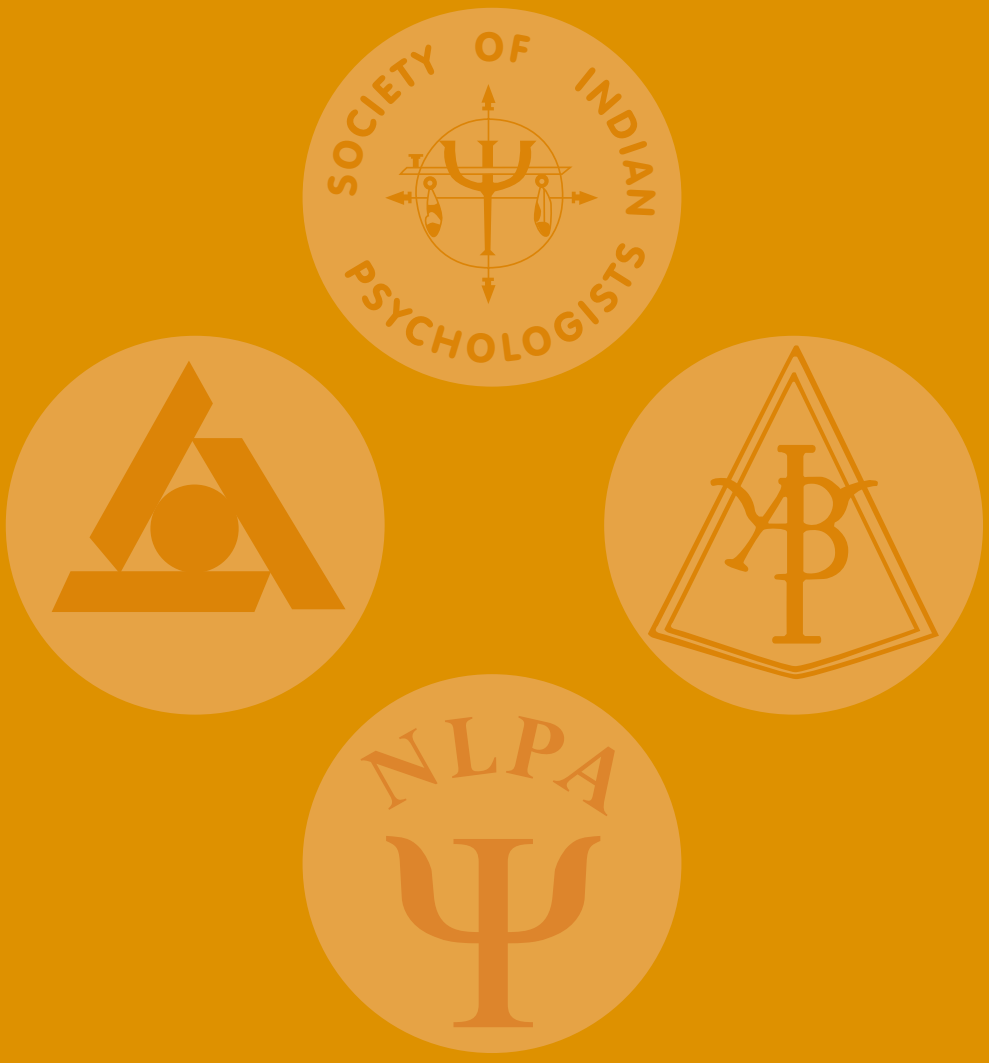
Psychological Treatment of Ethnic Minority Populations



Council of National Psychological Associations for the Advancement of Ethnic Minority Interests

The Asian American Psychological Association (AAPA)
The Association of Black Psychologists (ABPsi)
The National Latina/o Psychological Association (NLPA)
The Society of Indian Psychologists (SIP)

November 2003

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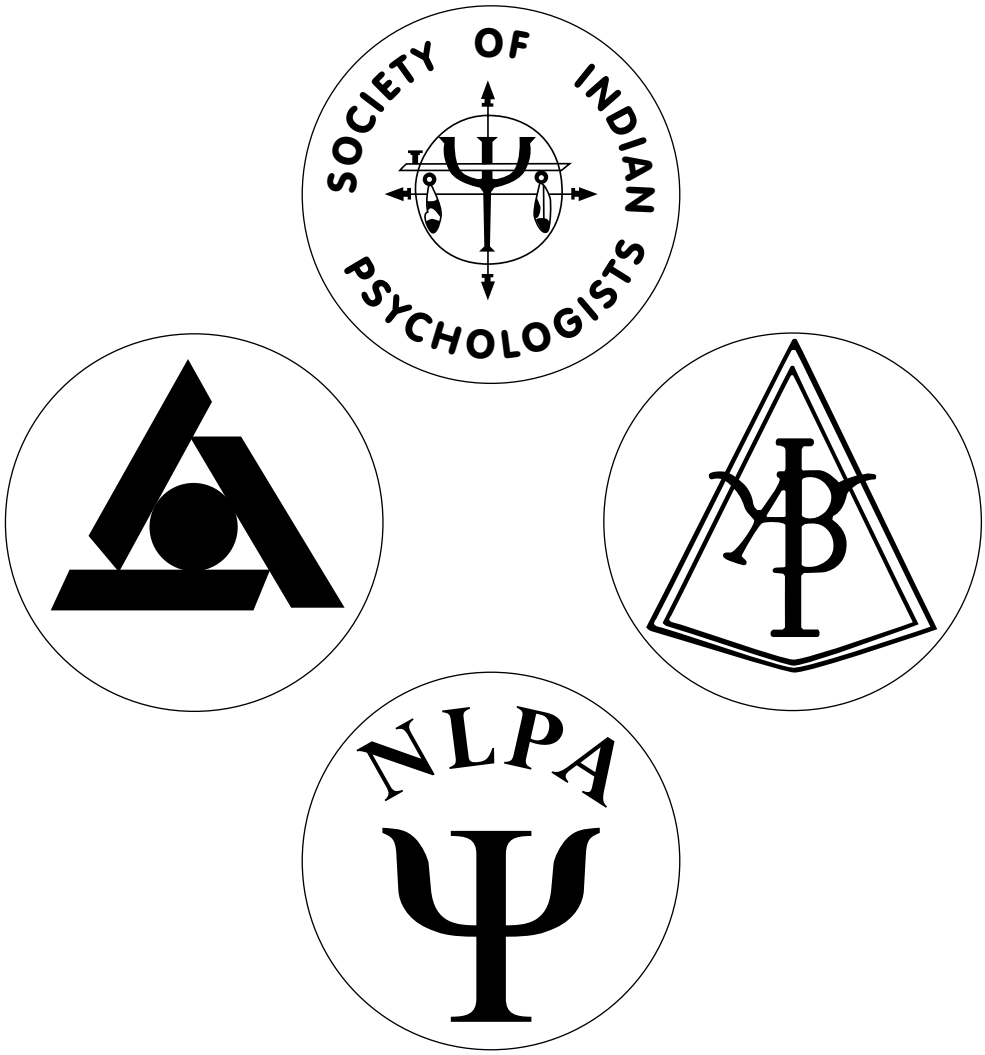

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Published by the Association of Black Psychologists, Washington, D.C., November, 2003

PREFACE

There are four national ethnic minority psychological associations represented in this document:

The Asian American Psychological Association (AAPA)
The Association of Black Psychologists (ABPsi)
The National Latina/o Psychological Association (NLPA)
The Society of Indian Psychologists (SIP)

This brochure was developed in response to critical concern among all of the nation's ethnic minority psychological associations about the cultural appropriateness of the theory and practice of much of the psychological treatment of ethnic minority populations in the United States. Consequently, the national ethnic minority psychological associations developed this brochure to empower ethnic minority consumers of psychological services and to inform psychological researchers and trainers as well as funders and providers of psychological services.

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FOREWORD

Precautions in the Use of Therapeutic Recommendations

In the ensuing chapters, representatives of the four major ethnic minority psychological organizations present suggestive pronouncements, declarations, and recommendations in working with specific racial/ethnic minority populations. They are grounded on the best available evidence in the clinical and research literature. As such, recommendations that enlighten us in practice are continually evolving as new knowledge and findings accumulate. Proposing a set of recommendations for specific populations of color is often fraught with potential danger. Thus, it is important that readers heed the following precautions.

- First, therapeutic recommendations can never substitute for a clinician's conscientious attempts to understand and become acquainted with the population being served. Everyone who hopes to deliver culturally relevant services to populations of color must have substantial training and experience in working with the groups they hope to serve. To believe that reading this document, alone, is sufficient to make one culturally competent would be the height of naivete.
- Second, therapeutic recommendations serve as guideposts that stimulate and inform the practitioner as to treatment issues. In this case, their distillation is based upon the concepts of multiculturalism and an understanding of the worldviews of the various racial/ethnic minority groups. While the recommendations are stated explicitly, practitioners should understand their rationale and conceptual framework before applying them. Uninformed application may result in services that are inappropriate and not beneficial to clients of color.
- Third, these recommendations should never be applied rigidly without regard for individual differences, subgroup variations, and the specific life circumstance of clients. To do so borders on stereotyping and would prove more harmful than helpful.
- Fourth, the pronouncements in this document are aspirational in nature. While they tell the practitioner that cultural competence in working with specific populations is not an end state, they connote the need for continual education on the part of the therapist. In essence, the path to becoming culturally proficient in working with racial/ethnic minority populations is a continuous and lifelong journey.
- Last, to aid in readability, the data and much of the general information on the specific racial/ethnic minority groups are not directly cited in the body of the text, but in a special reference section. As mentioned previously, these pronouncements are based on the best available evidence taken from findings in the field. Readers will note that these findings are divided into two sections: (a) references from which most of the data have been taken, and (b) recommended readings believed helpful to practitioners.

Derald Wing Sue, PhD
2002

CHAPTER 1: CULTURAL COMPETENCE IN THE TREATMENT OF ETHNIC MINORITY POPULATIONS

By Derald Wing Sue, PhD, Teachers College, Columbia University

The call for cultural competence in mental health practice has been a frequent theme voiced by the four major ethnic minority psychological associations (Asian American Psychological Association, Association of Black Psychologists, National Latina/o Psychological Association, and the Society of Indian Psychologists). In an effort to address concerns and provide assistance to service providers, these four associations have produced this booklet, *Psychological Treatment of Ethnic Minority Populations*. Its purpose is to (a) produce a highly readable brochure summarizing in broad terms the mental health issues of greatest concern to the four ethnic minority psychological associations, (b) increase awareness regarding the need for balance between culturally universal modes of helping with the increasing recognition of the effectiveness of culture-specific and indigenous healing approaches, and (c) provide culturally relevant mental health practice recommendations to practitioners and students who work with ethnic minority populations.

This booklet follows the successful completion of another major publication *Guidelines for Research in Ethnic Minority Communities* (2000), and plans are underway to produce additional publications focusing on culturally competent education and training and testing and assessments.

The Diversification of the United States

We are fast becoming a multicultural, multiracial, and multilingual society. The recently released 2000 U.S. Census reveals that within several short decades, persons of color will become a numerical majority. These changes have been referred to as the "diversification of the United States" or literally the "changing complexion of society." Much of the change is fueled by two major trends in the United States: the increasing immigration of visible racial/ethnic minorities and the higher birth rates among the minority population when compared to their White counterparts. In 1990, 76% of the population was composed of White Americans; in the year 2000, their numbers had declined to 69%.

While the U.S. Census Bureau projects that racial/ethnic minorities will become a numerical majority by the year 2050, many private surveys predict that the demographic transformation will occur decades sooner. The disparity in estimates is because of statistical sampling techniques indicating that persons of color are usually undercounted by census collection methods. Even more impressive is the use of a "diversity index" that measures the probability of selecting two randomly chosen individuals from different parts of the country who may differ from one another in race or ethnicity. That index now stands at "49," indicating that there is nearly a 50% chance those two individuals selected will be of a different race or ethnicity. Nowhere is the explosive growth of minorities more noticeable than in our public schools, where students of color now comprise 45% of those attending. The following 2000 U.S. Census figures will give the reader some idea of the differential impact on certain regions in the United States.

- Over 50% of the state of California is composed of minority groups.
- Over 30% of New York City is internationally born.
- Approximately 70% of the District of Columbia is African American.
- Close to 37% of San Francisco is Asian American.
- Nearly 70% of Miami is Latino.

