CHAPTER 4

Impact of Race, Ethnicity, and Culture on the Expression and Assessment of Psychopathology

L. KEVIN CHAPMAN, RYAN C. T. DELAPP, and MONNICA T. WILLIAMS

THIS CHAPTER PROVIDES an overview and framework for understanding race, ethnicity, and culture as factors that affect adult psychopathology. Of primary interest are the assessment and treatment of psychopathology that integrates culturally salient values, ideologies, and behaviors into the mental health care of ethnic minorities. Moreover, the chapter is organized into two sections. In the first section, we present a model that highlights relevant multicultural factors that should be considered when working with ethnic minorities. The second section provides a discussion of how to effectively apply the knowledge of these multicultural factors when assessing or treating individuals with diverse ethnic backgrounds. Ultimately, the main objective of this chapter is to encourage mental health professionals to acknowledge the impact of race, ethnicity, and culture on adult psychopathology in order to optimize the efficaciousness of mental health services provided to ethnic minority individuals.

Existing literature has clearly demonstrated the importance of multicultural competency in the assessment and treatment of ethnic minorities. Particularly, the relevance of ethnicity (or "a voluntaristic self-identification with a group culture, identified in terms of language, religion, marriage patterns and real or imaginary origins"; Bradby, 2012, p. 955) in adult psychopathology has been substantiated by evidence identifying disparities in prevalence rates, symptom presentation, and severity, as well as mental health service utilization across diverse ethnic groups. For example, Himle et al. (2009) found that most anxiety disorders (with the exception of PTSD) were more prevalent among non-Hispanic Whites in comparison to African Americans and Caribbean Blacks. However, despite their lower prevalence rates, researchers reported that African Americans and Caribbean Blacks experienced anxiety disorders that were greater in severity and more functionally impairing, which demonstrates how experiences with mental illness can vary by ethnicity.

Moreover, ethnicity has been implicated as a differentiating factor in the diagnosis and treatment of schizophrenia (Fabrega et al., 1994; Gara et al., 2012).

These studies highlight the susceptibility of misdiagnosed schizophrenia in African American patients due to the tendency for African Americans to endorse more psychotic symptoms during diagnostic assessments. As a result, Gara and colleagues (2012) emphasize the importance of culturally sensitive diagnostic assessment tools by explaining how an inability to effectively discriminate schizophrenia and schizoaffective disorders can lead to poor treatment outcomes. Additionally, the relevance of ethnicity in adult psychopathology is bolstered by the findings of Alegría and colleagues (2007), who used data from the National Latino and Asian Study (NLAAS) to identify factors that influence the treatment seeking behaviors of Latino individuals. Specifically, researchers found that the age of migration, Latino ethnicity (e.g., Mexican, Puerto Rican), birth origin (e.g., U.S.-born, foreign-born), primary language spoken, and years of residency in the United States were all influential factors in the use of mental health services and the satisfaction with care received. Most notably, these findings highlight the impact of varied immigration statuses on the perspectives that ethnic minority individuals bring to the mental health arena. Overall, the aforementioned studies clearly underscore the need for multicultural competency in mental health professionals given that one's self-identification with an ethnic heritage has proven to be a vital differentiating factor in the presentation of symptoms and treatment outcomes across diverse adult samples.

RELEVANCE OF ETHNIC IDENTITY AND ACCULTURATION IN ADULT PSYCHOPATHOLOGY

An understanding of the interaction between multicultural factors (e.g., ethnic identity, acculturation) and sociocultural factors (e.g., socioeconomic status, life stress) in ethnic minority patients has become undeniably germane to providing these individuals with effective mental health care. Prior to learning "how" to integrate the understanding of this interaction within assessment, diagnostic, and treatment practices, mental health professionals must possess the knowledge of "what" multicultural factors exist. Accordingly, Carter, Sbrocco, and Carter (1996) have proposed a theoretical model that acknowledges the role of ethnicity, or a "shared culture and lifestyle," as a pivotal underlying construct in the epidemiology, symptom expression, and treatment of psychopathology in ethnic minority individuals (p. 456). Though initially created to explain variations of anxiety disorders in African Americans, the Carter et al. (1996) model can be utilized to more broadly understand the relationship between ethnicity and adult psychopathology by comprehending the salience of ethnic identity and acculturation in all ethnic minorities.

In particular, ethnic identity is a multifarious construct characterized by how people develop and maintain a sense of belonging to their ethnic heritage (Roberts et al., 1999). Important factors influencing a person's ethnic identity include whether they personally identify as a member of an ethnic group, their sentiments and evaluations of the ethnic group, their self-perception of their group membership, their knowledge and commitment to the group, and their ethnic-related behaviors and practices (Burnett-Zeigler, Bohnert, & Ilgen, 2013). Extant literature has provided several models explaining the developmental stages of ethnic identity (Cross, 1978;

Cross & Vandiver, 2001; Phinney, 1989). Collectively, each model describes identity shifts between ethnic ambivalence (lack of interest or pride in one's ethnic background), ethnic exploration (curiosity in one's ethnic background potentially accompanied by a devaluing of other ethnic heritages), and multicultural acceptance (integration of one's commitment to their ethnic background and an appreciation for other ethnic heritages). Evidence supports that individuals high in ethnic identity (i.e., closer to multicultural acceptance) typically have higher levels of self-esteem, develop more protective coping mechanisms, experience more optimism, and report fewer psychological symptoms (Roberts et al., 1999; Smith, Walker, Fields, Brookins, & Seay, 1999; McMahon & Watts, 2002). Notably, Williams, Chapman, Wong, and Turkheimer (2012) compared the relationship between ethnic identity and the psychological symptoms of African American and European American adult samples. Researchers found that higher levels of ethnic identity were related to lower depressive and anxious symptoms in African Americans yet associated with a slight elevation in anxious symptoms for European Americans. Such findings illustrate the protective nature of a strong ethnic identity for minority members. However, some studies suggest that individuals with a strong sense of belonging to their native heritage can amplify the impact of culturally specific stressors (e.g., discrimination; social inequalities), thereby enhancing their focus on their difference from majority culture (Yip, Gee, & Takeuchi, 2008). Past literature has found that the stage of ethnic identity development, age, and level of perceived stress can attenuate the buffering influence of high ethnic identity (see review by Burnett-Zeigler et al., 2013).

Another relevant construct implicated in the Carter et al. (1996) model is acculturation, traditionally defined as the extent to which ethnic minorities adopt the values and participate in the traditional activities of mainstream culture. Recent reconceptualizations of the acculturation process utilize a multidimensional perspective where ethnic minorities must reconcile discrepancies in one's identities (the salience of one's ethnic versus national identity), one's value system (individualism versus collectivism), one's language proficiency, one's cultural attitudes and knowledge, as well as one's cultural practices (Park & Rubin, 2012; Schwartz et al., 2013; Yoon et al., 2013).

According to a meta-analysis of 325 studies about the relationship between acculturation and mental health, Yoon and colleagues (2013) found that mainstream language proficiency was negatively associated with negative mental health, whereas endorsing an ethnic identity was positively related to positive mental health. Most importantly, these findings demonstrate how complex the relationship between acculturation and psychopathology can be, which emphasizes the need for mental health professionals to consider the relevance of each acculturation dimension (e.g., identity, language, value system, behaviors) when working with ethnic minorities. Furthermore, the acculturative stress of integrating disparities in ethnic and mainstream culture across these dimensions can result in difficulties adapting to mainstream culture and/or perceived rejection from one's native heritage (Schwartz et al., 2013), which has been associated with psychopathology in ethnic minority adults (e.g., more eating-disorder symptoms [Van Diest, Tartakovsky, Stachon, Pettit, & Perez, 2013]; greater levels of depression [Driscoll & Torres, 2013; Park & Rubin, 2012]). When confronted with such cultural disparities, extant literature has identified biculturalism, or the ability for ethnic minorities to effectively integrate elements of

two cultural streams, as one of the most protective acculturation statuses against negative health outcomes (Schwartz et al., 2013).

Alternative acculturative statuses include strongly adhering to the mainstream culture and devaluing native heritage (assimilation), strongly adhering to the native heritage and devaluing the mainstream culture (separation), and exhibiting little interest in adhering to either cultural stream (marginalization; see Matsunaga, Hecht, Elek, & Ndiaye, 2010; Yoon et al., 2013). Overall, existing literature has yielded inconclusive findings clarifying the impact of acculturation on the mental health of ethnic minorities (see Concepcion, Kohatsu, & Yeh, 2013), which has been accredited to the multiple definitions of acculturation (e.g., time since immigration, language fluency, acculturation status) and examining this construct in few ethnic minority groups (Burnett-Zeigler et al., 2013; Yoon et al., 2013).

Aside from having knowledge of ethnic identity and acculturation, mental health professionals must also understand how these constructs interact to influence the psychopathology expressed in many ethnic minority individuals (Yoon et al., 2013). In referencing the Carter et al. (1996) model, African Americans who maintain a strong ethnic identity and are highly assimilated in the dominant culture are believed to endorse traditional beliefs of mainstream society (e.g., individualism) and exhibit symptoms presentations consistent with the current diagnostic nomenclature. Notably, it is theorized that these individuals may feel conflicted by being acculturated to believe psychological treatment is effective while embodying a mistrust of societal systems in mainstream culture as a result of historically significant cultural experiences (e.g., perceived discrimination from individuals of the dominant culture). Similarly, Carter et al. (1996) conceptualized that African Americans low in ethnic identity yet highly assimilated will exhibit a traditional symptom presentation, but be more willing to seek, persist through, and benefit from traditional treatment practices. In contrast, individuals high in ethnic identity who strongly de-identify with mainstream culture (separation acculturation status) represent a subset of ethnic minorities who may display unique symptom presentations and utilize culturally specific explanations for their symptoms, thereby resulting in a greater likelihood for misdiagnosed psychopathology. Further, these individuals are theorized to be less likely to seek treatment due to mistrust in and/or a limited knowledge of mental health care.

Although there is a dearth of literature devoted to examining the additive impact of ethnic identity and acculturation on adult psychopathology (Chae & Foley, 2010), several studies provide evidence supporting the broad application of the Carter et al. (1996) model across diverse ethnic minority groups. Burnett-Zeigler et al. (2013) examined the relationship between ethnic identity, acculturation, and the lifetime prevalence of mental illness and substance use in African American, Latino, and Asian samples. Results indicated that higher levels of ethnic identity, and not higher acculturation, were related to decreased lifetime prevalence of psychiatric illness and substance use for each minority group. Notably, higher acculturation (e.g., use of English language or social preference for individuals not in ethnic group) was associated with increased prevalence of depression in African Americans and Hispanics, increased bipolar diagnoses in Hispanics, and increased anxiety disorder diagnoses for all minority groups. Regarding substance use, higher acculturation was related to increased lifetime prevalence of alcohol and drug use among the Hispanic and Asian sample. These findings suggest that having a strong sense of pride and

belonging to an ethnic heritage is protective; however, nondominant individuals who are unable to maintain cultural ties with their native heritage (e.g., first language, relationships with members of ethnic group) may be more susceptible to negative health outcomes.

Nascent literature has provided a more specific understanding of the interaction between these two constructs by utilizing acculturation statuses (e.g., integration, assimilation, separation) instead of a broad definition of acculturation (e.g., English literacy; time of residency). In particular, Matsunga and colleagues examined the interaction between ethnic identity and acculturation status in Mexican-heritage adolescents living in the southwest region of the United States and found that an integration acculturation status was more prevalent than assimilation as well as more predictive of a strong ethnic identification (Matsunaga et al., 2010), which suggests that a strong ethnic identity and a successful integration of two cultures are closely associated. Furthermore, Chae and Foley (2010) found that high ethnic identity strongly predicted positive psychological well-being among Chinese, Japanese, and Korean Americans whereas an assimilation acculturation status predicted poorer psychological well-being among Korean Americans. Also, researchers found that Asian Americans with an integration acculturation status experienced significantly higher psychological well-being compared to other acculturation statuses. Most importantly, these findings suggest that ethnic minorities who maintain a strong sense of belonging to their ethnic heritage (high ethnic identity) and who have successfully integrated the identities, value systems, and cultural practices of their native and mainstream heritages (integration) exhibit fewer clinical symptoms and more life satisfaction.

