A

ACADEMIC ACHIEVEMENT AND MINORITY INDIVIDUALS

The academic achievement of some minority individuals and groups remains a ubiquitous and seemingly intractable problem in the United States. The problem is usually defined in terms of mean differences in standardized achievement test scores between certain racial or ethnic groups. There is good reason for concern because on virtually every measure of academic achievement, African American, Latino, and Native American students, as a group, score significantly lower that their peers from European backgrounds. Moreover, it appears that gaps first manifest early in school, broaden during the elementary school years, and remain relatively fixed during the secondary school years.

THE NATURE AND SCOPE OF THE PROBLEM OF MINORITY ACADEMIC ACHIEVEMENT

One source of information that has documented academic achievement trends among minorities for more than three decades is the National Assessment of Educational Progress testing program. If the term "minority" is defined as a racial or ethnic group within a larger population, then the lower performance in achievement is associated with students from certain minority populations defined as African American and Hispanic. If the term "majority" is used to define a racial or ethnic group that characterizes the larger population, then the higher performance in achievement is associated with students from European backgrounds. These data have consistently shown significant achievement gaps between certain racial or ethnic groups on standardized tests in different subject areas and across grade levels. Other measures of academic achievement, such as grades and class rankings, show similar differences in minority and majority achievement.

Beyond the consistency of the disparities in minority and majority achievement, it is by no means clear what these discrepant scores really mean. To characterize racial and ethnic differences as minority differences suggests that these groups have had similar experiences and that these experiences influence their behavior in a similar way. However, this is not the case. There is tremendous variability within and across racial and ethnic groups even though they are ascribed minority status in U.S. society. For example, native-born African Americans and immigrants of African ancestry are similar in terms of race and minority status, but they have had different culturally mediated socialization experiences that affect their achievement motivation and academic performance differently. However, because academic achievement is usually reported as a mean score for African Americans, it is difficult to differentiate the nature of the performance of either minority group. But it is important to know which minority groups are performing high or low because such information is critical for informing appropriate intervention for both groups.

FACTORS THAT INFLUENCE LOW MINORITY ACHIEVEMENT

Since the 1960s, numerous perspectives have been advanced about the differences in academic achievement among minority and majority students and groups. Reasons include unequal opportunities to

learn, limited access to educationally relevant resources, ethnic and racial stereotyping, and cultural incompatibility between the home and school culture. Each will be discussed briefly.

Limited Opportunities to Learn

In reviewing the literature on who gets access to rigorous curricula in schools, it appears that, on the basis of standardized test results, a disproportionate number of racial and ethnic minority individuals, particularly those from low-income backgrounds, are judged as "low ability" and assigned to low-track or remedial classes. In contrast, individuals of European descent, particularly those from high-income backgrounds, are more likely to be considered "gifted and talented" and placed in enriched or accelerated programs. Because track enrollment determines the level of courses students take and the quality of the curriculum and instruction to which they are exposed, this means that minority students, on average, are less likely than their majority peers to engage in high-caliber curricula. Diminished opportunity to learn high-level material results in low academic achievement.

Limited Access to Institutional and Other Resources

Well-equipped libraries, mentoring, tutoring, quality teaching, rigorous curricula, low counselor–student and teacher–student ratios, small class sizes, extracurricular experiences, and computer and other technologies are examples of key resources in education that may be viewed as preconditions for enabling high levels of academic achievement. Unfortunately, a disproportionate number of individuals from certain minority groups (e.g., African Americans, Latinos, and Native Americans), particularly those from low-income backgrounds, are likely to attend schools with limited access to these resources, thus minimizing their opportunity to do well academically. Moreover, many of these individuals live in economically distressed communities where they experience poor health and inadequate nutrition, factors that place them further at risk educationally.

The Effects of Racial Stereotyping

Racial stereotyping is a deeply held, stigmatizing belief in unalterable genetic or cultural inferiority that many members of a majority population hold about individuals and groups who have been assigned minority status in society. In the United States, the effects of racial stereotyping have a particularly devastating effect on the academic motivation and achievement of some individuals from racial and ethnic minority groups, particularly those who have been brought into society involuntarily through slavery and conquest (e.g., African Americans, Mexican Americans, and Native Americans). In the education sphere, some individuals from these ascribed caste-like minority groups have rejected this form of stereotyping by developing coping mechanisms to protect their identity. In so doing, these identity-protection strategies serve to dampen their achievement motivation, which, in turn, results in low academic achievement.

Cultural Incompatibility Between Home and School Culture

Schooling is ineffective for some children from racial and ethnic minority groups because classroom practices may be incompatible with their cultural background. Cultural incompatibilities include a lack of respect for children's conversational style and collaborative participation structures. Such misunderstandings can contribute to diminished commitment to academic engagement and academic underachievement.

RECOMMENDATIONS FOR IMPROVING MINORITY ACHIEVEMENT

Reducing or eliminating the minority achievement gap remains one of the most serious challenges in U.S. education today. Efforts to close the gap should take the following considerations into account.

Disaggregation of Data

Individuals from minority groups have different socialization experiences that have a differential impact on their academic motivation and performance. Disaggregation of achievement data is necessary to identify which minority individuals and groups are doing poorly and which are doing well. Such information on the variability in minority achievement may then be used to target appropriate instruction for different individuals and groups.

Adequate Exposure to Supplementary Education

School alone cannot ensure high academic achievement. Indeed, parents or significant others of high-achieving students recognize the importance of supplementary education and routinely make it available to their children over the course of their schooling. Examples of supplementary education include academic summer camps, after-school and weekend tutoring, use of libraries and museums as resources for learning, and access to mentors and models who are themselves high achievers. Low-achieving minority students must have adequate exposure to supplementary education.

Adequate Exposure to High-Quality Teaching

Low-achieving students must have adequate exposure to high-quality teaching that is responsive to their strengths, needs, and interests. This means not only that they must have opportunities to participate in curricula and instructional activities that are known to be conducive to high academic achievement, but also that these experiences must be accommodative to their learning strengths and needs.

Access to Educationally Relevant Resources

High-achieving students have access to educationally relevant resources in the schools they attend and through their families and communities. Such resources must be made available to low-achieving students as well.

—Eleanor Armour Thomas

See also *The Bell Curve*; Head Start; Intelligence Tests; Scholastic Assessment Test

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ACCESSIBILITY OF HEALTH CARE

DEFINITION AND SCOPE OF HEALTH CARE ACCESS

The health disparities and health care inequalities experienced by major American ethnic groups (compared with Caucasian Americans) have been well documented. Health disparities are defined as higher rates of chronic and disabling illness, infectious disease, and mortality experienced by members of ethnic minority groups compared with Caucasians. One of the most important factors contributing to health disparities is limited access to health care. Therefore, improving access to health care is considered one of the greatest opportunities for reducing health disparities in the United States.

Access to health care can be considered at two levels: primary access and secondary access. Primary access involves entry into the health care system and access to basic care. Secondary access involves the quality of care received by individuals with primary access. Primary and secondary health care access will be discussed with respect to four major cultural groups in the United States: African Americans, Hispanic Americans, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives. Primary access issues include health insurance rates and the accessibility of health care facilities. Secondary access issues include quality of care, access to specialists, access to culturally similar health care personnel, language barriers, and discrimination.

AFRICAN AMERICANS

Lack of insurance is considered the most significant barrier to health care, and for a majority of Americans, health insurance provided by employers makes health care affordable. The uninsured rate for African Americans under age 65 is 19.9%. Unemployment is

strongly tied to the lack of insurance among African Americans; however, a disproportionate number of African American workers whose employers do not provide health insurance are also counted among the uninsured. Among African Americans, poverty and unemployment rates are 24.4% and 11.6%, respectively, compared with 8.2% and 5.6%, respectively, for Caucasians.

Another primary health care access issue for African Americans is the availability of health care providers. In poor, ethnic communities, there is a limited supply of health resources, primarily because patients in these communities cannot afford to pay for the services provided. As a result, health care facilities cannot be maintained. This reality has driven the creation of community health centers and hospital-based providers. Reduced geographic proximity to health care providers has a particularly strong impact on urban African American communities that rely heavily on public transportation, which increases the time and cost of accessing care.

A major secondary access issue is the quality of care received by African Americans. Inequalities in medical care exist even when African Americans have insurance plans that are similar to majority group members. For example, African American patients with health maintenance organization (HMO) insurance report more difficulty seeing a specialist and obtaining tests and treatment, suggesting that barriers exist well beyond entry into the health care system.

Another secondary access issue is the lower number of physicians from ethnic minority groups. This decreases health care access for minority patients because prospective patients are often reluctant to visit health care providers who may be racially or ethnically different from them.

Language barriers also influence secondary access. Patient–physician communication has been reported to be more problematic for African American patients than for Caucasian patients, even though both patients and physicians may speak the same language. Finally, discrimination is a major barrier to secondary access, affecting physicians' perceptions of patients as well as treatment decisions. For example, a negative perception of African American patients is associated with a lower likelihood of recommending treatment.

HISPANICS

The majority of the 35 million individuals in the United States counted as Hispanic or Latino are of Mexican heritage, and the remainder are from Caribbean and South American backgrounds. The uninsured rate for Hispanics under 65 years old is 33%, the highest rate among the major ethnic groups in the United States. The high uninsured rate among Hispanic populations is largely tied to immigration status. An estimated 72% of foreign-born persons in this group are not American citizens, and public insurance programs such as Medicaid deny services to immigrants. Furthermore, immigrants are more likely to work in low-wage, low-benefit jobs that do not offer health insurance. Hispanic Americans also rely heavily on public transportation, which necessitates traveling greater distances and incurring greater costs for medical care.

With regard to secondary access, Hispanic patients experience barriers similar to those of African Americans, including a lower quality of care afforded by lower-end insurance plans and discrimination. The language barrier is a significant secondary access issue for Hispanic groups: Limited English proficiency on the part of Hispanic patients, combined with a lack of Spanish-speaking health care providers, can result in misdiagnosis and inappropriate treatment of symptoms.

ASIAN AMERICANS AND PACIFIC ISLANDERS

Asian Americans and Pacific Islanders (AAPIs) represent a diverse group with more than 60 different national and ethnic origins and more than 100 different languages. This group makes up about 5% of the total U.S. population (more than 12 million). According to the Institute of Medicine, the uninsured rate for AAPIs under age 65 is 22%. The rates vary significantly, however, among subgroups, and the highest rate is found among Korean Americans (34%), who experience higher rates of poverty. The rates are also higher for Southeast Asian and South Asian groups. In addition to poverty, immigrant status is a significant barrier to obtaining insurance. Of the AAPIs who are foreign born, 52.9% are not American citizens and therefore cannot access publicly funded insurance programs.

Even for AAPIs who have health insurance, poor perceived quality of care is a major secondary access issue. A large survey of individuals in a West Coast HMO revealed that AAPIs consistently had the worst access ratings across a variety of measures compared with other minorities. Limited English proficiency is

also a significant secondary access issue for AAPIs. Census data from 1993 estimated that more than 1.5 million AAPIs live in "linguistically isolated" households, that is, those in which no person over age 14 speaks English "very well."

Finally, discrimination affects secondary health care access for AAPIs. Because of their achievements in the socioeconomic and educational spheres, AAPIs have been labeled the "model minority." This label is misleading because it fails to recognize the tremendous diversity within the AAPI group and because it can blind people to the real needs and problems of AAPI subgroups.

AMERICAN INDIANS AND ALASKA NATIVES

American Indians and Alaska Natives (AIANs) represent a variety of culturally diverse and distinctive groups who speak more than 300 languages and comprise 562 federally recognized tribes. According to the 2002 U.S. Census, 4.1 million people (1.5%) identify themselves as AIANs. The health care situation of AIANs is somewhat unique compared with other ethnic groups because the U.S. government is obligated by treaty and federal statutes to provide health care to members of federally recognized American Indian tribes. The federal Indian Health Service (IHS) was established in 1955 to meet this need. Those AIANs who can readily access IHS services can receive free primary care; limited specialty services are available free of charge through contracts with private providers. Unfortunately, the IHS faces a number of obstacles to providing health care access to those it was intended to help. These obstacles include limited funding and geographical limitations. The IHS has 34 urban Indian health programs, but these programs represent only 1% of the total IHS budget. As a result of the limited funding, many areas have no services. In addition, IHS facilities are located on or near reservations, although the majority of AIANs live in urban areas away from their home reservations.

The gap between the need for IHS services and access to these services was highlighted by a 2004 Kaiser Foundation study, which revealed that more than one-third (35%) of AIANs under age 65 are uninsured and only 19% have access to IHS services. The problem is worse among low-income AIANs, almost half of whom (48%) are uninsured. Only 23% of uninsured, low-income AIANs have access to IHS services. Finally, communication difficulties are important secondary access issues for AIANs. Compared with Caucasians, AIANs report more dissatisfaction with the quality of care received and poorer communication with health care providers.

CONCLUSION

Ethnic minorities in the United States have poorer health status and less access to health care than Caucasians, largely as a result of lower rates of insurance coverage. Although health insurance coverage addresses the primary access issue, it does not address the myriad secondary access issues that minority Americans face after they get their foot in the door of the U.S. health care system. These secondary access issues include less accessible facilities, poorer quality of care, language and communication barriers, and discrimination. Greater attention to both primary and secondary health care access issues is needed to elucidate the processes that place minority group members at a disadvantage when they seek health care.

—Lisa C. Campbell
—Tamara Duckworth Warner

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ACCULTURATION

Early conceptualizations of acculturation described an interpersonal transformation that occurs when cultures come into sustained contact. Social scientists noted complex changes that can take place, including the conversion of values, the blending or separation of cultures, and personality and developmental growth.

Researchers attempted to use the acculturation process to examine the impact of modernization and industrialization on various communities and cultures during the 19th and 20th centuries. In the early part of the 20th century in the United States, acculturation became synonymous with *assimilation,* the loss of one's original culture and the adoption of a new host culture. This process was used to describe the experiences of immigrants from an array of places (e.g., Europe, China, Japan, and Mexico). The ultimate goal of American acculturation became the achievement of assimilation into a melting pot society.

Today, acculturation is considered a more dynamic process that occurs along various dimensions rather than a simple movement from a culture of origin toward assimilation. In addition, acculturation can occur on both the group and the individual levels, thus considering more of the consequent psychological adaptation and adjustment. Four acculturative stages have been described: contact, conflict, crisis, and adaptation. Furthermore, adaptation can include several strategies: (1) *assimilation*—the individual or group gives up (or is forced to give up) the cultural identity of origin and desires a positive relationship with the host culture; (2) *separation*—the individual or group retains the original culture (or is restricted from adopting the new culture through segregation) and desires no positive relationship with the host culture; (3) *integration*—the individual or group desires to retain the culture of origin as well as maintain a positive relationship with the host culture; and (4) *marginalization*—the individual or group no longer retains the original culture and has no desire (or is not allowed) to have a positive relationship with the host culture.

The dynamic quality of acculturation is further expressed by the gradual changes that occur in several areas (or dimensions) and affect the individual and potentially the cultural group as a whole (e.g., language, cognitive style, behavioral patterns, personality, identity, attitudes, and values).

One particular negative consequence of the acculturation process is the phenomenon of *acculturative stress.* Acculturative stress is defined as negative tension that can be directly related to threats, conflicts, or crises centered on one's cultural identity, values, or other emotional and behavioral patterns of living. Prolonged stress, especially of an extremely high level, can manifest itself in both psychological symptoms of distress (e.g., anxiety, depression) and physiological symptoms of distress (e.g., pain, fatigue, dizziness).

MEASUREMENT OF ACCULTURATION

One of the greatest challenges in understanding the role of acculturation in adjustment is the assessment of this construct. Despite the shift in the conceptualization of acculturation from a one-dimensional process to a multidimensional one, the measurement of acculturation has failed to reflect this reformulation. Indeed, most of the published acculturation scales require respondents to choose among terms that assess the unidirectional movement of individuals from traditional culture to majority culture, or they include scoring techniques that reflect this unidirectional movement. However, there are a very small number of measures developed recently to assess the various dimensions of acculturation by measuring two or more cultures independently of each other. This measurement approach is consistent with the concept of *biculturalism* (or bicultural competence), namely that adaptation to a host culture is possible without completely abandoning the culture of origin.

The most commonly measured aspect of acculturation is language, including spoken or written language, language preference, and language proficiency. Cultural preferences—such as the preference for engagement with people from one's culture of origin versus the host culture, a sense of acceptance by a particular cultural group, or cultural pride—are other popular indicators of acculturation. In addition, it is common for many scales to use demographic or proxy variables of acculturation (e.g., generation of respondent, place of birth, language of interview).

In a small number of acculturation scales, an assessment of adherence to cultural traditions, beliefs, and values is provided. Measures that focus on these cultural indexes may be particularly important for cultural groups such as African Americans or American Indians, for whom English-language issues, length of U.S. residency, and immigration status may be less pertinent.

Indeed, certain ethnic groups have been significantly underresearched in regard to acculturation. It has been suggested that greater attention be given to developing theories of acculturation that are specific to these groups' cultures to inform the development of sound and appropriate measures. Similarly, little attention has been focused on acculturation in children and youth; greater consideration to acculturation across the life span would increase our knowledge of the specific challenges and adaptations related to the age of the individual.

THE RELATIONSHIP OF ACCULTURATION TO ADJUSTMENT

Measures of acculturation are often used to predict psychological and physical distress symptomatology (e.g., depression, anxiety, substance abuse, physical pain, fatigue). Research conducted primarily with Latino and Asian American immigrants suggests that the relationship of acculturation to adjustment is a complex one. Some studies suggest that newly arrived immigrants are more vulnerable to symptoms because of a heightened level of acculturative stress. In particular, low English proficiency seems to be one of the most consistent predictors of psychological distress in these groups. However, in most of these studies, it is difficult to know whether preexisting stressors (e.g., experience of torture and persecution, loss of loved ones and material possessions) encountered in the country of origin may have predisposed these groups to experience the negative impact of acculturation to a new culture. Demographic variables such as age, sex, and socioeconomic status may lessen the effects of acculturative stress.

Other studies indicate a higher level of acculturation may be related to higher levels of psychological and physical distress. For example, an immigrant who has lived in the United States for a long period of time may be more vulnerable to psychological problems because of the loss of traditional cultural beliefs, values, or behaviors, which may offer protection from stress. In addition, long-term U.S. resident immigrants or U.S.-born members of cultural groups may be exposed to racial discrimination, social oppression, and new cultural standards, leading them to engage in risky behaviors (e.g., casual sexual encounters or increased consumption of alcohol). Some large studies have found this to be the case in certain Latino groups, such as Mexican Americans and Puerto Ricans. Alternatively, some theorists suggest that newer immigrants are particularly strong and resilient and therefore have lower levels of psychiatric disorders than their U.S.-born counterparts. However, research support for this position is limited.

Despite varying speculations regarding the nature of the relationship between acculturation and adjustment, it is important to avoid attempts to simplify explanations. This relationship should be viewed as representative of complex interactions among historical, social, cultural, group, and individual factors. In addition, multiple measures of adjustment and stress may be required when examining the effects of acculturative stress due to emic (culture-specific) ways of thinking about and expressing distress.

—Pamela Balls Organista

See also Acculturation Measures; Acculturative Stress; Biculturalism

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ACCULTURATION MEASURES

In light of the growing number of people of color represented in the 2000 U.S. Census, research in psychology is working to expand the field's understanding of the needs of ethnically and culturally diverse populations. Besides documenting differences in how people from diverse ethnic groups think, act, and believe, the most progressive research seeks not only to determine where important distinctions lie but also to demonstrate the meaning of group differences. Researchers have argued that the most meaningful difference, both between and within ethnic groups, is the value that an individual places on his or her culture. Recently, the measurement of that value has come in the form of acculturation measures. Designed to identify attachment to one's culture of origin, to a new culture, or to both, acculturation measures can be invaluable tools for understanding group differences.

The need for acculturation measures was created in part by the problems researchers had interpreting findings when people of color were included in study

samples. When people of color were combined into one group (i.e., people of color versus Caucasian subsamples), researchers struggled to determine what role, if any, cultural differences played in the results. Furthermore, when people of color were separated into different groups according to ethnic identification, researchers also had difficulty determining the role of culture within and between groups. That is, it was and is unclear what role culture plays in research findings because researchers did not have a method for controlling or testing the level of "culturalness" present in a given sample of people of color. Within-ethnic-group differences are often larger than between-group differences, and researchers needed a way to ensure that when sampling people of color from one ethnic group, the group represented a homogeneous representation of a specific level of cultural attachment. Acculturation measures were thought to be one step toward untangling the effects of culture by creating a method for assessing levels of cultural attachment, especially within ethnic groups.

Early models for acculturation measures suggested that acculturation was best conceptualized on a single continuum. Advocates of this perspective believed that acculturation is a process of moving from one's culture of origin to the other end of the spectrum, whereby a person becomes a member of a new or host culture. Some measures of acculturation in this system indicated only high or low involvement in one's host culture (unicultural), and some represented a true continuum from attachment to the culture of origin to the dominant culture (dual cultural). A central tenet of these approaches was that individuals cannot be equally immersed in two cultures at one time and likely have to give up some aspect of one culture to be a part of a different culture. Examples of measures from this approach include the African American Acculturation Scale, the Asian Values Scale, and the Acculturation Measure for Chicano Adolescents.

During the 1980s, several researchers began developing an extension to the previous notion that acculturation was best represented by a linear progression and instead suggested that a unicultural or dual-cultural perspective ignored individuals who were *bicultural.* Biculturalism, in this sense, represents individuals who maintain adherence to more than one culture at a time. Researchers proposed that acculturation is a bilinear process with one continuum representing a process whereby individuals can experience either marginality (adherence to no culture) or involvement and either uniculturalism or biculturalism. Examples of measures representing this approach include the Acculturation Rating Scale for Mexican Americans and the Biculturalism Involvement Questionnaire.

The idea of acculturation was expanded even further in the 1980s and 1990s, when research began to address a multilinear or typology approach to acculturative status. That is, researchers put forth the idea that individuals could be classified according to their acculturation perspective along four basic constructs. Specifically, individuals could demonstrate *integration, assimilation, separation,* and *marginalization.* Individuals were thought to express attitudes of acculturation that combined levels of adherence to the host and indigenous cultures. Furthermore, the level of adherence could be measured and placed on a continuum.

Integration is thought to be expressed when a person is bicultural, or active in his or her culture of origin and in the dominant culture. Assimilation is thought to occur when a person is active in the dominant culture and has little interest in aspects of his or her native culture. Separation is manifested when a person remains integrated into his or her culture of origin and uninterested in learning about or participating in the dominant culture. Finally, marginalization occurs when a person is inactive in both the culture of origin and the dominant culture. Although these ideas are fairly new, efforts are under way to create measures that assess the four acculturation typologies. The main difference between the latter perspective and the biculturalism model is that the multilinear model includes measurements of acculturation across different settings and cultures. From their earliest inception, acculturation measures, whether unicultural, bicultural, or multicultural, have generally been designed with the culture of origin in mind. That is, most measures are created to capture one's attachment to the culture of origin of a particular group (i.e., African Americans, Asian Americans). Despite efforts to this point, the field is still in its infancy, with most measures of acculturation requiring greater research and stronger psychometric findings before widespread use is possible.