The conclusions that can be drawn from these statistics are inescapable. First, it is difficult for mental health practitioners not to encounter clients and client groups who differ from them in terms of race, ethnicity, and culture. Second, the worldviews of a culturally diverse population are likely to be quite different from that of the helping professional. How normality and abnormality are defined and what is regarded as "helping" (therapy) may differ considerably from that of the traditionally trained mental health professional. Third, the need to become culturally competent in mental health practice has never been more urgent.

Cultural Bias and Disparities in Mental Health Practice

At the annual convention of the American Psychological Association in 2001, the Surgeon General of the United States presented a report on the mental health status of racial/ethnic minorities. The report summarized several key findings: (a) the mental health needs of people of color continue to be unmet, (b) there is a strong need to understand both cultural and sociopolitical factors affecting the life experience of these groups, and (c) cultural competence in the delivery of services is absolutely essential to the psychological and physical well-being of persons of color. To this is added an emerging finding: The mental health practitioner is not immune from inheriting the prejudicial attitudes, biases, and stereotypes of the larger society. Even the most enlightened and well-intentioned mental health professional may be biased with regard to race, gender, and social class. These conclusions and findings have been based upon demographic data, process and outcome research, the collective input of ethnic minority scholars/practitioners, and clinical findings. Some of these are presented below.

- Individual and institutional racism continue to affect the quality of life for people of color; in the mental health fields, this is often reflected in stressors that lead to emotional problems, such as anxiety and depressive disorders, and physical health problems.

- Because of racism, the health status for persons of color reveals disturbing disparities related to life span, death rates, and susceptibility to illness.
- Racial/ethnic minority groups have less access to health care, the nature of services is woefully inadequate, they are more likely to be medically uninsured, and the services provided are often inferior and more likely to result in the death of racial/ethnic minority clients.
- Traditional mental health care is often inappropriate and antagonistic to the cultural values and life experiences of populations of color. Rather than feeling that they have been provided benefits, clients often feel invalidated, abused, misunderstood, and oppressed by their providers.
- The system of care is often monocultural and ethnocentric in the assessment, diagnosis, and treatment of racial/ethnic minority populations. As a result, the clinicians' determination of normality and abnormality, what constitutes mental health, and intervention strategies are often culture-bound.
- Clinicians are not immune from inheriting the biases, stereotypes, and values of the larger society. They often unintentionally act out these biases in the treatment of their clients of color.
- Cultural values, assumptions, and beliefs often affect how psychological distress is expressed among diverse populations, the manner of symptom formation, and help-seeking behavior.
- Western psychological practices would benefit from incorporating some of the basic assumptions and practices of indigenous healing.
- The basic assumption of "universalism in mental health practice" must be moderated by culture-specific knowledge when working with a culturally diverse population.
- Culture-specific mental health treatments consistent with the cultural values and life experiences of a particular group may prove more effective than conventional forms of treatments.

Recommendations for Cultural Competence in Mental Health Practice

Diversity has had a major impact on the mental health profession, creating a new field called multicultural psychology. In 1994, the *Diagnostic and Statistical Manual of the American Psychiatric Association* acknowledged the importance of considering culture, race, and gender in the formulation of mental disorders. Although still limited in scope, DSM-IV-TR contains several places where race, culture, and gender influences are acknowledged: (a) discussion sections that present cultural variations in clinical presentations, (b) an outline for cultural formulation designed to assist clinicians in evaluating individuals from a cultural context, and (c) an outline of cultural-bound syndromes in other societies.

The increasing recognition of the need for providers of mental health services to be culturally competent when working with racial/ethnic minority populations means several things. First, clinicians must become aware of their own worldviews, their biases, prejudices, beliefs, and values. Without this awareness, there is an ever-present danger that helping professionals may unwittingly impose their worldviews upon their minority clients, resulting in cultural oppression. Second, it is important for therapists to become aware of the worldview of clients and client groups that differ from them. Does the helping professional understand the life experiences, values, beliefs, and assumptions of persons of color? Without this awareness, the helping professional cannot possibly understand or empathize effectively with their clients. Third, there is a strong need for helping professionals to develop culturally effective helping modalities and goals consistent with the life experiences and cultural values of their culturally diverse clientele. This means that clinicians must be flexible in their therapeutic approaches, play alternative helping roles (advocate, consultant, facilitator of indigenous healing approaches), and be willing to take a systemic perspective in interventions.

The following abbreviated characteristics of culturally competent helping have been adapted from the *American Psychological Association Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002) and endorsed by the national ethnic minority psychological associations. It is important, however, to note that these recommended attributes of cultural competence contain both culture-specific and culture-universal assumptions. They must be applied with caution and supplemented with the specific population guidelines outlined in the chapters to follow.

Awareness

- Culturally competent therapists are aware of and sensitive to their own racial and cultural heritage and value/respect differences. They are aware that their worldviews are only one of many and that care must be exercised when using a worldview to make determinations of normality or abnormality. Differences are not seen as necessarily deviant or pathological.
- Culturally competent therapists are aware of their own background/experiences and biases and how they influence psychological processes. They make conscious efforts to not impose their biases upon culturally diverse groups.
- Culturally competent therapists recognize the limits of their competencies and expertise. They realize that it is unethical to work with culturally diverse populations without specialized training or expertise.
- Culturally competent therapists are comfortable with differences that exist between themselves and others. They realize that discomfort over differences can hinder an effective therapeutic relationship. Further, they do not profess, "color blindness."

- Culturally competent therapists are in touch with negative emotional reactions toward racial/ethnic groups and can guard against their detrimental effects on persons of color.
- Culturally competent therapists are aware of stereotypes and preconceived notions they may hold for specific populations other than their own.
- Culturally competent therapists respect religious and/or spiritual beliefs of others. They avoid making judgmental evaluations of clients whose belief systems differ from theirs.
- Culturally competent therapists are aware that we live in a pluralistic environment and that we are a multicultural and multilingual society. They value bilingualism as indicative of increased skill acquisition and recognize that it does not reflect a negative bias toward the larger society.

Knowledge

- Culturally competent therapists have knowledge of their own racial/cultural heritage and how it affects perceptions. They are able to understand themselves as racial cultural beings.
- Culturally competent therapists possess knowledge about racial identity development. For White therapists, this means being in touch with White identity development and White privilege issues.
- Culturally competent therapists are able to acknowledge their own racist attitudes, beliefs, and feelings. They are knowledgeable about individual, institutional, and cultural racism and how they have been socialized and culturally conditioned.
- Culturally competent therapists are knowledgeable about their own social impact and communication styles. In other words, they are in touch with their style of helping and how it may or may not facilitate the process and outcome of therapy.
- Culturally competent therapists are knowledgeable about the groups they work or interact with. They do not profess expertise in working with clients of color unless they possess knowledge and skills specific to that population.
- Culturally competent therapists understand how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth.
- Culturally competent therapists understand and have knowledge about sociopolitical influences, immigration issues, poverty, the effects of minority status, feelings of alienation and powerlessness, and so forth.
- Culturally competent therapists understand culture-bound, class-bound, and linguistic features of psychological help.
- Culturally competent therapists know the effects of institutional barriers and that barriers cause hardship in the psychological adjustment of minorities. They also realize that the very nature of mental health practice may be biased, unfair, and inaccessible to certain populations.
- Culturally competent therapists know the biases likely to affect assessment, evaluation, and diagnosis of minority clients.
- Culturally competent therapists have knowledge about minority family structures, community, and so forth. They realize that the family values may be radically different from that of the majority culture.
- Culturally competent therapists know how discriminatory practices operate at a community level.

Skills

- Culturally competent therapists seek out educational, consultative, and multicultural training experiences. Because traditional training of mental health professionals is often limited to knowledge of a White middle class population, the potential provider must actively educate himself or herself about a diverse population.
- Culturally competent therapists are not passive in seeking to understand themselves as racial/cultural beings. They deliberately and consciously explore their cultural heritage and values.
- Culturally competent therapists make an honest effort to familiarize themselves with the relevant research data on racial/ethnic minority groups.
- Culturally competent therapists do not live in isolation from a diverse world. They are involved with culturally diverse groups outside of their work role—community events, celebrations, neighbors, and so forth. They realize that becoming culturally competent comes best through lived experience.
- Culturally competent therapists evidence therapeutic flexibility in individual, group, and systemic interventions. They are able to engage in a variety of verbal/nonverbal helping styles and can play many alternative helping roles besides the traditional counselor-therapist ones.
- Culturally competent therapists can seek consultation with traditional healers. In this respect, they have developed liaisons with the larger minority community.
- Culturally competent therapists take responsibility for providing linguistic competence for clients through being bilingual or having referral resources available.
- Culturally competent therapists have expertise in the cultural aspects of assessment.
- Culturally competent therapists must balance their traditional helping roles with understanding and ability to intervene in the larger system. They work to eliminate bias, prejudice, and discrimination as causes of mental disorders and/or as reflected in mental health services.
- Culturally competent therapists are able and willing to educate clients in the nature of their practice.

Those interested in a more detailed elaboration of these characteristics of culturally skilled professionals are encouraged to obtain the readings recommended below.

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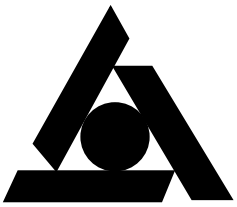
CHAPTER 2: RECOMMENDATIONS FOR THE TREATMENT OF ASIAN AMERICAN/PACIFIC ISLANDER POPULATIONS



By Gayle Y. Iwamasa, PhD
Asian American Psychological Association

Introduction

According to the 2000 U.S. Census, "single race" Asian Americans and Pacific Islanders comprised 4.2% of the U.S. population. Of the individuals who reported being multiracial, almost 13% reported being partially of Asian heritage. Asian Americans/Pacific Islanders is one of the fastest growing visible racial/ethnic groups, with a projected increase in population to 6.2% by 2025, and 8.9% by 2050. Although the three largest Asian ethnic groups are Japanese, Chinese, and Filipino, the terms "Asian American" and "Pacific Islander" encompass more than 50 distinct racial/ethnic groups, in which more than 30 different languages are spoken. Indeed, Asian Americans/Pacific Islanders is the most diverse racial/ethnic group in terms of country of origin, religious/spiritual affiliation, cultural background and traditions, and generational and immigration experiences.

Prevalence rates of mental illness among Asian Americans/Pacific Islanders are believed to be no different from those of other Americans. However, the type of psychopathology, ethnicity and generational status, acculturation and cultural background all appear to influence the manifestation of psychological distress among Asian Americans/Pacific Islanders. For example, rates of depression appear to be similar among Asian Americans/Pacific Islanders and White Americans, while the prevalence of substance abuse appears to be significantly lower among Asian Americans/Pacific Islanders. In contrast to domestically born Asian Americans, Southeast Asian and other Asian American/Pacific Islander immigrants who experienced violence, war, or economic oppression prior to their arrival in the United States appear to suffer psychological distress more frequently.

Understanding the mental health issues of Asian Americans/Pacific Islanders is important because of the vast heterogeneity of the group, the various Asian cultures' beliefs about mental health, and the emphasis on the connection between the mind and body. Among many Asian Americans/Pacific Islanders, interpersonal harmony and the focus on family influence the experience, interpretation, and expression of psychological distress. For example, in some Asian cultural groups, the experience of psychological distress is not only a reflection on the individual in distress, but also reflects on the entire family. Thus, shame, embarrassment, and loss of face contribute to whether or not an individual will admit to experiencing psychological problems. These cultural values affect the willingness of Asian Americans/Pacific Islanders to seek professional psychological treatment; Asian Americans/Pacific Islanders have been found to underutilize traditional mental health services. In addition to cultural values such as stigma and loss of face, limited English proficiency, differing conceptualizations of distress, and limited access to culturally competent services also contribute to low treatment utilization rates. Psychological researchers have documented that those Asian Americans/Pacific Islanders who do seek professional mental health treatment are more likely to terminate treatment prematurely.

Implications for Culturally Competent Care

- There is an increased need for culturally competent mental health services and providers with expertise in working with this population.
- Mental health providers must be aware of the great interethnic variations among Asian Americans/Pacific Islanders.
- Because the manifestation of mental disorders is affected by cultural, generational, and acculturation levels, treatment providers must assess these specific cultural factors when working with Asian American/Pacific Islander clients.
- Treatment providers need to understand the role of cultural values such as interpersonal harmony, loss of face, and filial piety on their Asian American/Pacific Islander client's beliefs about psychological distress and the implications for mental health services.

