

Minority Issues in Mental Health – Asian Americans and Hispanics

January 28, 2004
Larry Merkel, M.D., Ph.D.

Introduction

Immigration is a complex phenomenon and has been at the center of U.S. history.

The relationship of immigration to mental health is also complex. Many variables influence the outcome of immigration from a mental health perspective.

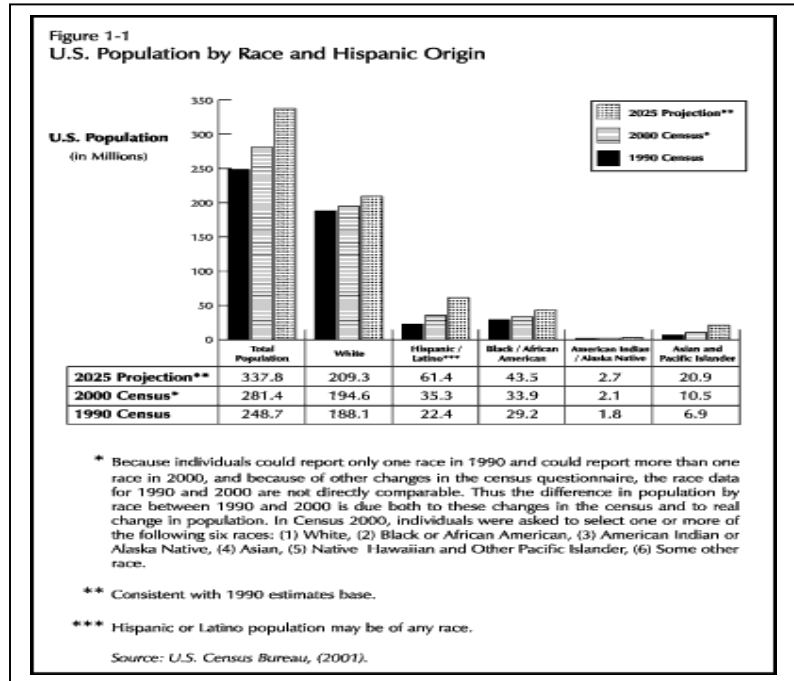
Different cultures appear to prepare their members more or less well for immigration. The mental health outcome also varies with the host country.

Immigration factors have been divided into pre-flight, during flight, and post-flight or resettlement factors. The presence of an already existing ethnic community into which the new immigrant can settle appears to aide eventual successful resettlement. The concept of the U.S. as a melting pot is not truly

descriptive of the process of acculturation. It suggests some sort of homogenizing effect, which does not clearly happen. For many generations post-migration, families and individuals retain pre-migration values and influences. The process of being a refugee is quite different from voluntary immigration and entails the experience of forced movement, trauma, and often great loss, with a more or less permanent separation from the country of origin. The individual adaptation to immigration varies. One conceptualization examines the mutual influence of the strength of ties both to the native country and the host country. This results in four possibilities:

		Host Country	
		(+)	(-)
Native Country	(+)	Integration	Traditionalism
	(-)	Acculturation	Marginalization

Using standardized psychiatric criteria in cross-cultural research has the advantage of allowing comparison with other studies, but has the disadvantages of



missing high levels of distress that may not fit criteria for any specific disorder, missing variation in manifestation of mental disorders due to cultural differences, and often miss those not living in households in communities, such as those in various institutions.

ASIAN AMERICANS

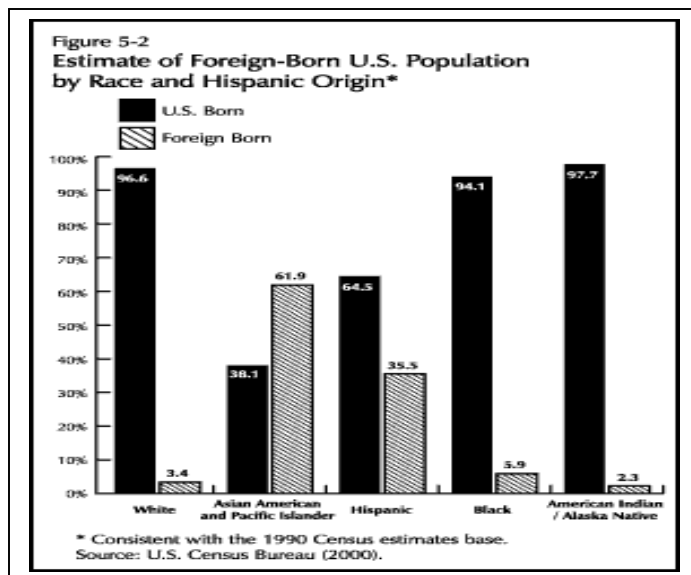
Population - Background

History: Although some Chinese came to the U.S. in the 1700s, they did not come in large numbers until the 1840s to work on the transcontinental railroad and in mines. They provided 80% of the labor for the transcontinental railroad. Between 1848 and 1882 approximately 300,000 came. This corresponded with the Gold Rush and the Civil War and the need for cheap labor. However, starting in 1870s the US economy took a drastic downturn and the Chinese laborers were seen as a threat. In 1882 the Chinese Exclusion Act was passed which limited admission of unskilled Chinese laborers. Ironically, after this the economy again improved and there was again a need for cheap labor. At this time Japanese migrants came first to Hawaii to work in the sugar cane plantations and eventually migrated to the US mainland. In 1907 and 1908 the government started limiting Japanese and Korean immigrants. In 1917 immigration from South Asia was restricted (Surgeon General 2001).

After the Spanish-American War and the subsequent Philippine-American War, Filipinos became American subjects. However, Filipino migration to the US was limited under the Tydings-McDuffie Act of 1934, on the rationale that freedom would be granted soon to the Philippines (Surgeon General 2001).

In 1942 President Roosevelt signed Executive Order 9066, which ordered the removal of Japanese on US soil, including 70,000 U.S. born Japanese, for a total of 120,000 people, to concentration camps in the west (Surgeon General 2001). Those interned in these camps remained for the duration of the war. Many of those held in these camps lost their homes and livelihoods. It was not until 1988 that President Regan offered an official apology and reparations were made to the sum of \$20,000 to each surviving internee. Ironically, despite doubts of the Japanese American's loyalty to the U.S., Japanese American males were eventually allowed to join the Army forming the 442nd Regimental Combat Team, which ended up being the most highly decorated unit for its size during WWII.

The 1965 Immigration Act liberalized immigration and stopped discrimination against Asians, allowing a rapid increase in Asian immigrants, going from 7% of immigrants to 25% in 1970 (Surgeon General 2001). In 2002 immigrants from Asia accounted for over 32% of all immigrants,



second only to those from North America.