AFRICAN AMERICANS

Targeting traditional African American culture, two measures of dual culturalism represent the available tools for measuring acculturation in the African American population: the African American Acculturation Scale and the Scale to Assess African American Acculturation.

Both measures offer promise to the study of acculturation among African Americans; however, the psychometric properties of both measures are rather unclear, and greater study of their validity and reliability, especially their stability over time, is needed.

HISPANIC AMERICANS

The choices for measuring acculturation in Hispanic populations are more varied than for the African American population and include measures of both monocultural and bicultural acculturation. Furthermore, measures specific to the cultures of Cuban, Mexican, and Puerto Rican Americans are available. Several of the bicultural measures (e.g., Bicultural Involvement Questionnaire, Cultural Lifestyle Inventory, Bicultural Scale for Puerto Rican Americans, and Acculturation Rating Scale for Mexican Americans) allow for measurement of attachment to the culture of origin as well as the host culture, but they lack normative data to enhance interpretation for their use. These measures represent adequate psychometrics and some evidence of construct validity.

NATIVE AMERICANS

The Navajo Family Acculturation Scale, the Navajo Community Acculturation Scale, and the Rosebud Personal Opinion Survey represent the best tools available for measuring acculturation among Native American samples. Although there are more than 500 recognized tribes in the United States, each with its own unique culture, so far only the Rosebud Personal Opinion Survey is designed to be a general measure for Native populations. More research is needed to establish the psychometric properties of these measures.

ASIAN AMERICANS

Like the Native American measures, only three measures are commonly used with Asian American populations: the Acculturation Scale for Chinese Americans, the Suinn-Lew Asian Self-Identity Acculturation Scale, and the Asian Values Scale. The latter two measures are designed for use with all subgroups of Asian Americans (e.g., Japanese, Korean) and appear to have adequate psychometric properties.

Only one measure, the Multicultural Acculturation Scale, is designed for use with all cultural groups and based on the bilinear acculturation model. The scores on this measure give a general sense of attachment to an ethnic group versus attachment to American values. This measure represents the first step toward developing a cross-cultural measure of acculturation, but more research is needed to determine its psychometric properties.

CONCLUSION

Researchers recognize that people of color represent more than differences in ethnic groups and bring to bear their cultural influences on research findings. Measuring the role of culture is the direction of the field, and to this end, several measures of acculturation are available for use with different cultural groups. By including a measure of acculturation, researchers can be assured that their findings are the result of the study variables and not necessarily within-group differences among the sample. For these measures to be of real use, however, more research is needed to establish the psychometric properties of acculturation measures. Moreover, new measures or updates of older versions are needed to keep up with changes in acculturation theory. Research that addresses the construct validity and long-term stability of acculturation measures would advance the field and allow for more sophisticated research questions. For example, acculturation measures that address biculturalism and measure acculturation status across settings are needed. Finally, acculturation measures generally measure behaviors (e.g., eating habits, social preferences) associated with attachment to a particular culture or cultures, and this may not represent the true nature of the acculturation experience. Focusing on behaviors only, researchers may neglect the importance of an individual's values, beliefs, and knowledge, all important parts of cultural adherence.

—Yo Jackson

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ACCULTURATION SCALES: ACCULTURATION, HABITS, AND INTERESTS MULTICULTURAL SCALE FOR ADOLESCENTS

Acculturation—the interchange of cultural attitudes and behaviors—involves changes in styles of speech, social behaviors, attitudes, beliefs, customs, celebration of holidays, and choices of foods and entertainment. Immigrants generally follow one of four general acculturation patterns: (1) *integration*—combining aspects of the new culture with aspects of the native culture; (2) *assimilation*—replacing the native cultural orientation with the new cultural orientation; (3) *separation*—retaining the native cultural orientation while rejecting the new cultural orientation; or (4) *marginalization*—becoming alienated from both cultures.

Measuring adolescents' acculturation levels in large, population-based surveys is difficult. Most published acculturation scales for adults contain words or concepts that young adolescents cannot comprehend. Most brief acculturation scales assess only language usage, which is only one facet of the acculturation process.

The Acculturation, Habits, and Interests Multicultural Scale for Adolescents (AHIMSA) is a brief, multidimensional, multicultural acculturation measure for use in large-scale, classroom-based, paper-and-pencil surveys of early adolescents from varying cultural backgrounds. The AHIMSA includes questions that are relevant to adolescents, including their choice of friends, favorite music and television shows, favorite holidays, foods eaten at home, and general ways of thinking.

The items include the following: "I am most comfortable being with people from . . . ," "My best friends are from . . . " "The people I fit in with best are from . . . ," "My favorite music is from . . . ," "My favorite TV shows are from . . . ," "The holidays I celebrate are from . . . ," "The food I eat at home is from . . . ," and "The way I do things and the way I think about things are from . . ." The response options are "the United States," "the country my family is from," "both," and "neither." The AHIMSA generates four subscores: United States Orientation (assimilation), Other Country Orientation (separation), Both Countries Orientation (integration), and Neither Country Orientation (marginalization). Subscale scores are calculated by summing the number of responses in each of the four categories. The score on each subscale can range from 0 to 8. Researchers might elect to use one or more of the four orientation scores depending on their research questions.

The AHIMSA was developed through multiple rounds of pilot testing and psychometric analysis. First, existing acculturation measures were examined to identify questions that could be simplified or modified for adolescents. This resulted in an initial set of 13 items. These 13 items were shown to middle school students in focus groups to assess their interpretation of the items. Items that were confusing were reworded. The set of 13 modified items was administered to a pilot sample of sixth-grade students. Items with low variance were eliminated from the scale. Item response-curve analyses were used to select a final set of items that differentiated students at all levels of the scale. The final set of items included eight questions.

In a study of 317 sixth-grade adolescents in Southern California, the means on the United States Orientation, Other Country Orientation, Both Countries Orientation, and Neither Country subscales were 3.93, 0.50, 3.25, and 0.26, respectively. The United States Orientation, Other Country Orientation, and Both Countries Orientation subscales were correlated with the subscales of a modified Acculturation Rating Scale for Mexican Americans–II (ARSMA-II), English-language usage, and generation in the United States, providing evidence for the validity of those three subscales. The Neither Country Orientation subscale did

not appear to be a valid measure of marginalization, a construct that is difficult to operationalize and difficult for adolescents to conceptualize.

Inclusion of the AHIMSA scale in surveys of adolescents provides a more complete understanding of the role of acculturation in adolescents' behavioral choices, which could lead to the creation of more culturally appropriate educational programs for adolescents in a multicultural society.

—Jennifer B. Unger

See also Acculturation

FURTHER READING

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ACCULTURATION SCALES: ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS–II

The Acculturation Rating Scale for Mexican Americans (ARSMA) is a seminal bilingual acculturation measure designed for use with both clinical and nonclinical Mexican American populations. The development of the ARSMA was a timely response to the booming Mexican American population. According to the 2000 U.S. Census, the Latino population is now the largest ethnic minority group in the United States, and 58.5% of this group is composed of Mexican Americans. Since its creation, the ARSMA has served as the model for many acculturation measures used with other ethnocultural groups.

The original ARSMA was a linear measure of acculturation developed by Israel Cuéllar, Lorwen C. Harris, and Ricardo Jasso in 1980 to assess cultural preferences and behavioral tendencies. In response to criticism that their measure obliged respondents to choose between two cultures and did not accurately reflect acculturation adaptation styles, Israel Cuéllar, Bill Arnold, and Roberto Maldonado produced a revised version in 1995. The ARSMA-II was designed to use an orthogonal, multidimensional approach to acculturation assessment by capturing varying levels of biculturalism and allowing individuals to rate their orientation to Mexican and U.S. mainstream culture independently. This was achieved by dividing the original ARSMA items into two sections, one for each cultural orientation. The ARSMA-II classifies respondents into one of four styles of acculturation: *assimilation* (highly identified with U.S. mainstream culture only), *integration* (highly identified with both cultures), *separation* (highly identified with Mexican culture only), and *marginalization* (low levels of identification with both cultures).

The ARSMA-II retains its original version's behavioral focus but also includes an affective (positive/negative) affirmation of ethnic identity. Scale 1 of the ARSMA-II contains two subscales: the Anglo Orientation Subscale (13 items) and the Mexican Orientation Subscale (17 items). An optional Scale 2 (18 items) was included to assess feelings of marginality and difficulty accepting Anglo, Mexican, and Mexican American ideas, beliefs, customs, and values. All items are scored on a five-point Likert scale ranging from 1 (not at all) to 5 (extremely often/almost always). Overall, the measure assesses three principal constructs: language, ethnic identity, and ethnic interaction or ethnic distance. The ARSMA-II demonstrates good internal consistency of subscales (alphas ranging from .68 to .91) and test-retest reliability (ranging from .72 to .96). Additionally, the validity of the ARSMA-II has been supported by significant associations with the ARSMA and generational status.

The strong psychometrics of the ARSMA-II have made it a very popular instrument, used in more than 75 publications since 1980. The bilingual format, availability of a software scoring program, ease and brevity of administration, variety of content areas assessed (moving away from relying exclusively on language), and success in differentiating between generational levels are additional advantages. On the other hand, the ARSMA-II has been criticized for its limited applicability to other Latino ethnic groups, absence of an assessment of cultural values (e.g., individualism, collectivism, familism), nonrepresentative sample (379 college students), lack of norms for children, and problems with classification (portions of samples that do not fall into categorical acculturation styles, insignificant differences between classifications).

A host of studies using the ARSMA and ARSMA-II have empirically linked Mexican American acculturation with a variety of constructs, including ethnic identity, socioeconomic status, mental health, academic

attainment, gang involvement, relationship satisfaction, health risk behaviors, eating disorders, suicidal ideation, depression, clinical elevations on personality tests, self-esteem, coping, and counseling expectations. Experts in the field of acculturation underscore the need for longitudinal studies of the acculturation process to more accurately capture the developmental and dynamic nature of acculturation. Many urge that revisions to acculturation scales should include direct measures of contextual mediators or moderators of acculturation (e.g., reason for immigration, immigration policies, attitudes toward immigrants, political environment).

—Rebecca E. Ford
—Yarí Colón
—Bernadette Sánchez

See also Acculturation; Mexican Americans

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ACCULTURATION SCALES: AFRICAN AMERICAN ACCULTURATION SCALE

Acculturation is defined as the extent to which an ethnic minority individual participates in the values and beliefs of the dominant ethnic-majority culture. Acculturation can be thought of as a continuum from traditional at one extreme, to bicultural in the middle, to acculturated at the other extreme. Traditional individuals retain almost exclusively the values and beliefs of their culture of origin and do not participate in the majority culture. Bicultural individuals are fluent in both their culture of origin and that of the majority. Bicultural individuals can further be classified as "blended," having melded aspects of both cultures, or "code-switchers," those who alternate between the two cultures. Acculturated individuals participate almost exclusively in the majority culture and have rejected most aspects of their culture of origin.

In the United States, the concept of acculturation has generally been applied to immigrant ethnic groups. However, as the developers of the African American Acculturation Scale (AAAS), Hope Landrine and Elizabeth Klonoff, have demonstrated, the concept of acculturation can be meaningfully applied to African Americans. Despite the long residence of African Americans in the United States, individual African Americans, like individuals in other ethnic minority groups, may choose to participate in the majority culture to a greater or lesser extent.

The AAAS is designed to tap some of the cultural domains in which African Americans display relatively distinctive beliefs and practices, such as religion, health, and child rearing. Scores on the scale have been found to be independent of demographic variables such as education, income, and gender. Three versions of the scale have been published: The first version (AAAS), published in 1994, contained 72 items that were divided into eight sections; a shorter version (AAAS-33), published in 1995, contained 33 items on 10 empirically derived subscales; and a revised version (AAAS-R), published in 2000, contained 47 items on eight factors. The AAAS-R, like its predecessors, has been shown to be psychometrically sound, with internal consistency reliability of .93 and split-half reliability of .79. Discriminant validity of the AAAS-R was established by comparing African Americans with differing levels of segregation; African Americans with other ethnic groups; and African American drinkers (who tend to be less traditional) with abstainers.

The AAAS has been used in studies in several areas of psychology, including health psychology, mental health, and neuropsychology. In health psychology, scores on the AAAS have been linked to cigarette smoking and hypertension. In general, the research suggests that an individual's level of acculturation may be related to (1) how much racism he or she experiences (more traditional people experience more racism), which is related to how much the person smokes (more racism results in greater smoking), and (2) how stressful the racism is perceived as being (more traditional people experience racism as more stressful), which is related to hypertension (more stressful racism results in higher blood pressure levels).

In mental health research, AAAS scores have been shown to predict depression, stress levels, and coping styles. Additionally, the relationship between mental

health and coping styles may be different for acculturated individuals than for traditional individuals. In neuropsychology, the AAAS has been helpful in understanding why African Americans, particularly elders, score significantly lower than European Americans on tests of cognitive ability. The AAAS has proven to be a valuable tool in elucidating the unique role that cultural factors play in the experiences and behaviors of African Americans in the United States.

—Tamara D. Warner

See also Acculturation; Mexican Americans

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ACCULTURATION SCALES: ASIAN AMERICAN MULTIDIMENSIONAL ACCULTURATION SCALE

The Asian American Multidimensional Acculturation Scale (AAMAS) is a measure of acculturation based on orthogonal assessment of three different cultural dimensions, which comprise four specific acculturation domains. Advancements in acculturation theory have established the desirability of a bidimensional approach to the measurement of acculturation, one that takes into account orientation to both the culture of origin and the host culture, thereby challenging the zero-sum assumption of a unidimensional approach in which acculturation to one culture comes at the expense of the other. The AAMAS is based on a *multidimensional* approach that includes orthogonal assessments of acculturation to the Culture of Origin (AAMAS-CO) and to European American culture (AAMAS-EA). The AAMAS further extends acculturation theory with the addition of a third cultural dimension, a pan-ethnic Asian American cultural dimension (AAMAS-AA), which is unique to the AAMAS. This dimension assesses the formation of a shared Asian American identity and culture, which is of increasing significance for Asian Americans.

The items on the AAMAS were adapted from the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) and converted to a multidimensional format by asking respondents to rate each item according to three referent groups: (1) their Asian culture of origin, (2) other Asian American cultures, and (3) mainstream European American culture. The primary strengths of the AAMAS include its ability to provide a more complex assessment of Asian American acculturation along cultural and domain-specific dimensions, as well as its ease of administration and use across different ethnicities. The primary weakness of the measure is that, like the SL-ASIA, the AAMAS is primarily a measure of behavioral acculturation. The AAMAS is intended primarily as a research measure, and to date, the predominant application has been for this purpose.

ACCULTURATION DOMAINS

In addition to the three cultural dimensions, exploratory and confirmatory factor analyses support four specific acculturation domains: language, food consumption, cultural knowledge, and cultural identity. Measures of internal consistency for each domain by cultural dimension range from .65 (food consumption in the AAMAS-CO) to .89 (cultural knowledge in the AAMAS-CO).

RELIABILITY AND VALIDITY

Results of three separate studies provide strong evidence of the instrument's reliability and validity. Estimates of internal consistency for each cultural dimension ranged from .87 to .91 for the AAMAS-CO, from .78 to .83 for the AAMAS-AA, and from .76 to .81 for the AAMAS-EA, and estimates of stability over time ranged from .75 to .89. Evidence of validity includes a significant negative correlation between the AAMAS-CO and generational status. Assessment of concurrent validity comparing the AAMAS subscales with the Asian Values Scale revealed expectedly modest correlations, whereas for divergent validity, there was little to no relationship with the Rosenberg Self-Esteem Scale.

ADMINISTRATION AND SCORING

The 15 items on the AAMAS are worded so as to facilitate administration across different ethnicities.

The instructions direct the respondents to rate each item according to their own Asian culture of origin, other Asian groups in the United States, and the mainstream host culture. The items are scored on a scale ranging from 1 (not very well) to 6 (very well). Only item 15 is to be reverse scored before adding up the responses for each cultural dimension for a total score, then dividing by 15 to obtain the scale score. Using this method, a separate score is obtained for each cultural dimension.

—Ruth H. Gim Chung

See also Asian/Pacific Islander

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ACCULTURATION SCALES: BIDIMENSIONAL ACCULTURATION SCALE FOR HISPANICS

The Bidimensional Acculturation Scale for Hispanics (BAS) was developed in 1996 to provide researchers with a relatively short measure of acculturation that could address the conceptual and psychometric limitations of other acculturation scales. The BAS uses two dimensions to define acculturation, avoiding the faulty assumption that gains in learning a non-Hispanic culture imply losses in the individual's understanding of or preference for Latino culture. As such, the BAS measures respondents' behavioral characteristics in two cultural domains: Hispanic and non-Hispanic. Furthermore, the BAS is useful in research with individuals from all Latino backgrounds rather than with individuals from one subgroup (e.g., Cuban Americans, Mexican Americans).

The BAS was developed by analyzing a large number of items addressing a variety of acculturative areas (e.g., language use, preference for ethnic social events). A random sample of 254 adult Hispanics was asked to report preferences and abilities in 30 areas in which acculturation can have an impact on behavior. Exploratory principal components and factor analyses were conducted on the original responses (separately for language-related items and social behaviors) to identify factors that accounted for large proportions of the variance. The final scale includes items that had correlations greater than .45 with a given factor and did not load heavily in more than one factor.

The BAS includes 24 items measuring linguistic usage, language proficiency, and electronic media usage. Half of the items refer to English use or English-language proficiency, and the other half addresses the same areas as they refer to Spanish use or proficiency. Each of the items is scored on a four-point Likert-type scale with anchors of "almost never" (scored as 1) and "almost always" (scored as 4) for the usage-related questions and "very well" (scored as 4) or "very poorly" (scored as 1) for the linguistic-proficiency items. The scale produces two acculturation indexes, one for each cultural domain, which are obtained by averaging responses to the 12 items relevant to each cultural domain (range of 1 to 4). An average score close to 1 indicates a low level of cultural proficiency in a given cultural domain (e.g., Latino), whereas an average score close to 4 indicates a high level of cultural proficiency on that same cultural domain. An average score of 2.5 can be used to dichotomize respondents into low or high levels of adherence to the specific cultural domain.

The BAS has shown high levels of reliability and validity. In the original study, the scale showed an alpha coefficient of .87 for the items in the Hispanic domain and .94 for the items in the non-Hispanic domain. Validity was established using a number of approaches, including correlations with respondents' generational status ($r = .50$ for the non-Hispanic domain and –.42 for the Hispanic domain), length of residence in the United States ($r = .46$ for the non-Hispanic domain and –.28 for the Hispanic domain), age of arrival in the United States ($r = –.60$ for the non-Hispanic domain and .41 for the Hispanic domain), and respondents' own assessments of their acculturative status ($r = .47$ for the non-Hispanic domain and –.38 for the Hispanic domain). In addition, the scale correlated highly ($r = .79$ for the non-Hispanic domain and –.64 for the Hispanic domain) with the Short Acculturation Scale for Hispanics (SASH).

The BAS has been used with Latinos of all national backgrounds and all generations, and the validation study was conducted with Mexican and Central

Americans. The items that make up the scale in English and in Spanish and the scoring instructions are available in the original publication. The scale has been useful in providing a comprehensive understanding of Hispanic acculturation in areas as diverse as physical health, mental health, drug and tobacco use, educational achievement, employment, and criminal behavior.

—Gerardo Marín

See also Acculturation; Acculturation Scales: Short Acculturation Scale for Hispanics

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ACCULTURATION SCALES: EAST ASIAN ACCULTURATION MEASURE

The East Asian Acculturation Measure (EAAM) is a 29-item self-report instrument designed to measure the social interaction and communication styles (both competency and ease and comfort in communicating) of East Asian (i.e., Chinese, Japanese, and Korean) immigrants in the United States.

MODELS OF ACCULTURATION

Researchers typically conceptualize the acculturation of Asian ethnic groups as a unidimensional construct that ranges from low acculturation, indicating a primary Asian identification, to high acculturation, indicating a Western identification, with an imputed midpoint representing a bicultural identification. This model has three key deficits: (1) Acculturation often does not occur in a neat linear or unidimensional manner; (2) the distinction between acculturation and ethnic identity is often obfuscated; and (3) identification with neither Asian nor Western cultures (i.e., marginalization) is not assessed.

In contrast, the EAAM is based on a multidimensional model of acculturation and examines four modes of social interaction and communication: (1) with ethnic group peers (separation), (2) with members of the host culture (assimilation), (3) with members of one's ethnic group and members of the host culture (integration), and (4) with neither one's own group peers nor members of the host culture (marginalization). The EAAM items do not assess ethnic identity (i.e., identity associated with belonging to a certain ethnic group). Instead, ethnic identity among East Asian immigrants may be assessed using the East Asian Ethnic Identity Scale.

NORMS, RELIABILITY, AND VALIDITY

The EAAM was originally studied with 150 East Asian immigrants (75 men, 75 women) with a mean age of 28.7 (SD = 6.40). The internal consistency (alpha) coefficients were .76, .77, .74, and .85 for separation, assimilation, integration, and marginalization, respectively. Significant negative correlations were found between separation and assimilation and between integration and marginalization. Length of stay in the United States was significantly and positively associated with assimilation and integration but significantly and negatively associated with marginalization. Normative data for the EAAM are currently being developed. Although the EAAM performed well psychometrically on the initial sample, its psychometric properties need to be established with other East Asian and non-Asian samples, including those with varying socioeconomic and educational backgrounds and English-language proficiency.

CLINICAL PRACTICE AND RESEARCH

Although many acculturation measures provide proxy measures of acculturation (e.g., generational status, English-language proficiency), the EAAM allows researchers to assess a pattern of attitudes and behaviors relevant to socialization and communication in various situations along multiple dimensions. Such information may be of clinical as well as social importance. The EAAM assimilation scale score significantly predicts increased willingness to use psychological services, whereas the EAAM marginalization scale score significantly predicts guarded self-disclosure, a potentially important impediment to engagement in traditional psychotherapy. In terms of social functioning, the EAAM integration scale score significantly predicts perceived egalitarian treatment from Americans, whereas the EAAM marginalization scale score significantly predicts perceived ethnic-group

discrimination (i.e., "people from my ethnic group are discriminated against").

—Declan T. Barry

See also Asian Values Scale; Asian/Pacific Islander

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ACCULTURATION SCALES: SHORT ACCULTURATION SCALE FOR HISPANICS

The Short Acculturation Scale for Hispanics (SASH) is one of the most frequently used acculturation scales in research with Latinos. The SASH was developed in 1987 after lengthy analysis of the responses of 363 Hispanics (e.g., Cubans, Mexican Americans, Puerto Ricans, and Central Americans) and 228 Caucasians to questions dealing with ethnic contact patterns, proficiency and preference of language use, preferred ethnicity in social relations, and characteristics of media use. Exploratory principal components factor analyses were conducted on the original responses to identify factors that accounted for large proportions of the variance. The final scale includes items that had correlations greater than .60 on a given factor and did not load heavily in more than one factor.