Myths and Misinformation

The promulgation of the "model minority" myth, that Asian Americans and Pacific Islanders are the most similar to European Americans, and, thus, are viewed as "models" for and/or "better than" other ethnic minority groups, has created many problems for Asian Americans/Pacific Islanders. The result has been (a) a lack of attention to Asian American/Pacific Islander issues in mental health research and clinical practice, (b) the creation of antagonisms with other minority groups who may view Asian Americans/Pacific Islanders as co-conspirators with European Americans, and (c) interference with the development of collaborative efforts and coalition building among racial/ethnic minority groups.

Another erroneous belief about Asian Americans/Pacific Islanders is that they all achieve academic success. Although it is true that education is highly valued in many traditional Asian cultures, the within-group differences in academic achievement among various Asian Americans/Pacific Islanders are large. Academic achievement among Asian Americans/Pacific Islanders has been found to vary by ethnicity, generational status, gender, and socioeconomic status.

Regarding socioeconomic status, although some Asian Americans and Pacific Islanders are somewhat better off financially as compared to other ethnic minority groups, they are still more than 1-1/2 times more likely than White Americans to live in poverty. Also, in many Asian American/Pacific Islander households, all individuals of working age (including adolescents and extended family members) are employed in one or more jobs outside the home, resulting in a higher medium family income. These figures are often used to support the success myth when in actuality they are a statistical artifact.

Type of employment is also quite diverse among Asian Americans and Pacific Islanders. Many Asian American/Pacific Islander immigrants, although often trained in specific vocations such as medicine, engineering, and business, can only find menial low-paying jobs, which is why they often supplement their income with additional employment. Even among highly educated and acculturated Asian Americans/Pacific Islanders, research has documented a glass-ceiling effect, whereby many Asian Americans and Pacific Islanders are unable to be promoted beyond a certain position because of discrimination and institutionalized racism and/or sexism.

Finally, the stereotype of Asian American/Pacific Islander individuals all looking the same is grossly inaccurate if one simply examines the range of phenotype between various Asian American/Pacific Islander groups. For example, Filipinos, Korean Americans, Native Hawaiians, and Cambodian immigrants are quite different phenotypically. Skin color, hair color and texture, facial features, height, weight, etc., vary dramatically among many of the Asian American/Pacific Islander ethnic groups, and biracial and multiracial Asian Americans and Pacific Islanders have even more phenotypic differences.

Implications for Culturally Competent Care

- Treatment providers should be aware of inaccurate historical stereotypes and myths about Asian Americans/Pacific Islanders and how they have affected the mental health of Asian Americans/Pacific Islanders.
- Treatment providers should assess their own stereotypes and myths about Asian Americans/Pacific Islanders and work to abolish them.
- Treatment providers should be knowledgeable of the diversity in educational and occupational achievement among Asian Americans/Pacific Islanders.
- Treatment providers should be knowledgeable about the socioeconomic status of Asian Americans/Pacific Islanders and the frequent need for family members to have multiple employment in order to make ends meet.
- Treatment providers should understand that Asian Americans and Pacific Islanders are immensely diverse in many ways and not make assumptions about a client's experiences and adherence to traditional cultural values and practices.

Inadequacies of Traditional Mental Health Care

The number of Asian American/Pacific Islander mental health providers is very low, as are mental health services accessible to various Asian American/Pacific Islander communities. The paucity of bilingual and culturally competent therapists compounds the problem of inadequate mental health care. Even the U.S. Surgeon General documented inadequate mental health treatment for Asian Americans and Pacific Islanders because of inappropriate and biased treatment models that reflect a White American, middle-class orientation.

Historically, Asian Americans and Pacific Islanders have had good reason to mistrust mental health service providers. Misdiagnosis and underdiagnosis of mental illness among Asian Americans and Pacific Islanders who have serious mental health and health implications continue to be a problem. Lack of knowledge regarding ethnopharmacology and Asian Americans/Pacific Islanders continues to put Asian Americans/Pacific Islanders at risk. Culture-bound nosological systems, such as the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-TR* (American Psychiatric Association, 1999), also do not adequately address the mental health conceptualization of many Asian Americans and Pacific Islanders. Researchers have documented that treatment adherence is influenced by the match between the client's and the treatment provider's explanatory model of the symptoms and illness. If the treatment orientation matches that of client, the client will be more likely to agree with the provider's explanation and suggested treatment. If the treatment orientation is different from that of the client, the client will not likely benefit from the treatment. Indeed, many mental health treatment providers lack knowledge and training regarding the existence, prevalence, manifestation, and treatment of Asian culture-bound syndromes. For example, "hwa-byung" (Korean syndrome similar to, yet different from DSM-IV major depression), "taijin kyofyusho" (Japanese disorder similar to, yet different from DSM-IV social phobia), and "koro" (Southeast Asian syndrome now referred to as genital retraction syndrome in the global mental health literature) are all psychological disorders that have been documented in Asian Americans/Pacific Islanders. Clinicians unaware of such disorders are at higher risk for misdiagnosing such problems and, thus, implementing culturally inappropriate interventions. Interestingly, the researchers are now documenting the existence of these disorders among non-Asian American/Pacific Islander individuals.

Implications for Culturally Competent Care

- More Asian American/Pacific Islander and bilingual treatment providers are needed.
- Mental health treatment providers should be trained and educated in culturally competent treatment models.
- Culturally appropriate mental health treatment for Asian

Americans/Pacific Islanders should be cost-effective, accessible (located within Asian American/Pacific Islander communities), and provided at convenient times (e.g., after work and weekends).

- Current mainstream diagnostic systems should include specific considerations for the experience and expression of various symptoms and disorders among Asian Americans and Pacific Islanders.
- Mental health treatment providers should be knowledgeable about the prevalence, manifestation, and treatment of Asian culture-bound syndromes.

Culture-Specific Views of Mental Health and Healing

For many Asian Americans and Pacific Islanders, mental health is strongly related to physical health. In many Asian American/Pacific Islander ethnic groups, the belief is that if one is physically healthy, then one is more likely to be emotionally healthy. Emotional or psychological health is also believed to be strongly influenced by willpower or cognitive control. For example, when one is feeling sad, not dwelling on negative thoughts or avoiding negative thoughts is viewed as an appropriate coping method. In addition, focusing on one's family or community and behaving in a way that maintains interpersonal harmony in the face of psychological distress is demonstrative of strong will and emotional health. As such, many Asian Americans and Pacific Islanders associate stigma and loss of face with admitting to psychological problems. As a result, in many Asian American/Pacific Islander cultures, individuals may often report somatic or physical manifestations of stress, as they are viewed as more acceptable than psychological symptoms. Whether these Asian Americans and Pacific Islanders experience the distress as somatic and/or psychological when having problems remains to be examined.

Indigenous healing has long been a practice of many Asian Americans and Pacific Islanders. Traditional healers are often religious leaders, community leaders, or older family members. Religion/spirituality, community, and family may also be seen as protective factors for the development of psychological distress among Asian Americans and Pacific Islanders. For example, low divorce rates and extended family households demonstrate the emphasis on family and unity. They also indicate strengths in interpersonal relationships and loyalty. In addition, this results in a strong built-in social support system for many Asian Americans and Pacific Islanders. Some traditional Asian American/Pacific Islander indigenous healing practices are controversial. For example, in some Asian cultures, "coining" and "cupping," the practice of vigorous rubbing of coins or cups on the skin of ill children to cure them, often results in bruising. This has resulted in these parents being reported for child abuse.

Implications for Culturally Competent Care

- Treatment providers should be aware of their Asian Americans and Pacific Islander clients' cultural beliefs related to psychological distress and how they may influence their symptoms of distress.
- Treatment providers should assess if their Asian Americans and Pacific Islander clients are experiencing both somatic and psychological symptoms of distress.
- Treatment providers should develop treatment plans that match the explanatory models of their Asian American/Pacific Islander clients and explain the treatment model to the clients and how the suggested treatment will be of benefit to the clients.
- Treatment providers should be aware of the environmental context in which their Asian American/Pacific Islander clients live and be cognizant of the implications of their suggested treatment on the clients' family members, as it will likely influence treatment adherence.
- Treatment providers should be knowledgeable and respectful of Asian American/Pacific Islander indigenous healing practices.

Oppression and Racism as Mental Health Issues

Historically, racism and sexism toward Asian Americans and Pacific Islanders in the United States has been prevalent. Whether mandated by the U.S. government (e.g., Gentleman's Agreement of 1860, antimiscegenation laws, unconstitutional internment of Japanese Americans during World War II) or acted upon by individuals via hate crimes, Asian Americans and Pacific Islanders continue to face oppression and racism in the United States. For many Asian Americans and Pacific Islanders, the sense of collectivism and group identity results in a shared experience of discrimination, even when such events are experienced by other Asian Americans and Pacific Islanders. Psychological researchers have documented the effects of transgenerational psychological trauma among Asian Americans and Pacific Islanders. For example, children of Japanese Americans interned during WW II experienced negative psychological sequelae from the internment. The concept of transgenerational trauma also is particularly important given the large number of Asian Americans and Pacific Islanders who have emigrated to the United States from countries ravaged by war, famine, and economic and political upheaval. Although their progeny may not have personally been tortured, raped, or beaten, their parents who did experience those atrocities may pass down the psychological trauma to them.

Many Asian Americans and Pacific Islanders are regularly bombarded with messages to assimilate and that their culture and heritage are not valued. A specific example is the English-only initiative. Rather than valuing multilingual individuals as an important resource, several states have had

English-only initiatives that could be interpreted as intolerance and non-acceptance for individuals who speak languages other than English. These initiatives are typically generated by European Americans who lack the ability to speak other languages as well as knowledge of the future potential economic growth and resources of the population they purport to represent. An interesting irony is that a century ago, European Americans prevented non-English speaking ethnic minorities from learning English for fear that they would become educated and, thus, compete economically. Although the most frequently spoken languages in the world are Asian, the U.S. education system places more value on European-based languages over Asian languages, creating yet another barrier. This is most readily observed by examining the foreign language offerings in most middle schools, high schools, colleges, and universities. This results in fewer individuals having the capability to communicate with Asian American/Pacific Islander immigrants whose first language is Asian, which, in turn, affects the number of treatment providers who can provide services in clients' first language.

When employed, Asian Americans and Pacific Islanders continue to experience the glass-ceiling effect. Although trained and competent, in many companies, Asian Americans and Pacific Islanders find it difficult to move beyond mid-level positions. Stereotypes of Asian American/Pacific Islander employees of being smart, hardworking, and reliable, yet passive and quiet, result in many individuals being passed over for much-deserved promotions and recognition. Implications for negative effects on self-worth are clear. Negative stereotypes of Asian American/Pacific Islander men being undesirable, while stereotypes of Asian American/Pacific Islander women as exotic and sexualized are also psychologically damaging.

A damaging result of the model minority myth is that many Asian Americans/Pacific Islanders are invisible minorities. This is particularly the case when discussions of diversity focus only on "Black/White" issues. Related to mental health, the consequence of being an invisible minority is particularly problematic. As a result of the lack of attention to the mental health needs and experiences of Asian Americans and Pacific Islanders, combined with the lack of recruiting of Asian American treatment providers and researchers, little research exists on the mental health status of many Asian American/Pacific Islander groups. Those familiar with this literature tend only to be Asian American/Pacific Islander practitioners and not those unfamiliar with Asian American/Pacific Islander mental health issues. This may result in potentially harmful problems such as underdiagnosis or misdiagnosis.

Providers who lack cultural sensitivity and knowledge have been shown to provide different diagnoses, typically more severe, to ethnic minority individuals with the same symptoms as European Americans. Furthermore, given the current emphasis on psychopharmacology, there is real concern regarding whether or not Asian Americans and Pacific Islanders are being over-medicated or prescribed medications that actually exacerbate their psychological distress. What little research that exists which includes Asian Americans/Pacific Islanders in drug trials indicates that many Asian Americans and Pacific Islanders metabolize and tolerate medications at different levels as compared to other ethnic groups.

Implications for Culturally Competent Care

- In addition to assessing personal experiences of racism and oppression of their Asian American/Pacific Islander clients, treatment providers should be aware of the effects of collectivism on the experience of racism and oppression of Asian Americans and Pacific Islanders.
- Treatment providers should be knowledgeable about the effects of transgenerational trauma and how it may be manifested in Asian Americans and Pacific Islanders, particularly among immigrants from war-torn countries.
- Treatment providers should assess their Asian American/Pacific Islander clients' employment history and status, inquire about glass-ceiling effects, and assess the individual's responses to the discrimination.
- Treatment providers should be aware of the negative impact of the model minority myth on their Asian American/Pacific Islander clients.
- Treatment providers should remain up to date on the developing literature on the mental health issues of Asian Americans and Pacific Islanders and incorporate such knowledge into their practice with Asian Americans and Pacific Islanders.
- Treatment providers should be aware of the potential harm of underdiagnosis, misdiagnosis, and over medication of Asian American/Pacific Islander individuals.