After 1975 Southeast Asian Refugees began arriving (Surgeon General 2001). These refugees were located in various resettlement camps throughout the U.S. in the hope to not place too much of a burden on any one state. This was not effective and through large-scale secondary migration, Southeast Asian refugees have concentrated in select areas.

Asian Americans have faced a great deal of prejudice and discrimination. More recently they have been seen more as an “Ideal Minority,” which some have suggested is a subtle way to pit one minority group against another.

Present Characteristics:

The designation “Asian Americans and Pacific Islanders (AA/PI)” includes approximately 43 different ethnic groups. They speak over 100 languages and dialects. They are a rapidly growing minority group, moving from 3.7% of the population in 1980 to 7.2% in 1990, and to 10% in 2000 (Surgeon General 2001). Before 1965 there were only about 1 million Asian Americans in the U.S. According to the 2000 census there are 10.9 million AA/Pis in the U.S. About 3/5ths of Asian Americans are foreign born. Asians are 60% of world population (Surgeon General 2001).

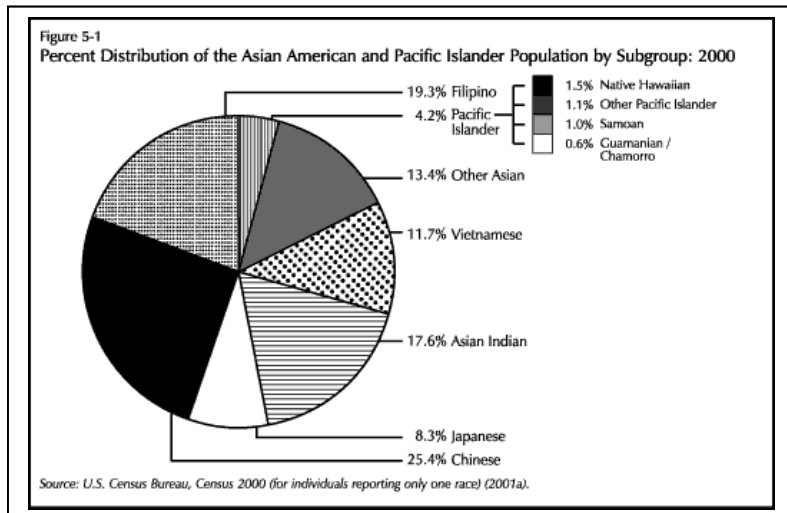
Yet many Asian immigrants remain isolated from mainstream society. The percentage living in linguistically isolated households (where on one over the age of 14 years speaks English very well) varies with group, such that: Total – 35%, Hmong – 61%, Cambodian – 56%, Lao – 52%, Vietnamese – 44%, Korean – 41%, Chinese 40% (Surgeon General 2001).

Over 50% of Asian Americans are located in the west, but 17% are in the south. Korean American and Asian Indian Americans are more diversely located geographically. Intentional efforts to disperse Southeast Asian refugees resulted in a great deal of secondary migration. Almost all (96%) of AA/PI are located in urban settings (Surgeon General 2001).

Religion and

Culture: Asian Americans practice a wide range of religions – Buddhism, Taoism, Hinduism, Christianity, Islam, and others. Many from China, Korea, Japan, and Southeast Asia have also been influenced by Confucian doctrine (Lin and Cheung, 1999). Spirituality is central to many of their beliefs with various spirits being seen

as playing an active role in their lives, especially in the areas of health and illness. Various concepts of balance between universal forces (*yin* and *yang*, *am* and *duong*, or *dosha*) are central to explanations of health and illness. Concepts of fate, retribution, and



cause and effect (karma) are also critical. Most of these cultures have ancient traditions of healing and medicine. These include spiritual practices, herbal remedies, acupuncture, massage, and diet and behavior manipulation (Lin and Cheung, 1999).

Cultural Values: In many Asian cultures the family is seen as central to an individual's sense of self and existence. Family cohesiveness and stability are stressed. It is expected that an individual will direct his or her behavior toward the good of the family. Preserving "face" or community reputation for the individual and the family is important, resulting in an emphasis on proper behavior, respect for others (especially elders), and compromise. Many of these values are antithetical to mainstream U.S. values, which often results in intergenerational conflict (Tseng 2003) and may negatively effect utilization of mental health services (Leong and Lau, 2001).

Family Structure: In general AA/Pis are more likely to live in family households, with 75% compared to 67% of non-Hispanic White and African American households. There are also fewer female head of household families. On the average they tend to wait longer to have children and have fewer children (Surgeon General 2001).

Often family decision-making is placed in the hands of family elders and their permission needs to be sought for significant events, including medical treatment.

Education: Asian Americans usually attain higher levels of education than other U.S. ethnic groups. For instance 44% of Asian Americans over the age of 25 have at least a college degree, compared to 28% for whites. For those of South Asian background the rate is 58%. On the other hand a larger percentage of Southeast Asians (about 2/3) have not completed high school, yet many of their children are advancing academically with 49% of Vietnamese, 45% of Cambodian, 32% of Hmong, and 25% of Lao between 18 and 24 years being enrolled in college in 1990 (Surgeon General 2001).

Income: There is marked variation in income among and between different ethnic groups and given the often large and extended households, per capita income must be considered. Overall, in 1998 the per capita income for AA/Pis was \$18,709, compared to \$22,952 for non-Hispanic whites. Yet a greater percentage of AA/PI families (33%) than non-Hispanic whites (29%) have incomes over \$75,000. However, non-Hispanic whites move ahead when per capita income is calculated. Of those living in poverty: Chinese American (14%), Korean American (14%), Thai American (13%), Asian Indian American (10%), Japanese American (7%), Filipino American (6%), Vietnamese (26%), Laotian (35%), Cambodian (43%), and Hmong (64%) (Surgeon General 2001).

Table 2-2: Per Capita Income By Ethnicity in 1999

	Per Capita Incomes
African Americans	\$14,397
Hispanic Americans	\$11,621
Asian Americans & Pacific Islanders	\$21,134
American Indians/Alaska Natives	Not Available
White Americans	\$24,109

Source: U.S. Census Bureau, Current Population Reports, Money Income in the U.S., 1999.

Mental Health Needs:

Trauma: Between 1975-1979 between 1 and 3 million of the 7 million Cambodian population died under the Pol Pot regime (Surgeon General 2001). Those Cambodians who survived and were relocated in the U.S. are often described as the “Walking Dead,” because of the trauma they witnessed and suffered. Other refugees from Southeast Asia have also suffered significant trauma, especially the “Boat People.”