RELEVANCE OF SOCIOCULTURAL FACTORS IN ADULT PSYCHOPATHOLOGY

Though an understanding of the aforementioned constructs is essential, it is equally important to examine the impact of other sociocultural variables that also exert a considerable degree of influence over the symptom presentation and treatment outcomes of ethnic minorities. Although extant literature has identified a myriad of variables that impact minority mental health, the current chapter solely focuses on socioeconomic status (SES), stressful life events, and age cohort, which were each identified by the Carter et al. (1996) model as important contributors to the mental health of ethnic minorities.

Researchers propose that SES can provide a more precise understanding of the relationship between ethnicity and adult psychopathology by focusing on the specific environmental elements that characterize each social class. Past literature has shown that high SES is related to better health outcomes. One study by Shen and Takeuchi (2001) examining the relationship between acculturation, SES, and depression in Chinese Americans found that SES was a better indicator of depressive symptoms than acculturation and that high SES individuals (i.e., high educational attainment and increased income) were related to better mental health outcome (i.e., fewer depressive symptoms) compared to low SES individuals. These findings suggest that it is through the variance in SES and related variables (e.g., perceptions of stress, social support, and physical health) that acculturation may impact the mental health

of nondominant individuals (Shen & Takeuchi, 2001). Contrarily, nascent literature has begun to propose that the association between social class and mental health is much more complex in that evidence has supported that low SES and/or foreign-born individuals are not automatically guaranteed poor health outcomes (John, de Castro, Martin, Duran, & Takeuchi, 2012). Given such findings, it suggests that mental health professionals should acknowledge the detrimental as well as the protective elements of one's social class.

Also, the Carter et al. (1996) model identifies stressful life events as a contributor to the variability in the psychopathology of ethnic minorities. Though a comprehensive understanding of the multiple forms of stress (e.g., violence exposures, neighborhood context, poverty, etc.) is beyond the scope of this chapter, extant literature pinpoints race/ethnic-based stress as influential to the mental health of ethnic minority individuals. In particular, Greer (2011) describes racism as "complex systems of privilege and power, which ultimately serve to threaten and/or exclude racial and ethnic minorities from access to societal resources and other civil liberties" (p. 215). As a result of such racial/ethnic injustice, many ethnic minorities are subjected to damaging race/ethnic-focused attitudinal appraisals (i.e., prejudice), race/ethnic-focused assumptions (i.e., stereotypes), and unjust treatment based upon their race/ethnicity (Greer, 2011).

Past studies have indicated that exposure to such race/ethnic-based experiences are strong indicators of mental health outcomes across diverse ethnic minority groups (e.g., discrimination was related to increased lifetime prevalence of generalized anxiety disorder in African Americans [Soto, Dawson-Andoh, & BeLue, 2011]; perceived discrimination was associated with increased anxiety, affective, substance abuse disorders among African Americans, Hispanic Americans, and Asian Americans [Chou, Asnaani, & Hofmann, 2012]). Notably, empirical evidence suggests that perceived discrimination may be particularly salient to African American clients, given that several studies have found African Americans to endorse greater degrees of perceived discrimination in comparison to other ethnic minority groups in the United States (Cokley, Hall-Clark, & Hicks, 2011; Donovan, Huynh, Park, Kim, Lee, & Robertson, 2013). Overall, when utilizing ethnic identity and acculturation to gain insight into the culturally specific worldviews of nondominant individuals, it is imperative that mental health professionals also examine the occurrence and impact of race/ethnic-based stressors on the psychopathology of ethnic minorities.

Finally, the Carter et al. (1996) model discusses the relevance of age cohort in the manifestation of psychopathology in ethnic minorities. The evolution of the "social, economic, and political climate" in the United States has yielded diverse experiences across generations of ethnic minorities in this country, thereby impacting the meaning of ethnicity for each generation (Carter et al., 1996, p. 460). In the context of each ethnic group, there are different historical details separating each generation; however, the impact of age cohort on psychopathology remains a relevant consideration. In general, existing literature has implicated intergenerational disparities in perceived racial discrimination (Yip et al., 2008), ethnic identity (Yip et al., 2008), acculturation status (Buscemi, Williams, Tappen, & Blais, 2012), and lifetime prevalence of psychiatric illness (Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, & Kessler, 2006) across the adult lifespan. One study particularly relevant to this chapter's discussion of the Carter et al. (1996) model examined the protective and/or exacerbating nature of

ethnic identity in the relationship between racial discrimination and psychological distress in Asian adults (Yip et al., 2008). Results indicated that ethnic identity appeared to buffer the negative impact of racial discrimination on the psychological distress for adults ages 41 to 50 yet exacerbate the effects of racial discrimination for adults ages 31 to 40 and 51 and older. In an attempt to explain these findings, Yip and colleagues (2008) theorize that the former age cohort is more likely to have a stable lifestyle with more coping mechanisms for stress, whereas the latter age cohorts may characterize adults who are in the exploration phase of their ethnic identity, which, therefore, heightens their sensitivity to being unfairly treated on the basis of their race/ethnicity. Furthermore, the parent-child relationship is another important way that intergenerational differences can impact adult psychopathology, especially for immigrant families (Kim, 2011; Vu & Rook, 2012).

In a study examining intergenerational acculturation conflict and depressive symptoms among Korean American parents, Kim (2011) found that greater discrepancies in cultural values between parent and child (greater intergenerational conflict) was related to increased parental depressive symptoms; an association more pronounced in mothers compared to fathers. It was proposed that the cultural expectations of the Korean mother (e.g., to be a "wise and benevolent" primary care giver) was conflicted by an incongruence with the value system of mainstream culture (Kim, 2011, p. 691). Collectively, such findings provide evidence that the Carter et al. (1996) model elucidates culturally specific considerations for psychological distress among diverse ethnic minorities.

SECTION 2: APPLICATION OF MULTICULTURAL FACTORS

Prior to addressing how the aforementioned factors can be applied to enhance the efficiency and effectiveness of treatment in ethnic minority patients, it is equally important to understand how culture, race, and ethnicity impact the evaluation of psychopathology within such populations. In the following section, the pertinence of validating assessment tools among ethnic minority groups is discussed. In particular, there is a general overview of common statistical methods used to establish measurement equivalence across diverse groups as well as important considerations when translating the results of such statistical methods to the in vivo assessment of ethnic minority clients.

Assessment

Historically, there has been a ubiquitous disconnect between investigating various facets of theoretical models that are endemic to ethnic minority populations, and the subsequent application of these constructs in practice. As mentioned earlier, there are a number of unique, culturally specific factors that undoubtedly influence the manifestation (and subsequent treatment) of various forms of psychopathology. There is a substantive literature underscoring the exigency for conducting translational research in ethnic minority populations that are beyond the scope of this chapter (for a review, see Hofmann & Parron, 1996; Nagayama Hall, 2001). Worth noting, however, are two relatively salient implications from the empirical literature. First, the need for culturally sensitive assessment tools that aid in the diagnosis of psychopathology in

ethnic minority individuals. Second, the need for investigators to delineate ingredients for culturally sensitive interventions, presumably as a result of uncovering culturally specific factors through rigorous assessment in ethnic-minority populations.

As noted in the previous edition of this chapter, establishing measurement equivalence (or lack thereof) is paramount before proceeding with effective translational research, particularly as it relates to ethnic minority populations. In the previous edition, the authors described (a) linguistic/translation equivalence (accuracy of translation/understanding from the perspective of the ethnic minority individual), (b) conceptual equivalence (whether the underlying construct maintains the same meaning in ethnic minority individuals as in European Americans), and (c) psychometric equivalence (whether the construct is measured the same across groups). Given that the previous edition provided readers with a thorough overview of the various components of measurement equivalence, the scope of the current chapter is to highlight more recent work in the area of measurement equivalence with the aim of delineating potential "ingredients" for culturally sensitive assessment tools in ethnic minority populations. Only a brief summary is provided in this edition.

The most important prerequisite to assessment with ethnic minority populations is taking a multicultural perspective rather than an ethnocentric one. In short, multiculturalism refers to the recognition of equality of various cultural groups and the right of individuals to follow their own specified paths (Shiraev & Levy, 2013). Ethnocentrism, on the other hand, refers to a cognitive bias that supports "judgment about other ethnic, national and cultural groups from the observer's perspective" (Shiraev & Levy, 2013, p. 19). Along these lines, when considering linguistic translation equivalence, one point worth noting is that evaluators must remain cognizant of the cognitive biases that we all possess and subsequently acknowledge that our literacy is culturally based (Shiraev & Levy, 2013).

Although many concepts translate naturally across cultures (e.g., numbers), scientists and practitioners need to be increasingly mindful of the interplay between culture, race, and ethnicity during *all* types of assessment. As previously noted, differences in racial identity, age, participation in acculturation experiences, and environment could significantly impact how many ethnic minority individuals respond to questions on a particular measure. Generally agreed upon standards have been established when language differences exist, particularly as it relates to forward and backward translation (e.g., Butcher, 1996). Appropriately trained, bilingual administrators are critically important when establishing linguistic translation equivalence.

More recently, significant strides have been made in the realm of conceptual and psychometric equivalence across racial and ethnic minority groups. Beyond basic theory, the question of conceptual equivalence can most accurately be investigated by determining psychometric equivalence. As such, it should be noted that the lack of either conceptual or psychometric equivalence neither precludes the elimination of an assessment tool nor suggests that the measure is not useful with a given ethnic minority population. Depending on the properties of the given measure, results of statistical analyses may suggest the necessity to modify the assessment tool into a more effective screener as a precursor for further diagnostic assessment (detailed later). Nonetheless, psychometric equivalence is arguably the most important standard to establish in order to fully understand how to proceed with assessment and subsequent treatment geared toward ethnic minority individuals.

Before proceeding, it is important to reemphasize the importance of heterogeneity in ethnic minority individuals and the relative differences in racial identity, acculturation, and the other previously described sociocultural constructs that influence the assessment experience. Historically, the exception during assessment has been to be mindful of cultural heterogeneity prior to assessment when, in fact, the understanding of this heterogeneity is most accurately described as the rule. Moreover, we are reemphasizing the importance of assessing relevant sociocultural variables as a preamble to the discussion of a very promising area of investigation in ethnic minority assessment and treatment, specifically, factor pattern analyses with certain measures.

Factor Pattern Investigations in Ethnic Minorities

Perhaps the most promising investigations in this area are the nascent, factor analytic studies that examine factor patterns across racial and ethnic minority groups, particularly in the realm of anxiety and related disorders. The majority of these investigations have utilized structural equation modeling (SEM), a comprehensive yet flexible approach that allows the investigator to examine various relationships among variables while controlling for measurement error (see Bentler, 1990; Hu & Bentler, 1999). The ability of an investigator to control for measurement area when examining measurement equivalence while simultaneously examining various components of the general linear model makes this approach very attractive over traditional analytic methods.

