improve our mental health system to better serve the needs of racial, ethnic, and cultural minorities. For example, the surgeon general's report proposed broad courses of action,

including continuing to build the science base, overcoming stigma, improving public awareness of effective treatment, ensuring the supply of mental health services and providers, ensuring delivery of state-of-the-art treatments, tailoring treatment to age, gender, race, and culture, facilitating entry into treatment, and reducing financial barriers to treatment.[3]

The supplement to the surgeon general's report documented specific disparities affecting mental health care of racial and ethnic minorities compared with whites.[2] This report noted that minorities have less access to, and less availability of, mental health services. They are less likely to receive necessary mental health services, and those who are in treatment often receive poorer-quality care. Finally, minorities are underrepresented in mental health research, a factor that is related to the differential research infrastructure. We believe that progress in implementing the policy recommendations from these three national reports as well as other reports has been significantly hampered by the differential research infrastructure.

A key policy recommendation is to build the necessary human capital to meet the mental health needs of the nation in terms of both science and practice. We also need to continue training mental health professionals in cultural competency.[22] We may benefit from ethnic matching between therapist and client; previous research on the cultural responsiveness hypothesis has shown that ethnic matching may solve the twin problems of underutilization and premature termination.[18]

Consistent with these policy recommendations, the National Alliance on Mental Illness (NAMI), a nonprofit grassroots mental health advocacy organization, has developed a public policy platform that addresses the issue of cultural diversity. Specifically, NAMI maintains the following public policy platform with regard to cultural diversity:

- People who come from different religious, ethnic, racial, or cultural backgrounds and who do not speak English as their primary language may have characteristics that deter them from benefiting fully from existing treatments and training opportunities.
- NAMI encourages the recruitment and training of professionals from diverse backgrounds, the development of materials in different languages for educational purposes, and the outreach of services to underserved groups.
- NAMI supports the incorporation of culture in the design and implementation of programs in order to make services free of cultural bias.[23]

In order to address the challenges associated with the various health disparities, the National Institutes of Health established the National Center for Minority Health and Health Disparities (NCMHD) as part of the Minority Health and Health Disparities Research and Education Act of 2000 (Public Law 106-525).[24] The mission of this center has been "to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. In this effort NCMHD will conduct and support basic, clinical, social, and behavioral research, promote research infrastructure and training, foster emerging programs, disseminate information, and reach out to minority and other health disparity communities."[25] It is encouraging to note that due to the importance of its mission, this center has recently been elevated to the status of an institute.[24] Let us hope that the new NCMHD will move us forward in the next 20 years, when another national mental health policy commission is formed to reassess the problem of cross-cultural barriers to mental health services in the United States.

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