Somatization: Many Asian cultures have been seen as not making a mind-body distinction as in the West, thus many from Asian cultural backgrounds are seen as presenting distress in a form consisting of predominately somatic complaints, or via somatization. Often the open display of emotion is curbed in favor social and family harmony, especially in Confucian influenced societies. Mental illness is sometimes seen as a marker of poor heritage and negatively influences chances for marriage. Thus there is often great stigma attached to mental illness. These factors appear to result in a tendency to express emotional and psychological distress (from a Western perspective) as physical symptoms. It has been shown that Chinese Americans with mood disorders are more likely to emphasize somatic symptoms than African Americans or whites. Display of distress also varies with context (Surgeon General 2001). It is probably a mistake to see somatization as the need to disguise psychological symptoms behind physical masks, but rather as a culturally constructed idiom of distress (Lin and Cheung, 1999). There is evidence that “psychological” or “emotional” symptoms are recognized along with the more “physical,” but that they are not emphasized (Lin and Cheung, 1999). This may be closely tied to many Asian cultures not recognizing a body/mind distinction, but rather a body/spirit distinction (Lin and Cheung, 1999).

Epidemiology: There are very few studies that examine AA/PI populations. In many, all the subgroups may be lumped together into the AA/PI designation, thus diluting intergroup differences. Furthermore, since their population size is usually small they are not included in many studies. For instance in the ECA study, Asian Americans were only 2% of the sample and thus they were not considered in analysis. In addition there is concern as to whether or not the categories of mental disorder as structured in the DSM IV are appropriate for AA/PI populations. An example of this is the debate around Neurasthenia, which is a common diagnosis in China. Fatigue, poor concentration, weakness, memory loss, irritability, sleep disturbance, and various aches and pains characterize it, but any mood symptoms are seen as secondary and of less importance (Surgeon General 2001). A study of a random Chinese Americans in Los Angeles found that 7% report experiencing Neurasthenia (Zheng *et al.*, 1997). In addition Asian Americans have been shown to be given more “atypical” diagnosis, suggesting that DSM-IV categories may not fit well with Asian American presentations (Lin and Cheung, 1999).

The National Comorbidity Study (NCS) also included a small sample of Asian Americans, but it was an extremely diverse group and probably not

Table 5-1
Results of the Chinese American Psychiatric Epidemiological Study (CAPES) and the National Comorbidity Survey (NCS)

Mental Disorder		Rate in Chinese-American adults (CAPES)	Rate in national sample of adults (NCS)
Major Depressive Episode	Lifetime	6.9%	16.9%
	12-month	3.4%	10.0%
Dysthymia	Lifetime	5.2%	6.4%
	12-month	0.9%	2.5%

representative of any particular group. The Chinese American Psychiatric Epidemiological Study (CAPES), using DSM-III-R criteria measures the prevalence of a selected number of disorders in 1700 Chinese living in Los Angeles County. Almost all (90%) were born outside the U.S. Depression was measured using the CIDI (Surgeon General 2001). There are a number of small scale studies looking at specific populations, usually in one location, but the samples are often not randomly selected and of uncertain value. Of these conducted looking at youth from various groups the rate of emotional distress appears to be similar to those of white youth, although there may be higher rates of anxiety. Similar studies looking at older adults suggest that elderly Asian Americans have less or equal amounts of depression when compared to white elderly Americans (Surgeon General 2001). Older studies that measure symptoms, but not diagnostic categories often portray Asian Americans as having higher rates of depressive symptoms.

In general Asian Americans have lower suicide rates than whites: Chinese (8.3/100,000), Japanese (9.1/100,000), and Filipino Americans (3.5/100,000), compared to the U.S whites (12.8/100,000). However, there may be subpopulations that have high rates. Chinese women over the age of 65 have one of the highest rates in the U.S. Young migrant women of South Asian origin have high rates of suicide in other host countries, but the rate in the U.S. is unknown. In addition the profile of suicide rates is different in many Asian populations, with a bimodal distribution, being high in the young and the elderly (Surgeon General 2001).

Certain Asian American populations may be at greater risk for mental illness, especially refugees from Southeast Asia, given the traumas of the various wars, escape, resettlement, and asylum. Various studies have shown rates of PTSD from 14 to 70% and of depression from 50 to 73%. These diagnoses have been shown to persist even at 10 years (Surgeon General 2001). There is evidence that Southeast Asian groups show less improvement with treatment than other Asian American groups (Leong and Lau, 2001). Furthermore, elderly Asian Americans, especially those that are isolated may be at increased risk (Leong and Lau, 2001). Asian American women may be at increased risk for mental illness due to the double discrimination of race and gender (Leong and Lau, 2001).

Popular Categories: Many Culture Bound syndromes have been described among Asian populations, but their prevalence among Asian Americans is usually unknown. One exception is *hwa-byung* (“suppressed anger syndrome”), a syndrome described among Koreans characterized by sensations of chest constriction, palpitations, heat, flushing, headaches, dysphoria, irritability, anxiety, and decreased concentration. A community survey among Korean Americans in Los Angeles found a prevalence rate of 12%, which is higher than that found in Korea (Lin *et al.*, 1992). Neurasthenia has also been documented in Chinese Americans at the rate of 6.7%, comparable to that found in Asia. In addition only about 50% met criteria for a DSM-III-R mental disorder (Lin and Cheung, 1999).

Availability, Accessibility, and Utilization of Mental Health Services

Although in areas of high concentration there are clinics that specialize in meeting the needs of Asian Americans, few general mental health services are able to deal adequately with language barriers. In 1990 it was estimated that there were about 70 Asian American mental health providers for every 100,000 Asian Americans (Surgeon

General 2001). Specialized Asian American mental health treatment services have been established in large cities in the U.S. and appear to be successful in providing culturally sensitive care (Lin and Cheung, 1999).

Access to insurance varies with ethnic group. Overall 21% of AA/PI do not have health insurance. Of Koreans, 34% lack insurance. Asian Americans underutilize Medicaid. Of those Chinese Americans who are 200 % below the poverty level and thus eligible for Medicaid, only 13% have Medicaid coverage. This is compared to 24% of whites in this same income bracket (Surgeon General 2001).

There are few studies measuring utilization. The NCS showed that less than 25% of those with mental disorders sought care. In the CAPES, only 17% of those experiencing mental disorders sought care – 35% saw a mental health professional, 23% saw a medical doctor, and 47% saw a minister or priest. Other evidence shows that Asian Americans utilize various services, including talking with a friend or a relative at ¼ to ½ the rate of whites (Surgeon General 2001). Some studies show that those Asian Americans that do use mental health services are more severely ill than their white American counterparts (Lin and Cheung, 1999; Surgeon General 2001).

What little data exists on the use of alternative services shows that 50 to 90 % of various Asian American populations have made use of traditional and indigenous healers or healing practices (Surgeon General 2001). Asian American women are more likely to use traditional/informal health care practices than men (69 to 39%). Traditional Asian health care beliefs and practices often conflict with American practices, resulting in high levels of non-compliance with Western care. This also results in Western misperceptions of Asian beliefs and practices, such as believing that Asians do not understand preventative care or mistaking healing practices for child abuse.