The SASH includes 12 items measuring linguistic usage and preferences and the ethnicity of friends, social gatherings, and play partners for respondents' children. Each of the items is scored on a five-point Likert-type scale with anchors of "only Spanish" (scored as 1) and "only English" (scored as 5) for the language-related items and "all Latinos/Hispanics" (scored as 1) and "all Americans" (scored as 5) for the ethnic-preference items. The acculturation index is obtained by averaging responses to the 12 items (range of 1 to 5). An average score close to 1 indicates a low level of acculturation, whereas an average score close to 5 indicates a high level of acculturation. An average score of 2.99 can be used to dichotomize respondents into low acculturation (i.e., those with average scores lower than 2.99) and highly acculturated respondents (i.e., those with average scores greater than 2.99). Further research has shown that, when needed, the scale can be shortened to the first five language-related items.

The SASH has shown high levels of reliability and validity. In the original study, the scale showed an alpha coefficient of .92 for all 12 items and .90 for the first five language-related items. Validity was established using a number of approaches, including correlations with respondents' generational status ($r = .65$, $p < .001$), length of residence in the United States ($r = .70$, $p < .001$), age of arrival in the United States ($r = –.69$, $p < .001$), and respondents' own assessment of their acculturative status ($r = .76$, $p < .001$). In addition, the scale discriminates between first- and second-generation Hispanics.

The SASH has been used with Latinos of all national backgrounds and all generations, as well as with individuals of limited reading ability. The scale has also been adapted for use with other ethnic and national groups by changing the response categories to more accurately reflect the group being studied. The items that make up the scale in English and Spanish are available in the original publication. A version for children is also available.

A major limitation of the scale is that it measures acculturation as a unidimensional phenomenon anchored at one cultural pole by a Latino dimension and at the other by a non-Hispanic dimension. Nevertheless, the SASH has a long history of effectively identifying Latinos with low or high levels of acculturation in different contexts and under a variety of circumstances. The Short Acculturation Scale for Hispanics is particularly useful when a rapid measure of acculturation is needed because of time constraints or length of study. The scale is also useful when researchers need to dichotomize respondents in terms of high or low levels of acculturation.

—Gerardo Marín

See also Acculturation; Acculturation Scales: Bidimensional Acculturation Scale for Hispanics

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ACCULTURATION SCALES: SUINN-LEW ASIAN SELF-IDENTITY ACCULTURATION SCALE

Developed to gauge acculturation in Asian Americans, the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) assesses the cognitive, behavioral, and attitudinal aspects of acculturation. The SL-ASIA is the most widely used measure of acculturation in Asian American populations. The SL-ASIA is based on a unilinear conceptualization of acculturation, which suggests that increased adherence to mainstream culture results in the reduction of adherence to the person's culture of origin.

The SL-ASIA is a paper-and-pencil self-report scale that consists of 21 multiple-choice items, each of which is rated on a five-point scale. Items assess language, identity, friendship choice, behaviors, generation and geographic history, and attitudes, and they are worded so as to be relevant to various Asian subgroups (e.g., Korean, Chinese, and Japanese). Scores are obtained by summing the answers for all 21 items and dividing the sum of scores by 21 to derive the final acculturation score. Acculturation scores can range from 1.00 (low acculturation) to 5.00 (high acculturation). An acculturation score of 3.00 represents a bicultural experience. Higher acculturation scores infer a greater degree of Western identification. In addition to total score analysis, one item allows the participant to rate himself or herself as either "very Asian," "bicultural," or "very anglicized."

PSYCHOMETRIC PROPERTIES

There is much evidence to suggest that the SL-ASIA is capable of producing reliable scores (e.g., see Ponterotto, Baluch, & Carielli, 1998). Scores on the SL-ASIA have generated internal consistency estimates ranging from .68 to .88 but typically fall in the mid .80s. In addition, there is much evidence that speaks to the construct validity of the SL-ASIA. For example, relationships have been found between SL-ASIA scores and generational status, residency in the United States, self-reported ethnic identity, attitudes toward counseling, willingness to see a counselor, and counselor ratings. Suinn and colleagues found the SL-ASIA items to be influenced by five underlying factors: (1) reading, writing, and cultural preference; (2) ethnic interaction; (3) affinity for ethnic identity and pride; (4) generational identity; and (5) food preference. This five-factor model of the SL-ASIA has been validated in both exploratory and confirmatory factor analytic investigations. Miller and colleagues also found evidence suggesting the SL-ASIA measures acculturation in an equivalent fashion for both women and men. Together, these pieces of evidence suggest the SL-ASIA produces reliable and valid scores of acculturation for Asian Americans.

UTILITY OF THE SL-ASIA

Because the SL-ASIA is a relatively brief, clear-cut instrument, it can be an effective piece of formal or informal assessment in clinical practice. As an assessment tool, the SL-ASIA supplies information about an individual's ethnic interaction, ethnic identity, language use, and social networks. By obtaining a deeper cultural and ethnic understanding of the individual, clinicians can begin to understand the phenomenological experience of the Asian American individual. In addition, because of the wording of the SL-ASIA items, the measure can be used with a wide range of Asian American subgroups.

LIMITATIONS

When using the SL-ASIA, it is important to recognize that the majority of items assess the behavioral dimension of acculturation (e.g., language preference). Recently, multidimensional conceptualizations of acculturation, which suggest that acculturation occurs on multiple dimensions (e.g., values and behavior), have been postulated. Therefore, it is helpful to understand that the SL-ASIA may not address other dimensions of the acculturation process.

—Matthew J. Miller
—Suzette L. Speight

See also Acculturation; Acculturation Measures

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ACCULTURATIVE STRESS

Acculturation refers to a process of cultural change that occurs when two or more cultural groups come into contact for an extended time, particularly when individuals in minority groups move into a new culture or host society. This is a complex, dynamic change process whereby individuals continuously negotiate among accepting, adapting to, or denying the characteristics of a majority culture, as well as retaining, changing, or rejecting certain components of their own culture. Psychological acculturation involves an adaptation or change in attitudes, behaviors, values, and identity.

As people undergo the process of cultural change, they often encounter difficulties or challenges in adapting to a new set of cultural customs and behavioral rules in a nonnative society, where they may lack resources and support from their native culture. *Acculturative stress* is defined as stress related to moving from one's culture of origin to another culture. Although the traditional view held that acculturation inevitably brings tremendous stress, the contemporary view attempts to understand acculturative stress through a lens of a stress-coping model. This model postulates that (1) acculturative stress may occur when the external and internal demands of the acculturation process exceed the individual's coping ability or resources, and (2) the level of acculturative stress depends on multiple factors, such as the mode of acculturation, nature of the acculturating group, characteristics of the host culture, and demographic variables (e.g., age, gender).

For example, it has been found that among international students in the United States, acculturative stress is associated with English fluency, satisfaction with social support, social connectedness, the need for approval, and maladaptive perfectionism. For African American college students, acculturative stress is associated with racial identity and racial socialization. For Latinos, acculturative stress is related to the efficacy of stress-coping resources, degree of acculturation, cohesion of the family, language use, and length of residence in the United States.

Not surprisingly, acculturative stress has been linked to academic performance and negative mental health consequences. For example, acculturative stress has been positively associated with lower academic performance, lower quality of life in general, excessive alcohol intake, body dissatisfaction and bulimia, identity confusion, anxiety, psychosomatic symptoms, depression, and suicidal ideation. Moreover, during the past five years, research related to acculturative stress has begun to identify variables that might mediate or moderate the relationship between acculturative stress and depression. For example, it has been found that maladaptive perfectionism moderates the relationship between acculturative stress and depression in international students. Similarly, perceived social support from friends has been shown to have a buffering effect between acculturative stress and depression for Korean adolescents from immigrant families in the United States. Likewise, family closeness, hopefulness for the future, and financial resources have been found to provide a buffer against the negative effects of acculturative stress experienced by Mexican immigrants. Thus, the relationship between acculturative stress and mental health in not necessarily a simple linear relationship but can be buffered by a range of personality variables, social support, and financial resources.

—P. Paul Heppner
—Hyun-joo Park
—Mei-fen Wei

See also Acculturation; Cultural Barriers

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AFFIRMATIVE ACTION

Few governmental policies have been as controversial as affirmative action. During the last several years, battles over affirmative action captured the public's attention as two cases—*Gratz v. Bollinger* and *Grutter v. Bollinger*—were heard by the Supreme Court. Generally heralded as successes for affirmative action, the two Supreme Court decisions, handed down in June 2003, have not stopped anti–affirmative efforts.

Part of the reason for the continued controversy is that affirmative action is not well understood. Often misrepresented as quotas or reverse discrimination, affirmative action is actually a system whose purpose is to detect and correct systematic institutionalized discrimination. Affirmative action aims to ensure, not to undercut, true equality of opportunity for all ethnicities and both genders.

WHAT IS AFFIRMATIVE ACTION?

The American Psychological Association defines affirmative action as occurring when an organization expends energy to make sure that there is no discrimination in employment or education and to ensure that equal opportunity exists. The United States received its first governmental mandate to initiate affirmative action by way of Executive Order 11246, issued by Lyndon Johnson in 1965. The order required all governmental agencies, as well as organizations that contract with the federal government, to enact proactive measures to ensure that the diversity within their organizations matches the diversity in the pool of qualified labor.

Ideally, hiring in the workplace and admissions in educational organizations would result in diversity within businesses and schools equal to that in society. Yet research shows that this is not the case. Regardless of the value of equal opportunity, it is clear that equal opportunity does not always exist in practice within organizations in the United States. Because of old habits of thought and behavior that create racial and gender insensitivity, as well as blatant and subtle racism and sexism, Caucasian men still enjoy unearned privileges in American society. They can find and keep employment more easily than others who are similarly qualified. They obtain better mortgage rates, car deals, housing, and health care than others.

Given the persistence of gender and racial discrimination, organizations have a choice: They can deal with discrimination retroactively after a complaint is made, or they can adopt an affirmative action policy to stave off complaints and to ensure that women and minorities are indeed receiving opportunities equal to those of Caucasian men. Many organizations voluntarily opt for affirmative action to minimize the chances of having to clean up a problem after the fact.

Affirmative action aims to assure true equality of opportunity. Yet affirmative action can also be distinguished from the ideal of equal opportunity. Affirmative action takes a proactive stance on ensuring fairness and diversity in employment and education. In other words, rather than assuming that equal opportunity exists, affirmative action takes into account that equal opportunity is flawed because of institutionalized racism and sexism.

AFFIRMATIVE ACTION IN EMPLOYMENT

All federal organizations are required to comply with the policy of affirmative action. Private organizations with more than 50 employees that contract with the federal government for amounts greater than $50,000 are also required to act as affirmative action employers. They are required, in other words, to develop and maintain an affirmative action plan in the workplace.

At the core of any affirmative action plan for federal contractors is a monitoring system. Organizations must make sure that the ratio of minorities and women to Caucasian men in their labor force is equal to that of the qualified labor pool. Similarly, federal contractors must monitor their promotions.

Sometimes the monitoring process reveals substantive differences—for example, that the proportion of women in the organization's labor force is lower than the proportion of qualified women in the available labor pool. When differences appear, corrective actions must be identified and undertaken.

The Office of Federal Contract Compliance Program (OFCCP) is the governmental agency charged with oversight of businesses that have contracts with the federal government. Although the majority of private organizations self-monitor their own hiring statistics, the OFCCP does run 3,000 to 5,000 compliance reviews on privately owned businesses per year. If an organization is found to be in noncompliance, the OFCCP helps the organization adhere to the rules. Organizations that are flagrant offenders of the rules

can be disbarred from holding federal contracts for a period of time.

AFFIRMATIVE ACTION IN EDUCATION

Affirmative action in education functions much as it does in employment. Typically, universities compile records from the admissions office that track the ethnicity and gender of applicants and students. The university uses these records to compare the diversity of the applicant pool to that of the accepted students, as well as to track the retention of students to make sure that all ethnicities and genders are being treated equally. If a problem is detected, the university can examine why the discrepancy exists and move to remedy the problem.

The state of California has a master plan for higher education that guarantees admission to the University of California to the top 12.5% of high school graduates. By monitoring the ethnicity and gender of the top students, the university noted that there were more Latino students available for admission than were being admitted. The problem was found to be the result of some specific factors. Latino high school students were less likely than others to be counseled by guidance staff to take the core class requirements to gain admission. In addition, Latino students were less able to take advantage of advanced placement courses than Caucasian students. To address these problems, the university has exempted the top tier of applicants (those who graduated in the top 4%) from the course requirements, and it is in the process of making advanced placement courses available online. These changes represent alternative paths to increasing diversity that aim to increase the eligibility of underrepresented students rather then giving preference to minority applicants.

In 1996, the voters of California passed Proposition 209 by a very narrow majority. In addition, the Regents of the University of California, under the prodding of Regent Ward Connerly, enacted two resolutions that removed the consideration of race, religion, sex, color, ethnicity, or country of origin as criteria for admission to the university as well as faculty and staff hiring. As a result of this policy change, the percentage of underrepresented group members admitted to the university dropped considerably in the following years. In 2001, the Regents unanimously voted to repeal the 1995 ban on race-conscious admission; however, because of the passage of Proposition 209, the ban is still in effect at the state level.

In recent years, the University of Michigan has been more in the public's eye than the University of California. In 1997, Jennifer Gratz and Patrick Hamacher, two European American students, challenged the race-sensitive admissions program of the undergraduate college at the University of Michigan. They had been rejected, whereas applicants of color with lower scores and grades had been accepted. Two months after the *Gratz* case was filed in federal court, Barbara Grutter, another rejected European American applicant, brought suit against the University of Michigan Law School. On June 23, 2003, the Supreme Court announced its decisions. It declared that race could not be used in formulaic approaches to admissions, but the Court also recognized diversity in higher education as a compelling state interest. Race-sensitive policies, the Court concluded, are not ipso facto unconstitutional.

WHY DO WE NEED AFFIRMATIVE ACTION?

Affirmative action is only one method of correcting injustices. More reactive means, such as bringing a lawsuit, are sometimes thought to be more fair and effective than affirmative action. There are three main reasons why affirmative action may be a more effective and less costly way of assuring fairness and stability than the reactive (lawsuit) approach. First, copious research in the social sciences has shown that, many times, the victims of discrimination "have blinders on," refusing to acknowledge discrimination until the situation is dire. Second, even fair-minded outside observers who have not themselves been the victims of discrimination have a hard time detecting imbalances without the help of systematically arranged aggregate data. Most affirmative action plans provide observers with aggregated data and thus allow them to detect patterns of fairness or unfairness that they would otherwise miss. Third, lawsuits are extremely costly for individuals and for organizations. Proactive measures that allow organizations to monitor their situations and to correct minor problems before they engender a lawsuit usually prove to be excellent investments.

DOES AFFIRMATIVE ACTION WORK?

Affirmative action plans in education have been shown to increase the presence and the success of hitherto underrepresented minorities. Indeed, without

race-sensitive admissions plans, imperfections in the admissions criteria would result in student bodies more Caucasian than at present. In our multiethnic society, the state has a compelling interest in achieving diverse student bodies, according to the U.S. Supreme Court.

In industry, affirmative action has also proven to be effective. Cost–benefit analyses have found that, in material terms, companies that use affirmative action benefit not only from avoiding costly lawsuits but also from the diversity in their workforce. Meanwhile, ethnic minority workers and Caucasian women benefit from the reduction in barriers that affirmative action brings.

Some opponents of affirmative action claim that the policy undermines the confidence of its intended beneficiaries. Certainly, people do not like to believe that they may have obtained positive outcomes as a result of special privilege. Notwithstanding stereotypes to the contrary, only a handful of ethnic minority individuals and Caucasian women mistake affirmative action for special privilege. Careful surveys show that the majority of direct beneficiaries see the policy not as one that gives them special privilege, but rather as one that reduces the previously unquestioned special privileges of Caucasian males.

In sum, affirmative action is a policy that attempts to make the ideal of equal opportunity an actuality. In employment and education, it entails careful monitoring of information so that subtle patterns of discrimination can be detected and imbalances can be corrected. Affirmative action promotes diversity. Rather than simply giving lip service to the values of fairness, justice, and diversity, affirmative action helps to ensure that these values are fulfilled in our society.

—Kristina R. Schmukler

See also Equal Opportunity Employment; Institutional Racism

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AFRICAN AMERICANS AND MENTAL HEALTH

PREVALENCE OF MENTAL ILLNESS AMONG AFRICAN AMERICANS

Mental disorders are highly prevalent across all populations, regardless of race or ethnicity. Within the United States, overall rates of mental disorders for most minority groups are largely similar to those for Caucasians. However, ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty—all of which take a toll on mental health. In some surveys, African Americans have been found to have higher levels of lifetime (or current) mental disorders than Caucasians. However, when differences in age, gender, marital status, and socioeconomic status are taken into account, the racial difference is eliminated.

In most major epidemiological surveys, the overall rates of mental illness for African Americans living in a community appear to be similar to those of non-Hispanic Caucasians. However, differences do arise when assessing the prevalence of specific illnesses. For example, African Americans are less likely to suffer from major depression and more likely to suffer from phobias than Caucasians. Although somatization is more common among African Americans than among Caucasians, rates of suicide for young men in both ethnic groups are similar. Researchers have also found lower lifetime rates among African Americans for several other major mental disorders, including panic disorder, social phobia, and generalized anxiety disorder. In contrast, African Americans have higher rates of posttraumatic stress disorder and substance abuse than Afro-Caribbeans or Caucasian Americans.

The general conclusion regarding the lack of racial differences in rates of mental illness does not apply to vulnerable, high-need subgroups such as the homeless or the incarcerated, who have higher rates of mental illness and are often not captured in community surveys. African Americans are overrepresented in these high-need populations. Although they represent only 12% of the U.S. population, African Americans make up about 40% of the homeless. The ratio is similar for people who are incarcerated: Nearly half of all prisoners in state and federal jails and almost 40% of juveniles in legal custody are African American. One

explanation for African Americans' higher rates of certain mental health problems is the stressful conditions created by racism, discrimination, and poverty. Whether racism and discrimination by themselves can cause these disorders is not clear, but there does appear to be a significant association between poverty and incidences of mental illness.

THE EFFECTS OF RACISM ON MENTAL HEALTH

There is no question that racism exists in the United States and that African Americans have been the primary recipients of negative stereotypes and discrimination. There are numerous definitions of racism present in the research literature. For the purposes of this discussion, the term *racism* is used to refer to any behavior or pattern of behavior that tends to systematically deny access to opportunities or privileges to members of one racial group while perpetuating access to opportunities and privileges to members of another racial group.

It has been argued that racism has a pervasive, adverse influence on the health and well-being of racial and ethnic minority populations in the United States. There are three general ways that racism may jeopardize the mental health of minorities: (1) Racial stereotypes and negative images may be internalized, denigrating individuals' self-worth and adversely affecting their social and psychological functioning; (2) racism and discrimination by societal institutions have resulted in minorities' lower socioeconomic status and poorer living conditions, in which poverty, crime, and violence are persistent stressors that can affect mental health; and (3) racism and discrimination are stressful events that can directly lead to psychological distress and physiological changes affecting mental health.

Racial attitudes toward African Americans have shifted over time. During the early 1940s, survey research found that most Caucasians supported policies and practices that limited interracial contact in schools, neighborhoods, and marriages. By the 1990s, these attitudes had shifted, and a majority of Caucasians endorsed such practices as integrated schools and interracial marriages. Although there have been changes in the attitudes of Caucasian Americans toward African Americans, negative stereotypes of African Americans persist. In general, Caucasians view African Americans more negatively than any other ethnic minority group. As recently as 1990, 29% of Caucasians viewed most African Americans as unintelligent, 44% believed that most are lazy, 56% endorsed the view that most prefer to live on welfare, and 51% indicated that most are prone to violence. There seems to be broad support for egalitarian attitudes toward African Americans, but this coexists with a desire to maintain at least some social distance from African Americans and a limited commitment to policies to eradicate entrenched inequalities.

Racism exists on both an individual and an institutional level. Historically, beliefs about the inferiority of African Americans were translated into policies that restricted their access to education, employment, health care, and residential opportunities. These restrictions led to disparities in essential resources, resulting in significant residential segregation and poverty within African American communities. Today, institutional racism is evidenced by the fact that the median income for Caucasian American households is almost 1.7 times higher than that of African Americans. Nearly 40% of African American children under the age of 18 are growing up poor, compared with 11% of their Caucasian peers. Racism can also be seen in less obvious differences, such as the economic benefits of educational attainment. In 1998, the U.S. Census Bureau noted that a household with an African American male college graduate earned 80 cents for every dollar earned by a comparable Caucasian household. The difference is even more marked for African American households with a female college graduate, whose median income is 74% of that of comparable Caucasians.

These differences in socioeconomic status and educational attainment have important consequences for mental health. Research has found that persons in the lowest categories of both income and education (who are disproportionately African Americans) are twice as likely as those at the highest levels (who are disproportionately Caucasian Americans) to meet the criteria for one of the major psychiatric disorders.

Racism is also thought to adversely affect mental health status through the subjective experience of discrimination. However, there are inconsistent results regarding the connection between racial discrimination and psychological distress. Some studies have found that exposure to racial discrimination is positively related to physical risk factors such as elevated levels of blood pressure and elevated levels of

psychological distress. Other studies have found the opposite or no racial differences in rates of psychological distress in African Americans compared with Caucasians. Some have hypothesized that this pattern may reflect the presence of coping strategies within the African American population that may mitigate some of the psychological consequences of exposure to racism. The link between perceived discrimination and mental health appears to be complex, and understanding the variables that moderate this relationship is a relatively new area of empirical research.

USE OF MENTAL HEALTH SERVICES

Disparities in access to and use of mental health services persist across racial and ethnic groups in the United States. These disparities vary, however, depending on geographical location, socioeconomic status, and type of service. In general, racial and ethnic minorities use fewer mental health services than do Caucasians with comparable distress and problems and have less access to mental health services than do non-Hispanic Caucasians. Considering that the incidence of mental illness is similar across racial and ethnic groups, minority individuals who require mental health services carry a greater burden from unmet mental health needs. Studies have shown that African Americans are less likely than Caucasians to seek help from therapists in private practice, mental health centers, and physicians. Yet African Americans prove no different from Caucasians in their use of public-sector therapists, and they are more likely than Caucasians to use inpatient services and the emergency room for mental health care. African Americans who have undergone treatment for mental health problems are also more likely than Caucasians to be confined to jails, prisons, and mental hospitals and more likely to become homeless at some point. These findings highlight the vulnerability of African Americans who are mentally ill and their high degree of social fragility.