The Delivery of Culturally Competent Care for Asian Americans and Pacific Islanders

In sum, culturally competent treatment of Asian American/Pacific Islander individuals should not be the responsibility solely of Asian American/Pacific Islander treatment providers. Little effort has been made to recruit and train Asian Americans and Pacific Islanders for careers in mental health, resulting in limited numbers of Asian American/Pacific Islander clinicians. Rather, the mental health field must be accountable for providing accessible, well-trained, and knowledgeable treatment providers who can offer culturally competent interventions and services to an increasingly diverse population.

As the population of Asian Americans and Pacific Islanders continues to grow and become more diverse, the demand for appropriate services will continue to grow as well. Not providing these services will result in negative effects, not just for the Asian American/Pacific Islander population, but also for the U.S. population as a whole.

Addressing this growing need is not simple, but needs to be addressed from a systemic and multilevel perspective.

- Multilingual Asian Americans/Pacific Islanders should be valued for their skills and recruited and trained to be mental health professionals.
- Treatment providers must continually examine their own personal stereotypes and biases and how it may be affecting their work with Asian American and Pacific Islander clients.
- Treatment providers must seek knowledge, training, and skills so that they may provide culturally competent services to diverse Asian American/Pacific Islander clients.
- Training programs must be accountable for training their students to be culturally competent treatment providers. This should not be the responsibility solely of ethnic minority faculty, but all faculty in training programs must be accountable.
- Supervisors should be knowledgeable about and prepared to address issues of cultural competence in supervision.

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CHAPTER 3: RECOMMENDATIONS FOR THE PSYCHOLOGICAL TREATMENT OF PERSONS OF AFRICAN DESCENT

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Introduction

Defining persons of African descent can be a multifarious task since its membership consists of such a broadly diverse group. At its most inclusive understanding, persons of African descent would include all of humanity, since humankind's biological womb can be traced to East-Central Africa. However, utilizing such a holistic and inclusive perspective grounded in humankind's history and transmission of cultural ethos is uncommon in the West and most Western psychological models.

The mono-cultural hegemony of a western dichotomous logic partitions humanity into subgroups definable primarily based upon appearances often conveniently used to foster generalizations. We are choosing a more holistic and congruent perspective which defines persons of African descent as those who share a spiritual, physiological, and historical connection to the continent of Africa, influencing a complex constellation of mores, values, customs, traditions, and practices that shape their response to life circumstances. Amongst those persons who would fit under the African descent category, there are some who identify with being African, culturally and ancestrally, and some who do not. The nature of one's sense of identity, the degree of assimilation and/or acculturation to the Western culture, and one's internalization of a Western worldview will be important variables to understand in the treatment of persons of African descent.

As with all groups, we would expect to find a high degree of within group variability in terms of the incidence of a state or trait, however, prevalence is likely to be more culturally determined. The distinguishing cultural features characterizing persons acknowledging African descent and identifying with African ancestral tradition are common in various forms throughout the African Diaspora. While specific histories and experiences vary, there are common subtexts of history, spirituality, worldview, culture, oppression, enslavement, colonization and neo-colonialism that are critical to an understanding of the collective and individual mental health of persons ofAfrican descent and to efficacious psychological treatment.

There are varying amounts of data available on the diverse groups of persons of African descent that live in the United States. Most get classified as African American once coming to this country, whether or not they are Africans from groups transported to the Caribbean or South America, and are now coming by choice to this country along with those from Europe, Asia, and the continent of Africa, or Africans whose forced immigration and labor built this country's wealth. According to the 2000 US Census, the numbers of African Americans vary from 34.7 million to 36.4 million (approximately 13% of the population) depending on whether respondents selected only one racial designator or several (multiracial).

Since most traditional western psychological models and literature rely on DSM-IV diagnostic categories to assess mental health status, the treatment issue identified are often restricted to this western orientation. However, a culturally congruent African centered perspective would view mental health and treatment as holistically integrated phenomena whose processes are interwoven between individual and collective contributions to states and traits of mind and health, and the subsequent biopsychosocial environment. The cultural understandings informing this view of mental health and treatment require careful examination and assessment of the health of the larger social context, its social institutions and the nature of the social environment created. Mental illness would represent the disruption of a healthy social context in which institutional structures and other systems of social organization functioned to support individual and collective well-being.

Pathology in the individual is presumed to be reflective of dysfunction in the larger social group and context, and, healing would be required for the collective, as well as the individual. Embracing mental health as a multi-dimensional construct concerned with the entire community, past and future generations, and the physical environment, a range of psychological issues from mental illness to the problems of daily life, would all have to be potential targets for intervention. Treatment from

an African centered cultural perspective would focus on societal functioning and relationships from the individual's cognitions and behaviors to the collective institutionalization of ideas, beliefs, mores, practices and systems of organization. In this social context with its focus almost solely on an individual's "pathology", the statistics available on the treatment of African Americans are grossly insufficient, inadequate in meaning, and extremely lacking in terms of reflecting a culturally congruent, viable approach to treatment for this population, however some of them are given below.

- State Hospital Admission Rates (1980B1992) were 163.6 per 100,000. However the admission rate for African Americans was 364.6 per 100,000.
- Admission rates to Veteran Administration Hospitals for the general population was 386.6 per 100,000. However, for African Americans the rate was 118.2 per 100,000.
- Data from the National Institute of Health demonstrate that African Americans are more frequently diagnosed on admission to the state hospitals with severe mental illnesses than any other racial group.
- 56% of African Americans admitted to state hospitals received a primary diagnosis of schizophrenia, while only 38 % of a similar population received a similar diagnosis.
- 50% discontinue psychological services after the initial session.
- Tend to enter mental health treatment at a later stage in the course of their mental illness.
- Under-consume mental health services of all kinds.
- Over-consume in-patient state hospital psychiatric services at twice the rate of corresponding European American populations.
- Are often misdiagnosed by mental health practitioners as having a severe mental illness.

Myths and Misinformation

When it comes to acknowledging people of African descent in this country, the focus of differences is often placed on race rather than culture. Since the institution of racism has existed since this county's inception, and is thus systemic, people of African descent have not been assumed to have a culture (an idea founded on the historical legacy of being legally defined as less that human and having no rights). Fragmented attempts to define the culture of persons of African descent in America have fallen victim to a "ghettocentric" approach that extracts mis-representations from those living in "poverty" and generalizes these biased characteristics to all people of African descent. The approximation of quality treatment and service delivery will therefore require helping professionals to look at themselves and gain the level of self-knowledge in which one's biases resulting from socialization in this culture are acknowledged, and monitored, throughout the process of engagement, diagnosis and treatment. It is imperative that the following stereotypes and images be interrogated for self-serving bias and set aside, otherwise the African American client should be referred to a more competent professional.

Prevalent Stereotypes & Images of Persons of African Descent

- Intellectually inferior and anti-intellectual in cultural tradition
- Culturally deprived and/or disadvantaged
- Prone toward violence and aggression
- If not overtly violent, ridden with repressed hostility
- Sexually promiscuous
- Pursuing a White ego ideal
- Weak superego development and poor ego development
- Poor impulse control and ability to delay gratification
- Lack of initiative and insight
- Apathy and resignation
- Incapable of abstract reasoning and deep thought
- Lazy and lacking motivation

Implications for Culturally Proficient Care:

Awareness

- As mental health professionals we must face our history of self-serving social bias and misdiagnosis with regard to this population. From the beginning, behaviors that were healthy and supported their human agency have been consistently defined as "insane" (e.g., for trying to escape from one's abusers, the mental illness of drapetemania was diagnosed) by the professional mainstream. Moreover, one can also suspect that the dominant group might consider behaviors that should be identified as self-destructively "insane", to be "sane" and acceptable.
- Must engage in some structured self-knowledge processes to unearth and overcome hidden biases that are the

consequence of socialization into dominant culture.
- Must be able to think outside the "box" and suspend judgment based on what might be true for other cultural groups given their worldview.
- Must overcome the mono-cultural hegemony that constricts and constrains modern psychology and our understanding of humanity

Knowledge
- Comprehensive historical understanding of the incessant misrepresentations of Africa/African Americans in the literature, media, and the American imagination.
- The impact of institutional and personal racism is essential to considering quality treatment.
- People of African Descent are not a simplistic homogeneous group. Individual differences should be expected based on one's value system, level of acculturation / assimilation into the dominant culture, worldview orientation, and life experiences.
- Not all African Americans come from an urban impoverished environment. (30.3% make $19,999 or less per year, 15.3% make $20,000 - $24,999 per year, 23.1% make $25,000 - $34,999 per year, 17.7% make $35,000 - $49,999 per year, and 13.6% make more than $50,000 per year).
- Research done in academia on college students, even African American college students, may not generalizable to their general population, since 21.5% of African Americans do not earn a high school diploma, and 83.5% do not earn a bachelors degree.

Skills
- Must learn to use a diagnostic system and treatment modality that affirms an African/African American way of being in an anti-African environment.
- Must become knowledgeable of the client's professed worldview orientation and the importance that spirituality may play in the client's life.
- Must take into account the psychological impact of the brutal system of dehumanizing assaults institutionalized to support the exploitive economic agenda of trans-Atlantic slave trade and maintained today in the global economy.
- Must develop the capacity to engage in holistic and integrative analyses that have the potential to restore to health the community as well as the individual.
- Must engage in therapeutic practices that are culturally congruent and consistent with the client's health and well-being.
- Must be able to embrace and act on a standard of ethics and ethical practice consistent with culturally congruent care.

Inadequacies of Traditional Mental Health Care

The current mental health care system fails this particular population since the underlying assumptions that go into creating psychological theories and precepts to explain human behavior, do not take an African worldview into consideration. As a consequence conceptions of mental health have not been inclusive of the more holistic and integrative definitions that require focus on the society/community and the individual, both moral and economic development, respect for nature and humanity, the spiritual and material aspects of being.

For example, the notion of communalism is often replaced by an individualistic, competitive, survival of the fittest, might makes right, mode of interaction. For the person of African descent who uphold traditional values, a multi-dimensional sense of self precludes focus on that sort of autonomy. To be human involves identifying with a collective inclusive of ancestors and future generations that is aligned with a search for the highest of stages of development and will nurture a reciprocal relationship between the person and the community. Understanding the responsibilities that one has to the other, Self, ancestors and future generations, form an integrated connectedness that through certain obligations in congruence with the survival of the group as a whole, allows the person to obtain a sense of psycho-spiritual and socio-cultural significance that is imperative in maintaining good mental health. While a small part of Western psychology has begun to integrate spirituality into its theory and research, it is seen as a key feature of human experience from an African centered psychological perspective, as opposed to its current tenuous, if not inferior, status as an abstract possibility or characteristic of formal religion in most of "mainstream" western psychology. Without this shift, culturally competent diagnosis and proficient treatment become impossible.

Current Inadequacies
- A lack of competently trained culturally congruent or appropriately bicultural therapists.

- Adherence to only “mainstream” culture-bound and class-bound therapeutic models
- Overlooking the multi-generational trauma evoked by a long history of socially sanctioned abuse that has not been dealt with collectively in a therapeutic manner.
- Lack of acknowledgment of the larger social context of open and covert hostility in which this cultural group has been forced to develop an individual and collective will.
- A lack of appreciation and understanding of the collective group's history, strengths, capacity to cope with terrorism, and support for its diversity.
- Limited knowledge of individual and collective well being promoted through cultural strategies adapted and maintained in a hostile social context.
- Lack of awareness of the post-traumatic slavery syndrome.
- Failure to identify and acknowledge multi-generational trauma.
- Lack of knowledge and understanding of what mental health would look like from a holistic, consistent, and cohesive cultural frame of reference

Culture Specific Views of Mental Health and Healing

Persons of African decent still aligned with the traditions of their ancestors view mental health from a holistic perspective that includes an inseparable relationship between the balance of the person's physical, spiritual, social, and psychological well-being. If any of these facets are out of alignment, the person cannot claim to be healthy. To be healthy from this perspective is to have all aspects of human functioning in harmony with nature and the universe. The goal of the healer, or mental health professional, is to identify the target of intervention and to prescribe a therapeutic plan that has the capacity to reinstate balance into this holistic system.