In their review of Asian American utilization of mental health services, Leong and Lau (2001) recognize several barriers to seeking mental health care: level of acculturation (more acculturated are more likely to seek mental health care), cognitive barriers (differentials in beliefs about the nature of mental illness), affective barriers (primarily shame and needing to preserve face), value orientation barriers (a emphasis on the collective and the suppression of negative feelings and thoughts), and physical barriers (economic and geographic realities). Once Asian Americans access mental health services they have a high rate of dropping out. Leong and Lau (2001:206) explain this through the use of the concept of “threats to cultural validity.” This includes such factors as therapist bias, inappropriate use of diagnostic measures, cultural factors affecting symptoms expression (somatization), language capabilities of the patient, and the pathoplasticity of psychological disorders.

Outcome

There are very few studies that empirically measure outcome of mental health treatment in Asian Americans (Leong and Lau 2001).

There is increasing evidence that Asian Americans respond to lower doses and experience side effects at lower doses of neuroleptics, antidepressants, lithium, and benzodiazepines (Lin and Cheung, 1999; Tseng 2003). This relates in part to genetically lower levels of various P-450 isoenzymes and possibly to dietary factors (Lin and Cheung, 1999). There may also be pharmacodynamic differences, explaining the need for lower levels of lithium (Lin and Cheung, 1999).

Studies of therapy show that Asian Americans tend to respond only as well, if not worse than white samples and to drop out sooner than white samples. Ethnic matching seems to reverse this tendency. One study of the effect of ethnic, gender, and linguistic matching on outcome with Asian American outpatients in Los Angeles showed that improvement did not correlate with either ethnic or linguistic matching, but that ethnic matching had a significant effect on dropout rate. Gender matching had no effect on outcome variables (Flaskerud and Liu 1991). Ethnically focused clinics also seem to be more acceptable and successful than mainstream clinics (Leong and Lau 2001).

Treatment Recommendations

Interpersonal behavior between the Asian American patient and the caregiver may be critical. Direct eye contact is minimized and seen as disrespectful. The use of “Yes” may often mean “I understand” or “I hear you,” and not necessarily “I agree.” Formality is a sign of respect. Questioning the doctor or raising objections is seen as offensive and a sign of poor character in the patient. Family members expect to be included in evaluations and treatment decisions (Lin and Cheung, 1999). It is often advised that therapists be more active and directive. Therapy that is structured may be more acceptable (Lin and Cheung, 1999).

Several traditional Asian forms of therapy may provide guidelines for therapy with Asian Americans (Kitano and Matsushima 1976), for example Morita and Naikan therapies from Japan. Morita Therapy emphasizes acceptance, with a focus on the here and now, the group, behavioral control over moods, and interdependence, while Naikan Therapy focuses on the important relationships in one’s life, emphasizing increased empathy and understanding of these others (Kitano and Matsushima 1976).

HISPANIC AMERICANS

Population – Background

History

Mexicans became citizens in the U.S. after the Mexican War (1846-148) along with the annexation of California, Arizona, New Mexico, and parts of Colorado, Wyoming, and Utah as well as Texas’ joining the U.S. in 1845. Large numbers of Mexicans entered the U.S. during the period of the Mexican Revolution (1910-1917). Continuing disparities between the U.S. economy and that of Mexico have contributed to a continuous flow of immigrants, many unauthorized (Surgeon General 2001).

Christopher Columbus claimed Puerto Rico for Spain on November 19, 1493. Puerto Rico was conquered by Spain in 1509 and the original inhabitants were enslaved and eventually exterminated. After this African slaves were brought in to work on the farms and plantations. Slavery ended in 1873 and Spain granted it autonomy in 1897. The U.S. annexed Puerto Rico after the Spanish American War in 1898 and in 1917 U.S. citizenship was granted to Puerto Ricans. During WWII Puerto Rico provided several large military bases. After WWII large numbers of Puerto Ricans began migrating to the U.S. This migration was spurred by large-scale agricultural failure and loss of many jobs in the 1950s and 60s. Since the 1980s many Puerto Ricans migrate back and forth between the island and the mainland. Many come to the U.S. hoping for economic

opportunity with the desire to eventually return to Puerto Rico. Columbus claimed Cuba for Spain on October 27, 1492, but Spain did not start colonizing Cuba until 1511 and by 1515 a brutal conquest of Cuba was complete. Like Puerto Rico the native population was enslaved and forced to work in the mines and plantations. By 1555 most of the native population had been decimated. Cuba lost appeal as increasing riches became discovered in Mexico and other parts of the mainland. In the late 16th century Cuba became an important port and naval base for Spain to protect its gold trade from Mexico. In the early 17th century African slaves were introduced, but Cuban law allowed for slaves to buy their freedom. Thus by the early 18th century there was a large population of free Africans who intermixed with the Spanish and remaining native inhabitants.

Through the 18th century Cuba became increasingly autonomous from Spain. The slave revolt in Haiti in 1791 resulted in a boost to the Cuban sugar cane production. However, increasing numbers of African slaves were needed to work the plantations. Between 1798 and 1860 approximately half a

million slaves were brought to Cuba. It is during this period that Santería, a religion combining West African beliefs and Catholicism developed. Throughout the 19th century Cuba became increasingly close to the U.S., with the U.S. government making several offers to Spain to buy Cuba. Between 1868 and 1878 Cubans revolted against Spain, but were defeated. In 1886 slavery ended in Cuba. In 1895 Cubans started another revolution, with American aide. In order to protect U.S. business interests in Cuba an American presence was established via the battleship Maine. When it exploded in Havana harbor February 15, 1898 the U.S. declared war on Spain. This changed the Cuban revolution into a conquest by the U.S. Cuba gained a degree of independence in 1901 with an establishment of their own constitution. However, over the next years Cuba's government was very unstable and there were periodic landings of U.S. troops to assert control and protect U.S. interests. During this time there was increasing economic dependence on the U.S. This situation continued to varying degrees until the Communist Revolution in 1959 and the establishment of Castro as dictator. At first Cuban migration to the U.S. after Castro's take over consisted mainly of educated elites who opposed communism. A steady flow of refugees occurred over the following years as Cubans sought the U.S. coast and asylum in small boats. Between 1959 and 1962 more than 200,000 people left Cuba for the U.S. Between 1965 and 1973 125,000 Cuban refugees came to the U.S. in Freedom Fights. In 1980 another 125,000 came to the U.S. in the Mariel Boatlift, during a severe economic crisis in Cuba. In the early 1990s as the Cuban economy again faltered, the rate of flow of refugees again increased, reaching a peak in

Table 6-1
Percentage of Hispanic Americans in State Populations: 2000

	Hispanic Population		Percent Hispanic of State Population	
	Number	Rank	Percent	Rank
New Mexico	765,386	8	42.1	1
California	10,966,556	1	32.4	2
Texas	6,669,666	2	32.0	3
Arizona	1,295,617	6	25.3	4
Nevada	393,970	14	19.7	5
Colorado	735,601	9	17.1	6
Florida	2,682,715	4	16.8	7
New York	2,867,583	3	15.1	8
New Jersey	1,117,191	7	13.3	9
Illinois	1,530,262	5	12.3	10

Source: U.S. Census Bureau, (2001b)

1993 and 1994 when over 6000 refugees reached Miami, but with many more perishing in the passage. Castro had announced that anyone wishing to leave Cuba could. The large numbers caused a reversal of U.S. policy to encourage refugees and to grant asylum and soon boats were being turned back.