Many investigators interested in the assessment and treatment of ethnic minority individuals have employed SEM in order to determine whether commonly used assessment tools are equivalent (or contain invariant factor patterns) across European American individuals (the majority in the United States) and ethnic minority individuals. The most commonly used method for making this determination is one facet of the SEM, confirmatory factor analysis (CFA) also referred to as the "measurement model" (Hoyle & Smith, 1994). In other words, does the construct that is purportedly measured by "X" tool in European Americans yield the same results in a specific ethnic minority population? Several studies have yielded promising results related to psychometric equivalence for various tools in the anxiety disorders literature for use with ethnic minority populations. For instance, Chapman, Petrie, and Vines (2012) found that the factor structure of the Symptom Checklist 90–Revised (SCL-90-R), a commonly utilized measure of psychological distress, was equivalent in a sample of African American females. These results suggest that the SCL-90-R in its current form has established empirical support for utilization in a community sample of African American females.

Other studies have examined measurement equivalence using similar methodology with disparate findings when utilizing different measures. As mentioned earlier, factor *variance* does not preclude the elimination of a measure; rather it may suggest the need for a *modified* version of the measure. For instance, Melka and colleagues (Melka, Lancaster, Adams, Howarth, & Rodriguez, 2010) examined the Fear of Negative Evaluation Scale (FNE) and the Social Avoidance and Distress Scale (SAD) in a sample of non-Hispanic White and African American young adults and found that several items on both measures needed to be omitted for the African American sample. Similarly, Chapman, Williams, Mast, and Woodruff-Borden (2009)

investigated the original and other extant factor structures of the Beck Anxiety Inventory (BAI), arguably the most widely used self-report measure for anxiety symptoms in general, in a sample of African American and non-Hispanic White adults. Results revealed that the original factor structure was not equivalent in the African American sample and that a 19-item version of the BAI best fit the African American sample (Chapman et al., 2009). Similar results have been obtained with other, widely utilized measures of family functioning (Family Assessment Device; Chapman & Woodruff-Borden, 2009), specific phobias (Chapman, Kertz, Zurlage, & Woodruff-Borden, 2008; Chapman, Vines, & Petrie, 2011), and perceived control over anxiety (Chapman, Kertz, & Woodruff-Borden, 2009), further underscoring the importance of understanding cultural factors related to assessment in ethnic minority individuals.

Clinical Utility Assessment in Ethnic Minorities

In attempts to further understand which assessment tools have adequate clinical utility in ethnic minority samples, other investigators have employed statistical techniques aimed at predicting the presence of psychopathology from screening tools. The extent to which screening tools are sensitive at predicting the presence or absence of a specific disorder, particularly in ethnic minority populations, has a number of implications for clinical work. In short, the assessment process may be streamlined through early detection of disorders, which in turn allows the clinician to spend more time in (a) building rapport with ethnic minority clients and (b) engaging in time-limited, clinical intervention. Along these lines, a receiver operating characteristic analysis (ROC) is one such method that has been heavily utilized to predict the presence of various medical conditions (e.g., diagnosing breast cancer via digital mammograms [Cole et al., 2004]; pneumonia detection [Lynch, Platt, Gouin, Larson, & Patenaude, 2004]) and psychiatric conditions (e.g., dexamethosone suppression test for predicting major depressive disorder [Mossman & Somoza, 1989]; harm avoidance scores predicting generalized anxiety disorder [Rettew, Doyle, Kwan, Stanger, & Hudziak, 2006]; predicting PTSD with PTSD Checklist in female veterans [Lang, Laffaye, Satz, Dresselhaus, & Stein, 2003]).

Although a description of a ROC analysis is beyond the scope of this chapter, worth noting is that the ROC analysis calculates an area under the curve (AUC), which determines the suitability of a given measure as a screening tool, because it reflects the likelihood that a participant who meets criteria for a diagnosis selected at random will score higher on a measure than a randomly selected control participant (see Bredemeier et al., 2010). Moreover, a ROC analysis provides optimal cut scores for specific measures in predicting the presence of particular disorders. In a more recent investigation, Petrie, Chapman, and Vines (2013) investigated the sensitivity and specificity of the Positive and Negative Affect Scales Expanded Form (PANAS-X) at detecting social anxiety disorder in a sample of African American women. Results suggest that the PANAS-X is a clinically useful measure at predicting social anxiety disorder in African American females. More specifically, a score above 11 on the Negative Affect Scale of the PANAS-X indicates further examination (e.g., a diagnostic interview) is warranted to assess the presence of social-anxiety disorder, whereas a score below 35 on the Positive Affect Scale reveals the need for further

examination to determine the presence of *any* anxiety disorder. Chapman, Petrie, and Richards (under review) yielded similar results with other measures predicting social anxiety disorder, specifically for the Social Phobia Scale (SPS; cut score of 6>), Albany Panic and Phobia Questionnaire (APPQ; score of 7>), Social Interaction Scale (SIAS; cut score of 15>), and a social "fear factor" from the Fear Survey Schedule–Second Edition (FSS-II; cut score of 7>). It should be noted that the social "fear factor" (see Chapman et al., 2008; Chapman et al., 2011) is composed of only four items.

Taken together, these results suggest that the assessment of sociocultural factors at the beginning of treatment in addition to the utilization of assessment measures that demonstrate clinical utility in ethnic minority samples (or when modification is necessary) is critically important to effective assessment. Readers are encouraged to further explore the aforementioned measures to further determine their clinical utility in ethnic minority samples.

EXPRESSION / ASSESSMENT OF PSYCHOPATHOLOGY

Aside from the administration of culturally sensitive assessment tools to aid in the accurate diagnosis of psychopathology among ethnic minority patients, extant literature has implicated cultural factors endemic to ethnic groups that may influence the expression of their symptomology. In the following section, a general overview of how factors, such as perceived discrimination and stigma of mental illness, impact various forms of symptom expression among non-Western and Western ethnic groups is presented.

Expression of Psychopathology Differs Across Cultural Groups

It is often unclear how symptom profiles may differ between ethnic groups when typical research studies use structured instruments, based on an a priori set of questions believed to exemplify the disorder under investigation (Guarnaccia, 1997). Measures based on Western notions of prototypical symptoms will fail to capture cultural differences in the expression of all disorders. Thus, variations in symptom patterns are often overlooked or misunderstood. Such misunderstandings affect how we, in turn, conceptualize even seemingly well-defined disorders.

The *DSM-5* recognizes several cultural concepts of distress, or mental disorders that are generally limited to specific cultural groups for certain dysfunctional and/or distressing behaviors, experiences, and observations (American Psychiatric Association, 2013). However, many culture-bound syndromes are likely unrecognized variations of common Western ailments. For example, susto is a Latin American folk illness attributed to having an extremely frightening experience, thought to include "soul loss" as part of the syndrome. People afflicted with susto may have symptoms that include nervousness, loss of appetite, insomnia, listlessness, despondency, involuntary muscle tics, and diarrhea. The symptoms of susto are actually quite similar to posttraumatic stress disorder (PTSD), which includes anxiety, avoidance, dissociation, jumpiness, sleep disturbances, and depression. When referring to soul loss within susto, a closer meaning to this may actually be loss of "vital force," as the soul is typically not thought to have actually left the body until death (Glazer, Baer, Weller, Garcia de Alba, & Liebowitz, 2004). This could resemble the fatigue and

anhedonia, which may be a part of depressive symptoms within PTSD. Additionally, feeling as if one's soul has been lost may be an idiom of distress for dissociation. Therefore, the concept of susto as a culture-bound syndrome may be better conceptualized as a culture-specific description of PTSD itself.

Interestingly, folk treatments for the disorder include elements of exposure-based therapies for PTSD (e.g., Williams, Cahill, & Foa, 2010). During the treatment ritual, the individual afflicted with susto must recount their terrifying experience while lying on the axis of a crucifix on the floor. Fresh herbs are swept over the afflicted individual's body while the folk healer says a series of prayers (Gillette, 2013). Sugar, water, and tea may also be used (Glazer et al., 2004). If the first session is not effective, the process is repeated every third day until the patient is recovered. This repeated recounting process is a critical active ingredient in prolonged exposure, a highly effective treatment for PTSD developed by Foa, Hembree, and Rothbaum (2007), and likely accounts for the effectiveness of the folk remedy.

Another example of the connection between *DSM* disorders and culture-bound syndromes can be seen in the enigmatic ailment called koro. Though uncommon in Western cultures, koro is characterized by anxiety over the possibility of one's genitalia receding into the body, resulting in infertility or death (Chowdhury, 1990). To prevent any envisioned shrinkage or retraction of the genitals, a koro sufferer will perform certain behaviors (i.e., pulling of genitals, spiritual rituals, securing genitals to prevent retraction) intended to reduce or eliminate this risk.

Obsessive-compulsive disorder (OCD) is characterized by distressing and typically implausible obsessions, with compulsions designed to reduce the anxiety caused by the obsessions. Davis, Steever, Terwilliger, & Williams (2012) note the possibility that koro is simply a form of OCD, as an alternative to the current classification as a culture-bound syndrome. The most salient feature of koro concerns the anxiety surrounding the retraction and shrinkage of genitalia. The degree to which this distress can impair the daily functioning of those with koro has marked similarities to the construct of obsessions in OCD. This, coupled with the improbability of one's genitalia actually receding into one's body, makes it possible to categorize this fear as an obsession.

Sexual obsessions are extremely common in OCD worldwide (Williams & Steever, in press), but these types of thoughts are considered taboo or embarrassing in most cultures. Thus, the stigma and shame attached to the experience of sexual symptoms of OCD is highly distressing (Gordon, 2002). Furthermore, Bernstein and Gaw (1990) note that sexual identity questions and conflicting feelings about sexuality are common in the experience of koro. Similarly, approximately 10% of treatment-seeking OCD patients report concerns about their sexual identity as a main concern (Williams & Farris, 2011). In OCD, these worries often manifest as fears of experiencing a change in sexual orientation, which is strikingly similar to the worries reported to underlie many cases of koro. Finally, koro has been shown to respond well to behavioral psychotherapy and medications like selective serotonin reuptake inhibitors (SSRIs; Buckle, Chuah, Fones, & Wong, 2007). These same treatments have long been the preferred method of treatment for OCD and its subtypes (e.g., NICE, 2005). Thus, koro is likely simply a cultural variant of OCD.

Although listed in *DSM-5* as a culture-bound syndrome, neurasthenia, or shenjing shuairuo, is currently a recognized mental disorder in the World Health Organization's *ICD-10* and in the Chinese Classification of Mental Disorders. Traditional

Chinese medicine describes shenjing shuairuo as a depletion of vital energy and reduced functioning in critical internal organs. The Chinese Classification of Mental Disorders considers it a mental disorder that may include weakness, emotional symptoms, excitement symptoms, tension-induced pain, and sleep disturbances. Neurasthenia has been considered a somatic illness, similar to or the same as major depressive disorder, but involving culturally sanctioned idioms of distress (Shiraev & Levy, 2013).

Likewise, there are many conditions that may be considered Western culture-bound syndromes, due to their infrequency or absence in other cultures. These may include: anorexia nervosa, adolescence, drug abuse, chronic fatigue syndrome, animal hoarding, ADHD, Munchhausen by proxy, premenstrual syndromes, dissociative identity disorder, and even Type A personality. Many maintain that all psychiatric disorders, regardless of culture, are always culturally influenced constructs. Still others assert that the *DSM* is in itself a culture-bound document and question whether it should be used at all outside its country of origin (Nadkarni & Santhouse, 2012).

Expression of Psychopathology Differs Within National Borders

It may be misleading to present cultural differences in psychopathology as an issue only applicable to those in non-Western or developing nations. The expression of psychopathology can and does differ among U.S. ethnic groups that may be considered fairly acculturated (i.e., that share a common language and national borders).