African Americans, both those in the general population and those who have been diagnosed with a mental illness, display more positive attitudes toward seeking mental health care than Caucasians, yet they use fewer services. It is interesting to note that prior to their actual use of services, African Americans' attitudes toward seeking mental health services are comparable to—and in some instances more favorable than—those of Caucasians. Once they have used services, however, African Americans tend to hold more negative attitudes about mental health services and report being less likely to use them in the future than are Caucasians with comparable needs and usage.

BARRIERS TO MENTAL HEALTH SERVICES

A number of variables have been suggested to explain the racial disparity in the use of mental health services. Barriers to mental health care occur at three levels: individual, environmental, and institutional. *Individual barriers* reflect factors that originate from within the individual, such as culture-specific beliefs and knowledge about mental illness that may influence help-seeking behavior.

Mistrust of mental health services is as a major barrier for ethnic minorities seeking treatment, and it is widely accepted as pervasive among African Americans. It arises from both historical persecution and present-day struggles with racism and discrimination. Mistrust also arises from documented abuses and perceived mistreatment, both in the past and more recently, by medical and mental health professionals. It has been found that 12% of African Americans and 15% of Latinos—compared with 1% of Caucasians—feel that a doctor or health provider judged them unfairly or treated them with disrespect because of their race or ethnic background.

Individuals who are more mistrustful of Caucasian providers are less willing to seek mental health treatment and expect less satisfaction from such therapeutic encounters. Given the low numbers of ethnic minorities trained to deliver mental health services, many systems are unable to deliver racially matched providers. African American clients who must rely on racially different providers may face clinicians who are culturally insensitive, and this experience may negatively influence their attitudes toward mental health services.

For some African Americans, limitations in understanding the problem and in their awareness of possible solutions, strategies, and resources are obstacles to seeking mental health services. When experiencing problems, many African Americans perceive that they are having a normal response to a difficult life situation and believe that they should keep trying to manage their difficulties on their own. As their problems increase or reoccur and begin to interfere with their ability to function, African Americans are more likely to rely on informal support from friends, family members, and clergy to try to deal with the situation rather

than seek formalized mental health services. It has been noted that about 43% of African Americans rely exclusively on informal help, 44% use both informal and formal providers, and less than 5% turn exclusively to formal sources of help when they are experiencing personal difficulties. This approach to handling problems seems to be supported by family members, significant others, and influential African American community members.

Certain cultural beliefs, such as the need to resolve family concerns within the family and the expectation that African Americans should always demonstrate strength in the face of problems, inhibit individuals from seeking mental health services. There is a cultural expectation that life is difficult and that African Americans as a cultural group should be able to effectively cope with adversity. Another cultural factor that may influence the use of mental health services is one's beliefs about the causes of mental illness. Individuals who identify causes that are consistent with those espoused by mental health professionals (such as the importance of early experiences in families and the effect of trauma on development) are more likely to seek mental health services than those who endorse more discrepant views. Ethnic minority populations more strongly endorse folk beliefs—for example, that imbalances in natural forces cause illness or that supernatural, spiritual, or mystical forces cause illness. They also believe that a lack of moderation or willpower and weakness of character cause illness. It is unlikely that individuals who hold such beliefs about the causes of mental illness will seek formal approaches to mental health treatment.

Environmental barriers reflect factors that occur within the external environment and inhibit attempts or increase the difficulty of efforts to seek help. Mental illness and mental health treatment continue to be plagued by a stigma that adversely affects help-seeking behavior. *Stigma* refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness. Stigma is widespread in the United States and other Western nations. Research conducted during the 1980s found that African Americans held more negative views of mental illness than Caucasians. In more recent studies, however, it has been found that African Americans hold less stigmatized views of mental health services than in the past. But there continues to be a belief that mental health services are only for those who are seriously mentally ill.

Institutional barriers are factors related to the ability of the individual seeking services to actually access mental health care. The surgeon general's report on culture, race, and ethnicity identified access to care as a major issue involved in mental health service disparities among African Americans. The report identified numerous institutional barriers to mental health services, including a lack of or inadequate insurance coverage, disjointed services, and the location of culturally specific services. There are few high-quality mental health services located in low-income communities, where the majority of African Americans reside. Twenty years ago, many more services were provided in these communities through federal and private funding. These services are no longer available because of increasing budget cuts and shifts in priorities for government spending and private philanthropy. African Americans seeking mental health services must often travel relatively long distances to find available, affordable care. They often experience problems with transportation, inflexible job schedules, and limited resource knowledge, all of which serve as barriers to care.

The cost of mental health services has also been noted as a significant barrier to seeking mental health treatment. African Americans, the majority of whom live in poverty, frequently lack adequate insurance to cover mental health services. Hourly fees for treatment are perceived as excessive and are considered a luxury in the face of basic needs and ongoing financial challenges. Even for African Americans who receive Medicaid benefits, bias is experienced because medication is often the recommended treatment. More often than not, psychotherapy and counseling are not offered as treatment options. With the further marginalization of African Americans by managed care and other insurance companies, access to quality mental health services has become more difficult and costly. Although there is considerable evidence that mental health service needs are high within the African American community, the service shortfall that exists precludes access, thereby exacerbating the emotional strain on African Americans as individuals and as a cultural group.

Misdiagnosis is a further barrier to African Americans and other ethnic minorities receiving adequate mental health care. Minority patients are among those at greatest risk for nondetection of mental disorders in primary care. Missed or incorrect diagnoses carry severe consequences if individuals are given

inappropriate or possibly harmful treatments, leaving their underlying mental disorder untreated. Institutional racism was evident over a century ago in the form of separate and often inadequate mental health services for African Americans. It continues today in the form of medical practices for diagnosis, treatment, prescription of medications, and referrals. There is ample evidence that African Americans are overdiagnosed for schizophrenia and underdiagnosed for bipolar disorder, depression, and anxiety as a result of providers' stereotypical attitudes and beliefs. To date, there has been limited research on the extent of bias and stereotyping of African Americans among mental health providers; therefore, the role that stereotyping plays in the racial disparities in mental health service utilization and effectiveness remains unclear.

CULTURE-SPECIFIC APPROACHES TO ASSESSMENT, DIAGNOSIS, AND INTERVENTION

African American psychologists recognize that traditional psychology is limited in its understanding of people of color and that much of the history of the field has reflected bias and discriminatory attitudes and beliefs about African American individuals, families, and communities. Today, many ethnic minority researchers and scholars are recommending that mental health providers become more culturally sensitive in an effort to enhance the effectiveness of their intervention efforts with African American clients. It has been suggested that providers should take a multifaceted therapeutic approach, one that (1) identifies the therapist's own attitudes and beliefs about the world based on developmental and sociocultural influences; (2) examines how the therapist's background and worldview may differ from the client's and may hinder the therapeutic process; (3) strikes a balance between the therapist's need to learn from the client about his or her experiences and the use of community and interagency resources to help understand the client's background; and (4) stresses a therapeutic approach that incorporates multicultural theories and practices.

Understanding African Americans from a multicultural perspective requires that mental health providers really listen to clients and try to understand clients from within their cultural context. Adopting this approach to working with African American clients will help providers become more adaptable in their theoretical orientation, flexible with their skills and strategies, and sensitive to clients' cultural idiosyncrasies. The development of a therapeutic or conceptual orientation is an ongoing process, and mental health providers must be willing to continue this developmental process well beyond their graduate school education. To be most effective in their work with African Americans, mental health providers must accept that different worldviews can coexist and adapt their skills and abilities so they are applicable to other cultures.

An abundance of literature on African Americans and their culture is available to mental health providers who are committed to enhancing their cultural sensitivity and awareness of this ethnic minority group. It is not possible to review this literature in detail, but a brief discussion of some of the newer theoretical approaches to working with African Americans can provide examples of new trends in the field.

One new approach is the multicultural assessment-intervention process (MAIP) model. This model requires the mental health provider to employ a systematic approach to assessment and intervention that uses cultural information to inform service delivery and improve the quality of services provided to African Americans. Questions are addressed at various points in the assessment-intervention process to emphasize the relevance of assessment instruments, increase the reliability and accuracy of clinical diagnoses, and foster the use of more credible and beneficial intervention services. In the MAIP model, there is a recognition that cultural and racial differences are essential in the understanding of the self and important in the delivery of mental health services to ethnic minorities. It requires a willingness to address problems on the basis of these differences during assessment, diagnosis, and treatment and a commitment on the part of mental health providers to undergo the necessary training to become culturally competent.

A second approach that seems to hold promise for enhancing access to mental health services calls for collaboration between the field of psychology and the African American church. The African American church in general and the clergy in particular have traditionally played important roles in providing supportive resources to the African American community. Although there are a number of African-centered models of psychotherapy in which spiritual development is understood as central to human development, few mental health providers have actively collaborated with the African American church. There are several barriers that impede collaborative efforts between

psychologists and the church: Few academic departments require training for mental health providers in religious or spiritual issues, and mental health providers have limited understanding of the traditions of the different denominations that make up the African American church. To overcome these barriers, providers need to examine their own beliefs regarding religion and spirituality and obtain additional training in religious or biblical counseling. Increasing the collaboration between the African American church and mental health providers will make it possible to provide culturally relevant mental health services to many African Americans who currently do not use traditional mental health delivery systems.

A third recommended treatment approach for working with African Americans focuses on cultural strengths within the African American community and factors that promote resilience. *Resilience* refers to the notion that some people are able to succeed in the face of adversity. It involves factors and processes that interrupt the trajectory from risk to problem behavior or psychopathy. A resilience perspective highlights the development of competencies, assets, and strengths in individuals' lives, and it includes the maintenance of healthy development despite the presence of a threat or recovery from trauma. These psychosocial resources and resilience factors can insulate the individual from such significant stressors as racism or provide coping mechanisms to reduce the negative effects of stress.

Well-established psychosocial resources, such as supportive social ties, perceptions of mastery or control, and self-esteem, have been shown to serve as protective factors for individuals coping with stress and adversity. In addition, research suggests that other culturally specific resources seem to enhance coping among African Americans. These include religious beliefs and behavior, ethnic-group identity and consciousness, and racial socialization experiences. The term *racial socialization* refers to the process of communicating behaviors and messages to children for the purpose of enhancing their sense of racial or ethnic identity, partially in preparation for racially hostile encounters. The association between African Americans' perceptions of racial discrimination and mental health is moderated by experiences with racial socialization in families and by levels of self-esteem.

These newer approaches to understanding and promoting mental health in African Americans hold promise for the development of mental health services that are culturally appropriate and effective. As they become the accepted standard of care in the field, there is hope that existing racial disparities will be significantly reduced or eliminated in the future.

CONCLUSIONS

The mental health needs of African Americans have been well documented in the psychological literature, and over the last decade, there has been a serious effort to incorporate race, ethnicity, and culture into our understanding of mental health and mental illness. Although gains have been made in developing more culturally sensitive treatment interventions, there continues to be evidence of bias in the assessment and diagnosis of mental disorders among African Americans. There are also multiple barriers that have a negative impact on African American clients' access to high-quality mental health services and effective utilization. There are a number of areas for future research, such as the need to better understand the help-seeking attitudes and behaviors of African Americans in the utilization of mental health services and the role that stigma plays in this process. A final question that will need to be examined more thoroughly in the future relates to the effects of cumulative stress on the emergence and progression of mental health problems experienced by African Americans.

Focusing on cultural strengths and resilience is clearly an important direction for the future; however, we should not lose sight of the fact that promoting individual (or collective) resilience is not a substitute for systemic, institutional change. There is compelling evidence that African Americans and other racial and ethnic minorities experience a disproportionately high disability burden from unmet mental health needs. The racism, discrimination, and economic deprivation that plague much of the African American community require system-level change. Ultimately, reducing disparities in the mental health treatment of African Americans will require a societal commitment to social justice and equity.

—Elizabeth E. Sparks

See also African/Black Psychology; Africentric; Association of Black Psychologists; Black Racial Identity Scale

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AFRICAN/BLACK PSYCHOLOGY

African/Black psychology is a system of knowledge grounded in the perspectives of African-descent persons and designed to describe their personalities, attitudes, emotions, and behaviors. This system of knowledge is based on an African cosmology and corresponds to African conceptions of the social universe. Essentially, it is a science of exploring the lives of African-descent persons from a perspective that is centered on their experiences.

Although African psychologists acknowledge the existence of an African/Black psychology derived from the development of early African civilizations in Egypt and Ethiopia, formal study and articulation of African psychological concepts, theories, and models have only recently begun to take shape. This formal development is marked by three pivotal moments in history: (1) the work of Francis Cecil Sumner, (2) the founding of the Association of Black Psychologists, and (3) Wade Nobles's publication on the philosophical basis of African psychology in 1986.

In 1992 and 1996, Chancellor Williams and Daudi Ajani ya Azibo, respectively, discussed how the destruction of Black African civilization, beginning as early as 4500 BCE and continuing through the present day, has arrested the development and ownership of African-centered conceptions of the human experience. Historically, Eurocentric psychological explanations have been the primary mode of understanding the behaviors of African/Black persons. In response to this approach, Dr. Francis Cecil Sumner, the first African American to receive a PhD in psychology in the United States (in 1920), began a program of investigation to refute racist and pejorative theory and research that argued for African/Black inferiority. Sumner was named the "father of Black American psychologists," and his work is considered an initial response to Eurocentric psychology, which has been used to validate the mistreatment of African-descent persons.

In response to discontent with the American Psychological Association, the Association of Black Psychologists (ABP) was established in 1968 with an agenda to address issues of race, culture, and oppression as they concern African/Black persons and to promote the refutation of cultural-deficit models and comparative studies that portray African/Black persons as deviant. The ABP is credited with three contributions to the field of African/Black psychology. The first is the reemergence of African psychology based on an African cosmology; second, the development of the *Journal of Black Psychology;* and finally, the Annual International ABP convention, at which African/Black psychologists throughout the diaspora collaborate and learn from one another while building an African/Black psychological community.

In 1972, Wade Nobles's literary contribution, *African Philosophy: Foundations for Black Psychology,* was the final development to clearly link ancient African philosophical thought to the psychology of African/Black people. Following the establishment of the ABP, three camps developed among African/Black psychologists: Eurocentric, Black, and African. Eurocentric psychologists are of African descent and employ Eurocentric theory and research in their work with African-descent persons. Black psychologists are described as reacting to White supremacist notions and racist formulations promoted by Eurocentric psychological theory and research. Finally, African psychologists are described as being proactive in the development of African/Black psychological research and theory, which is centered on the experiences of African/Black people and connected to an African system of knowledge (i.e., cosmology, ontology, axiology, worldview, ideology, and ethos). Nobles's essay was the first published work to articulate the African philosophical basis of African psychology—a seminal piece that initiated the propagation of proactive African/ Black psychological research orientation, theory, and practice.

AFRICAN/BLACK PSYCHOLOGICAL DEVELOPMENTS

African/Black psychological research orientation, theory development, and practice are significantly guided by the Afrocentric school of thought founded by Molefi Asante during the late 20th century. Asante coined the term *Africalogy*—the Afrocentric study of phenomena, events, ideas, and personalities related

to Africa—to describe the generation of theory and practice across all disciplines (including psychology) centered on Africa and African descendants. A review of developments in African/Black research orientation, theory, and practice follows.

Research Orientation

There are four tenets of the Afrocentric method by which Africalogists (i.e., researchers of Africa and African-descent persons) are guided. First, researchers examine themselves in the process of examining the subject of study, thus maintaining a practice of introspection and retrospection throughout the course of study. Second, the Afrocentric research method requires cultural and social immersion and discourages traditional scientific distance in the study of African and African-descent persons. Third, the Afrocentric method requires the researcher to have familiarity with the history, language, philosophy, and myths of the people under study. Fourth, the Afrocentric method views research as a vehicle by which to humanize research participants and, ultimately, the world. Later theorists elaborated the Afrocentric research method, explicating and concretizing concepts offered by Asante's initial work.

Theory

African/Black psychological theory has been developed to explain the personalities, attitudes, emotions, and behaviors of African-descent persons from a perspective that is centered on their experiences. Personality and developmental psychological theories have experienced the most growth. Additionally, identity theory has witnessed further growth and development. In her groundbreaking work, Dr. Frances Cress Welsing (1970) presented the *Cress theory of color confrontation and racism,* which explains the hostile treatment of African-descent persons by those of European descent. Other personality theories that explain African-descent persons have been offered by African/Black psychologists such as Na'im Akbar, Daudi Ajani ya Azibo, and Linda Meyers.

Akbar's early conceptualizations of African/Black psychology sought to redefine normalcy for African-descent persons by considering their logical reactions to an oppressive social environment. He coined terms such as *misorientation* and *mentacide,* which describe African-descent persons' psychological response to a racially hostile and oppressive environment. Continuing this work, Azibo developed an African-centered nosology of Black personality disorders that systematized 18 disorders of the African personality. Several studies have substantiated the integrity of Azibo's nosology. Like Akbar and Azibo, Linda Meyers presented the framework of optimal psychology to explain the manifestation of the African worldview in the psychology of African/Black persons.

Developmental psychological theory has focused on the redefinition of normative growth and development of African/Black children. The work of Amos Wilson is noteworthy. Wilson's work concentrated on the developmental psychology of African/Black children and the development of culturally responsive child-rearing and learning environments that would promote their optimal development. In this vein, Neferkare Abena Stewart focused her work on the early development of African/Black infants across the world to generate developmental milestone norms (e.g., average age for sitting up, walking, talking, etc.) for these children.

Racial identity theory has also witnessed tremendous growth over the last 30 years. In 1970, William Cross introduced formidable work on "Nigrescence" (i.e., the Negro-to-Black conversion) that investigated the process by which African/Black persons develop an integrated identity with regard to race. Cross's initial work influenced subsequent developments in gender and racial identity development theory.

Practice

The practice of African/Black psychology has only recently been formally presented as a cohesive system of treatment, although African-centered approaches to treatment in social services, educational, and mental health settings have been employed for some time. In 1990, Frederick Phillips presented an Afrocentric approach to psychotherapy. This approach is spiritually based, focusing on achieving balance and alignment within persons and systems. Basic principles of Afrocentric therapy—harmony, balance, interconnectedness, cultural awareness, and authenticity—are guided by the African worldview.

CONCLUSION

The field of African/Black psychology continues to develop, reclaiming and elaborating on the African

historical and cultural legacy. As growth in the field persists, several developments are anticipated. The expansion of existing theories and the development of new theoretical conceptualizations and practical approaches are expected, as the existing theories and models are at least three decades old. Additionally, psychological studies grounded in Afrocentric theory that demonstrate the effectiveness of African/Black psychological interventions and their generalizability among African/Black persons in diverse settings and contexts are needed. Finally, as a concerted effort takes hold among African/Black psychologists to meet the mental health needs of African-descent persons throughout the diaspora, the development, implementation, and evaluation of theory and interventions for African-descent persons outside the United States will most likely be expanded.

—Wendi S. Williams
—Julie R. Ancis

See also Association of Black Psychologists

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AFRICENTRIC

The term *Africentric,* and the more commonly used term *Afrocentric,* describe a worldview in which African people and culture are the central unit of analysis, with a focus on social and historical context. There are two critical aims in the framework of Africentric scholarship: (1) the reclamation and revision of the history of African people, who share common ancestral origins but are spread throughout the world (this international population represents the *African diaspora*) and (2) the resistance of European cultural hegemony and oppression.

The first aim is to transform scholarship. In particular, Africentric scholars have studied the impact of Black African civilizations, such as the ancient civilizations of the Nile Valley. This revisionist view of world history and antiquity counters the dominant perspective of African people, which commences with European conquest.

The second aim focuses on how individuals make meaning of the world within an Africentric cultural context. Africentric scholars argue that because the Western framework represents African people as deviant from the European ideal, it is futile to attempt to understand the behaviors of African people within a Eurocentric framework.

AFRICENTRIC PSYCHOLOGY

Connectedness is a primary tenet of the Africentric worldview. Contrary to the Western or Eurocentric perspective, which vales objectivity, the Africentric worldview recognizes the interconnectedness of the affective (feeling), cognitive (knowing), and behavioral (acting) domains. The African Self-Consciousness Scale is a measure that encompasses dimensions related to an individual's awareness of a collective sense of relationship to African people and resistance to forces of oppression. African self-consciousness is related to cultural and racial socialization among African Americans.

In the Africentric paradigm, the consequences of oppression manifest in the psyche of African people and are evident in behavior. The Africentric psychologist views cultural orientation as related to well-being. When African people adopt a foreign or Eurocentric worldview, maladaptive behaviors and psychopathology result. Thus, an Africentric framework explains the often-cited disparities between European Americans and African Americans in educational, health, or mental health outcomes as a consequence of oppression and detachment from the cultural source. Africentric psychologists and educators have designed culturally relevant interventions, such as youth rites of passage programs, to help counter the impact of racial oppression.

CHALLENGES TO AFRICENTRIC THEORY

One major challenge to Africentric theory is that within this framework, race is constructed as an essential characteristic. Africentric scholars have been critiqued for focusing on racial classification as deterministic rather than acknowledging the dynamic aspects of culture and the diversity of individual expressions of ethnicity. Some scholars of European classicism have challenged the veracity of some of the

claims made within the revised analysis of African people in ancient civilizations throughout the African diaspora. Other critiques address some Africentric scholarship that makes arguably sexist or homophobic assertions about interpersonal relationships in an authentic African cultural context.

CONCLUSIONS

This entry offers a brief review of Africentric perspectives on knowledge production, meaning making, and behavior. Although Africentric theory has gained more attention in recent years, this intellectual tradition is evident historically throughout Black scholarship in the diaspora. Africentric theory in psychology provides a framework for understanding the context of human behavior liberated from Western cultural biases regarding mental health. An Africentric paradigm transforms the analysis of how cultural worldview affects micro- and macro-level outcomes.

—Zaje A. T. Harrell

See also African/Black Psychology; Association of Black Psychologists; Culture

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ALASKA NATIVES

Mental health is important to an individual's general health, family relationships, and relationships within the community. A number of factors can contribute to mental health status, including biological, social, and psychological phenomena. Mental illness can have a significant negative impact on individuals, families, and communities. To effectively prevent or ameliorate mental health–related problems, current research and practice focus on these contributors to mental health. Specifically, the role of culture on mental health has become an important area of interest for researchers and mental health professionals. Although the Alaska Native community constitutes a small percentage of the U.S. population, an incredible diversity exists among its people. For example, differences among Alaska Native peoples can be found in geographical location, language, customs, beliefs, religion, family structures, and social structures. The degree of diversity among the Alaska Native peoples has important implications for psychological research and mental health treatment.

GENERAL INFORMATION

Though there is no single definition of *Alaska Native,* this term is typically used to describe the indigenous people of what is now the state of Alaska. Specifically, Alaska Natives are generally thought to include Eskimo, Indian, and Aleutian peoples. Nearly half of all Alaska Natives are Eskimo, which includes the Inupiat, Yup'ik, and Cup'ik peoples. About one-third of Alaska Natives are Indians, which encompasses the Athabascan, Eyak, Tlingit, Tsimshian, and Haida peoples. Finally, the Aleut people constitute approximately 15% of Alaska Natives.