Between 1970 and 1990 refugees began arriving in the U.S. from war torn El Salvador, Guatemala, and Nicaragua. They have often not been granted political asylum.

Present Population: From the above it can be seen that Hispanics are a diverse group, including Mexican Americans, some who have lived in parts of the U.S. for almost 400 years, Puerto Ricans, who are U.S. citizens and who migrate to the U.S. mainland, and refugees from Cuba and Central America.

Hispanics are the fastest growing minority population. With the 2000 census they totaled 35.3 million, equal to the number of African Americans. By 2050 they are expected to total 97 million, constituting about 25% of the U.S. population. They are a predominately young population such that by 2050 1/3 of all those under the age of 19 will be Hispanic

(Surgeon General 2001).

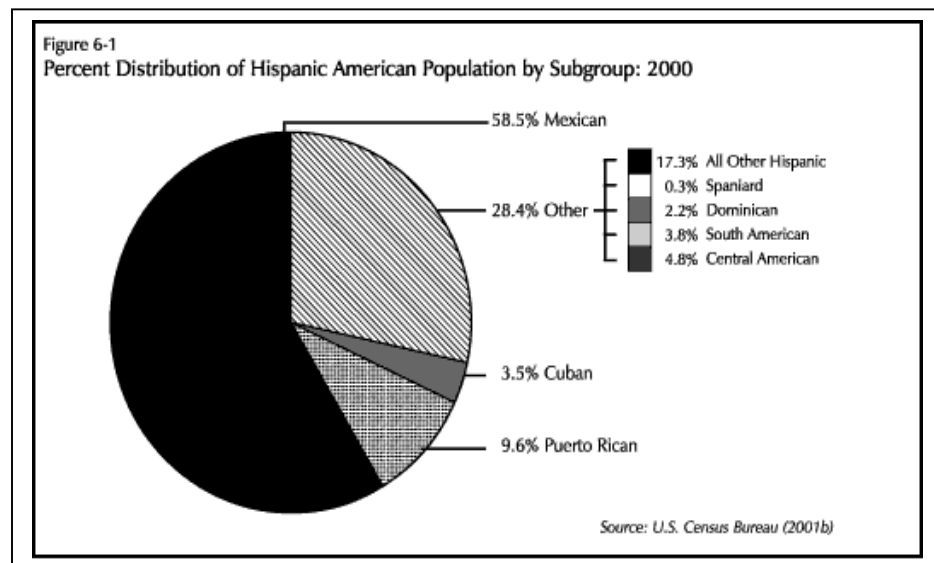
There are approximately 3,522,037 inhabitants in Puerto Rico. Approximately 71% are urban and over 80% are Catholic.

The vast majority of Hispanics in the U.S., over 60%,

in 2000 lived predominately in California, Arizona, New Mexico, Texas, and Colorado. There are also large numbers of Hispanics in New York, Florida, and Illinois. Puerto Ricans on the mainland live predominately in New York and New Jersey (Surgeon General 2001).

Religion: Whereas most Hispanics are nominally Catholic, the degree of adherence is variable. Especially in rural populations, but in many Hispanics, Catholic beliefs are combined with indigenous Indian or West African beliefs and practices.

Cultural Beliefs: Certain terms act to capture traditional Hispanic values. *Respeto* is translated as respect, but implies a mutual and reciprocal deference. Negative or critical expressions are discouraged. Deferential behavior is shaped by the importance of age, gender, and social position. Professional, especially doctors are to be treated with great respect. In turn, doctors are expected to display *personalismo*, which is an emphasis on building personal, warm relations. Doctors and other authorities are expected to take a personal interest in their patients. This is in part modeled on the



Patron system, which is central to much of Hispanic social relations, in which a person displays loyalty to an authority and social superior, in turn for protection and personal interest. *Confianza*, or trust is also central to positive relationships.

Family Structure: Family membership is very important, with young people, especially women remaining in the family until married. Whereas 30% of both white and African American household consisted of single persons in 1998, this was only true for 14% of Hispanics. More Hispanic households (63%) include children than are found in white (47%) and African American (56%) households (Surgeon General 2001).

Hispanics often emphasize the central importance of the family – *la familia*, which often includes not only three generations of the extended family, but also God parent relations and “adopted” children. Close friends are often included in the ring of family. There is an emphasis on patrilineal and patriarchal patterns. Males are seen as dominant, but this includes the obligation to be protectors and providers. Interdependence is emphasized over independence. In addition to the family, social involvement in one or more of the many local social organizations found in Hispanic communities is important. Loyalty to the neighborhood or *barrios* or *colonias* is stressed. Thus there is an ever widening ring of social connections, within which a person is maintained and by which they are defined. This is seen even in gang structure.

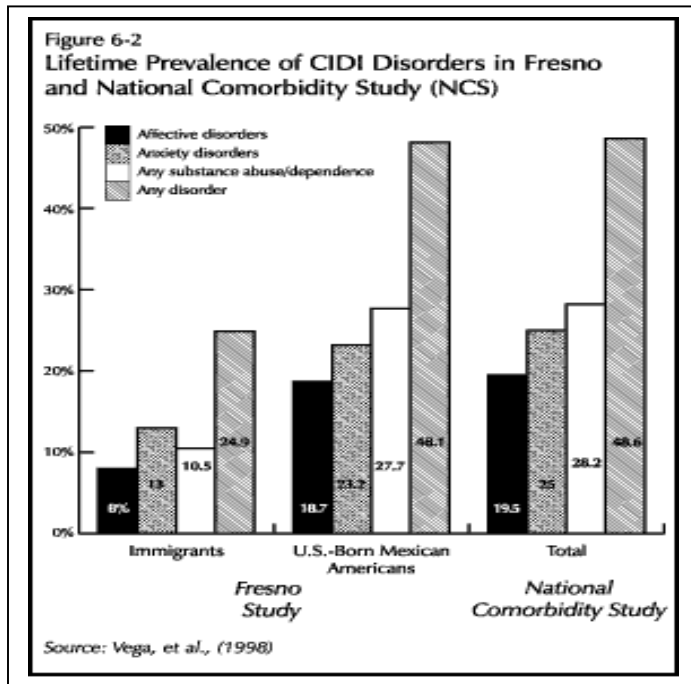
Education: Compared to the national average, Hispanics have less formal education. Of those over 25 years old, 56% have graduated high school and 11% have graduated college. This is 83% and 25% respectively for the nation as a whole. This varies with place of birth, such that Hispanics born in the U.S. have higher educational achievements. Cubans have higher levels of education (with 70% over the age of 25 having high school diplomas), while for Puerto Ricans this is 64%, and for Mexican Americans this is 50%. Cubans also have the highest rate of college degrees, comparable to the U.S. as a whole, while Puerto Ricans have less than half this rate and Mexican Americans about one quarter the rate (Surgeon General 2001).