For example, African Americans have been an integral part of American life for centuries, yet notable differences in psychopathology are nonetheless evident. A recent investigation of OCD in African Americans (Williams, Elstein, Buckner, Abelson, & Himle, 2012) found obsessive-compulsive concerns in six major areas, including (1) contamination and washing, (2) hoarding, (3) sexual obsessions and reassurance, (4) aggression and mental compulsions, (5) symmetry and perfectionism, and (6) doubt and checking. These dimensions are similar to findings of studies in primarily White samples (i.e., Bloch et al., 2008). However, African Americans with OCD report more contamination symptoms and were twice as likely to report excessive concerns with animals compared to European Americans with OCD. This indicates notable cultural differences, which is consistent with findings among nonclinical samples (e.g., Thomas, Turkheimer, & Oltmanns, 2000).

Williams and Turkheimer (2007) studied racial differences in OCD symptoms and found that a nonclinical sample of African Americans scored significantly higher on an animal attitude factor than European Americans, meaning they had greater concerns about animals, and it was determined that cultural factors explained this difference. It was hypothesized that the Western perspective of animals as pets is more socially acceptable among European Americans than other cultures that are more likely to regard animals as a source of food or vehicle for labor. Other cultural differences may relate to the historic practices such as the use of dogs as a means to hunt slaves or attack protesters during the Civil Rights era. This is consistent with recent work suggesting that African Americans may experience greater phobias of animals (Chapman et al., 2008). As such, cultural differences are plausible contributing factors for increased animal sensitivity among those with OCD.

Fear of being misunderstood was also more frequently endorsed by African Americans with OCD (Williams et al., 2012). An obsessive need to be perfectly understood could be a unique finding for African Americans related to fears of appearing unintelligent, resulting in *stereotype compensation*—an intentional effort to present oneself in a counterstereotypical manner (Williams, Turkheimer, Magee, & Guterbock, 2008).

Prevalence Rates May Differ for Cultural Reasons

Prevalence rates of various disorders also may differ for cultural reasons. For example, the National Survey of American Life (NSAL) conducted a comprehensive nationwide study of African American and Caribbean Blacks. They interviewed a large number of adults ($n = 5{,}191$) and adolescents ($n = 1{,}170$) in their homes, using professionally trained, ethnically matched interviewers. Their study was the first to examine the prevalence, age of onset, and gender differences in a number of mental disorders in a nationally representative Black sample (Taylor, Caldwell, Baser, Faison, & Jackson, 2007).

Findings were consistent with previous research indicating that anorexia nervosa is rare among African Americans. In fact, not a single woman in the study met criteria for anorexia in the previous 12 months, and there were no reports at all of anorexia in Caribbean adults. These findings indicate that Black Americans are at lower risk of anorexia than their White counterparts. Likewise, a related study found that Hispanic and Asian American female adults experienced similarly low rates of anorexia nervosa (Franko, 2007). The authors of that study suggested that detection and barriers to treatment may be a factor in the lower rates, but there has been very little research focused on what cultural factors may differentially protect minorities from this disorder and yet promote it in European Americans.

Another way that culture may impact psychopathology can be found in the frequencies of specific symptoms within a disorder. For example, Chapman and colleagues (Chapman et al., 2008; Chapman et al., 2011) found that both African American college students (2008) and African American adults from the community (2011) reported more animal and social fears than their European American counterparts. These results indicate the need for further exploration of cultural factors and their impact on psychopathology.

Stigma and Somatization of Distress Across Cultures

Although there is a general tendency toward somatization across all cultures, ethnic minority individuals in the United States appear more likely to express psychological distress through bodily symptoms for two primary reasons: (1) as compared to European Americans, there is a higher level of stigma associated with mental illness and, therefore, physical symptoms are more socially acceptable, and (2) there is more holistic conceptualization of the person, and, therefore, less of a distinction between mind and body among ethnic minorities (USDHHS, 2001).

For many groups there is considerable stigma attached to being afflicted by mental illness, and thus clients from these groups may be more comfortable reporting physical symptoms over affective and cognitive symptoms. One study of African

Americans found that concerns about stigma prompted most mental health care consumers to initially avoid or delay treatment, and once in treatment, they commonly faced stigmatizing reactions from others (Alvidrez, Snowden, & Kaiser, 2008). Hunter and Schmidt (2010) developed a model that incorporates stigma, racism, and somatization into the expression of anxiety in African Americans. The emphasis on physical illnesses over mental illness in African American communities is thought to be related to physical explanations of somatic symptoms of anxiety, including attributing these to conditions like cardiovascular disease, and subsequent help seeking oriented to these explanations. In particular, anxiety disorders among African Americans are likely to include both fears related to minority status and catastrophic interpretations of somatic symptoms. They propose that these differences, because of their implications for measurement and diagnosis, can explain reduced detection of certain anxiety disorders in African Americans compared with European Americans.

Western models of health and illness often depict a fragmented representation of the person to conceptualize mental and physical processes. For example the mind and body are regarded as separate (called *dualism*), and then the mind is even further divided in many common models (e.g., psychodynamic personality model of id, ego, and superego; cognitive behavioral therapy's affective, behavioral, and cognitive components). However, many cultures do not make a distinction between the mind and body. Additionally, many cultural traditions recognize the spirit as an integral part of the person, inseparable from the mind and body (e.g., Parham, 2002). Thus, omitting this component will reduce the salience of the treatment in such clients.

Spirituality and Religion

Spirituality and religious beliefs can be the most important facets of a person's identity, thus appreciating spiritual and religious diversity is essential to multicultural competency. In North America, 97% of adults profess spiritual beliefs, and 85% of the population is Christian; of these, 65% say their beliefs are central to their lives (Shiraev & Levy, 2013). When help is sought, clients typically look for someone who shares the same values. Thus, therapists will be viewed as more credible in the community if competent in religious/spiritual issues.

Devout or orthodox members of most religious traditions tend to have negative perceptions of the mental health professions, distrust therapists, and underutilize mental health services. This is in part because traditionally the field of psychology has been hostile toward religion. Psychologists are more secular and less religious than the population at large, and therapists have tended to reject organized religious involvement; thus, there is a religiosity gap between mental health providers and the U.S. majority. As a result, building trust may be challenging when working with devout clients, and, in such cases, learning about a client's religious tradition is essential to building rapport. At the very least, it is essential for therapists to avoid interventions that conflict with normative religious beliefs. Therapists need to be able to understand individuals and their beliefs within their cultural context (Richards, Keller, & Smith, 2004).

Over the past few years, an uneasy truce has developed between psychology and religion. This is due in part to new research that shows the important role of religion in

mental health and well-being. For example, meditation and prayer are correlated with reduced blood pressure and pulse, lower endocrine activity, and lower metabolism. Religious involvement has also been shown to buffer against emotional difficulties, such as depression and anger. Thus a variety of psychological and spiritual interventions may be appropriate with religious clients, depending on the client, the nature of the problem, and the therapist's religious affiliation.

Racism and Discrimination

As previously noted, the experience of being a stigmatized ethnoracial minority is a common phenomenon across cultures, with profound implications for mental health. This includes visible minorities in the United States and Canada, as well as ethnic and cultural groups in other countries, such as Blacks in the United Kingdom, Turks in Germany, and the Dalit in India. Many studies have established a link between discrimination and mental health outcomes. In the United States, African Americans experience the most racial discrimination, followed by Asian Americans and Hispanic Americans (Chou et al., 2012). Perceived discrimination has been found to be negatively correlated with mental health, and the effects seem to be strongest (most detrimental) for Asian Americans, followed by Hispanic Americans, followed by African Americans (Cokley, Hall-Clark, & Hicks, 2011).

In addition to overall psychological distress, racism and discrimination have been associated with several specific mental health problems, including stress (Clark, Anderson, Clark, & Williams, 1999), depression (Banks & Kohn-Wood, 2007; Torres, Driscoll, & Burrow, 2010), anxiety (Hunter & Schmidt, 2010), binge drinking (Blume, Lovato, Thyken, & Denny, 2012), and PTSD (Carter, 2007; Pieterse, Todd, Neville, & Carter, 2012). A strong, positive ethnic identity has been shown to be a potential protective factor against psychopathology among minorities (e.g., Williams, Chapman, et al., 2012), except when discriminatory events are severe (Chae, Lincoln, & Jackson, 2011). Failure to understand the role of racism and discrimination limits our understanding of mental health in stigmatized people groups.

Focusing specifically on the link between racism and PTSD can help us understand how Eurocentric models may sometimes be inadequate for identifying distress in minority populations. The criteria for a PTSD diagnosis implies that a traumatizing event must be negative and uncontrollable, whereby an individual's physical well-being is threatened (American Psychiatric Association, 2000). Although this description may address many forms of ethnoracially motivated traumatic events, it does not take into account ongoing low levels of racism that can lead to a general sense of distress and uncontrollability (Carter, 2007). These experiences, though they may not be physical in nature, attack the individual's identity and force the person to re-experience traumas associated with their culture's history (Helms, Nicholas, & Green, 2010).

Previous editions of the *DSM* recognized racism as trauma only when an individual met criteria for PTSD in relation to a discrete racist event. This is problematic given that many minorities experience cumulative experiences of racism as traumatic, with a discrete event acting as "the last straw" triggering trauma reactions (Carter, 2007). Thus, current conceptualizations of trauma as a discrete horrific event may be limiting for minorities. Recent changes to the *DSM* may open the door for wider recognition of

racism-related trauma. It is now within criteria that a person can have PTSD from learning about a traumatic event involving a close friend or family member, or if a person is repeatedly exposed to details about trauma (APA, 2013). This could encompass trauma resulting from ongoing racial stressors (Malcoun, Williams, & Bahojb Nouri, in press).

Moreover, existing PTSD measures aimed at identifying an index trauma fail to include racism among listed choice response options, leaving such events to be reported as "other" or made to fit into an existing category that may not fully capture the nature of the trauma (e.g., physical assault). This can be especially problematic since minorities may be reluctant to report experiences of racism to European American therapists (Carter, 2007), who comprise the majority of mental health clinicians in the United States (U.S. Department of Labor, 2012). Minority clients also may not link current PTSD symptoms to a single experience of racism if their symptoms relate to cumulative experiences of discrimination.

Bryant-Davis and Ocampo (2005) noted the similar courses of psychopathology between rape victims and victims of racism. Similar to rape victims, race-related trauma victims may respond with dissociation or shock, which can prevent them from responding to the incident in a functional manner. Victims may then feel shame and self-blame because they were unable to respond or defend themselves, which may lead to poor self-concept or self-destructive behaviors (Bryant-Davis & Ocampo, 2005). In the same investigation, a parallel was drawn between race-related trauma victims and victims of domestic violence. In both situations, survivors may feel shame over allowing themselves to be victimized.

Language and Symptom Expression

Another influence on symptom expression is the language used by clinician and client (Diaz et al., 2009). Malgady and Constantino (1998) examined the influence of language by experimentally varying the language spoken during an assessment interview with Hispanic clinicians. They found that severity of psychopathology was found to be highest in the bilingual condition, followed by the Spanish-speaking condition, and then the English-speaking condition. There was a tendency for clinicians to rate Latino clients speaking Spanish or Spanish and English as having more severe psychopathology and as functioning less well than Latino clients speaking English only. It was not clear whether this bias was in the form of overpathologizing on the clinicians' part or whether they are more sensitive to clients' presenting symptoms when assessing in Spanish. Nevertheless, there appears to be an important effect of language on diagnosis of psychopathology.

TREATMENT ISSUES

The understanding of the role of culture, race, and ethnicity on treatment is considerably important when working with ethnic minority patients. In the following section, a discussion of how such factors can influence various domains of the treatment process (e.g., therapeutic alliance, clinical judgments, and client perspectives) is presented. It is worth noting that the following treatment considerations are not comprehensive, but rather a general overview of how acknowledging the impact

of certain cultural factors when working with ethnic minority patients can enhance the efficiency and effectiveness of treatment.