The Alaska Native population is geographically dispersed throughout the state of Alaska, which is approximately one-fifth the size of the continental United States. In general, the majority of Alaska Natives reside outside the larger Alaska cities in villages of 2,500 people or fewer. Anchorage, the most populated city in the state, is home to approximately 14,000 Alaska Natives. Altogether, Alaska Native groups compose approximately 16% of the state's population. Not only are there geographical differences; linguistic and cultural differences can also be found among the Alaska Native peoples. For example, Alaska Natives speak 20 different languages, live in all major areas of Alaska, and vary in degrees of acculturation.

The Inupiaq live in the northern and northwestern region of Alaska, where they still live a subsistence lifestyle. Two major dialects, which resemble the dialects of Canadian and Greenlandic Eskimos, are spoken by the Inupiaq. The Inupiaq believe in the reincarnation of both animal and human spirits. This belief is often expressed in the ceremonial treatment of animals that are killed during a hunt and the naming of children after deceased relatives.

Distinguishable by their different dialects, the Yup'ik and Cup'ik are concentrated in southwestern Alaska. Also hunters and gatherers, the Yup'ik and

Cup'ik were once a mobile people following the migration of the game they hunted. Historically, social hierarchies among the Yup'ik and Cup'ik were based on gender, and men and women often lived in separate dwellings. Elders played an important role in the socialization of younger members of the group and were responsible for passing on cultural beliefs through storytelling.

Historically, the Athabascan people were concentrated around river ways in the Alaskan interior (central Alaska), where they would hunt, fish, and trap. Today, Athabascans live throughout the state of Alaska. Eleven languages are spoken by the Athabascan people. Although there are exceptions, the majority of Athabascan clans follow a matrilineal social structure. In the past, this matrilineal system influenced hunting practices, living arrangements, and the socialization of children. Among the many values the Athabascan people hold, sharing and respect for all living things are especially important.

The Eyak, Tlingit, Tsimshian, and Haida peoples inhabit the southeastern portion of Alaska, known as the Alaska panhandle, and use a matrilineal system of moieties, phratries, and clans. A *moiety* includes two subdivisions that can be broken down into several clans. A *phratry* is similar to a moiety but has four divisions instead of two. Like moieties, phratries include a specific number of clans. The matrilineal social system determines family name, inheritance, hunting practices, and living arrangements. The Eyak once occupied the southeastern corner of south-central Alaska and included two moieties. Currently, the Eyak people are concentrated on the Copper River Delta in Alaska, where they continue to live a subsistence lifestyle. As with the Eyak, Tlingit subsistence comes primarily from fishing but also includes the gathering of plants and hunting of game. Considered one of the most complex cultures of the North American Natives, Tlingit culture uses a social classification system that defines social norms and strata. Although one common language is shared by the Tsimshian people, four separate dialects are spoken depending on geographical location. Currently, the Tsimshian people are concentrated on Annette Island off the southeastern coast of Alaska. The Haida originally lived among the Queen Charlotte Islands in Canada, eventually settling on Prince of Wales Island off the southeastern coast of Alaska. Unlike the Tlingit and Tsimshian peoples, the Haida speak a language that is unrelated to the other Alaska Native languages.

Finally, the Aleut and Alutiiq peoples live in southern and southwestern Alaska, including the chain of islands off the Alaskan coast known as the Aleutian Islands. The Aleutian Islands are known for having some of the harshest weather in the world. The three major groups of the Aleut and Alutiiq peoples speak two different languages. The Aleut and Alutiiq also incorporate the Russian language into their everyday speech. This reflects the early contact between Russian fur traders and the Aleut and Alutiiq peoples. Like many of the others Alaska Native groups, the Aleut and Alutiiq peoples place a strong emphasis on kinship and sharing.

The Russian discovery of Alaska in 1741 brought significant changes to the indigenous Alaska Native population. Russian fur traders concentrated hunting efforts on much of the Alaskan coast in search of sea otter pelts, often trading with the Alaska Natives. By 1772, a permanent Russian settlement had been established in Unalaska. In 1795, Russian missionaries established the first Russian Orthodox Church on Kodiak Island. Although not all Alaska Native groups were negatively affected by the Russian fur trade, the mistreatment of the Aleuts is well documented. In particular, the Aleut people were enslaved and forced to hunt sea otters for the Russia fur traders. Eventually, interest in Alaska subsided when sea otters had been hunted to near extinction. In 1867, the United States purchased Alaska from Russia for 7.2 million U.S. dollars.

Outside interest in Alaska was rekindled when gold was discovered near Juneau in 1880 and again in the Klondike region in 1897. When vast quantities of gold were found in the Nome region in 1898, the Alaska gold rush began. This brought the arrival of numerous non-Natives to Alaska in a very short period of time. A booming commercial fishing and canning industry, in addition to a growing population of military personnel, created a significant population increase during the early 1900s. By 1959, Alaska's population had grown enough to qualify for statehood. With the discovery of oil and natural gas reserves on Alaska's North Slope, the influx of people to the state has continued to increase.

CUSTOMS AND BELIEFS

The cultural values and ways of life of the different Alaska Native groups have been permanently affected by the introduction of Western society. For example,

non-Native people brought diseases, racial discrimination, and modern industry to Alaska. These things have, in some cases, led to a loss of the traditional ways of the Alaska Native peoples. However, traditional beliefs still persist among Alaska Natives. Today, spirituality remains an important aspect of Alaska Native culture, and the traditional belief that humans, animals, and the earth share a relationship is fundamental to the modern belief system of Alaska Natives. With the introduction of organized religion to Alaska, some Alaska Natives have come to view their spirituality concurrently through traditional Native customs and non-Native religious perspectives (e.g., shamanism, Christianity).

In addition to beliefs about the relationship between animals, humans, and the earth, Alaska Native culture emphasizes harmony among an individual's mind, body, and soul. This is considered important to preserving overall health. Disharmony between mind, body, and soul, therefore, can result in mental and physical deterioration. In addition to its holistic view of life, Alaska Native culture places an emphasis on helping within the Native community. This can be seen in the continuance of the subsistence lifestyle of many of the modern Alaska Native groups. Each individual has a role in the daily functioning of the community. For example, elders among the clan are considered an important source of wisdom and advice among Alaska Native peoples.

Although not all Alaska Native cultures believe in shamanism, the idea that an individual can possess the power to see and influence spirits does exist in some Alaska Native groups. Among these groups, a shaman is sometimes considered the spiritual leader of the clan. In other instances, the shaman is seen strictly as a healer or an individual who influences the luck of the community.

In the case of mental or physical illness, the shaman's duties include determining the causes of the illness and deciding how to treat the underlying causes of that illness. For example, many physical or mental problems are considered to be the result of a broken taboo. A *taboo* is an inhibition or ban on specific behaviors or even thoughts based on Native customs and beliefs (e.g., not hunting the animal of your clan name). Many taboos are related to preventing illness or the promotion of a healthy lifestyle. A broken taboo disrupts the harmony between mind, body, and spirit, not only for the individual but also for the community as a whole. The shaman is responsible for identifying which taboo has been broken and advising the individual or the members of the community on methods for remedying the problem. This process typically involves the shaman entering a trance-like state to improve his or her ability to perceive supernatural phenomena that are important to the healing process. The reason for the illness or problem is then identified in an attempt to prevent future problems for the individual and the community.

Alaska Natives believe that the underlying cause of an illness can be either natural or supernatural; the source of the problem determines the method of intervention. The healing ceremonies that follow involve reestablishing community harmony. For example, prayers, songs, and other activities are used to create an atmosphere that facilitates a healing environment. During these ceremonies, participants sometimes wear masks or ornate costumes, dance, play musical instruments, and use images depicting the spirits they intend to attract.

HEALTH DISPARITIES

Because Alaska Natives and American Indians tend to be grouped together when it comes to health issues, it can be difficult to determine the specific mental and physical health problems Alaska Natives face. However, some information does exist about the mental and physical health problems of Alaska Natives. Some of the leading causes of death among Alaska Natives are cancer, unintentional injury, suicide, and homicide. Although cancer rates are decreasing among the general population in the United States, cancer rates among Alaska Natives are increasing. Compared with their non-Native counterparts, Alaska Natives are less likely to survive once they are diagnosed with cancer. The most common types of cancer among Alaska Natives are colorectal cancer and lung cancer. The high rates of lung cancer among Alaska Natives may be related to the high smoking rates among Alaska Native groups. Additionally, because tobacco sales to minors are common, Alaska Natives tend to start smoking at a younger age.

Death as a result of unintentional injury among Alaska Natives has been estimated to be almost four times that of the general population in the United States. Additionally, unintentional injury is the leading cause of death among Alaska Native children. Risk factors related to unintentional injury include poverty,

substance abuse, poor housing, lack of access to adequate medical treatment, and geographic isolation.

Suicide rates among Alaska Natives have been estimated to be twice the national average. Suicide rates are particularly high among Alaska Native males in their late teens and early twenties who live in nonurban areas of Alaska (i.e., villages). Though no one can say for sure, suicide is often the result of a lack of treatment for depression and substance abuse. These risk factors appear to be more common among the Alaska Native population. Barriers related to the utilization of appropriate mental health services may be a secondary contributor to suicide among Alaska Natives who suffer from depression and addiction. Some estimates show that Alaska Natives are four times more likely to die from homicide than their non-Native counterparts. In fact, nearly half of all deaths among Alaska Natives are a result of suicide or homicide. Again, alcoholism is considered by many to play a significant role in the high homicide rates within the Alaska Native community.

Alaska Natives also have higher rates of incarceration, homelessness, poverty, and alcohol and drug problems. Statistics on homelessness and poverty can be difficult to interpret because of the extreme variation in living circumstances among Alaska Natives groups. Several theories exist to explain the high prevalence of alcohol abuse among Alaska Natives. Some believe that the altered state induced by alcohol consumption was initially considered a valued spiritual experience among the Alaska Native peoples. Others postulate that the binge drinking of early Russian and American fur traders and trappers led to a skewed socialization of appropriate alcohol consumption. Finally, some believe that the problems many Alaska Natives face are the result of negative events experienced by their ancestors (e.g., racism, discrimination). These stressors are consequently passed down to each successive generation. Regardless of the reason for the high rates of alcoholism among Alaska Natives, most agree that this problem is a significant one.

TREATMENT AND PREVENTION EFFORTS

Smoking Prevention

A number of prevention programs have been developed to address the high rates of tobacco use among Alaska Natives. For example, the Alaska Native Health Board has developed tobacco-prevention programs to assist Alaska Native communities in reducing tobacco use. These prevention programs focus on discouraging tobacco use and preventing tobacco-related illnesses that ultimately lead to death. These programs are also intended to target Alaska Native youth to prevent early tobacco use.

Suicide

The Department of Health and Social Services Division of the Alcohol and Drug Abuse Community-Based Suicide Prevention Program provides support for Alaska Native communities to create prevention programs aimed at reducing suicide. This resource is particularly appealing because it allows communities to develop prevention programs to meet the specific needs of the community. In addition to these services, a number of agencies and organizations proactively initiate programs for the purpose of educating the Alaska Native community about suicide risk factors, preventing suicides, and providing a forum for discussing concerns related to suicide.

For example, the Western Athabascan Natural Helpers Program is a school-based program that targets at-risk schools for suicide prevention. Additionally, the Zuni Life-Skills Development Curriculum, the Wind River Behavioral Health Program, the Tohono O'odham Psychology Service, and the Indian Suicide Prevention Center are prevention programs developed for American Indian populations. Although these programs are not designed specifically for Alaska Natives, they may provide useful information about tailoring suicide-prevention programs to include Native customs and beliefs.

Unintentional Injury

The Alaska Injury Surveillance and Prevention Program (ISAPP) currently provides resources for preventing unintentional injuries among Alaska Native peoples. These programs work to improve environmental surroundings (e.g., by installing child car seats), encourage safety law compliance (e.g., child car seat use), and provide safety-related education (e.g., proper use of child car seats). The ISAPP uses a community-level approach that focuses on establishing specific programs that target the problems a particular community is facing (e.g., car seat–related accidents).

Homicide

In addition to programs designed to prevent unintentional injury, resources exist for the purpose of reducing and preventing intentional injury within Alaska Native communities (i.e., homicide). An example of such an organization is the Alaska Injury Prevention Center, which works to increase general community safety. The center works with Alaska law enforcement and community agencies to reduce the incidence of homicide through education, public service announcements, and community-based programs.

Alcoholism

Although a number of substance abuse programs are available in Alaska, few incorporate Native beliefs into treatment protocol. However, recent efforts have been made by such organizations as the Department of Health and Human Services to promote culturally sensitive treatment programs for Alaska Natives. Also, Internet resources have been used by this organization to overcome barriers that often result from the geographic dispersion of Native communities.

ALASKA NATIVE ORGANIZATIONS

In addition to prevention programs and organizations, a number of groups exist to provide services to Alaska Natives. For example, the Alaska Native Health Board provides a forum for discussing Alaska Native health issues. The purpose of this organization is to promote the overall well-being of the Alaska Native community.

The Alaska Native Knowledge Network is an organization that compiles and exchanges information related to Alaska Native culture. It was developed to provide federal agencies, private organizations, educators, and the public with insight into the Alaska Native way of life. Additionally, this network provides Alaska Natives with a method for preserving information about their customs and beliefs. The Alaska Native Knowledge Network also has resources for educators who are developing curricula for Alaska Native children and adolescents.

The Alaska Native Tribal Health Consortium is an organization that is owned by the Alaska Native tribal government and various Alaska Native health services organizations. The consortium is part of the Alaska Tribal Health System, which provides medical and mental health services to Alaska Natives. This system of health service providers aims to improve the physical and mental health of Alaska Natives.

The National Center for American Indian and Alaska Native Mental Health Research is a research organization affiliated with the University of Colorado's Department of Psychiatry. This program is sponsored by the National Institutes of Mental Health. The center focuses its research efforts exclusively on American Indian and Alaska Native peoples. This organization was developed to improve understanding of psychological issues among American Indian and Alaska Native populations.

The Center for Alaska Native Health Research is a research organization that conducts research among Alaska Native populations. Sponsored by grants from the National Institutes of Health and the National Center for Research Resources to the University of Alaska– Fairbanks, the center collects health-related information (e.g., nutritional information) among Alaska Native people. Utilizing both scientific and cultural approaches to examining health issues, the Center for Alaska Native Health Research looks to improve the health of Alaska Natives.

MENTAL HEALTH SERVICE UTILIZATION

It is common knowledge that ethnic and racial minorities in general are less likely to use mental health services. Although the specific rates of mental health service utilization among Alaska Natives have not been carefully examined thus far, the use of these resources appears to be particularly low in this population. Alaska Natives face barriers that are common to other ethnic groups, but they also face obstacles that are unique to the cultural, social, and geographic characteristics of their way of life. Negative past experiences with non-Native peoples (i.e., racism, discrimination, segregation) may result in a general mistrust of mental health professionals. This, coupled with a relative lack of mental health professionals of Alaska Native descent, may help explain the underutilization of psychological services. Another barrier to the use of mental health services is cost. Fortunately, the Indian Health Service (IHS) is a federally funded agency that provides affordable health care, including mental health services, to Native populations. However, geographic isolation can make it difficult to access IHS-designated clinics that offer mental health services to Alaska Natives.

RECOMMENDATIONS FOR RESEARCH

There is still a great deal that is unknown about the mental health issues faced by Alaska Native peoples. In general, future research efforts that focus on conducting culture-centered research among Alaska Natives would help us better understand the psychological needs of this population. The influence of cultural beliefs on psychological phenomena may improve our understanding of the suicide, unintentional injury, homicide, and alcoholism rates in this population. Ethical research conducted among specific Alaska Native groups that highlights differences among these groups could be improved. For example, when reporting treatment research methods and design in an Alaska Native sample, researchers should include information related to the specific group assessed in the study (e.g., Tlingit, Aleut). This would improve our understanding of the generalizability of treatment results, which could, in turn, aid in the translation of research into effective treatments.

This is not to say that research has not been conducted among Alaska Native groups; however, additional research is necessary. Specifically, further research should focus on the effects of non-Native versus Native mental health professionals on the client–therapist relationship, different utilization rates of mental health services among specific Alaska Native groups, and the effectiveness of incorporating cultural values and beliefs into the treatment process. Research that answers these questions will enable mental health professionals to more effectively address the mental health needs of their Alaska Native clients.

RECOMMENDATIONS FOR PRACTICE

Assumptions should never be made about any individual based on his or her ethnicity or race. However, an understanding of specific cultural values and beliefs can be an important factor in establishing an effective therapeutic relationship. For example, some Alaska Native cultures display a reserved communication style, which is sometimes viewed as unfriendly by non-Natives. Additionally, in some Alaska Native cultures, sharing information related to personal problems or complaints is not encouraged by the Native community. In these circumstances, trust becomes crucial to the therapeutic relationship. A lack of trust in the context of cross-cultural mental health treatment and suspicion of mental health professionals may not be uncommon.

As in some American Native cultures, Alaska Natives speech may proceed at a slower rate than for other people. Silence, pauses, and a lack of eye contact may be common during conversations and should not be perceived as avoidance or disrespect. Additionally, extending mental health treatment to include family members, respected elders from the community, or other community members may help to facilitate the treatment process. Alaska Natives may have different perceptions of disability and illness. For example, Alaska Natives sometimes believe that mental illness stems from a spiritual rather than a psychological or biological cause. Inquiring about an individual's perceptions of the contributors to mental health can help improve the development of an effective treatment plan. For example, including traditional Alaska Native treatments in addition to more conventional psychological methods may improve treatment adherence. Improved adherence to treatment recommendations will therefore improve treatment outcomes. Again, the holistic view of health shared by many Alaska Native peoples should be considered when explaining and treating psychological issues.

In addition to client and patient factors, mental health professionals should be aware of their own beliefs and cultural background. Because mental health professionals are also products of their own culture, they should be aware of attitudes and beliefs that may influence their perceptions of Alaska Natives. Consistently monitoring one's own beliefs and preconceived notions about Alaska Native peoples can improve a mental health professional's ability to function effectively in cross-cultural situations.

—Michael M. Steele

See also Native Americans

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ALCOHOL/SUBSTANCE USE AND ABUSE

Alcohol and illicit drug problems are not unique to the majority culture of the United States. They also exist

throughout the many cultural groups that compose the nation's ethnic minority population. Within the ethnic minority population, alcohol and illicit drug problems span age, gender, educational background, occupation, and socioeconomic status. What follows is an overview of alcohol and illicit drug use and misuse as it pertains to the ethnic minority population of the United States. This overview is divided into discussions of (1) the distinction between substance use and forms of substance misuse, (2) the role of cultural norms and acculturation in substance use, (3) the prevalence of substance use and misuse among ethnic minority groups, (4) interventions for substance use and misuse in ethnic minority groups, and (5) the impact of drug-control policies on ethnic minority groups. This overview does not address alcohol and drug problems outside the United States, but it is important to note that substance problems are prominent in other nations and have a negative impact on cultural groups around the globe. Neither will this overview address nicotine and prescription drug problems, both of which are also prominent domestic and international concerns.

DISTINGUISHING BETWEEN SUBSTANCE USE AND SUBSTANCE MISUSE

Understanding the nature of alcohol and illicit drug use and misuse among ethnic minority groups must begin by distinguishing among *substance use, substance misuse, substance abuse,* and *substance dependence* (ordinarily referred to as addiction or chemical dependence). Clarification of the terminology is important because patients, researchers, policymakers, law enforcement, and the media often use these terms interchangeably, and the definitions may be at odds with those of the mental health and medical professionals who are responsible for diagnosing and treating alcohol and drug problems. For example, a man arrested for smoking marijuana at a concert may consider himself a *substance user,* but the criminal justice system may label him a *substance abuser* and him to drug treatment, where he may be diagnosed with a *substance dependence* disorder (such as a cannabis dependence) by a psychologist.

A person engaging in substance use can be described as using a substance without any identified problem associated with such use. For example, a teenager may experiment with marijuana, experience no adverse effects, and refrain from further use. The term *substance misuse* is a general term that describes people who suffer from either a substance abuse or substance dependence disorder.

Colloquially, the term *substance abuse* is used to refer to any degree of substance use, ranging from one-time use of an illicit drug to severe addiction. Its definition among medical and mental health professionals, however, and its use here, refers to a *substance abuse disorder* marked by habitual use of a substance in a manner that is harmful to self or others but without strong signs of physical dependence or significant psychosocial negative consequences. For example, a man may drink heavily at bars on some weekends and then drive home in a state of intoxication. His behavior is dangerous because he is placing himself and others at risk of injury or death, but the role of alcohol in his life may not be so central as to reach the level of addiction.

Among medical and mental health professionals, a *substance dependence disorder* describes an addiction to a substance, marked signs of tolerance and withdrawal, and a number of negative consequences associated with the substance use, but continued use of the substance despite these consequences. Terms such as *alcoholic, junkie,* and *crackhead* are colloquialisms used to describe people who suffer from abuse of or dependence on alcohol, heroin, and crack cocaine.

THE ROLE OF CULTURAL NORMS AND ACCULTURATION IN SUBSTANCE USE

Each culture has a set of norms regarding the substance use of its members. Individuals within a given cultural group will vary in the extent to which their personal attitudes and behavior toward substances are consistent with these norms. Thus, the substance use of some individuals will closely follow their cultural norms, whereas the substance use of others will be at odds with their cultural norms. Despite these individual differences, cultural norms have been found to have a profound and multifaceted impact on the substance use of group members. They influence the particular drugs that are deemed acceptable for use, how and when drugs are used, and even the kinds of reactions that the drug produces in the user.

One facet of the relationship between cultural norms and substance use concerns the delineation between substances that are acceptable and unacceptable for use. The tolerance of some substances and the prohibition of others is a reflection of a cultural norm

that varies from culture to culture. For example, in the United States, where drinking is a traditional part of many social customs and practices, alcohol use is legal for those above a certain age. In contrast, alcohol use is illegal in many Middle Eastern cultures, where alcohol use is regarded as sinful.

A second facet of the relationship between cultural norms and substance use concerns how a particular substance is used. A substance that is ingested in one form in one culture may be ingested very differently by another culture. For example, in parts of South America, indigenous cultures ingest cocaine by chewing coca leaves rather than by snorting or injecting powder cocaine or smoking crack cocaine. In contrast, cocaine users in the United States snort or inject powder cocaine or smoke crack cocaine but do not chew coca leaves.

A third facet of the relationship between cultural norms and substance use concerns the delineation of appropriate versus inappropriate contexts for substance use. The use of a substance may be tolerated in one context but prohibited in another. For example, members of the Native American church regard the use of peyote in the context of worship as a sacramental act, one that allows the believer communion with God. Peyote's use during Native American worship ceremonies has persisted for several centuries. However, the use of the drug outside the ceremonial context is not culturally proscribed.