Causality and Mental Health Issues

- Imbalance in holistic system
- Psychological distress created by an unjust environment
- External and internalized oppression
- Forces of imbalance in nature
- One's ill actions or interpersonal misbehavior
- The power of the spoken word in consciousness
- Misaligned character and/or purpose

Views of Mental Disorders and the Nature of Helping

- Illnesses and disease occur for a reason, chance is a law unrecognized.
- Greater good can come from challenges caused by illness or disease.
- Getting to the cause of a disorder is preferable to manipulating or masking symptoms.
- Natural remedies, such as herbs, are preferable to artificially manufactured compounds.
- To hear or see things unheard or seen by others does not mean one is “crazy”.
- What is considered abnormal in Western culture may be a highly regarded gift in African culture, for example, remote viewing, clairvoyance, and clairaudience.
- Unhealthy, self-destructive behaviors may be seen as healthy by Westernized helping professionals and vice versa
- Reintegration of the “identified client” into the family, community, and/or other systems of social support is essential to effective treatment.
- Health is difficult to achieve and sustain in an society as toxic as this one

How does culture effect the manifestation of behavior disorders?

- Being in a culture/society that has historically been oppressive, hostile and negating to persons of African descent, the following outcomes can be identified.
- Effective functioning (maintaining a job, getting an education, etc.) within this social context can not be equated with being mentally healthy.
- Depression and anxiety are often expressed though anger and irritability.
- Mental heath issues underlie chemical dependency and often reflect attempts at self-medication
- Domestic violence often reflects internalized oppression
- Identification with the aggressor and internalized oppression are serious mental disorders
- Post-traumatic slavery disorders must be identified and treated

Manner of Symptom Formation

To the extent the larger socio-cultural milieu is toxic with the pathogens of classism (privileging of wealthiest socio-economic class, whose position is primarily contingent on the exploitation, manipulation, and dehumanization of others)

which emerge from a conceptual system that yields all oppressions including racism, good mental health will be difficult to achieve, much less sustain. For persons of African descent who are disconnected from holistic and integrative cultural traditions, recognition of this pathology and its outcomes may be obscured. For example, a history of enslavement, colonization, and neo-colonialism is the foundation for current state of affairs through out the African world. This state of affairs can impact symptom formation in a number of critical ways. One of the most common is the adoption of the beliefs and values of the dominant group to the detriment of one's own self and collective group, below are three examples.

- Identification with the aggressor—taking on the beliefs, values and behaviors of the oppressor, trying to be "more like" the oppressor, than the oppressor, manifesting in a anti-self disorder in which "the other" and his/her characteristics are perceived more desirable that one's own and there is no knowledge of one's own outside of the interpretation and context of "the other"
- Internalized oppression--anger, rage, and sense of inferiority and self-loathing turned inward, manifest in anti-self and alien-self disorders in which on acts in way detrimental to self and one's group of origin (e.g., willingness to play role of "overseer," or gatekeeper to block progress of member's of one's own group)
- Attempts to escape the perpetual mini-assaults and major life traumas of racism and white supremacy through psychotic escape, substance abuse, black-on-black crime, and suicidal behavior or homicide.

Indigenous or Culture-Specific Healing

- One becomes unhealthy when an imbalance exists between one's soul, spirit, body, and environment. The role of the mental health professional or healer is to identify the target of therapeutic intervention and restore balance to the holistic system.
- The spiritualization of everyday life and use of rituals can reinstate harmony to any aspects of the universe that may have been disrupted.
- Focus on individual in community, family, or collective–heal whole system.
- Identify the lesson to be learned from the experience instead of a "why me" attitude, the person may look at the experience as a chance to perfect an existing imperfection.
- Many of our challenges are divined as a part of realizing our purpose as a person in relation to the Creator prior to this lifetime. These obstacles are designed to provide the life experiences needed to strengthen one's soul in areas that need strengthening and enhance movement toward one's perfection.

Implications for Culturally Competent Care

- Among those persons of African descent whose investment in the traditions of their ancestors remains in tact, the following considerations should be taken into account:
- A multisensory, spiritual/material reality reinforces a connection to the universe.
- The cultural thrust to realize our divinity, right relationship with the Creator through union with the Higher Power and thus one another; is desirable and essential to health and well-being.
- The necessity to interrogate and pursue the upper reaches of human development is not resisted.
- Good/bad dichotomies are of less relevance than balance between the two.

Among those persons of African descent who have more totally assimilated or become acculturated, the degree and impact of internalizing oppressive socio-cultural conceptions and the ideas of inferiority promoted by the dominant culture must be examined.

Implications for Culturally Competent Care

- Must provide culturally congruent training so that more effective treatment can be provided
- Must employ a more holistic / integrative approach that examines the physical, spiritual, psychological, and social aspects of the presenting problem.
- Clinicians must receive adequate graduate, post graduate, continuing education and on-going professional in-service training in assessment and treatment issues with persons of African descent to ensure that clinicians are knowledgeable and skilled in their treatment
- Clinicians must develop the ability to effectively communicate cross culturally.

Oppression and Racism as Mental Health Issues

Most of these concerns have been alluded to earlier, since race is so often erroneously used interchangeably with ethnicity when it comes to persons of African descent. For reasons identified previously, continuing racism prevents equitable service delivery and culturally competent diagnosis and proficient treatment. Starting with African

Americans whose immigration to America was forced, and whose labor netted this nation – and most of Western European nations – the economic dominance they have enjoyed for centuries, the group is unique by virtue of the nature, quality, and degree of socially sanctioned violence, hostility, and aggression practiced by the dominant culture towards them generation after generation. At the same time, it is imperative to understand that their "beingness" is not limited to a reactionary navigation through foreign inhumane circumstances and conditions forced upon them. The resilience of this cultural group is astounding in the face of the non-stop negating onslaught from the dominant culture. As the formal mechanisms of cultural transmission remain under attack, disruption of the group's own indigenous strengths continue to be apparent. Those given opportunity typically flourish and often excel, according to the dominant cultural standards. Those most disenfranchised economically and educationally, may also experience the "good life," a life of peace, joy, and well-being, depending on their relationship to traditional African values and beliefs. Those who seek access, whether or not they may "get in" to the non-merit based system of material rewards offered by the dominant culture, also suffer, as they often internalize oppression and succumb to psychological incarceration. A more holistic and cohesive cultural orientation informs that all will be nurtured by a recycling system of incarnation, leading to their higher development. However, socio-economic class or access to the opportunity structure becomes a significant variable to which one should attend in looking at this collective group.

The Delivery of Culturally Competent, Proficient Care for People of African Descent

Knowledge, appreciation and understanding in the following areas are required.

- Cultural values, beliefs and world view
- Culture-bond syndromes and symptom expressions associated with persons of African descent
- Thresholds of psychological distress and tolerance, symptomatology, and natural support systems within the community
- Nuances of verbal and non-verbal language patterns, coding, and communication styles
- Dynamics of the conceptual frameworks and languages of persons of African descent
- The cosmology of persons of African descent .
- The attribution and manifestation of mental illness among persons of African descent
- The impact of "modernization" on people of African descent as they attempt to keep their inherited cultural fabric intact.
- The impact of the "global economy," "least model" minority status, on minority/majority relationships and politics.

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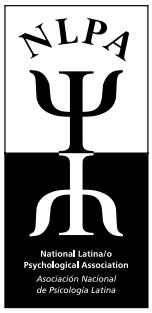
CHAPTER 4: RECOMMENDATIONS FOR THE PSYCHOLOGICAL TREATMENT OF LATINO/HISPANIC POPULATIONS



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Introduction

According to the 2000 U.S. Census, the number of persons in the United States who identify themselves as Hispanic is now over 35 million, or approximately 13% of the total U.S. population. This figure represents an almost 60% increase over the last decennial census and indicates that the number of individuals of Latino descent is increasing faster than expected. Because of high fertility and migration rates, Hispanics will soon constitute the largest minority group in this country. Indeed, Hispanic girls already rank as the largest minority group of girls in the country.

While Latinos share many commonalties, most notably language, religion, and core values that emphasize family, loyalty, and honor, they also are characterized by many differences. The majority (58.5%) are of Mexican origin, with Puerto Rican (9.6%), Cuban (3.5%), and Dominican (2.2%) backgrounds also reported. Recently, high rates of population growth have been noted for individuals from Central America, especially El Salvador and Guatemala. The various Latino groups vary in terms of their migration history to the United States. Whereas many ancestors of present-day Mexican Americans resided on this land when national borders were established more than 150 years ago at the end of the Mexican American War, Puerto Rican migration to the United States began in the latter half of the twentieth century in part because of high unemployment. White well-educated professionals considered political refugees began to immigrate from Cuba in 1959 and received economic assistance; in the 1980s, a subsequent wave of non-White and less-educated Cuban immigrants were subjected to stricter immigration policies and a cooler reception. More recently, individuals from Central America have sought residence in the United States because of high unemployment and political instability in their country of birth. Many are from rural areas, have few years of schooling, and are primarily laborers. As a result, they often perform long hours of manual labor for subsistence wages, little or no job security, and few employment benefits. More than 70% of all seasonal agricultural workers and 95% of migrant farmworkers are Hispanic; additionally, Hispanics are overrepresented in the electronics, oil, and petrochemical industries as laborers and assemblers. They are subject to widespread exposure to pesticides, chemicals, and other toxic substances that can affect physical and mental well-being.

Hispanics as a group tend to be younger, poorer, and less well educated than the overall U.S. population. With a median age of 25.9 years compared to 35.3 years for the entire U.S. population, Hispanics have lower rates of high school graduation (54.7% compared to 84.8%). Approximately 40% of Hispanic children under the age of 18 live in households below the poverty level, and 44% of the Hispanic poor and 35% of working Hispanics are without health insurance. Social isolation, high levels of poverty, low levels of education, and a lack of English fluency place many Hispanics at risk for physical and mental problems; these factors also create a barrier to successfully navigating the health care system in the United States. However, the increasing Latino population in the United States necessitates that mental health services be available and appropriate. The need for such services is critical given documentation of higher rates of suicidal ideation, suicide attempts, depression, teen pregnancy, binge drinking, and heroin and cocaine use. Hispanics have the highest rates of depression and are identified as a high-risk group for anxiety and substance abuse. Additionally, Hispanic adult men and women have an annual incidence rate of AIDS more than 3 and 6 times, respectively, the rate for non-Hispanic White adult men and women.

Although there remains much to be learned about the physical and mental health needs of Latinos, it is known that Latinos currently access both mental health and medical services at lower rates than the general population. They are less likely to receive services from a non-White professional and less likely to receive specialty services from a trained professional of any ethnic group. When they do receive services, they are more likely to receive services from nondoctoral level or paraprofessional personnel and to discontinue services before achieving therapeutic goals.

Myths and Misinformation

Although it is frequently assumed that the overall quality of life improves for Latino immigrants upon entry to the United States, contrary evidence has been reported. As one example, while Latinos as a whole display numerous positive health indicators such as a healthy diet, low levels of smoking, and a strong family structure, the beneficial effects of these factors diminish as individuals become acculturated. The rate of alcohol use has been shown to increase in all Latino groups with increased acculturation. Not only do Hispanic immigrants experience less mental illness than U.S. born Hispanics, but also it has been suggested that immigrant children who maintain strong ties to their ethnic community have fewer mental health problems than those who adapt rapidly to American society.

Latinos often are perceived by the public as engaging in and condoning violence to a greater extent than White Americans. Research has been inconclusive on this point and likely affected by sampling and experimental design limitations. When age, social class, and employment status are considered, differences in rates of violence diminish. Thus, there is no conclusive evidence to indicate Hispanics are inherently more violent than White Americans; rather, they are differentially affected by poor access to economic resources and other societal inequities that generate stress that may increase the likelihood of violence.

Hispanic families often have been reported to have lower educational expectations. Despite the widespread acknowledgement of the benefits of education, there are significant disparities in access to quality instruction throughout the education pipeline. Fewer Hispanic than non-Hispanic children attend preschool. Low school performance is associated with childhood poverty. So it appears that Hispanic children start behind and stay behind. Hispanics drop out of school at a rate that is almost four times the rate of their White peers. Fewer Hispanics pursue a college degree: In 1996, only 16% of Hispanic high school graduates between the ages of 25 and 29 years earned a bachelor's degree.

There is evidence that Hispanic children face greater challenges in their schooling: In 1995, 74% of Hispanic children spoke a language other than English at home, while 31% of Hispanic children had difficulty speaking English. Many limited-English-proficient children start school without the school readiness skills important for school success and require extra assistance. Unfortunately, many states are opposed to providing services to limited-English-proficient students. Moreover, parents who themselves may have had few years of school and know little English may not be able to assist because of their own language limitations and inadequate schooling. In effect, the problem appears to be related more to obstacles and lack of opportunity than to disinterest.

