

# TOWARD CULTURALLY COMPETENT CARE

by Karen S. Kurasaki, Ph.D. and Stanley Sue, Ph.D.

Traditionally in the practice of clinical psychology, psychologists held tightly to their special formula for wellness. As a field, it seems psychology has reluctantly progressed toward a model of consumer participation. Were it not for the strength of the consumer movement we may not even be where we are today. Yet we seem to have fallen short of attaining truly consumer-driven care. Never is it more apparent that we must listen to and learn from the mental health consumer, than when care planning for today's culturally and ethnically diverse population. The necessity rings loudly and clearly, especially in the state of California, where the population is so diverse. Among Asian/Pacific Islander-Americans (APIA), for example, numerous studies have indicated that nationwide, APIA mental health consumers tend to drop out of treatment prematurely, access services during acute crisis as a last resort, and benefit minimally from services

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rendered from mainstream systems of care. In light of such evidence, it is apparent that psychologists along with other mental health care providers need to seriously listen to the voices of consumers in order to provide care that is meaningful, compatible, and efficacious to all consumers —

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including those whose values and beliefs about mental health, healing practices, and experiences, may not fall into mainstream U.S. culture.

Many psychologists are now working with others in the research and policy arenas to improve care systems' responsiveness to the needs of the nation's multi-ethnic and multi-cultural consumer population. For instance, researchers at the National Research Center on Asian American Mental Health (NRCAAMH) are hoping to find answers to such questions as: "What are the roles of ethnicity and culture in diagnosis and treatment?" And, "How well does our current system of care provide culturally appropriate and effective services to ethnic minority populations?"

NRCAAMH is host to several research projects that examine how ethnicity and culture play a role in the mental health of Asian/Pacific Islander-

Americans, and in the delivery of mental health services. In one study, we are investigating the prevalence rates of psychiatric disorders among a largely immigrant sample of Chinese-Americans. Existing prevalence studies have shown that ethnic and racial groups vary in their presentation of psychiatric distress. This is because cultural differences, such as differences in belief systems, value systems, and life experiences, are believed to influence the manner in which individuals interpret their experiences (including emotional experiences), and report mental distress. For the case of Asians and individuals from Asian ancestry, some researchers have proposed that the Confucian tradition, for one, may play an important role in how these groups interpret their life experiences, including emotional experiences.

One of the primary features of the Confucian philosophy is its emphasis on a mind-body unity. If it is true that people from Asian backgrounds interpret their life experiences more holistically (i.e., mind-body), then it would follow that their psychological and physical health would be more integrated. Consequently, we would expect to see both emotional and physical symptoms expressed in response to significant life stress. We find there is intriguing evidence that this mind-body philosophy influences how emotional experiences are interpreted, simply in the Chinese language system alone. The words used to describe depression in Chinese languages are said to depict a physiological sensation — something pressing on the heart or chest. Others have suggested that societal attitudes may also influence tendencies to report certain types of symptoms. Several authors have noted that social norms in many Asian cultures discourage expression of strong affects such as dysphoria, while physical complaints to

express the strain caused by personal and interpersonal problems are more acceptable. Moreover, mental illness is highly stigmatized in many Asian cultures. In these Asian cultures, mental illness reflects poorly on one's family lineage and can influence others' beliefs about how suitable a person is for marriage if he/she comes from a family with a history of mental illness. All of this is to say that symptom expression may vary considerably between different ethnic groups, and that culture may very well underlie these variations in symptom patterns.

So, what does this all mean for the consumer? Well, despite evidence from cross-cultural studies that there are no universal expressions of mental illness, the Diagnostic and Statistical Manual (DSM) system tends to be applied systematically across all populations in the U.S., including people from very different ethnic, racial, and cultural heritages. The effects of this systematic implementation warrants serious consideration. Note first that the DSM system is Western developed. Might then people from non-Western cultures be at some risk for being misdiagnosed? And might the same risk be true for other ethnic minority groups, not just non-Western groups, whose needs are also not properly represented in this culture-laden DSM diagnostic system? These are critical questions that the mental health care field must address. They have important implications for access and quality of care.

Researchers at the NRCAAMH are just beginning to seek answers to these questions. The earliest report from the Chinese American Psychiatric Epidemiological Study (CAPES) showed that Neurasthenia — a condition characterized by physical symptoms, and one which is diagnosed in China but not in the U.S. — was the most common diagnosis (3.6%) among those who qualified for only one diagnostic category at some time in their lifetime. This is one example of how researchers are attempting to explore and better understand culture-bound syndromes, as a preliminary step to improving mental health services to ethnic minority populations.

### Promoting Better Outcomes

NRCAAMH researchers are also examining various aspects of treatment and service delivery, to identify what aspects promote better outcomes for ethnic consumers. The Center engages in joint projects with several treatment facilities, in order to directly examine service utilization patterns, and understand the components of delivering quality care to ethnic minority consumer populations. In recent years, we have evaluated patterns of mental health service use by an extremely diverse consumer population in Los Angeles County. In Los Angeles County, a number of programs exist that are designed to respond to the unique mental health needs of specific ethnic minority populations. These programs are known as ethnic-specific mental health programs. In general, ethnic-specific mental health programs involve consumer-therapist ethnic match, modifying treatment practices to be culturally responsive, and creating a culturally familiar treatment milieu. These ethnic-specific programs are believed to provide a better match between ethnic minority consumer needs and the services delivered, and thus lead to better treatment outcomes. Since longer amounts of time spent in mental health treatment is typically associated with better outcomes, consumer return rate (i.e., return to treatment after the first session) and length of stay in treatment are considered to be useful indicators of treatment outcome.

Between 1982 and 1988, ethnic minority consumers in ethnic-specific programs were compared to their counterparts in mainstream services. Return rates and length of treatment were higher for all ethnic minority groups (African-American, Asian-American, Mexican-American) in ethnic-specific programs, compared to their counterparts in mainstream programs. The findings were particularly striking for Asian/Pacific Islander-American and Mexican-American consumers in ethnic-specific programs. Asian/Pacific Islander-

Americans in ethnic-specific programs were 15 times more likely and Mexican-Americans 11 times more likely than their mainstream counterparts to return to treatment after the first session. In a current study, we are hoping to uncover which aspects of consumer-therapist match are most predictive of better treatment outcomes. We are optimistic that this and future research will continue to illuminate how best to serve today's diverse consumer population.

### What Will the Future Hold?

Where are we headed for the future? Mental health professionals and consumers are beginning to work together at the policy level to establish cultural competency standards in mental health services for underserved ethnic and racial populations. Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990 mandated access to services for all individuals. However, in the wake of new managed care policies that attempt to reduce excessive costs by restructuring services, access and quality of care to ethnic minority consumers are threatened. With these concerns in mind, a national panel of African-American, Asian/Pacific Islander-American, Latino/a, and Native-American mental health professionals and consumers was created to develop cultural competency standards.

While the Latino/a task group was the first to come together, the entire national panel has been working vigorously since October, 1996 to develop a set of standards that are now being put forth to lobby the support of key funding and policy making entities at local, state, and federal levels. Among the panel's top priorities are to ultimately implement national standards that ensure access to linguistically and culturally appropriate services, and coverage for diagnoses and services relevant to ethnic minorities consumers. It is through efforts such as these, with consumers and professionals working collaboratively, and research impacting policy, that we can continue to effect important changes in the mental health care system. ■