CLINICIAN AND CLIENT INTERPLAY

Many clients feel more comfortable discussing psychological problems with someone of the same ethnoracial background (e.g., Jackson et al., 2004), and they may answer questions about symptoms differently when ethnoracially matched (e.g., Williams & Turkheimer, 2007). Research shows that most people prefer to be matched to someone of the same ethnicity. Ethnic minority clients may perceive their counseling experience to be more effective when they are ethnoracially matched (Lee, Sutton, France, & Uhlemann, 1983), and European American clients may feel more comfortable with someone of the same ethnoracial group (Davis, Williams, & Chapman, 2011). Matching has been shown to strengthen the therapeutic alliance and improve retention (Flicker, Waldron, Turner, Brody, & Hops, 2008). However, cultural matching is not always possible due to a lack of availability of a clinician of the same ethnicity as the client, and it may not be desirable from the client's perspective (e.g., could be perceived as "forced segregation"; Pole, Gone, & Kulkarni, 2008). Furthermore, unmatched dyads provide an opportunity for expanded awareness and greater cross-cultural understanding in both the client and therapist. Thus cross-cultural training is essential for all clinicians (Williams, Tellawi, Wetterneck, & Chapman, in press).

Cultural traditions vary about the manner in which clinicians are regarded. Many consider therapists authority figures and will feel uncomfortable challenging or disagreeing with their clinician. For example, when a Japanese client enters a consulting room, it is common for the client to just sit very tensely in front of the therapist and calmly answer questions. Japanese clients typically want to perform ideally, and this is reflected in therapist-client relationship. Clients tell the therapist their issues, and then just wait for the therapist to analyze them. Clients expect the therapist to tell them what to do. From a Western viewpoint, this can be seen as dependent, but it is actually a way for Japanese people to show respect by giving power to those in authority. European American therapists can find it difficult to work with Japanese clients if the therapist is not aware of the power dynamics within the Japanese culture. When the Japanese utilize psychotherapy services, they generally apply Japanese methods of forming relationships, creating a hierarchical relationship between client and therapist. A Japanese client was assessed by a Western therapist without this understanding and the therapist believed the client had no sense of self, describing the client as passive, needy, and repressed. Japanese clients sometimes appear helpless and this might be misinterpreted as playing a victim role. However, from the client's view, it is considered culturally appropriate (Nipoda, 2002).

This example also illustrates how cultures differ in terms of what they consider to be the role of the therapist or healer. For example, within the Afrocentric framework, the essence of all things is spiritual. The spirit is energy and life force in each person, which constitutes a self-healing power. Thus, therapy becomes a process or vehicle in which individuals are helped to access their own self-healing power (Parham, 2002). This was illustrated in a recent study of male African American outpatients being treated for depression. Psychotherapy was viewed helpful only in that therapists helped clients to identify methods for improving their individual will and agency. For example,

psychotherapy may help one to express feelings, discuss consequences of one's actions, or understand why past events occurred or how past events impact reactions to current difficult life situations. The therapist was regarded as a vehicle for change rather than an agent of change (Casiano, McMickens, Williams, & Epperson, under review). Clients had learned to access their own self-healing power.

Role of Stereotypes, Biases, and the Clinician's Culture

Although most clinicians are now receiving some multicultural education in their training programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009), practical skills for working with members of specific minority groups are often not included. When clinicians and researchers lack the needed skills and education for effective cross-cultural interactions, they may rely on a *colorblind approach*. Colorblindness is the ideology that different ethnoracial groups should all be treated the same, without regard to cultural differences (Terwilliger, Bach, Bryan, & Williams, 2013). Minorities are often treated as if they lack characteristics that make them different from the dominant majority. Although the intent of colorblindness is to promote fairness, it often causes confusion and can paradoxically increase prejudice (e.g., Richeson & Nussbaum, 2004). When the idea of "treating everyone the same" is proposed, it is typically from the perspective of the dominant majority, implying that clients should be treated as if they were culturally European American (Terwilliger et al., 2013).

From a clinical standpoint, colorblindness could result in negative consequences for an ethnic minority client if a therapist were to suggest that the client engage in behaviors that are generally considered adaptive within European American psychological tradition but that may in fact be culturally incongruent outside of that tradition. For example, a therapist may encourage an adult client to move out of the parents' home and find his or her own apartment to assert autonomy. But in more collectivistic cultures, it may be abnormal for unmarried children to move out. Thus such an event could potentially result in a family crisis, conflict, and loss of needed emotional support. The goal, therefore, is not to treat participants as if they were European American, but as they should be treated based on the norms and customs of their particular culture. This approach, called *multiculturalism*, embraces the differences, strengths, and uniqueness of each cultural group (Terwilliger et al., 2013; Williams et al., in press).

Another issue of which clinicians must be aware concerns preconceived notions about clients based solely on ethnic group membership, or pathological stereotypes (Williams, Gooden, & Davis, 2012). These are generalizations about people used as a means of explaining and justifying differences between groups and thereby using these differences to oppress the "out-group." Social status or group position determines the content of stereotypes, and not actual personal characteristics of group members (Jost & Banaji, 1994). Groups that have fewer social and economic advantages will be stereotyped in a way that seemingly explains disparities, such as lower employment or higher illiteracy rates. Although disadvantaged group members may have greater difficulty finding a job due to in-group favoritism, discrimination, and institutional racism, the disadvantaged group member is characterized as unmotivated (could have found a job if he looked hard enough), unintelligent (not

smart enough to have that job), lazy (would rather take handouts than work), and criminal (will steal rather than work) (Williams, Gooden, & Davis, 2012).

It is important to understand that pathological stereotypes about cultural groups are unfair and inaccurate. Furthermore, all members of a society are affected by the negative social messages that espouse these stereotypes, casting disadvantaged groups in a negative light (Devine & Elliot, 1995). When we uncritically accept these negative messages, racism follows, even from professionals who mean well. This can lead to harmful, discriminatory behaviors toward clients, which may be conscious or unconscious, and overt or covert.

Perhaps the most common act of discrimination by clinicians is what is termed as the *microaggression* (Sue et al., 2007). A microaggression is a brief, everyday exchange that sends denigrating messages to a target simply because they belong to a racial minority group. Microaggressions are often unconsciously delivered in the form of slights or subtle dismissive behaviors. The target of a microaggression is often forced to ascertain whether another individual did, in fact, perpetrate a discriminatory act. This attributional ambiguity is inherently stressful and is different from an overt discriminatory act, which is more easily identified and explained. As such, the influence of racial microaggressions on stress and anxiety may lie in the uncertainty generated from such interactions (Torres et al., 2010). One study found that racial microaggressions directed against African American clients was predictive of a weaker therapeutic alliance with White therapists. This, in turn, predicted lower ratings of general competence and multicultural counseling competence, and unsurprisingly lower counseling satisfaction ratings. Racial microaggressions had a significant indirect effect on client ratings of White counselors' counseling competence through the therapeutic working alliance (Constantine, 2007).

It is important to understand that microagressions can be particularly harmful to vulnerable clients, who may already feel stigmatized and exposed even attempting therapy. Minority clients may find it difficult to respond to such remarks in counseling situations due to self-doubt and power dynamics. These problems contribute to feelings of distance from the therapist, unwillingness to disclose sensitive information, and early termination from treatment. Thus, clients may be unable to overcome the condition for which they sought help due to undesirable therapist factors. The degree of harm therapists may cause in this manner is unknown and likely underestimated (Constantine, 2007).

CULTURE AS AN INTEGRAL PART OF ASSESSMENT

Americans are socialized not to acknowledge race and ethnicity, due in part to concerns of appearing biased or racist (Gaertner & Dovidio, 2005). However, this avoidance contributes to difficulty recognizing, discussing, and adapting to cultural differences (Terwilliger et al., 2013). Many European American therapists are uncomfortable discussing race in cross-racial therapeutic dyads (Knox, Burkard Johnson, Suzuki, & Ponterotto, 2003). However, therapists actually have more success working cross-culturally when they address differences directly. Raising the issue o race early in the therapeutic relationship conveys cultural sensitivity and may address clients' concerns about a racially different counselor. When counselors communicate their own cultural background and acknowledge their client's cultural values, client

are more likely to see their counselor as credible and feel more relaxed in therapy (Owen, Tao, Leach, & Rodolfa, 2011). Culturally competent counselors are aware of how their own cultural backgrounds and experiences influence their attitudes and values surrounding psychological processes, and this recognition enables them to better access the client's needs (Delsignore, Petrova, Harper, Stowe, Mu'Min, & Middleton, 2010).

Thus, it is important that clinicians understand culture-specific differences, which can range from amount of eye contact to specific idioms of psychological distress. Mental health professionals must make culture an integral part of each assessment as it influences patterns of communication between clinician and patient and subsequent diagnostic and treatment outcomes (Alarcón et al., 2009; Williams et al., in press). There are too many different groups for any one person to have an in-depth understanding of all, so clinicians should at least receive training specific to the ethnoracial groups most commonly served, and seek additional information and consultation when confronted with clients from completely foreign cultures.

In its ongoing effort to more widely recognize cultural context, the *DSM-5* now includes a cultural formulation interview guide designed to help clinicians assess cultural factors influencing client perspectives on their symptoms and treatment options. It includes questions about client background in terms of culture, race, ethnicity, religion, and geographical origin. The interview facilitates the process for individuals to describe distress in their own words and then relate this to how others, who may not share their culture, see their difficulties. This gives the clinician a more comprehensive basis for diagnosis and care, and may be a good starting point for those clinicians working with ethnically different clients.

Mistrust of Medical Institutions and Establishment

According to the U.S. Surgeon General, "research documents that many members of minority groups fear, or feel ill at ease, with the mental health system" (NIH, 1999). African Americans have greater distrust of the medical establishment and mental health care, many believing that medical institutions hold racist attitudes (Gamble, 1993; Whaley, 2001). Negative perceptions may be rooted in historical abuses of slaves, who were often used to test and perfect medical procedures before they were attempted on Whites (Gamble, 1997).

The most well-known example of such abuses is The Tuskegee Study of Untreated Syphilis in the African American Male. This is the longest nontherapeutic experiment on human beings in medical history. Begun in 1932 by the United States Public Health Service (USPHS), the study was designed to determine the natural course of untreated syphilis in 400 African American men in Tuskegee, Alabama. The research subjects, who had syphilis when they were enrolled in the study, were matched against 200 uninfected subjects who served as controls (Heintzelman, 2003).

The subjects were recruited with misleading promises of "special free treatment," which were actually spinal taps done without anesthesia to study the neurological effects of syphilis, and they were enrolled without informed consent. The subjects were denied antibiotic therapy when it became clear in the 1940s that penicillin was an effective treatment for the disease. On several occasions, the USPHS actually interfered to prevent subjects from obtaining treatment elsewhere (Heintzelman, 2003).

In many cases, the infected subjects passed the disease to their wives and subsequently newborn babies. Over 100 people died directly from advanced syphilis. In August 1972 an investigatory panel found the study was ethically unjustified and that penicillin should have been provided. The National Research Act, passed in 1974, mandated that all federally funded proposed research with human subjects be approved by an institutional review board (IRB). By 1992, settlement payments of approximately $40,000 were made to survivors. President Clinton publicly apologized on behalf of the federal government to the handful of study survivors in April 1997 (Heintzelman, 2003).

Many African Americans see the Tuskegee Study as representative of much current medical research even today (Freimuth et al., 2001). For instance, one study examined attitudes toward biomedical research across four ethnically diverse adult samples and found that African Americans endorsed more fear of participation in research than non-Hispanic White adults, which suggests that a cultural mistrust of research remains salient among African Americans (Katz et al., 2006). Most importantly, in cases where ethnic minorities appear hesitant or distrusting of mental health care, it is important for mental health professionals to remember the historical significance of a cultural mistrust in health care systems. Cultural knowledge of institutional abuses, combined with regular experiences of racism, maintains cultural mistrust surrounding health care.