Income: Income parallels educational status with median family incomes being for Cubans, \$39,530, Puerto Ricans, \$28,953, and Mexican Americans, \$27,883. At the other end, 31% of Puerto Ricans are below the poverty level, while 27% of Mexican Americans, and 14% of Cubans are below the poverty level (Surgeon General 2001). Part of the advantage of Cuban Americans is explained by the circumstances of elite Cubans who fled Castro and who may have already had economic ties in the U.S.

Physical Health: Infant mortality, one measure of a populations overall health, is lower for Hispanic Americans than for African Americans and whites, even when controlling for education level of the mother. Babies born to Mexican American women born in Mexico have a higher birth weight than babies born to Mexican American women born in the U.S. possibly because Mexican American women born in the U.S. are more likely to smoke and drink alcohol than Mexican American women born in Mexico. On the other hand Latinos are twice as likely as whites to die from diabetes. They also have higher rates of hypertension and obesity than whites. Health indicators vary among Hispanic subpopulations, with Puerto Ricans having worse indicators than other Hispanics (Surgeon General 2001).

Need

As part of the ECA at the Los Angeles site, Mexican Americans were over sampled. Overall Mexican Americans had similar rates of psychiatric disorders as whites, but when Mexican Americans born in the U.S. were compared with those born in Mexico, those born in the U.S. had higher rates of depression and phobias. The same was found in the NCS. In addition the NCS also found though that Mexican Americans as a whole had total lower lifetime rates of disorder, as well as fewer anxiety disorders and substance use disorders. However, there were no differences between whites and Puerto Ricans and Other Hispanics in the NCS (Surgeon General 2001).



Studies of Mexican Americans living in Fresno County (Vega, *et al.*, 1998) also found that lifetime rates of mental disorders for Mexican Americans born in Mexico were significantly lower than for those born in the U.S, 25% compared to 48% respectively. In addition, Mexican immigrants who had lived in the U.S. over 13 years had higher rates than those who had been in the U.S. less than 13 years. The rates of those born in Mexico resemble those found in community studies in Mexico City (Surgeon General 2001). Studies have also shown that Puerto Ricans in Puerto Rico have lower rates of depression than Puerto Ricans in New York City (Surgeon General 2001). However, all of these studies are cross-sectional studies and thus are not able to directly demonstrate that acculturation is the responsible factor as has been hypothesized.

On the other hand, numerous studies investigating the prevalence of psychiatric disorders, the degree of emotional distress, the presence of depressive symptoms, or the presence of behavioral difficulties show that Hispanic youth have higher rates than white youth (Surgeon General 2001).

There is evidence that older Hispanics with health problems are at risk for depression, but it is not clear if the rate is higher than that for comparable whites (Surgeon General 2001).

There is some evidence that measure of depressive symptoms in Hispanic populations may measure distress, but not disorder (Surgeon General 2001). This may relate to somatization. Puerto Rican adults have been shown to have higher rates of somatic symptoms than Mexican Americans and whites (Surgeon General 2001).

Although Mexican American women do not report a rate of physical or sexual abuse from intimate partners at a different rate from other populations, they do report a significantly higher history of “heart problems” than other populations. Most of these women were felt to be unlikely to have actually had cardiac disease, and thus it was felt

to be a somatic manifestation of their distress. It was also suggested that such complaints might represent complaints characteristic of *ataques de nervios* (Lown and Vega, 2001).

A study of the prevalence of substance abuse problems and comorbidity with mood and anxiety disorders among Mexican Americans showed that the rate of alcohol or drug dependence or abuse increased from 17.3% in immigrants to 36.1% in native born males and from 2.1% in immigrant to 17.7% in native born women. The increase is attributed to a combination of Fiesta Drinking – a pattern of binge drinking common in Mexico, with the increased frequency of drinking found in the U.S. Latino males have been found to have a higher rate of mortality from alcohol related cirrhosis of the liver (13.3/100,000) than African American males (8.3/100,000) and white males (5.2/100,000) in 1996. The most common single diagnosis for Mexican American males was alcohol abuse/dependence at 10.3%, with 9.1% among immigrant males and 12.3% in native-born males. For women the most common diagnoses were non-substance disorders – mood disorder (6.5%) and anxiety disorder (12.7%). Native born males were much more likely to have a comorbid alcohol and drug and non-substance abuse disorder than immigrant males, whose comorbidity was more often the combination of an alcohol disorder with a non-substance use disorder (Vega, Sribney, and Achara-Abrahams, 2003).

In a study of two idioms of distress among Puerto Ricans in New York City – anger and injustice, their presence in community samples correlated with scores for depression, anxiety, and Somatization, as well as utilization of professional mental health care (Rogler, Cortes, and Malgady 1994).

Culture-bound syndromes reported among Hispanics include *susto* (fright sickness), *nervios* (nerves), *mal de ojo* (evil eye), and *ataque de nervios* (nervous attack). *Ataque de nervios* has been demonstrated to occur in Puerto Rico at a rate of about 14%. The appearance of symptoms of *ataque de nervios* may be related to major life problems and herald later psychiatric illness (Guarnaccia *et al.* 1993, 1996).

Guarnaccia (1993) has done much to characterize and define *ataque de nervios*, emphasizing the variability among Hispanic populations, its being seen as non-pathological, and its apparent relationship to Western categories of disorder. He prefers the concept of “popular illness” rather than culture-bound syndrome, which is seen as misleading and sometimes pejorative. On the other hand, an increasing frequency of *ataque de nervios* has been linked to dissociative disorders and the presence of childhood trauma (Lewis-Fernández, *et al.*, 2002).

Logan (1993) reviews the literature on *susto*.

Nervios is often related to a broader array of distress, which may or may not be related to a specific psychiatric disorder (Surgeon General 2001). Salgado de Snyder, Diaz-Perez, and Ojeda (2000) review the prevalence of *nervios*, its relation to psychological and somatic symptoms, and its comorbidity with anxiety and depressive disorders in Mexico. It is more in women (20.8% to 9.5%) and has a high comorbidity with anxiety and mood disorders at about 30% each.