Finally, cultural norms have a role in the kinds of effects a drug has on its user. For example, researchers investigating marijuana use in Jamaica during the 1970s found that marijuana users reported strength, endurance, and quickness from their drug use. These findings provide a sharp contrast to the amotivational syndrome marked by lowered drive, lack of ambition, and poor concentration that researchers have found among marijuana users in the United States.

Acculturation reflects the extent to which an individual has adapted to or acquired the beliefs of the majority culture. At first glance, the relationship between acculturation and substance use might appear straightforward. That is, the level of acculturation should yield predictable patterns of substance use, so that a minority group's substance use should come to closely resemble that of the majority culture as its degree of acculturation increases. This would intensify or lessen substance use depending on the culture's unique sanctions and prohibitions regarding substance use. For example, immigrants from a culture that sanctions a high degree of alcohol use will likely decrease their alcohol use as they become more acculturated to an adopted culture that has strong prohibitions on alcohol use.

Research on the relationship between acculturation and substance use has not been so straightforward or consistent. In fact, the effects of acculturation on substance use have been found to vary by age, gender, and cultural group. For example, research has linked increased levels of acculturation with less drinking among middle-aged Mexican American men and more drinking with other groups of Hispanic men.

THE PREVALENCE OF SUBSTANCE USE, ABUSE, AND DEPENDENCE AMONG ETHNIC MINORITY GROUPS IN THE UNITED STATES

The measurement of substance use in the United States is constrained because of limitations in the research methodology. For example, researchers have used disparate measuring strategies in alcohol and drug use surveys. This inconsistency in measurement technique has led to difficulty comparing findings across studies. In addition, researchers attempting to measure alcohol and illicit drug use in the population are always faced with people's reluctance to admit to substance use. The measurement of substance abuse and substance dependence disorders is more complex than simply measuring substance use because of the added burden of assessing both the quantities of substance use and the negative consequences associated with such use. Therefore, estimating the prevalence of substance abuse and dependence disorders is imprecise. The best research available provides only a rough estimate of the percentage of Americans who drink, use drugs, and suffer from substance abuse or dependence disorders.

Estimates of alcohol and illicit drug use among ethnic minority groups are even more subject to error because of additional problems associated with ethnic minority research methodology. One such problem is that most of the research on ethnic minority substance use employs umbrella labels for disparate cultural groups. For example, labels such as *Hispanic, Asian,* and *American Indian/Alaska Native* are common ethnic minority categories in the research literature. These terms, though descriptively useful in many ways, mask an array of distinct cultural groups contained within these groups. The label *Hispanic* encompasses people with origins in Cuba, Puerto

Rico, Mexico, South America, and other Central American and Caribbean nations. The label *Asian* encompasses people with origins in China, Japan, Korea, Hawaii, and other Pacific Islands. The label *American Indian/Alaska Native* encompasses several hundred tribal groups, people who live on reservations, people who live off reservations, and people with varying degrees of tribal exposure.

The use of these labels would not be a problem if rates of substance use among the various cultural groups within the label were equivalent. Unfortunately, it has become apparent that there are significant differences among the various cultural groups contained within these umbrella labels. For example, rates of alcohol use differ significantly among Native American tribes. In addition, it has become apparent that substance use rates differ among ethnic minority members who were born in the United States versus those who have immigrated more recently. For example, rates of abstinence from alcohol are significantly higher among Mexican American immigrant women than among third-generation Mexican American women.

ALCOHOL USE

The results of the most recent large-scale government survey on alcohol use, the 2002 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration, found that 51% of Americans over the age of 12 reported current use of alcohol. Overall, the survey found differences in rates of alcohol use among the nation's largest cultural groups. For example, 55% of Caucasians reported consuming at least one drink in the 30 days prior to the survey. Respondents reporting heritage from two or more races had the second-highest rate of past-month alcohol use at 49.9%, followed by 44.7% among American Indian/Alaska Natives, 42.8% among Hispanics, 39.9% among African Americans, and 37.1% among Asians. The rate of past-month binge drinking (defined as consuming five or more drinks in one sitting during the past 30 days) was highest among American Indian/Alaska Natives at 27.9%, followed by 25.2% among Native Hawaiians and other Pacific Islanders, 24.8% among Hispanics, 23.4% among Caucasians, 21% among African Americans, and 12.4% among Asians.

Rates of alcohol use can vary significantly within the cultural groups that make up the umbrella labels commonly used in survey research. The extent of such differences remains to be fully explored. However, research has thus far revealed differences among Hispanic cultural groups. For example, Mexican American men report a higher rate of frequent heavy drinking than do Puerto Rican and Cuban American men. Mexican American and Puerto Rican men are more likely to report a period of heavy drinking during their lifetime than Cuban American men. Cuban American women report less alcohol use than Mexican American and Puerto Rican women. In a similar vein, studies of drinking differences among Asian cultural groups have identified more alcohol abstainers than alcohol users in Filipino American and Korean American samples and more alcohol users than abstainers in Japanese American and Chinese American samples.

ILLICIT DRUG USE

The 2002 National Survey on Drug Use and Health found that 8.3% of the population 12 years and older had used an illicit drug during the month prior to the survey. Rates of drug use varied by cultural group. Respondents reporting heritage from two or more races had the highest rate of past-month drug use at 11.4%. American Indian/Alaska Natives had the second-highest rate of past month drug use at 10.1%, followed by African Americans at 9.7%, Caucasians at 8.5%, Hispanics at 7.2%, and Asian Americans at 3.5%. There were significantly different rates of drug use among those who fell under the umbrella label of *Hispanic.* Puerto Ricans had the highest prevalence rate at 10%, followed by Mexican Americans at 7.3%, Cuban Americans at 6.5%, and people of Central and South American origin at 5%. There were also significantly different rates of drug use among those who fell under the umbrella label of *Asian.* For example, past-month drug use among Korean Americans was 7%, whereas the rate was 5% among Japanese Americans and 1% among Chinese Americans.

SUBSTANCE ABUSE AND DEPENDENCE

The 2002 National Survey on Drug Use and Health estimated the prevalence rates of substance abuse and dependence disorders by asking respondents questions that reflect the criteria established by the American Psychiatric Association for the diagnosis of these disorders. For example, questions pertaining to substance abuse disorders probed for problems with

the law, work, friends, family, or school as a result of alcohol or illicit drug use. Questions pertaining to substance dependence disorders probed for physiological signs of tolerance and withdrawal and continued use of the substance despite the negative consequences associated with its use.

In the sample, 4.5% of the population reported symptoms consistent with a diagnosis of a substance abuse disorder. The same percentage reported symptoms consistent with a diagnosis of a substance dependence disorder. Alcohol was the most commonly reported substance problem, followed by marijuana, cocaine, and prescription pain relievers. American Indians and Alaska Natives had the highest rate of abuse or dependence at 14.1%, followed by persons from two or more races at 13%, Hispanics at 10.4%, African Americans at 9.5%, Caucasians at 9.3%, and Asians at 4.2%.

The high rates of abuse and dependence among American Indians and Alaska Natives may explain the high rates of substance-related health and social problems in this ethnic minority group. The death rate related to alcohol misuse is higher among American Indians and Alaska Natives than among the general population. For example, death from chronic liver disease and cirrhosis (consequences of heavy drinking) is four times more common among American Indians and Alaska Natives than in the rest of the U.S. population. Fatal alcohol-related motor vehicle accidents are three times more common. Alcohol-related suicide and homicide are also more common among American Indians and Alaska Natives than in the general population.

Negative consequences associated with substance abuse and dependence are overrepresented among African Americans and Hispanics. African Americans compose 10% to 12% of the U.S. population, and Hispanics compose about 10% of the population. Yet recent estimates indicate that African Americans and Hispanics make up 50% of new AIDS diagnoses (often a consequence of injection drug use). African Americans represent 51% of marijuana-related emergency room visits and 34% of cocaine-related emergency room visits. Overall, African Americans make up 21% of drug-related emergency room visits. Hispanics represent 15% of methamphetamine-related emergency room visits and 11% of overall drug-related emergency room visits.

Cultural differences are also evident in drug-related deaths. Recent estimates place heroin and morphine as the most commonly implicated substances in drug-related deaths among Caucasians and Hispanics (mentioned in 41% of cases involving Caucasian decedents and 47% of Hispanic decedents). In contrast, cocaine is the most commonly implicated substance in drug-related deaths among African Americans, mentioned in 64% of cases.

INTERVENTION

Interventions in the area of substance use and misuse can be broadly grouped into prevention programs, screening and assessment techniques, and treatment programs. Prevention programs are typically targeted toward adolescents or other individuals at high risk for substance use and misuse. The aim of prevention programs is to prevent or prolong the initiation of substance use and to minimize the substance use of those who begin. Screening and assessment techniques are used to aid the identification and diagnosis of substance abuse and dependence disorders. Treatment programs are targeted toward individuals who have already been identified as having a substance abuse or substance dependence disorder, typically a population that is older than the audience of prevention programs. The aim of treatment programs is usually abstinence from substances; however, some programs seek moderation of substance use rather than abstinence. Traditionally, interventions have been provided to ethnic minority group members without considering the compatibility of the intervention with the values, beliefs, and practices of the ethnic minority group. Over the past few decades, awareness has grown in the field of clinical psychology and other helping professions that an individual's cultural values and beliefs about substances influence his or her response to substance use and misuse interventions.

This awareness has led to the modification of some existing prevention programs and the creation of new prevention programs to increase their sensitivity to the cultural backgrounds of the ethnic minority groups attending the programs. One example is Life Skills Training, a program developed to help adolescents successfully resist peer pressure to use alcohol, tobacco, and illicit drugs. Researchers modified the program to enhance its sensitivity to the cultural background of African American and Hispanic adolescents, and they found greater reduction in alcohol consumption among the Hispanic and African American adolescents who attended the culturally sensitive version of the program compared with those who attended the standard version.

Awareness of the relevance of cultural differences has also informed the practice of screening and assessment. Screening and assessment techniques in the field of addictions, and mental health in general, were often developed and standardized on Caucasian clients, with little regard for how the instrument or technique would perform with ethnic minority clients. Applying a screening or assessment instrument developed on one cultural group to a different cultural group without first testing its adequacy is problematic. For example, if a screening instrument inquires about a set of alcohol problem warning signs that are uniquely manifested in a particular cultural group, the successful screening of alcohol problems in a different cultural group will be questionable.

Attempts to improve the multicultural utility of screening and assessment instruments have occurred through several avenues. One avenue is exemplified by the development of the Alcohol Use Disorders Identification Test. This popular alcohol screening instrument was developed on clients from many cultures on several continents to ensure that the test items would be appropriate for different cultural groups. Other avenues to improve the multicultural utility of screening and assessment instruments have included translating instruments into foreign languages and collecting normative data on ethnic minority populations. Improvements in the assessment process have also been made by training counselors to be sensitive to the ethnic minority groups they serve and to assess an ethnic minority group member's language preference, degree of acculturation, and ethnic identity.

Awareness of the relevance of cultural differences has led to concerns about the adequacy of existing treatment programs for ethnic minority clients. The dominant modality of substance abuse treatment in the United States has been the "Minnesota model" of treatment, which was developed from the principles of Alcoholics Anonymous. Alternative forms of substance abuse treatment based on cognitive-behavioral therapy and motivational enhancement therapy have become popular as well. The utility of these treatments with ethnic minority clients has not been fully evaluated. Attempts to improve treatment outcomes among ethnic minority clients have led to the development of culturally sensitive and culturally specific treatments. Culturally sensitive treatments modify existing treatment programs to make them more compatible with the beliefs and values of the ethnic minority clients being served. Culturally specific treatments use traditional cultural healing practices that fall outside mainstream psychological practices. For example, traditional cultural folktales have been incorporated into substance abuse treatment with Hispanic and Native Americans clients; peyote rituals and sweat lodges have been incorporated into treatment for Native American clients; and a public apology technique has been developed for Asian American clients. However, the use of such treatments is the exception rather than the norm with ethnic minority clients.

DRUG CONTROL POLICY

Historically, U.S. drug control policy has been associated with tension between majority group members and ethnic minority group members. Restrictions on alcohol, cocaine, opiates, and marijuana have all been linked with prejudices toward ethnic minority groups. For example, fear and intolerance of a new and growing immigrant group during the 19th century, the Irish, extended to their drinking habits and provided an impetus for the nation's first temperance movement. As a result of this movement, a third of American states were under alcohol prohibition by the end of the 1850s. Cocaine was a legal drug in the United States during the 19th century, used for a variety of recreational and medicinal purposes. Efforts to prohibit cocaine were prompted by claims that the drug provided African American men with superhuman strength and caused them to commit acts of violence against Caucasians, including raping Caucasian women.

Opiate drugs such as opium, morphine, and heroin also enjoyed widespread recreational and medicinal use during the 19th century. Opium smoking in particular was a common pastime of Chinese immigrants. Efforts to control opiates began as their addictive nature became more widely understood and were prompted by fear and intolerance toward the Chinese. Not surprisingly, prohibitions on smoking opium were enacted before prohibitions on morphine and heroin. Marijuana was used as a medicinal drug in the United States from the 19th century until the 1930s, and recreational marijuana smoking was a common pastime of Mexican immigrants. Similar to beliefs about African Americans and cocaine was the belief that marijuana could lead Mexicans to acts of violence and other forms of crime. These claims aided the establishment of legislation that ultimately led to the drug's prohibition.

Some have argued that contemporary drug control policy in the United States is discriminatory toward ethnic minority group members because they are more prone to the negative consequences of drug control policies than Caucasians. Compared with Caucasians, African Americans are more likely to be arrested for a drug-related offense, their drug-related arrests are more likely to result in conviction, they are more likely to be incarcerated after a drug-related conviction, and they serve longer prison terms for drug-related offenses.

The majority of individuals incarcerated for federal drug-related crimes are African American or Hispanic. Approximately 40% of incarcerated federal drug offenders are Hispanic, 30% are African American, and 25% are Caucasian. These numbers are well out of proportion to the percentage of each cultural group in the general population, and they are even more striking when one considers that rates of drug use among Hispanics, African Americans, and Caucasians are relatively similar.

Perhaps the most controversial topic concerning contemporary drug policy and ethnic minority groups concerns the federal mandatory minimum sentencing guidelines for crack and powder cocaine. The Anti–Drug Abuse Act of 1986 established vastly different mandatory minimum penalties for powder versus crack cocaine violations. For example, a first-time offender in possession of 5 grams of crack cocaine faces a mandatory minimum of five years' incarceration; however, a first-time powder cocaine offender would not face a five-year minimum penalty unless he or she were in possession of 500 grams of the drug. This discrepancy in the amount of crack versus powder cocaine required for a mandatory minimum has been called the "100:1 penalty." It has been argued that this sentencing guideline is especially discriminatory toward African Americans because approximately 85% of individuals convicted of crack cocaine offenses are African American.

In summary, cultural differences are a relevant variable in many aspects of psychoactive substance use. Cultural sanctions and prohibitions influence prevalence rates of substance use and misuse and explain differences in the rates of substance use among ethnic minority groups. The responses of ethnic minority group members to prevention and treatment programs is mediated by their cultural beliefs and values; positive and negative responses to programs may be related to the extent the intervention programs are congruent with culturally proscribed means of conceptualizing such problems. Finally, culture influences drug control policy to the extent that such policies reflect the formalization of the majority culture's views on legal and illicit substance use.

—Damon Mitchell
—D. J. Angelone

See also Drug Abuse Prevention in Ethnic Minority Youth

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AMERICAN COUNSELING ASSOCIATION

In 1952, four independent associations convened at a joint convention to form the American Personnel and Guidance Association. In 1983, this organization changed its name to the American Association of Counseling and Development, and 10 years later shortened its name to the American Counseling Association (ACA). Headquartered in Alexandria, Virginia, the ACA sees its role as promoting public confidence in the counseling profession. With members in the United States and 50 other countries, the ACA maintains a network of 56 branches and 18 divisions.

MISSION STATEMENT

The ACA's brief mission statement underscores its commitment to respecting human diversity: to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity.

CODE OF ETHICS

Consistent with its mission statement, The ACA's code of ethics refers to the importance of respecting

human diversity in virtually every major section of the code. Indeed, the preamble states that association members recognize societal diversity and support the individual's rights and development.

Under the section of the code titled "The Counseling Relationship," ACA members are expected to strive to understand the diverse cultural backgrounds of the clients with whom they work and to develop a clear understanding of how the counselor's own cultural, ethnic, and racial identity influences his or her values and beliefs about the counseling process.

An emphasis on cultural competency extends to other areas of the ACA's code of ethics. In the process of diagnosing their clients, for example, counselors are expected to recognize cultural influences on the definition of clients' problems and consider socioeconomic and cultural experiences before arriving at diagnoses.

When it comes to testing, the ACA code warns that counselors should be cautious in administering tests among culturally diverse populations, whose socialized behavioral and cognitive patterns may fall outside the range of the test's applicability and validity. Furthermore, counselors are advised to observe caution in interpreting the data of populations that differ from the norm group on which the test was standardized and to remain forever cognizant of the possible impact of a range of factors (age, color, culture, etc.) on test administration and interpretation.

Counselor educators are also expected to introduce material related to human diversity into all courses and workshops that are designed to promote the development of professional counselors.

MULTICULTURAL COMPETENCIES

One of the 18 divisions of the ACA is the Association for Multicultural Counseling and Development (AMCD). Chartered in 1972, the AMCD was originally called the Association of Non-White Concerns in Personnel and Guidance. The AMCD endeavors to advance cultural, ethnic, and racial understanding to improve and maintain personal development.

In 1992, an article was simultaneously published in the *Journal of Counseling and Development* and the AMCD's *Journal of Multicultural Counseling and Development.* The multicultural competencies that were outlined in that article have become part of the canon of the counseling literature. They are available from the ACA as three separate documents: "Cross-Cultural Competencies and Objectives," "Operationalization of the Multicultural Counseling Competencies," and "Dimensions of Personal Identity."

—G. Scott Sparrow

See also Multicultural Counseling; Multicultural Counseling Competencies

AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), headquartered in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States and the world's largest association of psychologists. The APA's membership includes more than 150,000 researchers, educators, clinicians, consultants, and students. Through its divisions in 53 subfields of psychology and affiliations with 60 state, territorial, and Canadian provincial associations, the APA works to advance psychology as a science, as a profession, and as a means of promoting health, education, and human welfare. The association's annual convention, held in late summer, is the world's largest meeting of psychologists.

The APA members sit on association boards, committees, and task forces and work with colleagues to shape policies for the association and to develop standards regarding psychological research, practice, education, and the application of psychology and psychological research to social issues.

The APA supports membership interests through its central offices and four directorates—Practice, Science, Education, and Public Interest—as well as through its meetings, journals (the APA publishes 46 journals), newsletters, books, e-products, continuing education programs, training, and accrediting activities. Members also benefit from the APA's federal legislative and regulatory advocacy and media relations, as well as an ethics education program.

The Science Directorate is the focal point of the APA's efforts to enhance psychological science and expand the recognition of its achievements. This directorate develops and manages programs serving APA members involved in academe and research and consolidates the APA's science activities.

The Practice Directorate promotes the practice of psychology and the availability and accessibility of psychological services for health care consumers through its national public education campaign, advocacy and legislative efforts, and work with state psychological associations.

The Public Interest Directorate promotes the science and practice of psychology by contributing to the improvement of the public's health and well-being. It works to inform social policies based on psychology's unique expertise in human behavior.

The Education Directorate works to advance the education and training of psychologists, the teaching of psychology, and the application of psychology to education and teaching.

Other functions of the association include the Research Office, the Office of Public Affairs, and the publication *Monitor on Psychology.* The primary mission of the Research Office is to collect, analyze, and disseminate information relevant to psychology's labor force and educational system. The Office of Public Affairs provides a link between the news media and the expertise of APA members. The *Monitor on Psychology,* the APA's official monthly magazine, informs readers of the latest advances in the field and the activities of the APA.

The APA is a nonprofit corporation chartered in Washington, D.C. In accordance with its bylaws and the association rules, the APA is governed by a council of representatives with elected representatives from its divisions and affiliated psychological associations. The APA's central office is guided by a board of directors and administered by a chief executive officer.

—Diane Willis

See also Committee/Office on Ethnic Minority Affairs, American Psychological Association; Council of National Psychological Associations for the Advancement of Ethnic Minority Interests

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AMERICANS WITH DISABILITIES ACT

The Americans With Disabilities Act (ADA) of 1990 is a civil rights act protecting persons with disabilities from discrimination. The ADA follows earlier civil rights legislation that provided similar protections against discrimination on the basis of race, gender, age, and national origin. The ADA is especially significant for ethnic and racial minorities with disabilities, whose experience has been described as a "double whammy" of having to cope with reactions to both race and disability.

The goal of the ADA is equal rights for persons with disabilities and their full inclusion and participation in society. The ADA brings a civil rights approach to persons with disabilities and moves away from seeing persons with disabilities as beneficiaries of charity.

The ADA specifically addresses employment discrimination, discriminatory access to local and state governments, public accommodations, access to establishments such as restaurants and supermarkets, and telecommunications availability (primarily for persons who are deaf and hard of hearing).

PRECURSORS OF THE ADA

The Architectural Barriers Act of 1968, which was concerned with access to federal and federally financed buildings for persons with disabilities, and Sections 501, 503, and 504 of the Rehabilitation Act Amendments of 1973, which mandated programmatic access of persons with disabilities to organizations receiving federal funds, were precursors of the ADA. The Education for All Handicapped Children Act of 1975 entitled children with disabilities to a free, appropriate education and reinforced inclusiveness by the U.S. government. The need for specific legislation protecting persons with disabilities from discrimination was bolstered by a report titled "Toward Independence," issued by the National Council on Disability in 1986.

The ADA's passage into law is significant because it involved many people working together to bring about change. The final passage of the ADA occurred because people with many different kinds of disabilities—from people who were blind to those with developmental disabilities, along with families and advocates—worked together in ways that were unprecedented in American disability history.

DISABILITY DEFINED

The ADA defines persons with disabilities as persons who have a physical or mental impairment that substantially limits one or more of their major life activities; who have a record of such impairment; or who are regarded as having such an impairment.

The ADA says that persons with disabilities may not be discriminated against in employment on the basis of their disability; however, they must be qualified for the job, with the requisite work, experience, education, and other requirements of the position, and must, with or without reasonable accommodation, be

able to perform the essential functions of the position. At the same time, there is an inherent obligation of employers to remove barriers and to provide "reasonable accommodation."

The ADA also extends the antidiscrimination mandate to local and state governments and to organizations in the public arena, such as banks, supermarkets, retailers, and restaurants. Government and businesses must remove barriers that are "readily achievable" and are not an "undue hardship" for them.