Lack of Awareness Can Result in Misdiagnosis

Evidence shows that minorities are often misdiagnosed, due to the factors described previously. These include:

- Misuse of assessment instruments that are considered to be "gold standards."
- Diagnostic criteria based on Eurocentric observations and conceptualizations, resulting in missed or misunderstood symptoms.
- Research findings based on Eurocentric diagnostic criteria, providing less helpful information about psychopathology in non-White populations.
- Lack of adequate multicultural training for clinicians, often resulting in a problematic colorblind approach.
- Pathological stereotypes about members of specific cultural groups that affect clinician judgments.
- Poor therapeutic working alliance due to lack of cultural awareness and microaggressions against clients.

These problems are not simply academic, but result in substandard care, inappropriate treatments, and premature termination from treatment. For example, research shows that African Americans and Hispanic Americans are often overdiagnosed with psychotic disorders, and underdiagnosed with mood disorders. In particular, African Americans are more often given the diagnosis of paranoid schizophrenia than European Americans with similar symptoms (Snowden & Pingitore, 2002). This could be due in part to misinterpretation by clinicians of "healthy cultural paranoia"—a defensive posture taken by African Americans when approaching a new situation that could involve racism or discrimination (Whaley, 2001). This paranoia is not completely unfounded given the reality of discrimination and racial tensions in the

United States. Additionally, African Americans are more likely to be admitted as inpatients, even after controlling for severity of illness and demographic variables (Snowden, Hastings, & Alvidrez, 2009).

For Hispanic Americans the research results are mixed. Chui (1996) finds that Hispanics receive a diagnosis of schizophrenia less often than African Americans and non-Hispanic Whites, but they more often receive diagnoses of other mental illnesses. Solomon (1992) reports that more Puerto Ricans are diagnosed schizophrenic than any other group, including other Hispanics. This could be due to the intersection of race and ethnicity as many Puerto Ricans are both Black and Hispanic. Furthermore, when minorities are diagnosed with psychotic or affective disorders the conditions are more likely to be considered chronic, rather than acute when compared to European Americans with the same diagnoses.

Likewise, assessments of dangerousness and potential for violence are overestimated for African American inpatients, in accordance with violent and criminal stereotypes (Good, 1996; Wood, Garb, Lilienfeld, & Nezworski, 2002). One result of this bias is the overmedication of Black psychiatric patients (Wood et al., 2002). This is compounded by the fact African Americans, like many other ethnic minorities, metabolize antidepressants and antipsychotic medications more slowly than Whites and may be more sensitive to the medications. This higher sensitivity is manifested in a faster and higher rate of response and more severe side effects, including delirium when treated with doses commonly used for White patients (Munoz & Hilgenberg, 2006). Thus, African Americans may exhibit poorer medication compliance, which then may be misinterpreted as resistance to treatment.

Interestingly, Hispanic Americans are less likely to be medicated at all (Hodgkin, Volpe-Vartanian, & Alegría, 2007). Aside from limited health care access among Latino populations (Perez-Escamilla, 2010), another potential explanation could be a lack of adherence to medication throughout the course of mental illness (Hodgkin et al., 2007; Colby, Wang, Chhabra, & Pérez-Escamilla, 2012). In particular, Hodgkin and colleagues (2007) utilized data from the National Latino and Asian American Study (NLAAS) and found that 18.9% of Hispanic Americans who discontinued antidepressant medication decided to do so without consulting a health professional. Researchers noted that possessing English-language proficiency, older age, being married, having insurance, and consistent visits to see a therapist were related to better antidepressant adherence in this sample.

African Americans are diagnosed less accurately than European Americans when they are suffering from depression and seen in primary care (Borowsky et al., 2000), or when they are seen for psychiatric evaluation in an emergency room (Strakowski et al., 1997). One study found that African Americans were less likely than Whites to receive an antidepressant when their depression was first diagnosed (27% versus 44%), and among those who did receive antidepressant medications, African Americans were less likely to receive the newer SSRI medications than were the White patients (Melfi, Croghan, & Hanna, 2000).

In terms of substance abuse, 15% of the general population will abuse a substance in their lifetime and 4% will abuse a substance within 12 months (Kessler et al., 2005a; Kessler et al., 2005b). Negative social stereotypes dictate that drug users are largely Black and Hispanic. Most people are surprised to learn that African American youth are significantly less likely to use tobacco, alcohol, or drugs than European Americans

or Hispanic Americans (Centers for Disease Control, 2000). In fact, African Americans spend 25% less than Whites on alcohol (U.S. Department of Labor, 2002). The National Longitudinal Alcohol Epidemiological Survey indicated that Whites were more likely to use drugs over their lifetime but Blacks were more dependent than Whites, underscoring differential access to effective treatments (Grant, 1996). Blacks and Whites tend to abuse different drugs (e.g., crack versus cocaine), and the drugs used by African Americans carry harsher penalties and are more likely to be the targets of law enforcement efforts (e.g., Beckett, Nyrop, & Pfingst, 2006). Thus, institutionalized racism may play a role in drug abuse outcomes and access to treatment.

CONCLUSIONS

This chapter represents a charge to mental health professionals to fully consider and subsequently integrate racial, ethnic, and cultural variables into inevitable work with ethnic minority individuals. The importance of such integration undoubtedly has a profound impact on several areas including but not limited to the following: assessment, expression of psychopathology, diagnostic practices, mental health disparities, treatment outcome studies, continued dearth of ethnic minorities involved in research studies, and a continued paucity of researchers and practitioners of color. Explicit acknowledgment of inherent biases that we all possess in addition to understanding the importance of incorporating cultural variables throughout *all* portions of our work with ethnic minority populations are important first steps to decreasing mental health disparities. Additionally, we continue to underscore the importance of reviewing the empirical literature as it pertains to ethnic minority populations since "all measures are *not* created equal." Moreover, there continues to be a disconnect between much of our scientific training with regard to making decisions about assessment measures, how psychopathology is expressed in many ethnic minority individuals, which often deviates from "traditional" expressions, and our subsequent implementation of treatment.

Although significant strides have been made in the more recent empirical literature endemic to ethnic minority individuals, we as mental health professionals have to be increasingly cognizant of integrating identified cultural factors throughout all facets of both our own work and in training the next generation. Ethnoracial minorities are currently 36.6% of the U.S. population, and 50.4% of all births (U.S. Census Bureau, 2011, 2012), with non-Hispanic Whites projected to be a minority in the United States by 2050 (Nagayama Hall, 2001). Thus, much of the work that we have highlighted is vitally important to our cultural competence in the 21st century.

REFERENCES

Alarcón, R. D., Becker, A. E., Lewis-Fernández, R., Like, R. C., Desai, P., Foulks, E., . . . Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry. (2009). Issues for *DSM-V*: The role of culture in diagnosis. *Journal of Nervous and Mental Disease, 197*(8), 559–560.

Alegría, M., Mulvaney-Day, N., Woo, M., Torres, M., Gao, S., & Oddo, V. (2007). Correlates of past-year mental health service use among Latinos: Results from the National Latino and Asian American study. *American Journal of Public Health, 97*(1), 76–83.

Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among Black mental health consumers. *Journal of Health Care for the Poor and Underserved, 19*(3), 874–893.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders.* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Banks, K., & Kohn-Wood, L. P. (2007). The influence of racial identity profiles on the relationship between racial discrimination and depressive symptoms. *Journal of Black Psychology, 33*(3), 331–354.

Beckett, K., Nyrop, K., & Pfingst, L. (2006). Race, drugs, and policing: Understanding disparities in drug delivery arrests. *Criminology, 44*(1), 105–137.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*(2), 238–246.

Bernstein, R. L., & Gaw, A. C. (1990). Koro: Proposed classification for DSM-IV. *American Journal of Psychiatry, 147*(12), 1670–1674.

Bloch, M. H., Landeros-Weisenberger, A., Sen, S., Dombrowski, P., Kelmendi, B., Coric, V., . . . Leckman, J. F. (2008). Association of the serotonin transporter polymorphism and obsessive-compulsive disorder: Systematic review. *American Journal of Medical Genetics Part B: Neuropsychiatric Genetics,* 147(6), 850–858.

Blume, A. W., Lovato, L. V., Thyken, B. N., & Denny, N. (2012). The relationship of microaggressions with alcohol use and anxiety among ethnic minority college students in a historically White institution. *Cultural Diversity and Ethnic Minority Psychology, 18*(1), 45–54.

Borowsky, S. J., Rubenstein, L. V., Meredith, L. S., Camp, P., Jackson-Triche, M., & Wells, K. B. (2000). Who is at risk of nondetection of mental health problems in primary care? *Journal of General Internal Medicine, 15*(6), 381–388.

Bradby, H. (2012). Race, ethnicity and health: The costs and benefits of conceptualizing racism and ethnicity. *Social Science & Medicine, 75,* 955–958.

Bredemeier, K., Spielberg, J. M., Silton, R. L., Berenbaum, H., Heller, W., & Miller, G. A. (2010). Screening for depressive disorders using the Mood and Anxiety Symptoms Questionnaire Anhedonic Depression Scale: A receiver-operating characteristic analysis. *Psychological Assessment,* 22, 702–710.

Breslau, J., Aguilar-Gaxiola, S., Kendler, K. S., Su, M., Williams, D., & Kessler, R. C. (2006). Specifying race-ethnic differences in risk for psychiatric disorder in a U.S. National Sample. *Psychological Medicine, 36*(1), 57–68.

Bryant-Davis, T., & Ocampo, C. (2005). Racist incident–based trauma. *The Counseling Psychologist, 33*(4), 479–500.

Buckle, C., Chuah, Y., Fones, C., & Wong, A. (2007). A conceptual history of koro. *Transcultural Psychiatry, 44*(1), 27–43.

Burnett-Zeigler, I., Bohnert, K. M., & Ilgen, M. A. (2013). Ethnic identity, acculturation and the prevalence of lifetime psychiatric disorders among Black, Hispanic, and Asian adults in the U.S. *Journal of Psychiatric Research, 47,* 56–63.

Buscemi, C. P., Williams, C., Tappen, R. M., & Blais, K. (2012). Acculturation and health status among Hispanic American elders. *Journal of Transcultural Nursing, 23*(3), 229–236.

Butcher, J. N. (Ed.). (1996). *International adaptations of the MMPI-2: Research and clinical applications* (pp. 26–43). Minneapolis: University of Minnesota Press.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13–105.

Carter, M. M., Sbrocco, T., & Carter, C. (1996). African Americans and anxiety disorders research: Development of a testable theoretical framework. *Psychotherapy, 33*(3), 449–463.

Casiano, D., McMickens, C. L., Williams, M., & Epperson, C. N. (Manuscript under review). Mental health perceptions and service utilization among depressed African American men in treatment at a community mental health center.

Centers for Disease Control. (2000). Youth risk behavior surveillance, United States, 1999. *Mortality and Morbidity Weekly Report: Surveillance Summaries, 49*(SS05), 1–96.

Chae, M. H., & Foley, P. F. (2010). Relationship of ethnic identity, acculturation, and psychological well-being among Chinese, Japanese, and Korean Americans. *Journal of Counseling & Development, 88*, 466–476.

Chae, D. H., Lincoln, K. D., & Jackson, J. S. (2011). Discrimination, attribution, and racial group identification: Implications for psychological distress among Black Americans in the National Survey of American Life (2001–2003). *American Journal of Orthopsychiatry, 81*(4), 498–506.

Chapman, L. K., Kertz, S. J., & Woodruff-Borden, J. (2009). A structural model analysis of psychological distress and perceived control on worry among African American and European American young adults. *Journal of Anxiety Disorders, 23*, 69–76.

Chapman, L. K., Kertz, S. J., Zurlage, M., & Woodruff-Borden, J. (2008). A confirmatory factor analysis of specific phobia domains in African American and Caucasian American young adults. *Journal of Anxiety Disorders, 22*(5), 763–771.