While nationally Hispanics have been shown to have a suicide rate about half that of the general U.S. population, Hispanic youth have been shown to have higher than average rates of suicidal ideation and suicide attempts (Surgeon General 2001).

Of those populations at high risk for mental disorders, Hispanics are under represented among the homeless and those in foster care. In contrast they are over represented among the incarcerated (9%) compared to whites (3%). Rates of mental

disorders among incarcerated Hispanics are equal to those found among other ethnic minorities and whites. Hispanic Vietnam Veterans have been shown to have higher rates of PTSD than African American and white veterans, even after controlling for combat exposure. This may relate to higher reporting of symptoms or possibly higher rates of pre-combat trauma exposure (Surgeon General 2001). Refugees from Central America have been difficult to study, because many are illegal and not likely to come forward for participation. However, what studies have been done show rates of PTSD around 50 to 60% (Surgeon General 2001).

Culturally associated strengths that promote resilience may include what has been termed a “dual frame of reference.” By this is meant that Hispanics retain ties back to their native countries, which allow a point of comparison with life in the U.S. Hispanics often show a high degree of ambition and aspiration to succeed. A high degree of spirituality may provide a source of strength. The importance of the support associated with the large extended families has also been cited as a source of strength (Surgeon General 2001).

Availability, Accessibility, and Utilization of Mental Health Services

About 40% of Hispanics have reported that they do not speak English or speak it only poorly, necessitating Spanish language services. It is unknown how many mental health workers are Spanish speakers. It has been estimated that there are about 29 Hispanic mental health workers for every 100,000 Hispanics, whereas the rate of white mental health workers is 173 per 100,000 (Surgeon General 2001).

Although only about 12% of the U.S. populations, Hispanics represent 25% of the uninsured. Nationally, 37% of Hispanics lack health insurance. Hispanic children are less likely to be insured than any other ethnic minority (Surgeon General 2001).

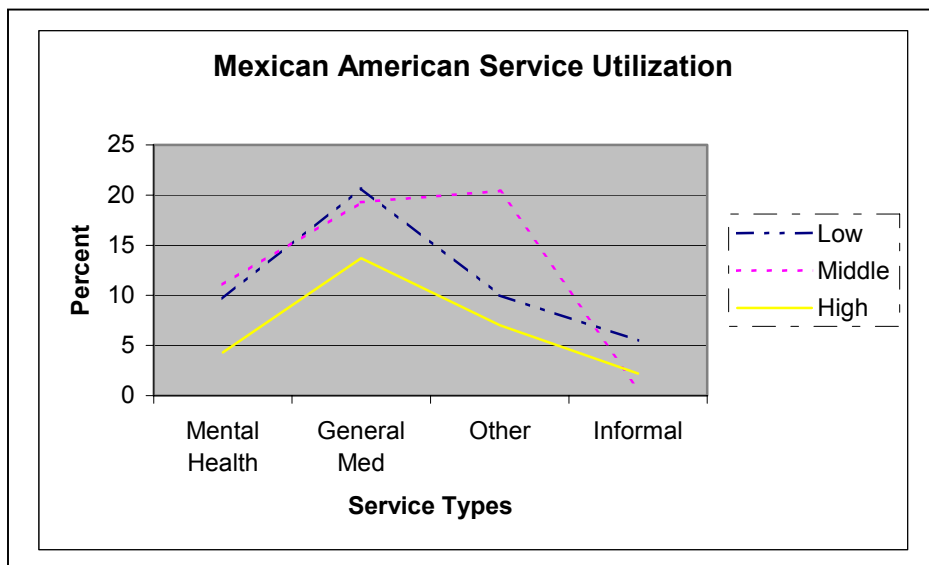
The ECA study showed that Hispanics with diagnosable mental illness were only half as likely to use mental health services as whites (11% compared to 22%) in the previous 6 months (Surgeon General 2001). The rate is even lower for Hispanic immigrants. The NCS reported utilization rates of about 10%. While Puerto Ricans in the U.S. tend to use general medical practitioners and underutilize mental health specialists when they have a diagnosed mental disorder, in Puerto Rico 32% and 85% of those with a diagnosed mental disorder have used mental health services (Surgeon General 2001).

Several surveys have placed the use of alternative and informal services at anywhere from 4 to 44% (Surgeon General 2001). However, the use of home/folk remedies may be very high.

There have been efforts to combine traditional and modern mental health services, especially in Puerto Rico.

It has been known for some time that Mexican Americans under utilize ambulatory health care. Several reasons have been suggested for this: 1) cultural differences in perception of mental disorders, 2) use of traditional healers as a preferred alternative, 3) a natural support system in the extended family and other dense social connections which lowers vulnerability, 4) lack of experience with American beliefs about mental illness, 5) reliance on primary care providers, and 6) lack of insurance and other accessibility barriers. These presume an equal amount of psychiatric morbidity compared to the general population, but several studies suggest that Hispanic immigrants,

but not refugees, actually have lower rates of mental illness. The rate of psychiatric morbidity seems to increase with time in the U.S., such that Hispanics born in the U.S. have higher rates than immigrants. This is also true for Puerto Ricans. This study designed to accurately measure utilization via extensive interviews with Mexican Americans living in Fresno County, California. Of those diagnosed with a history of a psychiatric condition (mood disorder, anxiety disorder, substance use disorder, comorbid mood and anxiety disorder, or comorbid substance use disorder with an anxiety and/or mood disorder), 28% use some sort of service, 8.8% used mental health services, 18.4% used general medical services, 12.7% used other professional services, and 3.1% used alternative/informal services. This varied with place of birth, education, income, the presence of comorbidity, and gender (Vega, Kolody, Aguilar-Gaxiola, and Catalano, 1999).



Treatment

Baez and Hernandez (2001) suggest that an understanding of Santería and Espiritismo are important for working with Latino patients. They present a system for appreciating the different degrees of acceptance of these spiritual systems that may be found clinically, stressing that believe is not an all or nothing phenomenon and may change with circumstances. They provide brief descriptions of each and examples of providing a respectful appreciation of the patient's beliefs.

One study of ethnic and racial matching, which studied the 12 month outcomes of 242 Hispanic patients and 2333 white patients in a community treatment program found that although Hispanic patients presented with more severe problems, there were no significant differences in outcome, with or without ethnic matching, except that Hispanic clients treated by Hispanic case managers had significantly less improvement in psychotic symptoms (Ortega and Rosenheck, 2002).