—Paul Leung

See also Disabilities; Racism and Discrimination

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ANTI-SEMITISM

Anti-Semitism refers to hostility toward Jews as a religious, ethnic, or racial group that is manifested on an individual, institutional, or societal level. This definition highlights one of the major difficulties of defining anti-Semitism accurately—that is, Jews often confound established notions of ethnic, racial, and religious identity. Unfortunately, many people see Judaism only as a religion, and others see Jews as Caucasian; the latter designation is particularly problematic for Jews of color. These categorizations are overly simplistic and do not fully describe the diversity of Jews. For example, there are Jewish ethnic differences (i.e., Ashkenazim, Sephardim, and Mizrachim) and different Jewish movements (i.e., Orthodox, Hasidic, Reform, Conservative, Reconstructionist, and Renewal). Hence, anti-Semitism is more than simple religious bias. It is important to note that many scholars no longer hyphenate the term *anti-Semitism* in order to cease the co-opting of this word for anything other than what it truly means: Jew hatred.

Anti-Semitism has been documented for more than 2,000 years and comes in many forms, including oppression, discrimination, segregation, pogroms, and genocide. Scholars have outlined seven categories of anti-Semitism: (1) religious (e.g., Jews' "refusal" to embrace Jesus); (2) social (e.g., limiting Jews' occupational choices); (3) political (e.g., blaming Jews for communism); (4) economic (e.g., the myth that all Jews are rich); (5) psychological (e.g., the majority culture's desire to assimilate Jews is projected onto Jews so that they are seen as wanting to take over the world); (6) sexual (e.g., Jewish women are stereotyped as being both teases and prudes simultaneously); and (7) racial (e.g., Jews are seen as biologically inferior).

Other examples of anti-Semitism include questioning the Jewish identity of nonreligious Jews, violence against Jews at the individual and community levels, denying the occurrence of the Holocaust, and bashing the state of Israel.

Why does anti-Semitism persist? Three factors appear to be responsible. The first and foremost is Christian anti-Semitism. With the creation and maintenance of Christian state power, the deicide myth (i.e., the erroneous belief that the Jews killed Jesus), the blood libel myth (i.e., the belief that Jews killed Christian children for religious ceremonies), and the New Testament's depiction of Judaism (e.g., Christianity superseding the Hebrew covenant with God) became institutionalized. This made anti-Semitism a state- and church-sanctioned activity, lasting for hundreds of years. In the United States, this led to the creation of an invisible yet powerful anti-Semitic system that provides unearned privileges to Christians in a process parallel to the way racism benefits Caucasians. This Christian dominance is just beginning to be deconstructed.

Second, Jews historically served as a middle class whom those in power used as an intermediary between the oppressed and the oppressors. As a stateless people, Jews were permitted to enter countries in exchange for serving those in power; simultaneously, a continuous low-level, unofficial campaign of anti-Jewish propaganda was kept alive among the oppressed majority. In times of threatened revolt among the oppressed, violent, official anti-Jewish propaganda emerged. Pogroms, massacres, and expulsions were organized to turn the resentments of the oppressed majority, prepared to revolt against the oppressors, toward the Jews as scapegoats. This strategy has been used throughout the last 2,000 years, and scholars contend that Jews are difficult to categorize because this intermediary status has made them

simultaneously part of both the dominant and subordinate groups.

The third factor is the invisibility of Jewish identity. The long history of oppression experienced by Jews, culminating in the *Shoah* (Holocaust), caused many Jews to hide or shed their Jewish identity in a desperate attempt to assimilate. Though many Caucasian Jews used their privileged skin color to "pass," the costs were severe (e.g., losing their Jewish culture). The success of Jewish American assimilation allowed anti-Semitism to persist because Jews became Caucasian and because their invisibility legitimized the denial of anti-Semitism.

—Lewis Z. Schlosser

See also Racism and Discrimination

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ANXIETY DISORDERS IN ETHNIC MINORITIES

Of the major diagnostic groups of mental disorders, anxiety disorders have one of the highest—if not *the* highest—reported prevalence rates in the United States. Anxiety is the most common mental disorder among women and the second most common among men. This entry provides a brief overview of the current literature on anxiety disorders in racial and ethnic minority groups, particularly among the four principal racial and ethnic minority groups in the United States: African Americans, Asian Americans, Hispanic Americans, and American Indians/Alaska Natives. Although these descriptors are necessary for ease of reading, it is critical to bear in mind the diversity within each category. Racial and ethnic groups are multifaceted rather than unidimensional, with many cultures existing within each group. Furthermore, these distinctions are based on U.S. national boundaries, and so they are somewhat arbitrary and do not entirely portray the cross-national status of some indigenous Hispanic and Native American groups. Given the scope of this entry, information concerning the assessment and treatment of anxiety disorders in ethnic minority groups is not included. Rather, attention is focused on known, unique aspects of anxiety disorders in ethnic minorities, as well as specific culture-bound disorders.

UNIQUE SYMPTOM EXPRESSION AMONG RACIAL AND ETHNIC GROUPS

The important role of culture in anxiety has been highlighted by developments in emotion theory. What constitutes anxiety varies by culture, and cultural variables may affect the way an individual describes his or her symptoms. For example, it may be more acceptable in certain cultures to express psychological distress through physical symptoms, such as a headache, as opposed to "feeling depressed." For further information on the somatization versus psychologization of descriptors for anxiety and depression, including idioms of distress, readers are referred to Laurence Kirmayer's review of differences in anxiety symptomatology by culture.

Thoughts, feelings, and bodily experiences are not necessarily seen as separate in many cultures. Therefore, in certain cultures, even serious anxiety symptomatology may not be brought to the attention of a health care professional. Additionally, the cultural expressions used to describe anxiety may overlap with traditional descriptors of affective, somatoform, and dissociative disorders, further complicating the clinical presentation. As a result, anxiety disorders in ethnic minorities may be misdiagnosed, perhaps more often than in the general population.

There are many examples of differences in the symptom expression of anxiety across cultures. In Hispanic cultures, for example, anxiety may present itself as *ataques de nervios,* a condition that involves attacks of anger, screaming, and other symptoms that may not be seen as panic or anxiety from other perspectives. Steven Friedman noted that, for men in some South Asian cultures, anxiety may be communicated as losing semen in urine. Qualitative ethnographic research has suggested that culture may affect the experience and presentation of anxiety among African Americans in a unique way, as described by Suzanne Heurtin-Roberts and collaborators. For example, African Americans may express anxiety through

expressions such as "high-pertension," "high blood," "nerves," and "falling out" rather than traditional psychological nomenclature, and they may report somatic symptoms related to problems with their blood. In their review of ethnographic research, Heurtin-Roberts and colleagues concluded that many African Americans describe anxiety primarily through somatic terms.

RISK FACTORS

Risk factors for developing anxiety include discrimination and racism experienced both by the individual and vicariously through a legacy of historical trauma. Additional factors (noted by Gayle Iwamasa and Shilpa Pai) that may influence the development of anxiety and other psychological disorders are racial identity, ethnic identity, and acculturation level. These three culturally related aspects are unique to each individual; therefore, they may act as protective factors or as risk factors in the development and possible continuation of anxiety. Many ethnic minorities in the United States face increased social stressors when compared with the Caucasian majority. For example, minorities are more likely to live in substandard housing, be unemployed, and have no health insurance. For all ethnic minority groups, racism and poverty are risk factors for psychopathology.

EPIDEMIOLOGY AND PREVALENCE

Although relatively few cross-cultural studies have examined the epidemiology of anxiety disorders, those conducted thus far have reported similar rates of anxiety disorders across the world. Prevalence rates of anxiety disorders across racial and ethnic groups within the United States, however, are inconsistent. The Epidemiologic Catchment Area (ECA) studies, conducted by the National Institute of Mental Health from 1980 to 1985, determined the lifetime prevalence of specific phobias and agoraphobia to be higher in African Americans than in Caucasians and Hispanic Americans at every level of education. Research has also indicated that rates of phobias, panic disorder, and sleep paralysis are higher in African Americans than in the general population.

However, in a subsequent examination of anxiety disorder prevalence, the National Comorbidity Survey of 1989, no racial differences were found in the prevalence of any anxiety disorders. Furthermore, Charlotte Brown and collaborators found no differences in anxiety disorder prevalence, symptoms, or impairment between African American and Caucasian patients in a primary medical setting. Taken together, the disagreement in prevalence rate findings for anxiety disorders across racial and ethnic groups is not surprising, considering the wide range of anxiety symptomatology. Therefore, future epidemiological research on anxiety within ethnic minorities is needed.

UNIQUE MANIFESTATIONS OF ANXIETY DISORDERS AMONG RACIAL AND ETHNIC GROUPS

Variations in the expression and experience of anxiety symptoms exist across ethnic and racial minority groups. One important caveat to consider is the heterogeneity inherent within ethnic groups. For this reason, an idiographic approach is essential to understanding anxiety disorders. Aside from the culture-bound syndromes, there is an unfortunate dearth of information on unique manifestations of the major anxiety disorders among ethnic and racial minority groups. Currently, the African American experience of anxiety has the most literature, particularly on panic disorder, although the amount of research is still largely inadequate.

African Americans

Information regarding the epidemiology of anxiety disorders in African Americans currently is available for panic disorder and obsessive-compulsive disorder.

Panic Disorder

Although research is limited, studies have suggested several factors that may influence the presentation of panic disorder (PD) among African Americans and differentiate it from PD among Caucasians, particularly hypertension and isolated sleep paralysis. Isolated sleep paralysis (ISP) is a condition that occurs while one is falling asleep or awakening; the person cannot move and may experience hypnagogic or hypnopompic hallucinations, tachycardia, hyperventilation, and fear. Different from a nocturnal panic attack, ISP has been described by the phrase "the witch is riding you." In a study of Caucasian and African American anxiety patients from clinical and community samples, African Americans with PD had by far the greatest incidence of recurrent ISP (59.6%), leading Steven Friedman and colleagues to conclude

that recurrent ISP may be a feature of PD that is unique to African Americans.

In an analysis of ECA data by Ewald Horwath and collaborators, African Americans and Caucasians had similar clinical features of panic disorder, although African Americans reported more tingling in the extremities and "hot and cold flashes" during panic attacks. African Americans with panic disorder described greater tingling and numbing of the extremities during panic attacks, as well as stronger fears of dying or going crazy, in studies by Steven Friedman and Cheryl Paradis and by Lisa Smith and collaborators.

Finally, in work by these same investigators, greater rates of comorbid posttraumatic stress and depression were noted among African Americans than among Caucasian panic disorder patients. These studies also revealed that the two groups employed different coping strategies; specifically, African Americans displayed less self-blame and used strategies involving religion, spirituality, and gratitude for one's good fortunes more than Caucasians.

Obsessive-Compulsive Disorder

The inclusion of African Americans in clinical research on obsessive-compulsive disorder (OCD) has been vastly inadequate despite the suggestion in the ECA data that the prevalence of OCD may be slightly higher in African Americans than in Caucasians. Current research has found little to distinguish the African American experience of OCD from that of other racial and ethnic groups. In a naturalistic treatment outcome study of African American, Caribbean American, and Caucasian OCD patients, Steven Friedman and colleagues found no differences in the type of OCD symptoms displayed, symptom severity, or treatment outcome across the three ethnic groups. Furthermore, no differences in religious symptomatology were found. Interestingly, although symptom severity was equivalent between Caucasians and African Americans, African Americans were less likely to report obsessive-compulsive symptoms initially and often revealed them only after the establishment of rapport. This hesitancy to disclose one's symptoms or distress may speak to the greater levels of shame found in African American compared with Caucasian OCD sufferers, as reported by Elaine Williams, Dianne Chambless, and Gail Steketee.

In case studies of African American women with OCD, Elaine Williams and colleagues described an unusually high amount of shame and a sense of being alone in the presentation of the disorder compared with Caucasian patients. Additional clinical issues for African American women with OCD included fears of going crazy (i.e., fear that their obsessions and compulsions indicated that they had "lost their mind") and, typical of OCD cases, obsessions that were influenced by their cultural belief systems. Specifically, one obsession involved a fear of being cast under a spell if the client touched a spot previously touched by another, which she explained could "put the root" on her. The authors noted the normalcy of a belief in root magic in some cultural groups, including those with Caribbean backgrounds. As noted by Peter Guarnaccia, clinicians should be cautioned against misdiagnosing patients' concerns about "root work," harmful magic, or supernatural forces as indicative of psychosis rather than anxiety.

Asian Americans

The Asian American population comprises a number of ethnic groups, including Asian Indians, Cambodians, Chinese, Filipinos, Japanese, Koreans, and Vietnamese, among others. Like other racial and ethnic groups, the extensive heterogeneity within this population proscribes broad assumptions concerning the cultural expressions of anxiety that are unique to Asian Americans. Research has indicated, however, a higher prevalence of certain anxiety disorders within subpopulations of Asian Americans. In particular, refugees of Southeast Asia are at increased risk for posttraumatic stress disorder (PTSD). This finding is consistent with the experience of brutal environmental strains such as habitation in refugee camps, combat, and torture. In addition, Asian American college students reported higher levels of social anxiety relative to Caucasians.

According to Derald Sue and David Sue, Asian Americans often express emotional and psychological stress through physical complaints, which are more culturally accepted. This tendency to communicate anxiety through somatic complaints was echoed by Dosheen Toarmino and Chi-Ah Chun in their guidelines for counseling Korean Americans; specifically, they noted that complaints about appetite, sleep disturbances, fatigue, headache, and restlessness often are expressed rather than descriptors such as "anxiety" or "depression." Sue and Sue noted that this emphasis on somatic complaints may result from a

belief that emotional distress is caused by physical ailments and that it will cease upon proper medical treatment for the physical problem.

Hispanic Americans

In recent years, the Hispanic population in the United States has seen rapid growth and diversification, including individuals from Mexico, Puerto Rico, Cuba, and other Central and South American countries. Like other minority groups, Hispanic Americans often underutilize mental health care services for a variety of reasons, such as poor financial circumstances or preferences for family support. Although there is an unfortunate paucity of information concerning the experience of the major anxiety disorders among Hispanic Americans, information is available on unique idioms of distress that may be used to describe anxiety (e.g., ataques de nervios) and culture-bound syndromes (e.g., nervios). Peter Guarnaccia and others have suggested that culturally related anxiety disorders among Hispanic Americans, such as ataques de nervios, may be a culturally shaped response to extreme stress because they often elicit family or other social support and usually occur at family conflicts, funerals, or accidents.

One culture-bound syndrome among Hispanic Americans, *susto,* may be an expression of PTSD or acute stress disorder. Resulting from a distressing or frightening event, susto may involve complaints of sadness, troubled eating or sleeping, and reduced estimation of self-worth, as well as various physical ailments, such as stomachaches. Certain symptoms of susto, such as disturbing dreams, are consistent with the PTSD criterion related to the reexperiencing of a traumatic event. Although susto may also indicate depressive or somatoform disorders, its resemblance to PTSD and acute stress disorder merit its consideration as an anxiety disorder.

American Indians and Alaska Natives

Although psychological disorders such as depression and substance abuse are believed to be more common among American Indians and Alaska Natives, problems with anxiety are increasingly being recognized among these groups. There are also culturally specific anxieties and anxiety disorders that appear to uniquely affect Native Americans. As indigenous peoples of North America, American Indians and Alaska Natives have endured hundreds of years of onslaught by other dominating cultural groups. The cultural stressors involved in this forced acculturation are numerous and include the loss of ancestral lands and forcible relocation to inhospitable or culturally foreign areas, systematic attempts to eliminate religion and language, imposed outside governance, treaty violations, mandated education in boarding schools, exposure to non-Native diseases and practices with disastrous health consequences, and even genocide.

Given these historical and contemporary stressors, it is not surprising that many American Indians and Alaska Natives experience culturally specific anxieties. Such anxieties, spanning social involvement with Native Americans and cultural knowledge, economic issues, and social involvement with the majority culture, have been identified by Daniel McNeil and colleagues using the Native American Cultural Involvement and Detachment Anxiety Questionnaire. Consistent with this idea of unique historically and environmentally based influences on the anxiety of American Indians and Alaska Natives, J. Douglas McDonald, Thomas Jackson, and Arthur McDonald have suggested that Native American college students who leave home to pursue their education may experience greater generalized anxiety than both their non-Native counterparts and reservation-based Native American students who stay near home at a reservation-based college. In addition to such culturally specific anxieties, other disorders that are culturally bound (e.g., kayak angst) or culturally related (e.g., intergenerational PTSD) may affect the indigenous peoples of North America.

CULTURALLY SPECIFIC ANXIETY DISORDERS

The following disorders, listed alphabetically, are unique to various cultural groups. Many of them are described in greater detail in other entries in this volume. This list is not exhaustive. Furthermore, although culturally specific disorders with a strong anxiety component are included, the majority of the syndromes described here do not map exactly onto the diagnostic categories of the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV-TR). Presentations may resemble adjustment,

depressive, dissociative, somatic, or psychotic disorders. Many, but not all, of the disorders described here are included in the glossary of culture-bound disorders in the DSM-IV-TR.

Ataque de Nervios (Hispanic Americans)

Ataque de nervios (attack of nerves) is described in the DSM-IV-TR as an expression most closely related to panic attacks and commonly recognized among Latin American and Latin Mediterranean groups. Common symptoms include shaking, palpitations, numbness, and a sense of heat rising to the head. Peter Guarnaccia noted "screaming uncontrollably" as the most common symptom reported, followed by "attacks of crying."

Brain Fag (African Americans)

Brain fag is a phrase indicating fatigue or exhaustion from intense thinking in many cultures. Difficulty thinking and concentrating is a common symptom, and somatic complaints have also been reported. Brain fag syndrome is most prevalent in rural areas; it may be a form of anxiety or depression disparate from traditional North American psychological terms.

Dhat (Asian Americans)

Syndromes with presentations similar to *dhat* include *jiryan* in India, *sukra prameha* in Sri Lanka, and *shen-k'uei* in China. Inherent in these cultures is an ancient belief that a man's vital energy resides in his semen. Dhat refers to feelings of extreme anxiety related to a supposed discharge of semen, usually thought to be passed through the urine, and an accompanying whitish discoloration of the urine. Numerous somatic symptoms often accompany the complaint of semen loss; weakness and exhaustion are commonly associated with dhat.

Frigophobia (Asian Americans)

Frigophobia, also known as *pa-leng* and *wei han zheng,* is a condition characterized by a severe fear of cold and winds, which are believed to cause fatigue, impotence, or death. Frigophobia, a disorder that is well-known in Chinese mental health practice, often involves somatic complaints (e.g., headaches, numbness) and avoidance behaviors related to cold (e.g., compulsive wearing of heavy clothing, even in warm temperatures).

Intergenerational Posttraumatic Stress Disorder (Many Racial and Ethnic Minority Groups)

Posttraumatic stress disorder is an anxiety disorder that has unique considerations for ethnic minority members because of potential cumulative trauma and the possible transmission of traumatic events to individuals of subsequent generations. For example, work by Sandra Choney and colleagues has suggested that intergenerational PTSD may occur in Native Americans in response to historical trauma. Robert Robin and collaborators described the impact of community trauma on the psychological health of American Indian individuals, a consideration that is consistent with the collectivist, extended-family orientation and oral traditions within American Indian and Alaska Native cultures. Therefore, the development and presentation of PTSD in Native American individuals may involve additional clinical considerations. Similar ethnocultural historical effects may be risk factors for PTSD for a variety of racial and ethnic groups. For a comprehensive reference concerning PTSD among African Americans, American Indians, Asian Americans, and Hispanic Americans, the work of Anthony Marsella and colleagues is recommended.

Hwa-byung (Asian Americans)

Hwa-byung, or *wool-hwa-byung,* refers to "anger syndrome" in Korean folk culture. Presenting symptoms include panic, fear of imminent death, fatigue, and insomnia, as well as somatic symptoms of indigestion, anorexia, general aches, and feeling a lump in the front of the abdomen.

Kayak Angst (Native Americans)

Kayak angst, a condition that has been historically identified among the Inuit of Greenland, bears a striking resemblance to panic disorder. Kayak angst has been described as a discrete condition of severe anxiety that overcomes seal hunters while fishing in one-man boats. A loss of direction, helpless feelings, and psychophysiological responsivity are characteristic. An intense fear of drowning that decreases by

returning to land or by the presence of other hunters has also been reported. Kayak angst shares many features of panic disorder, including unexpected onset and subsequent avoidance behavior (e.g., avoiding future hunting opportunities).

Koro (Asian Americans)

Koro, a diagnosis included in the Chinese Classification of Mental Disorders, is a syndrome known in Southeast Asia. Koro manifests as extreme anxiety that one's genitals will retract into the body, perhaps resulting in death, or that one's genitals have been stolen. Reports of koro have ranged from single cases to epidemics. Koro also is similar to *shen-k'uei,* or anxiety relating to a perceived loss of semen.

Nervios (Hispanic Americans)

Nervios is a frequently described expression of distress among Hispanic Americans. Nervios ranges from a small subset of symptoms to presentations resembling full disorders, and it includes broad categories of somatic symptoms, difficulty functioning, and emotional distress. Headaches, stomach problems, sleep disturbances, feelings of nervousness, dizziness, tearfulness, trembling, and tingling sensations are commonly reported symptoms.

Taijin-Kyofu-Sho (Japanese Americans)

Taijin-kyofu-sho, or *taijin kyofusho,* is often seen as a Japanese form of social phobia. Rather than intense fear of embarrassment or negative evaluation, as in the Western conceptualization of social anxiety disorder, this syndrome is characterized by anxiety resulting from a fear of offending others through one's body, appearance, odor, or movements.

CONCLUSIONS

Anxiety disorders are some of the most common psychological difficulties. As the population of the United States becomes increasingly more diverse, there is need for a greater understanding of anxiety disorders within ethnic and racial minority groups. Because one's expression and manifestation of anxiety may vary depending on one's cultural background, it is important for clinicians to understand each patient's conceptualization of his or her symptoms. In this vein, the ways in which anxiety is communicated by ethnic and racial minority clients may vary according to the cultural acceptability of psychological descriptors of distress and the ways in which emotional states are described within the client's culture. An understanding of this cultural complexity is a step toward removing semantic and other barriers to valid assessment and treatment.

Despite the high prevalence of anxiety disorders in the population, limited epidemiological data are available for racial and ethnic minorities. Therefore, more systematic research is needed to identify idioms of distress and anxiety symptomatology that may characterize the experience of anxiety for different cultural groups. Recognition of the significant overlap of anxiety disorders with other clinical syndromes—particularly affective, somatoform, and dissociative disorders—is critical. Finally, guidelines for clinicians in regard to anxiety and its relationship to culture are required to move toward an understanding of anxiety across ethnic and racial groups.