Chapman, L. K., Petrie, J., & Richards, A. (under review). Clinical utility of self-report measures in predicting social phobia in African American adults: A receiver operating characteristic analysis. Manuscript submitted for publication.

Chapman, L. K., Petrie, J., & Vines, L. (2012). The factor structure of the SCL-90 in a community-based sample of African American adults. *Psychiatry Research, 199*(2), 140–144.

Chapman, L. K., Vines, L., & Petrie, J. (2011). Fear factors: Cross validation of specific phobia domains in a community-based sample of African American adults. *Journal of Anxiety Disorders, 25*(4), 539–544.

Chapman, L. K., Williams, S. R., Mast, B. T., & Woodruff-Borden, J. (2009). A confirmatory factor analysis of the Beck Anxiety Inventory in African American and European American young adults. *Journal of Anxiety Disorders, 23*, 387–392.

Chapman, L. K., & Woodruff-Borden, J. (2009). The impact of family functioning on anxiety symptoms on African American and European American young adults. *Personality and Individual Differences, 47*, 583–589.

Chou, T., Asnaani, A., & Hofmann, S. G. (2012). Perception of racial discrimination and psychopathology across three U.S. ethnic minority groups. *Cultural Diversity and Ethnic Minority Psychology, 18*(1), 74–81.

Chowdhury, A. N. (1990). Trait anxiety profile of koro patients. *Indian Journal of Psychiatry, 32*(4), 330.

Chui, T. L. (1996). Problems caused for mental health professionals worldwide by increasing multicultural populations and proposed solutions. *Journal of Multicultural Counseling & Development, 24*, 129–140.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805–816.

Cokley, K., Hall-Clark, B., & Hicks, D. (2011). Ethnic minority-majority status and mental health: The mediating role of perceived discrimination. *Journal of Mental Health Counseling, 33*(3), 243–263.

Colby, J. A., Wang, F., Chhabra, J., & Pérez-Escamilla, R. (2012). Predictors of medication adherence in an urban Latino community with healthcare disparities. *Journal of Immigrant and Minority Health, 14*(4), 589–595.

Cole, E., Pisano, E. D., Brown, M., Kuzmiak, C., Braeuning, M. P., Kim, H. H., . . . Walsh, R. Diagnostic accuracy of Fischer Senoscan Digital Mammography versus screen-film mammography in a diagnostic mammography population. *Academic Radiology, 11*(8), 879–886.

...epcion, W. R., Kohatsu, E. L., & Yeh, C. J. (2012). Using racial identity and acculturation to ...alyze experiences of racism among Asian Americans. *Asian American Journal of Psychology,* ...(...), 136–142.

...tantine, M. G. (2007). Racial microaggressions against African American clients in cross-...cial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16.

..., W. E., Jr. (1978). The Thomas and Cross models of psychological nigrescence: A review. ...urnal of Black Psychology, 5,* 13–31.

..., W. E., Jr., & Vandiver, B. J. (2001). Nigrescence theory and measurement: Introducing the ...ross Racial Identity Scale (CRIS) In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. ...lexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 371–393). Thousand Oaks, ...A: Sage.

..., D. M., Williams, M. T., & Chapman, L. K. (2011). Anxiety and affect in racially unmatched ...yads: Implications for a therapeutic relationship. Poster presented for the 45th Annual ...onvention of the Association of Behavioral and Cognitive Therapies, Toronto, ON, ...ovember 10–13, 2011.

..., D., Steever, A., Terwilliger, J. M., & Williams, M. T. (2012). The relationship between ...the culture-bound syndrome koro and obsessive-compulsive disorder. In G. R. Hayes & M. H. Bryant (Eds.), *Psychology of culture* (pp. 213–221) Hauppauge, NY: Nova Science Publishers.

...agnore, A. M., Petrova, E., Harper, A., Stowe, A. M., Mu'Min, A. S., & Middleton, R. A. (2010). Critical incidents and assistance-seeking behaviors of White mental health practitioners: A transtheoretical framework for understanding multicultural counseling competency. *Cultural Diversity and Ethnic Minority Psychology, 16*(3), 352.

...ine, P. G. & Elliot, A. J. (1995). Are racial stereotypes really fading? The Princeton trilogy revisited. *Personality and Social Psychology Bulletin, 21*(11), 1139–1150.

...z, F., Miskemen, T., Vega, W. A., Gara, M., Wilson, D. R., Lesser, I., . . . Starkowski, S. (2009). Inconsistencies in diagnosis and symptoms among bilingual and English-speaking Latinos and Euro-Americans. *Psychiatric Services, 60*(10), 1379–1382.

...novan, R. A., Huynh, Q. L., Park, I. J., Kim, S. Y., Lee, R. M., & Robertson, E. (2013). Relationships among identity, perceived discrimination, and depressive symptoms in eight ethnic-generational groups. *Journal of Clinical Psychology, 69*(4), 397–414.

...oll, M. W., & Torres, L. (2013). Acculturative stress and Latino depression: The mediating role of behavioral and cognitive resources. *Cultural Diversity and Ethnic Minority Psychology,* 1–10.

...orega, H., Mulsant, B. M., Rifai, A. H., Sweet, R. A., Pasternak, R., Ulrich, R., & Zubenko, G. S. (1994). Ethnicity and psychopathology in an aging hospital-based population: Comparison of African-American and Anglo-European patients. *Journal of Nervous and Mental Disease, 18...*(3), 136–144.

...ker, S., Waldron, H., Turner, C., Brody, J., & Hops, H. (2008). Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. *Journal of Family Psychology, 22*(3), 439–447.

..., E., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide.* New York, NY: Oxford University Press.

...nko, D. L. (2007). Race, ethnicity, and eating disorders: Considerations for *DSM-V. International Journal of Eating Disorders, 40,* S31–S34.

...muth, V. S., Quinn, S. C., Thomas, S. B., Cole, G., Zook, E., & Duncan, T. (2001). African Americans' views on research and the Tuskegee Syphilis Study. *Social Science & Medicine,* ...(5), 797–808.

Gaertner, S. L., & Dovidio, J. F. (2005). Understanding and addressing contemporary racism: From aversive racism to the common ingroup identity model. *Journal of Social Issues, 61*(3), 615–639.

Gamble, V. N. (1993). A legacy of distrust: African Americans and medical research. *American Journal of Preventive Medicine, 9*(6 Suppl.), 35–38.

Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health, 87*(11), 1773–1778.

Gara, M. A., Vega, W. A., Arndt, S., Escamilla, M., Fleck, D. E., Lawson, W. B., . . . Strakowski, S. M. (2012). Influence of patient race and ethnicity on clinical assessment in patients with affective disorders. *Journal of American Medical Association, 69*(6), 593–600.

Glazer, M., Baer, R. D., Weller, S. C., Garcia de Alba, J. E. G., & Liebowitz, S. W. (2004). Susto and soul loss in Mexicans and Mexican Americans. *Cross-Cultural Research, 38*(3), 270–288.

Gillette, H. The science behind "susto"—a Latin American folk illness. Saludify. June 6, 2013. http://saludify.com/susto-latino-folk-illness/

Good, B. J. (1996). Culture and *DSM-IV*: Diagnosis, knowledge and power. *Culture, Medicine and Psychiatry, 20*, 127–132.

Gordon, W. M. (2002). Sexual obsessions and OCD. *Sexual and Relationship Therapy, 17*, 343–353.

Grant, B. F. (1996). Prevalence and correlates of drug use and *DSM-IV* drug dependence in the United States: Results of the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse, 8*(2), 195–210.

Green, D., Callands, T. A., Radcliffe, A. M., Luebbe, A. M., & Klonoff, E. A. (2009). Clinical psychology students' perceptions of diversity training: A study of exposure and satisfaction. *Journal of Clinical Psychology, 65*(10), 1056–1070.

Greer, T. M. (2011). Coping strategies as moderators of the relation between individual race-related stress and mental health symptoms for African American women. *Psychology of Women Quarterly, 35*(2), 215–226.

Guarnaccia, P. J. (1997). A cross-cultural perspective on anxiety disorders. In Steven Friedman (Ed.), *Cultural issues in the treatment of anxiety* (pp. 3–20) New York, NY: Guilford Press.

Heintzelman, C. A. (2003). The Tuskegee Syphilis Study and its implications for the 21st century. *The New Social Worker, 10*(4).

Helms, J. E., Nicholas, G., & Green, C. E. (2010). Racism and ethnoviolence as trauma: Enhancing professional and research training. *Traumatology, 18*, 65–74.

Himle, J. A., Baser, R. E., Taylor, R. J., Campbell, R. D., & Jackson, J. S. (2009). Anxiety disorders among African Americans, Blacks of Caribbean descent, and non-Hispanic Whites in the United States. *Journal of Anxiety Disorders, 23*(5), 578–590.

Hodgkin, D., Volpe-Vartanian, J., & Alegría, M. (2007). Discontinuation of antidepressant medication among Latinos in the USA. *Journal of Behavioral Health Services & Research, 34*(3), 329–342.

Hofmann, A. A., & Parron, D. L. (1996). How the new NIH guidelines on the inclusion of women and minorities apply: Efficacy trials, effectiveness trials, and validity. *Journal of Consulting and Clinical Psychology 64*, 851–855.

Hoyle, R. H., & Smith, G. T. (1994). Formulating clinical research hypotheses as structural equation models: A conceptual overview. *Journal of Consulting and Clinical Psychology, 62*, 429–440.

Hu, L.-T. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*(2), 238–246.

Hu, L.-T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modelling, 6*(1), 1–55.

Hunter, L. R., & Schmidt, N. B. (2010). Anxiety psychopathology in African American adults: Literature review and development of an empirically informed sociocultural model. *Psychological Bulletin, 2010, 136*(2), 211–235.

Jackson, J. S., Torres, M., Caldwell, C. H., Neighbors, H. W., Nesse, R. M., Taylor, R. J., . . . Williams, D. R. (2004). The National Survey of American Life: A study of racial, ethnic and cultural influences on mental disorders and mental health. *International Journal of Methods in Psychiatric Research, 13*(4), 196–207.

John, D. A., de Castro, A. B., Martin, D. P., Duran, B., & Takeuchi, D. T. (2012). Does an immigrant health paradox exist among Asian Americans? Associations of nativity and occupational class with self-rated health and mental disorders. *Social Science & Medicine, 75*, 2085–2098.

Jost, J. T., & Banaji, M. R. (1994). The role of stereotyping in system-justification and the production of false consciousness. *British Journal of Social Psychology, 33*(1), 1–27.

Katz, R. V., Russell, S. L., Kegeles, S. S., Kressin, N. R., Green, B. L., Wang, M. Q., . . . Claudio, C. (2006). The Tuskegee Legacy Project: Willingness of minorities to participate in biomedical research. *Journal of Health Care for the Poor and Underserved, 17*(4), 698–715.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005a). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602.

Kessler et al. (2005b). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617–627.

Kim, E. (2011). Intergenerational acculturation conflict and Korean American parents' depression symptoms. *Issues in Mental Health Nursing, 32*, 687–695.

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50*(4), 466–481.

Lang, A. J., Laffaye, C., Satz, L. E., Dresselhaus, T. R., & Stein, M. B. (2003). Sensitivity and specificity of the PTSD checklist in detecting PTSD in female veterans in primary care. *Journal of Traumatic Stress, 16*(3), 257–264.

Lee, D., Sutton, R., France, H., & Uhlemann, M. (1983). Effects of counselor race on perceived counselor effectiveness. *Journal of Counseling Psychology, 30*(3), 447–450.

Lynch, T., Platt, R., Gouin, S., Larson, C., & Patenaude, Y. (2004). Can we predict which children with clinically suspected pneumonia will have the presence of focal infiltrates on chest radiographs? *Pediatrics, 113*(3 Pt. 1) e186–e189.