Many teachers unfamiliar with Latino culture are unable to recognize or are unwilling to deal with cultural or linguistic differences. Because of language issues, Latino students may be distractible in class or misbehave. Language difficulties, if not correctly understood and dealt with, can lead to more severe adjustment problems as well as continue to limit the learning process. Unfortunately, many teachers base their perceptions on traditional middle class norms and evaluate lack of progress or differences in learning as deficiencies, often referring Latinos and other ethnic minorities for special education services. Indeed, the racial composition of a school district is a key predictor of special education enrollment. Minorities are enrolled in special education at significantly higher rates when there are lower percentages of minority students in the district; this trend persists even when class size, per pupil expenditures, poverty level, teacher pay, overall educational attainment, high school completion, and neighborhood crime rates are considered.

Inadequacies of Traditional Mental Health Care

Latinos experience similar obstacles to quality mental health services as other groups in the country. These include increasing costs, limited or no insurance, and unavailability of services. Geographic remoteness, limited transportation, and long work hours also may hinder access for Latinos living in rural areas. However, additional factors create difficulty for Latinos seeking appropriate and effective services. Many mental health service providers are not familiar with the unique cultural characteristics of Latinos and are unable to speak Spanish. They often rely on untrained translators who may not effectively communicate the nuances and intensity of psychological symptoms and concerns.

Many Hispanics often never seek nor receive specialized mental health services, but rather seek assistance from primary care providers stating physical complaints. More specifically, they mostly see general physicians, physician assistants, and/or nurse practitioners. As an example, 46% of Latino women have been reported to have depressive symptoms. However, Latino women are underrepresented in mental health services and overrepresented in general medical services. Physicians and other medical personnel unfamiliar with cultural manifestations of psychological distress may treat only the physical symptoms instead of probing for an emotional cause. In addition, psychiatric medications, particularly antipsychotics, can affect Hispanics at lower dosages than typically prescribed for Whites; therefore, it is important to monitor their medication carefully to prevent adverse side effects that may cause premature discontinuation of the treatment.

Limited English proficiency also affects the potential for the full range of psychological services. When providers are involved in evaluation and diagnosis, they may misinterpret symptom expression, particularly for more severe psychological disorders because they lack familiarity with cultural norms in emotional expression, mannerisms, and verbal style. Specifically, when the service provider is not fluent in Spanish and because Hispanics view outward expressions of emotion such as crying as healthy and appropriate, Latinos' symptoms are perceived as more severe, with communication difficulties seen as proof of a thought disorder, culture-specific mannerisms such as religiosity interpreted as bizarre, and emotional expression viewed as inappropriate affect. Performance on psychological and psychoeducational tests may not accurately reflect current functioning and abilities because the tests have been designed for and normed with English-speaking populations, reflect Anglo-American values, and do not contain culture-specific content or constructs.

In treatment, service providers often do not adequately understand specific Hispanic life experiences or recognize familial strengths and values. They may not be able to identify or draw on available community support to achieve therapeutic goals. Finally, the efficacy of many traditional treatments has not been established with Hispanic populations.

Implications for Culturally Competent Care

- There is a great need for an increase in the numbers of bilingual and bicultural service providers to competently evaluate, diagnose, and treat Latinos.
- There is a need to develop effective, affordable models to address the mental health and service needs of Latinos in both urban and rural communities. Such services should be community based and available before severe distress is experienced.
- There is a need to better train primary service providers and mental health specialists to accurately recognize symptoms of emotional distress in Latinos.

Culture-Specific Views of Mental Health and Healing

Many Hispanics embrace what has become known as the "mestizo" perspective, a dynamic process that strives for harmony with one's physical and social surroundings, recognizes the value of every person by encouraging respect for and acceptance of all individuals, an openness to new experiences, and a strong sense of spirituality. This perspective results in deference to elders and acceptance of their guidance, a strong commitment to family that extends beyond the nuclear family, and a collective, cooperative orientation. Included in this perspective is the concept of "personalismo," which stresses warm personal relationships.

Spirituality may extend beyond formal religion and involve continuity between the living and the dead. Thus, individuals may communicate with deceased relatives through prayer, visiting their gravesite, visions, or premonitions.

Most Hispanics view the mind and body as interconnected. The mind influences social, interpersonal, and spiritual matters. Physical and psychological illness results from conflicts in interpersonal relationships within the family and community rather than mere biology. Balancing one's biological needs with interpersonal experiences, achieving physical and spiritual harmony, and developing satisfying family and community relationships achieve health.

Additionally, many Latinos are strongly influenced by "simpatia," which strives for conflict-free relationships, encourages responsiveness to others' feelings, and respects the dignity of those around them. To some degree, machismo, which encapsulates expectations for males to include protecting and providing for one's family, is a strong influence on behavior, as is "marianismo," which encourages passivity, acceptance of injustice, and submission in women.

Latinos who lose their sense of harmony may manifest their distress through a Latino-specific syndrome. This includes "nervios," which is characterized by somatic complaints such as headache, dizziness, and tingling, crying, and other emotional expressions, and sleep problems. Another syndrome specific to Latinos is "ataque de nervios," which involves a loss of emotional control resulting in uncontrollable shouting, shaking, and crying; palpitations; shortness of breath; swearing; and physical aggression. It may involve falling down and convulsing. "Ataque de nervios" often is precipitated by stressful events such as divorce or the death or injury of a family member. It often is associated with panic disorder, depression, and generalized anxiety disorder. A third syndrome is "susto," an illness that is caused by a sudden frightening experience such as an accident or witnessing a sudden death or dangerous event. It involves fear that the soul will leave the body and results in physical illness that may include symptoms of anorexia, general malaise, insomnia, sadness, and involuntary muscle tics. Its most severe form, "espanto," can result in death. Some Latinos rely on "curanderismo," a set of folk medical beliefs and rituals that focuses on psychological, social, and spiritual needs. The "curandero/a" uses these beliefs to diagnose and treat physical, psychological, and spiritual dysfunction. Treatment may involve the use of herbs, food, meditation, and ritual.

Implications for Culturally Competent Care

- Latinos' strong family orientation and collective sense extends to medical care. Many Latinos will involve the entire family rather than only an individual or a child's parents in decisions about treatment.
- Latinos' adherence to "personalismo" may cause them to develop strong ties to their provider rather than the care setting. It also may result in the expectation that their service provider will interact in a caring manner and provide a more constant presence of support and assistance.
- Latinos' expressions of emotion may be more intense than what is typically experienced in the more reserved White American society. It is important to interpret these expressions within the context of cultural norms rather than automatically interpreting such behaviors as reflecting pathology.
- Strong religious beliefs and practices combined with family or community support for folk remedies may affect the Latino's willingness to seek mental health services. Mental health problems may be framed as spiritual concerns.
- Service providers need to explore previous efforts to address the presenting problem, including work with folk healers, to determine the potential for adverse interactions of herbs and other curative foods with prescription medicine.
- Providers should be prepared to work with the concepts of machismo, marianismo, respecto, and simpatia to develop culturally acceptable interventions that clearly differentiate between the ideal and pathological forms of these themes.

Oppression and Racism as Mental Health Issues

The underutilization of mental health services by Hispanics in the United States is deeply rooted in White America's refusal to recognize and value the central role of Hispanics in the past, present, and future of this country. The educational, political, and economic development of Hispanics has been characterized by a history of neglect, oppression, and long periods of passive if not deliberate denial of opportunity. While overt racism is no longer acceptable in many areas of modern American society, subtle and more overt vestiges of oppression and racism continue linguistically, educationally, and economically:

Language: A young child who speaks English as well as a second language such as German, French, or Italian is viewed as precocious. In contrast, many children who speak English and Spanish are considered deficient.

Education: Not only are a disproportionate number of Latino students placed into special education programs but districts with higher proportions of White teachers enroll minorities in special education at a higher rate.

Economic: Many Hispanics earn very low wages because of low levels of educational attainment. However, Latino high school and college graduates earn less than their White and African American counterparts. In addition, undocumented immigrants often live in extreme density conditions and may be exploited, working at the most difficult and undesirable jobs for less than minimum wage and at times not paid for their labor by unscrupulous contractors.

These and other issues may result in a general distrust and a lack of empowerment and adversely affect psychological functioning.

Limited access to quality instruction throughout the education pipeline has resulted in few Hispanics in faculty positions in professional training programs—currently, only 2% are graduate psychology faculty. This reduces the likelihood that mental health providers will be recruited and trained to deliver appropriate services.

Many mental health specialists are not Hispanic, are unfamiliar with the language and culture, and are unable to interpret symptoms from within a cultural framework, thus increasing the possibility for misdiagnosis. They often dismiss or do not understand the economic and psychological stressors that affect Hispanics in America; these include cultural insensitivity as well as subtle and overt forms of discrimination that pervade daily life and sustain second-class status. As a result, they may use treatment strategies that do not adequately address client needs.

Large numbers of Latinos live below the poverty level and are unable to access services until their condition becomes debilitating. Subsequent treatment often occurs in an emergency room setting that is poorly suited to culturally appropriate specialized care.

Aware of widespread opposition to bilingualism in the United States, some Latinos may view the lack of bilingual or bicultural therapist as further evidence of discrimination. They may be less trusting of service providers who cannot communicate effectively and therefore be reluctant to disclose information that could facilitate treatment or accept suggestions from someone who may lack credibility. Use of translators, particularly family members, may cause power issues within the family or community and additionally raise concerns regarding confidentiality or the accuracy of communication.

Implications for Culturally Competent Care

- Long hours of work and low wages will necessitate that mental health services be affordable, available within the community, and flexibly scheduled.
- Service providers must be aware of the social, political, economic, and educational forces that adversely affect the psychosocial functioning of Hispanics and be prepared to offer viable strategies to address these issues. This may require active efforts aimed at empowerment.
- Service providers must carefully establish trust through clear communication and actions.

Delivery of Culturally Competent Care to Hispanic Populations

Traditional mental health services in the United States were originally developed to treat White middle class individuals and have limited utility for Hispanics and other persons of color. To effectively address the mental health needs of this country's Latino population, it will be necessary to modify practices at both the individual provider and systems levels so that diagnoses and treatment can be individually tailored. Modified approaches to assessment and diagnosis should be developed along with new models for treatment that will reduce the likelihood of premature termination and increase the probability for therapeutic success. These approaches must reflect an understanding of and respect for Latino culture, traditions, beliefs, and values and incorporate these elements into services as appropriate.

Although only 31% of Hispanics were born outside the United States, 77% report that Spanish remains their primary language. Clearly, critical to any useful mental health service is the availability of effective communication. An initial step is the need to make linguistic accommodations, which can be facilitated by prioritizing the hiring of bilingual/bicultural service providers. Additional but less preferred strategies include paying trained interpreters to translate, providing Spanish language training for existing staff, and having interpreter services available by phone for emergencies.

In addition to language, providers must be able to recognize unique aspects of Latino culture. Specifically, they should be aware of the cultural subtleties and tacit rules that guide social interactions. They should strive to develop trust and demonstrate interest in the client's condition. Assessment procedures should address cultural and demographic factors, beliefs, practices, family organization and relational roles as well as the possible effect of stressors such as poverty and discrimination. Latino clients should be asked about their beliefs about the causes of their condition as well as history related to remediation efforts. The evaluator should obtain information related to immigration and acculturation. This information should be examined within the context of Latino culture to ensure accurate interpretation of symptoms.

Intervention plans should be developed with the client's active participation to address both physical and mental health needs as appropriate. It will be important to build on family strengths and base services whenever possible in the community; resources include but are not limited to schools, traditional healers, and faith-based organizations.

The unique sociopolitical and socioeconomic factors that impinge on the mental health of many Latinos in the United States may require that service providers not only understand these issues but that they serve in an advocacy capacity to facilitate the improvement of psychological functioning. To that end, institutional support must occur along with efforts aimed at the individual. There must be a widespread systematic effort to solicit the input of the community in shaping culturally relevant service delivery models. Organizations must earn the community's trust by constantly evaluating its efforts to provide relevant services and should constantly strive to ensure that its employees understand and value the role that Latino culture plays in promoting health and well-being. Agencies and organizations, not just individual providers, must strive to become culturally competent. They must accept and respect cultural differences, continually self-evaluate, pay careful attention to the dynamics of difference, and constantly strive to expand their cultural knowledge and resources and develop appropriate and effective service models.