There are very few studies examining treatment outcomes with Hispanics. A few small sample studies show favorable responses to antidepressants in depression. There is indirect evidence from a couple of large multicentered studies of depression treatment

using antidepressants and/or psychotherapy, which contained relatively large Hispanic samples, that Hispanics respond equally well compared to non-Hispanic samples (Surgeon General 2001). Compared to whites, Hispanics tend to utilize formal substance abuse programs over AA in the successful maintenance of abstinence from alcohol (Arroyo, Westerberg, and Tonigan 1998).

Like African Americans, Hispanics may often be falsely diagnosed with schizophrenia, when they are later shown to have Bipolar Disorder (Surgeon General 2001). Primary Care providers may be even more likely to miss depression in Hispanic patients than in whites (Surgeon General 2001).

Treatment Recommendations

Treatment often involves the active participation of other family members. It is important to be indirect about potentially embarrassing topics. It is important to show a personal interest and to cultivate personal loyalty. Encourage the asking of questions.

Ruiz and Casas (1976) describe a form of therapy developed through working with Chicano college students that stresses a here and now focus, problem identification, cognitive restructuring, in which the therapist is directive and behavioralistic in orientation, which may serve as a model for therapy with other Hispanic populations.

Bibliography

- Arroyo, J.A.; Westerberg, V.S.; and Tonigan, J.S. (1998). Comparison of Treatment Utilization and Outcome for Hispanics and Non-Hispanic Whites, J. Stud. Alcohol. 59: 286-291.
- Baez, A. and Hernandez, D. (2001). Complementary Spiritual Beliefs in the Latino Community: The Interface with Psychotherapy, Amer. J. of Orthopsychiatry. 71(4): 408-415.
- Berry, J.W. (1990). Acculturation and Adaptation: A General Framework, in W.H. Holtzman and T.H. Bornemann (eds.) Mental Health of Immigrants and Refugees. Austin, Tx.: Hogg Foundation for Mental Health: 90-102.
- Flaskerud, J.H. and Liu, P.Y. (1991). Effects of an Asian Client-Therapist Language, Ethnicity and Gender Match on Utilization and Outcome of Therapy, Community Mental Health J. 27(1): 31-42.
- Guarnaccia, P.J. (1993). *Ataques De Nervios* in Puerto Rico: Culture-Bound Syndrome or Popular Illness? Medical Anthropology. 15: 157-170
- Guarnaccia, P.J.; Canino, G.; Rubio-Stipec, M.; and Bravo, M. (1993). The Prevalence of *Ataques de Nervios* in the Puerto Rico Study: The Role of Culture in Psychiatric Epidemiology, J. of Nervous and Mental Disease. 181: 157-165.
- Guarnaccia, P.J.; Rivera, M.; Franco, F.; and Neighbors, C. (1996). The Experiences of *Ataques de Nervios*: Towards an Anthropology of Emotions in Puerto Rico, Culture, Medicine and Psychiatry. 20: 343-367.
- Kitano, H.H.L. and Matsushima, N. (1976). Counseling Asian Americans, in P.B. Pedersen, J.G. Draguns, W.J. Lonner, and J.E. Trimble (eds.) Counseling Across Cultures. Honolulu, Hawaii: University Press of Hawaii: 163-180.
- Leong, F.T.L. and Lau, A.S.L. (2001). Barriers to Providing Effective Mental Health Services to Asian Americans, Mental Health Services Research. 3(4): 201-214.
- Lewis-Fernández, R.; Garrido-Castillo, P.; Bennasa, M.C; *et al.* (2002). Dissociation, Childhood Trauma, and *Ataques De Nervios* Among Puerto Rican Psychiatric Outpatients, Amer. J. of Psychiatry. 159(9): 1603-1605.
- Lin, K.M. and Cheung, F. (1999). Mental Health Issues for Asian Americans, Psychiatric Services. 50(6): 774-780.
- Lin, K.M.; Lay, J.K.C.; Yamamoto, J.; *et al.* (1992). *Hwa-byung*: A Community Study of Korean Americans. J. of Nervous and Mental Disease, 180: 386-399.
- Logan, M.H. (1993). New Lines of Inquiry on the Illness of Susto, Medical Anthropology. 15: 189-200.
- Lown, E.A. and Vega, W.A. (2001). Intimate Partner Violence and Health: Self-Assessed Health, Chronic Health, and Somatic Symptoms Among Mexican American Women, Psychosomatic Medicine. 63(3): 352-360.
- Ortega, A.N. and Rosenheck, R. (2002). Hispanic Client-Case Manager Matching: Differences in Outcomes and Service Use in a Program for Homeless Persons with Severe Mental Illness, The J. of Nervous and Mental Disease. 190(5): 315-323.
- Rogler, L.H.; Cortes, D.E.; and Malgady, R.G. (1994) The Mental Health Relevance of Idioms of Distress: Anger and perceptions of Injustice Among New York Puerto Ricans, The J. of Nervous and Mental Disease. 182(6): 327-330.

- Ruiz, R.A. and Casas, J.M. (1976). Culturally Relevant and Behavioristic Counseling for Chicano College Students, in P.B. Pedersen, J.G. Draguns, W.J. Lonner, and J.E. Trimble (eds.) Counseling Across Cultures. Honolulu, Hawaii: University Press of Hawaii: 181-202.
- Salgado de Snyder, V.N.; Diaz-Perez, M.J.; and Ojeda, V.D. (2000). The Prevalence of *Nervios* and Associated Symptomatology Among Inhabitants of Mexican Rural Communities, Culture, Medicine, and Psychiatry. 24(4): 453-470.
- Surgeon General, (2001).
Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. Dept. of Health and Human Services, U.S. Public Health Service: Rockville, Md.
- Tseng, W.S. (2003). Clinician's Guide to Cultural Psychiatry. San Diego, Calif.: Academic Press.
- Vega, W.A.; Kolody, B.; Aguilar-Gaxiola, S.; Alderate, E.; Catalano, R.; and Carveo-Anduaga, J. (1998). Lifetime Prevalence of DSM-III-R Psychiatric Disorders Among Urban and Rural Mexican Americans in California, Arch. Of Gen. Psychiatry. 55: 771-778.
- Vega, WA; Kolody, B; Aguilar-Gaxiola, S.; and Catalano, R. (1999) Gaps in Service Utilization by Mexican Americans with Mental Health Problems, Amer. J. of Psychiatry. 156(6): 929-934.
- Vega, W.A.; Sribney, W.M., and Achara-Abrahams, I. (2003). Co-occurring Alcohol, Drug, and Other Psychiatric Disorders Among Mexican-Origin People in the United States, Amer. J. of Public Health. 93(7): 1057-1064.
- Zheng, Y.P.; Lin, K.M.; Takeuchi, D.; Kurasaki, K.S.; Wang, Y.X.; and Cheung, F. (1997). An epidemiological study of neurasthenia in Chinese-Americans in Los Angeles. Comprehensive Psychiatry. 38: 249-259.