Malcoun, E., Williams, M. T., & Bahojb-Nouri, L. V. (in press). Assessment of Posttraumatic Stress Disorder in African Americans. In L. T. Benuto (Ed.), *Guide to psychological assessment with African Americans*. New York, NY: Springer.

Malgady, R. G., & Constantino, G. (1998). Symptom severity in bilingual Hispanics as a function of clinician ethnicity and language of interview. *Psychological Assessment, 10*(2), 120–127.

Matsunaga, M., Hecht, M.L., Elek, E., & Ndiaye, K. (2010). Ethnic identity development and acculturation: A longitudinal analysis of Mexican-heritage youth in the Southwest United States. *Journal of Cross-Cultural Psychology, 41*(3), 410–427.

McMahon, S. D., & Watts, R. J. (2002). Ethnic identity in urban African American youth: Exploring links with self-worth, aggression, and other psychosocial variables. *Journal of Community Psychology, 30*(4), 411–431.

Melfi, C. A., Croghan, T. W., & Hanna, M. P. (2000). Psychiatric briefs. *Journal of Clinical Psychiatry, 61*, 16–21.

Melka, S. E., Lancaster, S. L., Adams, L. J., Howarth, E. A., & Rodriguez, B. F. (2010). Social anxiety across ethnicity: A confirmatory factor analysis of the FNE and SAD. *Journal of Anxiety Disorders, 24*(7), 680–685.

Mossman, D., & Somoza, E. (1989). Maximizing diagnostic information from the dexamethasone test. An approach to criterion selection using receiver operating characteristic analysis. *Archives of General Psychiatry, 46*(7), 653–660.

Munoz, C., & Hilgenberg, C. (2006). Ethnopharmacology: Understanding how ethnicity affects drug response. *Journal of Holistic Nursing Practice, 20*(5), 227–234.

Nagayama Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*(3), 502–510.

Nadkarni, A., & Santhouse, A. (2012). Diagnostic and statistical manual of mental disorders (DSM): A culture bound syndrome? Letter to the editor. *Asian Journal of Psychiatry, 5*, 118–119.

National Institute for Clinical Excellence. (2005). *Obsessive compulsive disorder: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*. London, England: Author.

National Institutes of Health. (1999). The fundamentals of mental health and mental illness. In *Mental health: A report of the surgeon general* (chap. 2). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Nipoda, Y. (2002). Japanese culture and therapeutic relationship. In W. J. Lonner, D. L. Dinnel, S. A. Hayes, & D. N. Sattler (Eds.), *Online readings in psychology and culture (Unit 10, chap. 3)* Bellingham: Center for Cross-Cultural Research, Western Washington University.

Parham, T. A. (2002). Counseling models for African Americans. In T.A. Parham (Ed.), *Counseling persons of African descent* (pp. 100–118) Thousand Oaks, CA: Sage.

Park, H., & Rubin, A. (2012). The mediating role of acculturative stress in the relationship between acculturation level and depression among Korean immigrants in the U.S. *International Journal of Intercultural Relations, 36*, 611–623.

Perez-Escamilla, R. (2010). Health care access among Latinos: Implications for social and health care reforms. *Journal of Hispanic Higher Education, 9*(1), 43–60.

Petrie, J., Chapman, L. K., & Vines, L. (2013). The clinical utility of the Positive and Negative Affect Scales–Extended Version (PANAS X) in predicting anxiety disorders in African American adults: A receiver operating characteristic analysis. *Journal of Black Psychology, 39*(2), 131–155.

Phinney, J. (1989). Stages of ethnic identity development in minority group adolescents. *Journal of Early Adolescence, 9*, 34–49.

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*(1), 1–9.

Pole, N., Gone, J. P., & Kulkarni, M. (2008). Posttraumatic stress disorder among ethnoracial minorities in the United States. *Clinical Psychology: Science and Practice, 15*(1), 35–61.

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*(3), 274–282.

Rettew, D. C., Doyle, A. C., Kwan, M., Stanger, C., & Hudziak, J. J. (2006). Exploring the boundary between temperament and generalized anxiety disorder: A receiver operating characteristic analysis. *Journal of Anxiety Disorders, 20*(7), 931–945.

Richards, P. S., Keller, R. R., & Smith, T. B. (2004). Religious and spiritual diversity in counseling and psychotherapy. In T. B. Smith (Ed.), *Practicing multiculturalism: Affirming diversity in counseling and psychology*. Hoboken, NJ: Wiley.

Richeson, J. A., & Nussbaum, R. J. (2004). The impact of multiculturalism versus color-blindness on racial bias. *Journal of Experimental Social Psychology, 40*(3), 417–423.

Roberts, R. E., Phinney, J. S., Masse, L. C., Chen, Y. R., Roberts, C. R., & Romero, A. (1999). The structure of ethnic identity of young adolescents from diverse ethnocultural groups. *Journal of Early Adolescence, 19*, 301–322.

hwartz, S. J., Waterman, A. S., Umana-Taylor, A. J., Lee, R. M., Kim, S. Y., Vazsonyi, A. T., . . . Williams, M. K. (2013). Acculturation and well-being among college students from immigrant families. *Journal of Clinical Psychology, 69*(4), 298–318.

hen, B., & Takeuchi, D.T. (2001). A structural model of acculturation and mental health status among Chinese Americans. *American Journal of Community Psychology, 29*(3), 397–415.

iraev, E., & Levy, D. (2013). *Cross-cultural psychology: Critical thinking and contemporary applications* (5th ed.). Boston, MA: Pearson (Allyn & Bacon).

mith, E. P., Walker, K., Fields, L., Brookins, C., & Seay, R. C. (1999). Ethnic identity and its relationship to self-esteem, perceived efficacy, and prosocial attitudes in early adolescence. *Journal of Adolescence, 22*, 867–880.

nowden, L., Hastings, J., & Alvidrez, J. (2009). Overrepresentation of Black Americans in psychiatric inpatient care. *Psychiatric Services, 60*(6), 779–785.

nowden, L. R., & Pingitore, D. (2002). Frequency and scope of mental health service delivery to African Americans in primary care. *Mental Health Services Research, 4*(3), 123–130.

olomon, A. (1992). Clinical diagnosis among diverse populations: A multicultural perspective. *Families in Society: The Journal of Contemporary Human Services, 73*, 371–377.

oto, J. A., Dawson-Andoh, N. A., & BeLue, R. (2011). The relationship between perceived discrimination and generalized anxiety disorders among African Americans, Afro Caribbeans, and non-Hispanic Whites. *Journal of Anxiety Disorders, 25*, 258–265.

trakowski, S. M., Hawkins, J. M., Keck, J., Paul, E., McElroy, S. L., West, S. A., . . . Tugrul, K. C. (1997). The effects of race and information variance on disagreement between psychiatric emergency room service and research diagnoses in first-episode psychosis. *Journal of Clinical Psychiatry, 58*, 457–463.

ue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271.

Taylor, J. Y., Caldwell, C. H., Baser, R. E., Faison, N., & Jackson, J. S. (2007). Prevalence of eating disorders among Blacks in the National Survey of American Life. *International Journal of Eating Disorders, 40*(S3), S10–S14.

Terwilliger, J. M., Bach, N., Bryan, C., & Williams, M. T. (2013). Multicultural versus colorblind ideology: Implications for mental health and counseling. In A. Di Fabio (Ed.), *Psychology of counseling* (pp. 111–122) Hauppauge, NY: Nova Science.

Thomas, J., Turkheimer, E., & Oltmanns, T. F. (2000). Psychometric analysis of racial differences on the Maudsley Obsessional Compulsive Inventory. *Assessment, 7*(3), 247–258.

Torres, L., Driscoll, M. W., & Burrow, A. L. (2010). Racial microaggressions and psychological functioning among highly achieving African-Americans: A mixed-methods approach. *Journal of Social & Clinical Psychology, 29*(10), 1074–1099.

U.S. Census Bureau. (2011). State and County QuickFacts. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

U.S. Census Bureau. (2012). *Most children younger than age 1 are minorities, Census Bureau reports.* Release CB12-90. Retrieved from http://www.census.gov/newsroom/releases/archives/population/cb12-90.html

U.S. Department of Health and Human Services (U.S. DHHS). (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Labor. (2002). Consumer expenditures in 2000, Bureau of Labor Statistics, Report 958 (also Table 51). Retrieved from http://www.bls.gov/cex

U.S. Department of Labor. (August 2012). Labor force characteristics by race and ethnicity, 2011. U.S. Bureau of Labor Statistics, Report 1036.

Van Diest, A. M. K., Tartakovsky, M., Stachon, C., Pettit, J. W., & Perez, M. (2013). The relationship between acculturative stress and eating disorder symptoms: Is it unique from general life stress? *Journal of Behavioral Medicine*, 1–13.

Vu, H. Q., & Rook, K. S. (2012). Acculturation and intergenerational relationships in Vietnamese American families: The role of gender. *Asian American Journal of Psychology*, 1–12.

Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *The Counseling Psychologist*, *29*(4), 513–531.

Williams, M., Cahill, S., & Foa, E. (2010). Psychotherapy for post-traumatic stress disorder. In D. Stein, E. Hollander, & B. Rothbaum (Eds.), *Textbook of anxiety disorders* (2nd ed.) Arlington, VA: American Psychiatric Publishing.

Williams, M. T., Chapman, L. K., Wong, J., & Turkheimer, E. (2012). The role of ethnic identity in symptoms of anxiety and depression in African Americans. *Psychiatry Research*, *199*, 31–36.

Williams, M. T., Elstein, J., Buckner, E., Abelson, J. M., & Himle, J. A. (2012). Symptom dimensions in two samples of African Americans with obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, *1*(3), 145–152.

Williams, M. T., & Farris, S. G. (2011). Sexual orientation obsessions in obsessive–compulsive disorder: Prevalence and correlates. *Psychiatry Research*, *187*(1), 156–159.

Williams, M. T., Gooden, A. M., & Davis, D. (2012). African Americans, European Americans, and pathological stereotypes: An African-centered perspective. In G. R. Hayes & M. H. Bryant (Eds.), *Psychology of culture* (pp. 25–46). Hauppauge, NY: Nova Science.

Williams, M. T., & Steever, A. (in press). Cultural manifestations of obsessive-compulsive disorder. In C.W. Lack (Ed.), *Obsessive-compulsive disorder: Etiology, phenomenology, and treatment*. Fareham, UK: Onus Books.

Williams, M. T., Tellawi, G., Wetterneck, C. T., & Chapman, L. K. (2013). Recruitment of ethnoracial minorities for mental health research. *Behavior Therapist*, *36*(6), 151–156.

Williams, M. T., & Turkheimer, E. (2007). Identification and explanation of racial differences on contamination measures. *Behaviour Research and Therapy*, *45*(12), 3041–3050.

Williams, M. T., Turkheimer, E., Magee, E., & Guterbock, T. (2008). The effects of race and racial priming on self-report of contamination anxiety. *Personality and Individual Differences*, *44*(3), 746–757.

Wood, J. M., Garb, H. N., Lilienfeld, S. O., & Nezworski, M. T. (2002). Clinical assessment. *Annual Review of Psychology*, *53*, 519–543.

Yip, T., Gee, G. C., & Takeuchi, D. T. (2008). Racial discrimination and psychological distress: The impact of ethnic identity and age among immigrant and United States-born Asian adults. *Developmental Psychology*, *44*(3), 787–800.

Yoon, E., Chang, C., Kim, S., Clawson, A., Cleary, S. E., Hansen, M., . . . Gomes, A. M. (2013). A meta-analysis of acculturation/enculturation and mental health. *Journal of Counseling Psychology*, *60*(1), 15–30.