Proper service delivery is contingent upon an adequate number of trained professionals. Training programs must increase the number of Hispanic faculty members and trainees as well as the knowledge base regarding the role that culture and ethnicity plays in psychosocial development of Latinos. Faculty and practitioners alike must recognize the limits of their own competence and seek consultation and/or make referrals to others when their knowledge or skills regarding Latinos clients is lacking.

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National Latina/o Psychological Association
Asociación Nacional de Psicología Latina

CHAPTER 5: RECOMMENDATIONS FOR THE TREATMENT OF AMERICAN INDIAN POPULATIONS

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Introduction

Although the American Indian/Native American/Alaska Natives population has the lowest numbers of minority group members in the United States, it possesses the greatest diversity among the Native tribes. According to the 2000 U.S. Census, the American Indian population comprises 0.9% of the population, with 2.4 million people. This very diverse group consists of about 550 federally recognized tribes and nearly 300 tribal groups that have not achieved federal recognition.

There are 300 existing American Indian reservations and trust lands in the United States. Approximately 37% of Native people still reside on these lands or within tribal jurisdictions. Roughly one half of the nation's American Indian and Alaska Natives live in the western states. American Indian people have a unique status within the United States because of the treaties that were made with the U.S. government in the early history of the European immigration. Federally recognized tribes are sovereign governments with jurisdiction over designated areas, and they have a government-to-government relationship at the federal and state levels. The Bureau of Indian Affairs (BIA) is the federal government agency responsible for overseeing reservation (and some urban) Native interests in all areas except health, which is the domain of Indian Health Service (IHS). Under the Indian Self-Determination Act, tribes may elect to contract with these agencies to provide services to their people, such as law enforcement or mental health services, rather than have them provided by BIA or IHS.

American Indians are the only minority group in the United States that has a legal definition of their race (.25 blood quantum). This method is used to determine eligibility for services. Not all Native people recognize the federal government definition, and asking, "how much Indian are you?" would be an inappropriate and insensitive question to ask a Native person. Over 150 Indian languages are still used, and there are elders who still speak only their own language. Native tradition is an oral one, with history and stories passed down orally. Only within the 1900s did most Native tribes begin to try to develop a written language. Because of this, very few Native people can read or write in their own language.

Unemployment on American Indian reservations is consistently high, ranging from 80% in some plains states to 20% in more prosperous tribes. The poverty rate is quite high and similar to those of African American and Hispanic people. It is reported that nearly one third of all American Indian adults are functionally illiterate, and those 25 years and older have an average of 9.6 years of formal education. This is below the 10.9 year national mean and is the lowest of any ethnic minority group in the nation. On a more encouraging note, in the fall of 1996, 134,000 American Indians were enrolled in the nation's colleges and universities, up from 84,000 in the fall of 1980. During the 1995-1996 school year, about 15,000 of the nation's American Indians and Alaska Natives received college degrees.

In the face of very difficult times, American Indian people have demonstrated extraordinary strength, and many have found healthy ways of coping with the stress of forced acculturation, attempted genocide, loss of land and culture, and the death of loved ones. They have coped by practicing Native spirituality, valuing connections with families and communities, and initiating a grassroots movement toward healthier life styles. Unfortunately, all these stressors have taken their toll on American Indian and Alaskan Native people. Depression and adjustment reactions are the most prevalent mental health problems, with suicide among adults more than twice as high as rates in the majority culture, and in school-age children 3 times greater than that of White Americans. A congressional hearing on Native juvenile alcoholism and drug abuse reported that 52% of urban Indian adolescents and 80% of reservation Indian adolescents engaged in heavy alcohol or drug use compared to 23% of their urban, non-Indian counterparts. Delinquency and arrest rates are the highest of any ethnic minority group. Because of alcohol problems and family disruption, child abuse is also a problem in some tribes.

There is a severe shortage of mental health personnel to serve American Indian and Alaska Native people, and American Indian and Alaska Native people tend to underutilize the facilities that do exist. Of those Native people who do seek mental health services, many do not return after their initial visit. In the view of traditional majority mental health providers, this is a problem. This pattern, however, can be seen as culturally congruent with Native healing ways and not seen as problematic. Often Native people are unaware of the services available and often perceive the services as unresponsive to their needs. Fear and mistrust of the non-Native providers and their methods and the insensitivity of these providers to Native culture are also sited as reasons for the underutilization of existing mental health services.

Given the unique history and challenges facing Native American people, culturally competent mental health treatment must consider the following:

- Many Native Americans will seek help from family members or traditional healers before considering professional mental health services. Professionals should acknowledge family and community resources as an intricate part of treatment.
- Many who seek professional help will stay only for one session. It is important to discuss the fact that counseling and psychotherapy are healing processes that differ from traditional healing methods so that they understand what to expect from the counseling process (length and number of sessions, etc.).
- Because many providers serving Native people are non-Native, sensitivity to cultural issues is imperative, but often absent. Each tribe needs to have guidelines describing culturally competent treatment and training for those mental health workers who do not understand or accept the culture.
- Trust of the formal mental health system is low. As in the majority culture, providers for Native people must earn their respect by providing services that are culturally sensitive and effective.
- There is a strong need to understand that tribes and the individuals within each tribe differ greatly and cultural knowledge needs to be tribal specific.

Myths and Misinformation

Many myths and stereotypes have plagued Americans. Some of them are listed below:

- Indians are drunks. While it is a rare Native person who has not had alcoholism touch their lives in some way, the majority are not alcoholic.
- All Indian people receive money from the federal government ("live off the government"). Some tribes obtain tribal money from mineral lease, casinos, land lease, and so forth. However, the federal government does not provide funding to Indian people except in specific instances, such as educational scholarships, or in the case of competitive grant awards as with other groups.
- Indians are lazy and do not value time. In most American Indian cultures, time is viewed differently from the majority culture. The Native view of time is that there is always time and compulsive punctuality may not be seen as important. This differing view of time is an acculturation stressor that affects Native people who interface with the majority culture. Although often interpreted by members of the majority culture as a lack of respect or client resistance, issues around time must be discussed in a therapy context, and a solution negotiated.
- Lack of eye contact means Indian people are shifty and untrustworthy. In many Native cultures, direct eye contact is viewed as aggressiveness or a lack of respect. Thus, the lack of eye contact is a sign of respect rather than disrespect.
- The "cold-fish" handshake of most Native people is a sign of unresponsiveness. The sensitive and gentle touching of hands that constitutes the handshake of many American Indians is contrary to the more aggressive and competitive-like firm and energetic hand grasp of the majority culture. It is a more humble greeting style, not unresponsive.
- All Indian people are quiet and nonverbal. Most Native people will be quiet and watch, will not interrupt or speak unless they deem it necessary. However, Native tradition was and is an oral tradition, and many Native people are great orators and storytellers.
- All Indian people are stone faced and solemn. Though they may appear solemn to outsiders when in unfamiliar situations, most Native people use teasing and humor as a way of relating, and it is often very subtle. In relaxed and familiar surroundings, Native people are outgoing and highly verbal with much laughing and joking.

Implications for Culturally Competent Counseling

- Mental health workers need to be aware that the loss of land, life, stable economies, and cultures are powerful forces that have infused chaos into a once- stable and functional culture. To understand the impact of these forces on their life and their methods of coping with these stressors will be therapeutic for Native clients.
- Psychosocial stressors such as poverty have a global impact that directly affects the issues that may bring a Native person to counseling. Consequently, the role of a mental health worker is more broadly defined in these cases and may include being an advocate, serving as a consultant, and providing psychoeducation to clients, agencies, and the community.
- The differing way of eye contact may, where it exists, require an adjustment that a mental health worker must accommodate. Sessions may need to be structured differently; for instance, the traditional sitting face-to-face with a client may be adjusted to sitting side-by-side, or with adolescents, it may mean being involved in a craft or activity with talking as a byproduct during the activity.
- A gentle hand shake, where it is different, must be accommodated by the mental health worker and not confused with a lack of assertiveness, a shame-based personality, or unresponsiveness on the part of Native clients.
- There may be more and longer periods of silence in a session with a Native client, and the counselor may need to allow more time before responding, respecting the clients time to think and finish their response. The

entire session may be conducted at a slower and more relaxed pace. Rushing the pace will silence the client and probably will be seen as a lack of respect.

- Native people may be less inclined to express emotion, particularly the men. Native people feel as deeply as other people but may have little experience or may not value expressing feelings. Learning to recognize feelings and the impact of those feelings on their behavior may be part of the therapeutic process. Finding culturally appropriate and healthy ways for clients to cope with or express their feelings will be a challenge each therapist must face.

Inadequacies of Traditional Mental Health Care

Indian Health Service is the largest single provider of mental health services to American Indian people. In 2001, IHS employed 194 mental health workers, 54% of them being American Indian. Native people were seeking services for alcohol and substance abuse problems, anxiety, panic, depression and grief, cultural conflict, and suicide attempts. Adequate funding is an ongoing problem for IHS and frequently the only services that can be provided are crisis intervention and emergency care. It should be noted, however, that IHS does not serve many Native people, so this information relates only to those Native people who have access to IHS services. The state of the art in the assessment and diagnosis of psychological disorders of traditional Native people is a work in progress. The use of psychological tests that have a normative sample from the majority population, even with statistically appropriate numbers of minority participants, does not reflect the psychological make up of an American Indian. Also, because of the diversity among tribes, caution must be exercised if a test uses data from one tribe in the development of the normative sample. It cannot be generalized to other Native tribes. While DSM-IV-TR includes cultural concerns and encourages practitioners to consider culture for diagnosing persons from different cultures, no guidelines or criteria are offered for specific minority groups.

Implications for Culturally Competent Treatment

- The validity of the current diagnostic system with Native people has not been tested and must be used with caution as cultural factors may affect the expression of symptoms.
- American Indian psychologists tend to use diagnostic labels less frequently than non-Native psychologists, and mental health service providers need to question the use of diagnostic labels that may not be relevant for a culturally different client.
- Western psychological assessment instruments must be interpreted and used with extreme caution with American Indian clients.
- The shortage of mental health programs and personnel limits the depth of care that can be offered for Native clients, especially children and adolescents.
- The shortage of American Indian mental health workers compromises the cultural sensitivity of the treatment offered. An essential component of treatment of any ethnic minority client, including American Indian clients, is to assess the level of the client's acculturation to the majority culture and its values versus the client's adherence to "old ways"(the tribes traditional cultural values).

Culture-Specific Views of Mental Health and Healing

American Indian tribes are very diverse across the nation, so to make statements regarding specific views of mental health is a difficult task. Members of the Navajo Tribe who are traditionally taught view good mental health as being in harmony within themselves, other people, the world around them, and their spirituality. Being out of harmony creates "dis-ease" and unhappiness, which can be manifested physically, emotionally, socially, and spiritually, as well as in behaviors. As with most other tribes, medicine people may be used to diagnose the problem and provide the appropriate treatment. In Lakota Sioux, "ta-un" means being in a state of well-being. To achieve ta-un, one must engage in certain behaviors and introspections prior to engaging in social interactions or group collective actions.

For a Hopi, one achieves well-being, peace, and strength through self-control and adherence to the values of wisdom, intelligence, poise, tranquility, cooperation, unselfishness, responsibility, kindness, and protectiveness of all forms of life. Although there are significant tribal differences, many Native American people hold similar values.

In general, Native people view the world in a holistic rather than compartmentalized fashion. Mental health cannot be separated from spiritual health or from physical health because a problem in one area causes problems in all areas. Showing respect, not wishing to offend, being indirect, and being subtle describe Native traditional ways of interacting. In interdependent cultures, as opposed to independent cultures, the survival of the group is primary, so great care is taken to respect and honor each person so the harmony of the group is not disrupted. The need for an individual to be responsible is not for personal gain or glory but for the good of the group and the maintenance of community solidarity.

The problems of an individual in some tightly knit Native communities become the problems of the community as well. Treatment there would include family and friends rather that just the healer and the client. The goal is not to strengthen the client's ego but to enhance the client's connectedness to the community, which also strengthens the community. Mental health providers are advised to be functional in the systems approach to treatment.

Implications for Culturally Competent Treatment

- The Native client's level of acculturation must be assessed prior to planning treatment. Treatment plans for a traditional Native client may need to differ significantly from those of an acculturated Native person.
- Providers for American Indian people need to possess a depth of understanding of collectivistic cultures and the implications for treatment. For instance, encouraging assertiveness and independent thinking may serve clients as they walk in the larger society. How these skills will be functional for Native clients in their own community needs to be discussed with those clients.
- Treatment strategies need to strengthen clients' connectedness to the community if the clients wish to remain part of that community, and if it is a healthy community.
- The mental health treatment providers for American Indian people need to work toward a depth of understanding of the specific tribal culture in order to be capable of cultural empathy for clients of that tribe, if the clients ascribe to the culture of their tribe.
- The mental health provider may become an active part of the Native community and will need to consult with an expert regarding the maintenance of healthy boundaries and maintaining ethical standards.
- Native healers and Native healing experiences and spiritual solutions may frequently be a part of the mental health treatment that may require the coordination and cooperation of the mental health worker. Referrals may need to be made to the Native healers or medicine person in lieu of traditional Western mental health treatment.
- Because of past experiences and the history of Native people, patience will be required for a non-Native service provider to gain the trust of a Native client, especially a more traditional Native person.
- A directive, rather than a nondirective, approach may be most comfortable for some Native clients because their experience in medical and spiritual healing prepares them for directive approaches. Again, acculturation must be considered.
- Group work, especially when it is consistent with the culture and values of Native people, may be the most effective treatment, especially for Native children because of the interdependent nature of Native communities.

Oppression and Racism as Mental Health Issues

The history of American Indian people includes the invasion of European immigrants, loss of the war effort to keep their land, forced removal of Native people of the eastern United States to the Oklahoma area, confinement of Native people to reservations, decimation of the population by diseases such as smallpox, disruption of Native culture by constant fighting and moving, religious persecution, and introduction of alcohol. In the early 1800s, the policy of the U.S. government was to kill or remove Native people from their historic homelands in the eastern United States to accommodate the growing need for land by European settlers. The Native people were cheated, tricked, and forced to move, and many died of cold, disease, and starvation during these moves. This Indian removal effort is known to Natives as the "trails of tears" because of the deep sorrow experienced by the Native people who lost their land and loved ones. During this 400-year period in their history, numerous Native people died, and traditional Native culture was severely disrupted. The 1900s were a period of recovery, with tribes seeking to maintain their traditional ways under the constant pressure of acculturation stressors and the need to survive and thrive in the "modern" world.

Two major cultural genocide efforts further disrupted and complicated the recovery of Native people during the 1900s, Indian boarding schools and the Indian Relocation Program. The boarding schools were a forced education and Christianizing effort by the U.S. government and various churches to change the "heathen" and uneducated Native people into "civilized" and Christian citizens. Children were forcibly taken from their homes and placed in government or church boarding schools, their hair was cut, they were put in uniforms, beaten if caught speaking their language or practicing their own ways, and they were not allowed visits from their families or visits to their homes. An entire generation of Native people was subjected to this treatment, and the extent and severity of the abuse suffered by these children is still being uncovered and still affecting their offspring.

The effects of the boarding schools have been far reaching and intergenerational in their impact on American Indian people. The generation of Native people who were subjected to this atrocity experienced a loss of their culture and a loss of the opportunity to learn parenting skills. Because of the severe physical and sexual abuse perpetrated upon these unprotected and captive Native children, as adults, they have experienced depression, anxiety, and post-traumatic stress disorder, as well as some of them becoming perpetrators of abuse themselves. In addition, many of these Native people turned to drugs and alcohol to cope with the pain they were experiencing.

The Indian Relocation Program was part of an effort in the 1960s to do away with American Indian reservations. Native people on the reservation were offered travel assistance and funding support to leave the reservations and move to large cities (Los Angeles, Chicago, Denver, and others) to find a job and settle there. These large cities still have large populations of American Indian people who have remained there and are now "urban Indians" as opposed to "reservation Indians." The effect of the Indian Relocation Program was not to abolish reservations but to create Indian ghettos in large cities and to further disrupt the culture. Many of these Native people became "marginalized,"

meaning that they no longer fit into their own cultural group nor were they part of the majority population. Thus, they were, basically, without a culture. Their children grew up distanced from their extended family and their culture, perhaps visiting only during the summers and likely not speaking their native language, while simultaneously experiencing discrimination from the majority culture.

Implications for Culturally Competent Treatment

- Many Native people hold a deep mistrust of White people and of the U.S. government. The mistrust is often reflected in the therapeutic relationship.
- Many Native people hold a deep resentment for the treatment that Native people have experienced over the past 500 years; and many are still grieving the losses they and their people have experienced.
- Mental health providers need to be aware that if this suspicion and resentment exists for a Native client, it is grounded in reality. Acceptance of their worldview and the reality of the client's experience is critical.

Delivery of Culturally Competent Care for American Indians

In summary, the following broad guidelines should be used to develop culturally competent care for American Indians.

- The American Indian population is extremely diverse. Mental health practitioners who lack culturally specific knowledge and skills need to consult with professionals who do possess such understanding.
- Providers of mental health services need to be aware of the effects of collectivistic cultures on human development and how that effect differs from human development in individualistic cultures.
- Mental health providers also need to be aware of the effects of intergenerational trauma on individuals and on communities. The symptoms of intergenerational trauma can easily be misconstrued as psychopathology, thereby leading to misdiagnosis and a faulty treatment plan.
- In the delivery of culturally competent care for American Indian people, mental health providers must know that Natives differ along a continuum of acculturation and ascription to any given value of their tribes or bands. No two Indians are alike, no two tribes or bands or family members are alike. So, providers must ignore anything that they have ever read about American Indians and get to know the persons sitting in front of them.

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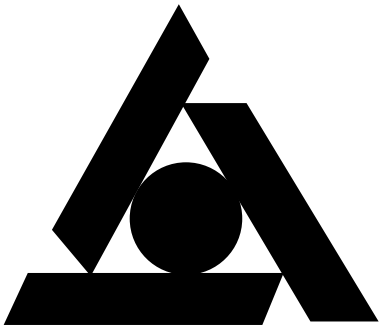

ASIAN AMERICAN PSYCHOLOGICAL ASSOCIATION

The Asian American Psychological Association (AAPA) was founded in 1972 by Asian mental health professionals in California. AAPA seeks to (1) advance the welfare of Asian Americans by encouraging, assisting, and advocating research on and service to Asian Americans; (2) develop and apply theories of Asian American psychology, mental health, and cross-cultural competence; (3) conduct meetings, issue publications and other educational materials, and inform others of socio-psychological issues facing Asian Americans; and (4) perform other activities to further the advancement of Asian Americans in today's society.

AAPA's purpose is to:

1. Enhance the welfare of the Asian American community through the application and development of psychological theory and practice.
2. Advance psychology as a science.
3. Strengthen the repertoire of skills for those engaging in Asian American psychological research, teaching, clinical service, policy and theory.
4. Foster professional relationships among psychologists with interests in Asian American psychology.

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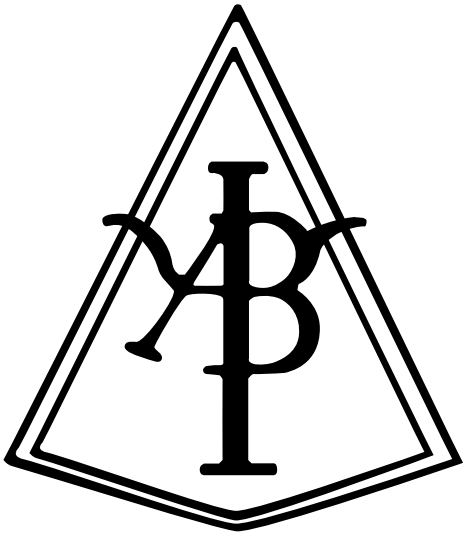

THE ASSOCIATION OF BLACK PSYCHOLOGISTS

The Association of Black Psychologists was organized in September 1968 in San Francisco when a group of Black Psychologists from across the nation decided to form an organization that would:

- Promote and advance the profession of African Psychology
- Influence and affect social change
- Develop programs whereby psychologists of African descent can assist in solving problems of Black communities and other ethnic groups.

Guided by the principle of self- determination, these psychologists set about building an institution through which they could address the long neglected needs of the Black psychologists and the larger community. Their goal was to have a positive impact upon the mental health of the national Black community by means of development and implementation of programs, services, training and advocacy.

The Association has expanded to an international professional organization whose mission and commitment is to advancing psychology as a science and profession. These accomplishments are reflected in its 25 + year history of publishing the *Journal of Black Psychology* and its on-going, active involvement in promoting an improved understanding of humanity. The Association has been in the forefront of exploring and analyzing the interdependence of various institutions within society (e.g., family, educational, legal, religious, and political), their effect on persons of African descent, and the relationships between those institutions and the social realities they foster. The Association's commitment to supporting human strength and resilience is reflected in the following goals:

1. Enhance the psychological well-being of Black people in America and throughout the world.
2. Promote constructive understanding of Black people through positive approaches to research.
3. Develop an approach to psychology that is consistent with the experience of Black people.
4. Define mental health in consonance with newly established psychological concepts and standards regarding Black people.
5. Develop internal support systems for Black psychologists and students of psychology.
6. Develop policies for local, state and national decision-making which impact on the mental health of the Black community.
7. Promote values and a life style that supports our survival and well-being as a race.
8. Support established Black organizations and aid in the development of new independent Black institutions to enhance the psychological, educational, cultural and economic milieu.

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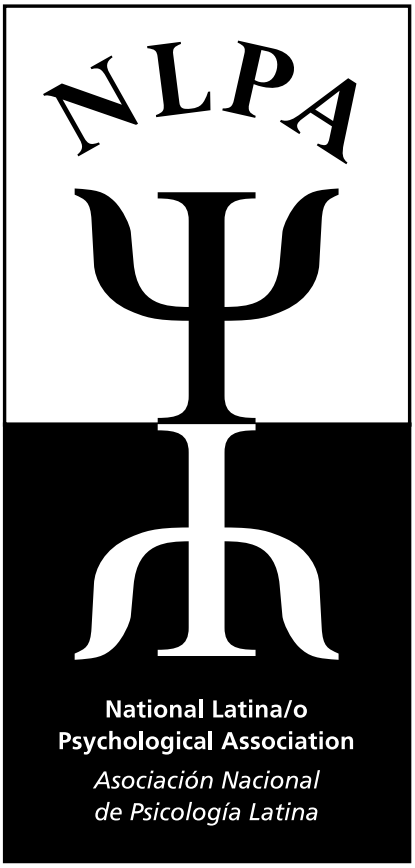

THE NATIONAL LATINA/O PSYCHOLOGICAL ASSOCIATION

At a conference of Hispanic psychologists convened at Lake Arrowhead, California in November 1979, jointly sponsored by the Spanish Speaking Mental Health Research Center and the National Institute of Mental Health, it was agreed by those present to constitute the National Hispanic Psychological Association. The by-laws of the association state that its purpose is to:

1. Promote the development and understanding of psychology from the perspective of Hispanic culture, to generate and advance scientific psychological knowledge and foster its effective application for the benefit of the Hispanic populations.
2. Promote training programs that prepare Hispanic psychologists and facilitate cooperation among them.
3. Increase the number of Hispanic psychologists.
4. Promote and support the work of Hispanic psychologists and facilitate cooperation among them.
5. Influence institutional policy at the national, regional, state and local levels for the benefit of Hispanics.
6. Promote open communication with members of Hispanic communities at all levels for our mutual education.

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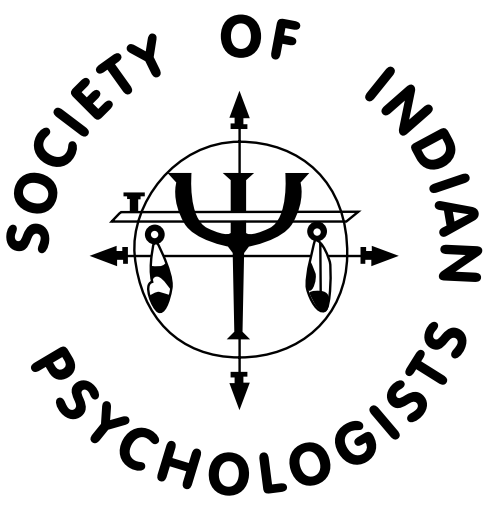

THE SOCIETY OF INDIAN PSYCHOLOGISTS

The aims and purposes of the Society of Indian Psychologists (SIP) includes but are not limited to the operation of a national body organized for non-profit, charitable, and professional purposes; to provide an organization for Indian and Native people who are vitally concerned with improving the mental well-being of their people; to create, through an exchange of skill, expertise and experiences, opportunities for career development, positive inter- and intra-personal relationships, and general personal enhancement of Indian and Native peoples; to encourage all Indian and Native people to become involved in improving the quality of their lives.

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