—Rebecca K. Widoe
—Renata K. Martins
—Daniel W. McNeil

See also Cross-Cultural Psychology; Culture-Bound Syndromes: Ataque de Nervios; Culture-Bound Syndromes: Brain Fag; Culture-Bound Syndromes: Dhat; Culture-Bound Syndromes: Hwa-byung; Culture-Bound Syndromes: Koro; Culture-Bound Syndromes: Nervios; Culture-Bound Syndromes: Taijin Kyofusho; Posttraumatic Stress Disorder

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ASIAN AMERICAN PSYCHOLOGICAL ASSOCIATION

The Asian American Psychological Association (AAPA) was founded in 1972 as a group effort spearheaded by a small but dedicated and influential handful of Asian American psychologists such as Derald Sue, Stanley Sue, Roger Lum, Marion Tin Loy, Reiko True, and Tina Yong Yee. What began as informal meetings to stay connected and offer an exchange of information and support among this select group in the San Francisco Bay Area has become a major ethnic minority psychological association with more than 400 members. The growth of the AAPA as an influential force within psychology reflects the growing needs and demands of the Asian American population, which is currently the fastest growing ethnic minority group in the United States.

Since its inception in the 1970s, the AAPA has grown and struggled to overcome many barriers to become a highly visible organization with many objectives, the focus of which are the mental and psychosocial health issues of Asian Americans. Some of these goals include advocating for Asian Americans and promoting Asian American psychology in the form of research, policies, and practices. Other key objectives of the organization include the training and education of Asian American mental health professionals. Important AAPA initiatives have included lobbying the U.S. Census Bureau to recognize and include Asian American subgroups in census data, presenting state-of-the-art information on Asian Americans to various presidential commissions and surgeon general's reports, and promoting Asian American perspectives within organized psychology.

Many journals, books, and newsletters focus on Asian American psychology and advocacy of service delivery to this population. From Stanley Sue's pioneering *Mental Health of Asian Americans* to the landmark *Handbook of Asian American Psychology,* each of these works have helped to lay the groundwork for development of the field of Asian American psychology.

The AAPA operates through an elected executive committee that serves a two-year term and consists of a board of directors, which includes a president, vice president, past president, membership and financial affairs officer, secretary/historian, and four board members. As the AAPA began to form an established identity, it began to publish an official newsletter, the *Asian American Psychologist,* which eventually evolved into a journal. Currently, the AAPA has returned to the newsletter format, which is published on a regular basis, three times annually. It consists of topics revolving around AAPA news, events, advertisements, accomplishments, and issues pertaining to Asian American psychology.

The AAPA holds a national annual convention the day before the American Psychological Association convention. The national convention features programs related to Asian American psychology, training, research, policies, and education. The convention is designed to optimize interactions between the presenters and the participants so that levels of intimacy, learning, mentoring, and comradeship are established. The AAPA also maintains a Web site (www.aapaonline.org) and an active Listserv for discussion. The current executive committee of the AAPA has initiated a Digital History Project for the association, and soon, digital copies of the historical record will be available on its Web site.

The future of the AAPA seems clear: to continue its efforts to promote the well-being of Asian Americans through training, research, and service and to serve as the primary professional organization for Asian American psychologists.

—Frederick T. L. Leong
—Arpana Gupta

See also Asian/Pacific Islanders

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ASIAN/PACIFIC ISLANDERS

Estimates suggest that, at the present time, just over 60% of the global population resides on the continent of Asia; however, this is an underestimate of the global population of Asian and Pacific Islanders (API) because numerous API reside outside Asia. In the United States alone, Asian and Pacific Islander Americans (APIA) represent one of the fastest-growing minority populations. Nonetheless, they remain overwhelmingly underrepresented in psychological research.

ASIAN AND PACIFIC ISLANDER AMERICANS IN THE UNITED STATES

The Chinese were among the first API immigrants to the United States. The increasing rate of Chinese immigration, initially fueled by the gold rush, was rapidly stifled with the passage of the Chinese Exclusion Act of 1882. As the number of immigrants from other API nations (e.g., Japan, Korea, and India) began to steadily increase, a number of parallel legislative acts were passed during the early 1900s to restrict their immigration as well. As a result, API immigration slowed to a trickle until the enactment of the 1965 Immigration Act, which eased restriction on immigration from API nations, catalyzing a resurgence of API immigration. Although the majority of APIA arrived after 1965, there are substantial numbers of APIA refugees and American-born APIA.

Current data suggest that there are more than 12.5 million APIA residing in the United States, representing nearly 4.5% of the nation's population. The majority of APIA have taken residence in the western United States (51%), and the remainder are spread throughout the South and Northeast (19% each), as well as the Midwest (12%). It is estimated that there are approximately 43 different ethnicities represented by API in the United States, displaying a tremendous diversity in terms of language, culture, religion, level of education, and socioeconomic status.

ISSUES IN THE RESEARCH CONCERNING ASIAN AND PACIFIC ISLANDER AMERICANS

Although significant advances have been made within the last 20 years in regard to ethnic minority research, research within the field of psychology using APIA participants remains sparse, and the literature that does exist is often inconclusive. There have been numerous attempts to illuminate the reasons for the paucity of research, as well as the inconsistencies within the existing literature, involving this group of people.

Some researchers argue that the discriminatory and exclusionary tactics aimed at APIA tend to be greater than those directed at other ethnic minority groups. These biases are believed to stem from the fact that API decided to immigrate to the United States, unlike other minorities, who had little choice. Thus, the sentiment suggests that APIA do not deserve to be studied until other groups have been given their due attention. Although some may consider this a rather extreme point of view, it should not be too quickly dismissed, regarded as an extremist position, or viewed as an impossibility. It is quite possible that at some level, these erroneous beliefs have the power to influence or even tarnish one's view of various ethnic groups, hence reducing interest in the conduction of research on those groups.

Additionally, many researchers have suggested that common (mis)perceptions of APIA as professionally and financially successful may lead to a lack of interest in research on this population. Such perceptions may contribute to a mistaken belief that these enhanced financial resources are accompanied by superior psychological resources, thus better equipping these individuals to combat the stresses typically associated with immigration and acculturation. Such unsubstantiated thinking may lead to the unfounded belief that APIA, because of their financial success, simply do not suffer from psychological distress, or if they do, they are in possession of superior coping resources that allow them to better deal with distress. Thus, their status as "worthwhile" and "important" subjects for research is further made subordinate.

One reason the research on APIA is so inconclusive may stem from the astonishing diversity of the people suggested for inclusion in this broadly defined group. The APIA represent one of the most diverse ethnic groups in the United States. However, the term *Asian* is ill defined and often leads to misunderstanding and ambiguity.

The definition of APIA currently used by the U.S. Census Bureau, though comprehensive, is not without its own complexities. Although it identifies several subcontinents and provides examples of the identified groups therein, its seeming "broad stroke" grouping of these minorities creates room for perceptions of cultural homogeneity among the distinct groups.

Within recent decades, social etiquette and political correctness have encouraged the discontinuation of the use of the term *Oriental.* Previously, this term was used primarily to describe individuals of East Asian descent, for example, those of Cambodian, Chinese, Japanese, Philippine, or Vietnamese background. However, when the term *Oriental* was deemed no longer appropriate for use in reference to individuals, it was replaced by the much broader and more nebulous term *Asian.* Thus, all the people of the vast Asian continent were grouped together under one umbrella term. No attention was given or attempt made to distinguish the vastly heterogeneous peoples of this immense continent. There are undoubtedly numerous significant differences among the cultures, customs, and fundamental beliefs of individuals originating from the different regions of Asia and the Pacific Islands, yet they are often treated as one group. Thus, the preponderance of research using "Asian" participants lacks a truly representative sample of APIA participants. Omissions in the literature become apparent as the Chinese and Japanese appear to be the predominantly addressed cultures.

This leads back to the question of defining the API population, both globally and within the United States. The importance of differentiating various API populations, such as South Asians from East Asians from Pacific Islanders, appears to stem naturally from the basic principles of scientific methodology and representative sampling. Psychological research has long been criticized for its overwhelming lack of sampling diversity and representativeness. The majority of our current psychological principles and theories are biased by research conducted primarily on middle-aged, Caucasian males or undergraduate psychology students. Such concerns have been echoed by a number of researchers within the psychological community.

The field of psychology, in its relentless pursuit of internal validity, has neglected the importance of external validity. It appears that this neglect has served as a fault in a good deal of the current literature. The balance between external and internal validity is a difficult matter for virtually all psychological research. Additionally, the lack of operational definitions to identify various groups has proven to be a disconcerting conundrum. At what point do we consider a people "a group" necessitating differentiation and separation as its own population? Many suggest that such a question opens up a never-ending Pandora's box. In fact, it appears that there is no definitive point at which a particular group of people is identified as a unique people, "deserving" of distinction and individuation from other groups. Such distinctions are potentially quite subjective, but they must be arrived at,

operationally defined, and employed by the community of researchers in a way that is relevant to the research question under investigation and that allows the research to be more consistent and comparable across studies.

PSYCHOLOGICAL DISTRESS

Psychological distress is an expansive term that encompasses factors such as depression, anxiety, and other conditions. As our world continues to grow into a more unified and global community, constructs such as depression and anxiety require reevaluation and revision. Such constructs, as they currently exist, have been defined within a context of limited cultural and contextual variability. Cross-cultural variations in the manifestation of symptomatology associated with psychological disorders may render our current diagnostic and classificatory systems inadequate and inaccurate as we begin to consider such constructs in a cross-cultural context.

Numerous authors have commented on the role of culture in psychological illness, stressing the concerns of culturally specific perceptions of illness and the consequential responses. Thus, it may be posited that cultural context affects the ways in which biological changes within the body as well as psychological phenomena are manifested. An individual's manifestation of psychological distress is thus undoubtedly affected by his or her given culture's expectations, taboos, and beliefs regarding etiology.

It has been suggested that cultural influence on symptom manifestation affects the account of illness provided to the clinician. In other words, a construct such as depression may exist cross-culturally, yet its manifestations may vary in accordance with cultural variations and differences. Such disparity in the manifestations of psychological symptomatology may lead to difficulty in precise diagnoses. This may further result in the prescription of inappropriate, unsuitable, and thus ineffective treatments.

PSYCHOLOGICAL DISTRESS IN ASIAN AND PACIFIC ISLANDER AMERICAN POPULATIONS

A great deal of research has been conducted on distress manifestation in APIA populations; however, the findings have been equivocal. Some studies indicate a lower manifestation of depressive symptoms than in Caucasian Americans, whereas others studies indicate no such trend. A few of these studies have gone so far as to hypothesize that many of the symptoms associated with depression—as it is currently conceptualized by the majority of the Western world—are rare and perhaps even nonexistent for individuals with backgrounds that are not rooted in Western societies. A number of factors may be implicated in the disparate findings within the literature. Given the array of distinct cultures that fall under the APIA umbrella, the confounding of classification may lead to erroneous results. Also, the measures used in the collection of data may not be appropriately normed or standardized for use within the various populations, effectively making the results uninterpretable or invalid. The age range of the participants may also play a role as an additional confound, as there is reasonable evidence suggesting that an individual's age may vary symptom presentation and manifestation.

Although it is important to bear in mind that these confounds have been obstacles to research on minorities in general, there are other factors that one must consider when attempting to integrate the contrasting research findings concerning APIA in particular.

From the lay perspective, many APIA are often referred to and viewed as the "model minority," based on perceptions and stereotypes of APIA as educationally, professionally, and financially successful. Therefore, one might then be tempted to explain research findings with hypotheses that are influenced by these stereotypical beliefs. For example, one might suggest that studies reporting elevated levels of symptomatology stem from the use of inappropriate assessment devices that have led to inaccurate and unsubstantiated elevations, or that observed elevations are the result of variations in culture. Another example is that studies suggesting lower levels of depression may be viewed as indicating a lack of depressive symptomatology in APIA populations and thus greater psychological adjustment and superior coping faculties. These hypotheses, which are potentially influenced by stereotypical beliefs regarding this population, are made to be consistent with popular belief.

FACTORS THAT SUGGEST INCREASED PSYCHOLOGICAL DISTRESS IN ASIAN AND PACIFIC ISLANDER AMERICAN POPULATIONS

In contrast to the mixed results of the APIA studies on depression, consistent results have been observed

when one considers the concept of psychological distress from a much broader, and consequently more ill-defined, perspective. There are many indications that Asian Americans experience as much, if not more, emotional difficulty and psychological distress as Caucasians. The level of stress is attributed to increased experience of psychological stressors that are directly related to acculturative stress or to difficulties associated with the process of immigration. For example, immigrants are often faced with a variety of changes related to climate, the nature of their residence, and the characteristics of the community in which they reside. They also face changes in diet, perhaps because of the unavailability of foods and ingredients to which they are accustomed, and dangers associated with exposure to new and different diseases, which their immune systems may not be used to. Social changes also abound: Immigrants are often faced with the trauma of separation from family and friends, which is compounded by the lack of a social support system in their new environment. Finally—though quite significantly—changes associated with the general attitudes, values, and religious beliefs of the culture in which immigrants now find themselves may contribute to acculturative stress as well.

Immigrants face these challenges on a daily basis. They are continually inundated with aspects of their new culture, and although this process places pressure on both the immigrant and the host culture, the immigrant bears the brunt of the pressure to accommodate. Given these challenges and in light of the ingrained roles and values immigrants often arrive with, acculturation is often experienced as a difficult and at times a painful process. Some studies have proposed correlates associated with APIA immigrants' experience of acculturative stress. Some general trends in this research suggest that women exhibit greater acculturative stress than men and that immigrants who have chosen to migrate and plan to remain permanently express more positive attitudes about their new host culture and exhibit better overall mental health.

Furthermore, it has been suggested that APIA are seen as lacking a distinct position among the people and immigrants in the United States; they are often viewed simply as the "other" group, not quite fitting within other U.S. minorities. Many people of other ethnicities who have immigrated have a historical role that, to some extent, defines their place as an immigrant group. European Americans may be conceptualized as the conquerors from a historical perspective. African Americans are perceived as being an oppressed people, having been brought to this continent under the chains of slavery, against their will. Latino Americans are viewed as the original inhabitants of this land or as a colonized people. Among this landscape of immigrants, APIA may be perceived as lacking a distinctive role in relation to other people who are here. This may adversely affect APIA ethnic identity formation during the process of acculturation, leading to even greater experience of psychological distress.

MANIFESTATION OF PSYCHOLOGICAL DISTRESS

One significant issue when studying ethnic minorities is that studies may use measures that do not focus on relevant manifestations of psychological distress in a given minority population. For example, a measure that assesses the social and emotional components of depression would be insensitive and inappropriate if a particular ethnic group manifests depression in a more somatic manner. Thus, attempting to assess depression with an inappropriate or insensitive device may lead to overlooked diagnoses. Conversely, the use of an inappropriate assessment device may lead to superfluous diagnosis or an overestimation of the severity of a disorder. For example, consistent elevations were found in Minnesota Multiphasic Personality Inventory scores on Scale 2 (Depression) and Scale 8 (Schizophrenia) in a sample of Hong Kong students. Such observations could lead one to believe that individuals from this population suffer from elevated levels of depression- and schizophrenia-related symptomatology. Furthermore, what is considered to be withdrawn behavior—and thus viewed as disturbed behavior among Caucasian Americans—may be the norm for Hong Kong Chinese. Similar problems with profile elevations have been observed in a variety of other ethnic minority groups.

It is difficult to make a global statement about the mental well-being of the APIA population because of the heterogeneity of the group. Although somatization has been indicated in groups such as South and East Asians, there is little evidence to suggest a similar trend within the Pacific Islander groups. Additional distinctions may be noted in the culture-specific disorders through which psychological distress is manifested. The Japanese, for example, conceptualize a disorder called *taijin kyofusho* as a multityped syndrome that encompasses some aspects of the Western

personality, delusional, body dysmorphic, and anxiety disorders. The Korean *hwa-byung,* which may be grossly identified as a mixture of anxiety and depression, has distinct features (e.g., pain in the epigastrium) that are not found in depressive manifestations of other cultures. And *koro* and *dhat,* anxiety expressed through concern for genital function, are distinctly Asian Indian–bound disorders. This variance in symptom presentation, as well as the uniqueness of culture-bound disorders, creates an obstacle to generalization across the different groups.

Regarding the construct or theoretical identification of depression, it is quite possible that the manner in which it is conceptualized in the Western world is not culturally relevant to this population. Thus, it is possible that the construct of depression may be conceptualized and manifested in an entirely different manner. If this is the case, the instruments we currently use to assess that construct may not be valid with this population.

One consistent finding that lends support to this notion is the utilization of somatization as a means of expressing psychological distress among APIA. Somatization, or the physical manifestation of psychological stress, often includes the presentation of fatigue, dizziness, angina, and other body sensations. Though advances have been made in the battle against the negative stigmatization of mental illness and mental health concerns, these prejudices remain firmly seated within our society, as well as within many of the world's cultures. In this respect, API cultures are in no way exempt from these biases against mental illness. In fact, it may be argued that intolerance of mental illness is exaggerated in the eastern cultures of the API. These cultures adhere to a more collectivistic tradition rather than the individualistic tradition observed in Western cultures. As a result, the expression of emotion and mental illness is discouraged in these societies in an effort to maintain a given social status and to "save face" in their community. Thus, it is often more readily acceptable to display psychological distress through somatic manifestations, as has often been observed among individuals of API ancestry.

A number of researchers have suggested that APIA have different help-seeking preferences that result from this alternative expression of symptom manifestation. Studies suggest that APIA rarely present emotional or interpersonal problems on occasions when they do seek out professional treatment. Rather, they tend to focus on concerns regarding their occupation, somatic complaints, and educational concerns. In the United States, Asian and Pacific Islander populations exhibit lower rates of both inpatient stays and employment of psychiatric services than any other cultural group.

One reason for the disparate rates may lie in the perception of the mind–body relationship. Western cultures tend to take a dualistic approach to the mind–body relationship, whereas Eastern cultures take a more holistic stance. This means that, although those of Western thought can make a distinction between somatic and psychological ailments, such a distinction can only be made with great difficulty and high inaccuracy for those of a holistic perspective. The implication of such variance has bearing on the language used in symptom description, as well as the cause attributed to their manifestation. Linguistic barriers, too, have been cited as a source of diagnostic problems, particularly in cases in which translation is used. Because translation is unable to coherently employ word-for-word equivalence between two languages, terms that are particular to a culture may fall by the wayside, effectively confounding the message's meaning. Perceptions of pain, for example, may be presented differently by those of the Asian culture, with psychological distress expressed as somatized pain. When faced with ambiguous symptom presentation, general practitioners and psychiatrists may be unable to classify the disorder. Research on the topic appears to support this conjecture and indicates that the Western construct of depression allows for only a subsyndrome in many evaluations of Asian individuals. This underdiagnosis and nontreatment effectively reinforces the tendency to seek aid from nontraditional medicine.

Another fact that might account for the low treatment rates is the perceived need for psychiatric assistance. Beyond the treatment efforts exerted for somatic symptoms, specific cultural views on the cause of the disorder often spur individuals to seek treatment from natural healers and other nontraditional medical personnel. Supernatural causes such as magic curses or the *Djinn* have been cited as reasons why such services have been employed.

When psychiatric disorders are diagnosed, the cultural barriers affecting the utilization of psychiatric services may also retard treatment progress. The patient's perception of his or her ailment and its cause has a great impact on the efforts of the psychologist. Because a good patient–clinician alliance is an integral part of any treatment, addressing culturally specific concerns (e.g., reporting style, spiritual beliefs, etc.), behavioral norms (e.g., direct eye contact), and

therapeutic approaches has a great influence on the therapeutic outcome.

CONCLUSION

As the population of the United States grows and increases and its makeup becomes more diverse, greater understanding of cultural differences is a matter of increasing precedence. Though the body of literature on the APIA is increasing, the rate at which progress is being made is insufficient. Methodological and categorical issues impede the progress of research, and they are further complicated by erroneous "model minority" perceptions that often surround these groups. What may be abstracted from the literature is that the APIA are as vulnerable to psychological distress as any other culture. In fact, the process of acculturation may exacerbate this vulnerability through elevated stress levels. The manifestation of distress as a psychological disorder interacts with cultural background, affecting syndrome detection and inaccurately depicting these groups. If psychology is to disabuse itself of such misconceptualizations, misperceptions, miscalculations, and mistreatments, culturally specific manifestations and diagnostic criteria need to be addressed in the diagnosis, treatment, and research of individuals within these groups.

—Reece O. Rahman
—Ilya Yaroslavsky

See also Asian Values Scale; Chinese Americans; Filipino Americans; Japanese Americans; Korean Americans; Model Minority Myth

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ASSOCIATION OF BLACK PSYCHOLOGISTS

The Association of Black Psychologists (ABP) was founded in 1968 in San Francisco, California, by 28 psychologists of African descent. This was the first national organization to be established by and for psychologists of African descent. Its establishment was based on the unique history of African descent, especially enslavement and its social, economic, and psychological effects on people of African descent worldwide. These founding members called for specialized training and expertise in addressing the psychological well-being of the African community locally, nationally, and internationally.

The founding members also desired to develop an approach to psychology consistent with the experience

of people of African descent. They envisioned that the newly formed organization would promote and advance the profession of African psychology, influence and affect social change, and develop programs whereby psychologists of African descent could help to solve the problems of people of African descent and other ethnic and racial groups.

FOUNDING MEMBERS

The 28 founding members of the ABP were Joseph Awkard, Aubrey Escoffery, Florence Farley, Wiley Bolden, Jane Fort, George Franklin, Alvis Caliman, Avlin Goings, Robert Green, Norman Chambers, Robert Guthrie, William Harvey, Harold Dent, Leslie Hicks, Thomas Hilliard, Anna Jackson, Walter Jacobs, Adelbert Jenkins, Reginald Jones, Melvin King, Lonnie Mitchell, Wade Nobles, David Terrell, Dalmas Taylor, Charles Thomas, Ernestine Thomas, Robert Williams, and Joseph White.

Members of this group represented a myriad of psychological disciplines, professions, and locations across the United States.

FIRST ACTIONS—RESPONSES

The formative group of founding members submitted seven petitions of concerns proposing that the American Psychological Association (1) officially endorse the Kerner Commission's Report of Civil Disorders; (2) develop or implement policies related to the African American community; (3) bring its resources to finding solutions to the problems of racism and poverty; (4) establish a committee to study the misuse of standardized psychological instruments; (5) reevaluate the adequacy of certified training programs in clinical and counseling training programs in terms of their relevance to social problems; (6) recommend to each psychology department steps to be taken to increase the number of African American students in their graduate program; and (7) implement and evaluate the progress of the foregoing recommendations in consultation with representatives from the ABP. The requests were received and reviewed by the American Psychological Association, but they were not fulfilled.

CURRENT ASSOCIATION GOALS

By examining approaches to research that had traditionally represented people of African descent as deviant, including but not limited to the inferiority, deficiency, or disadvantaged models, the goals of the association became not only to enhance the psychological well-being of people of African descent but also to promote constructive understanding through positive approaches to research. These research goals expanded to include the development of psychological concepts and standards consistent with African or African American culture, the development of support systems for psychology students, and the promotion of values that support well-being. Association members were also encouraged to foster relationships with local, state, national, and international policymakers to better influence the mental health and community needs of the African-descent community. Several annual awards are granted each year, including an award to support student research and an award for service, scholarship, and community service.

ORGANIZATIONAL STRUCTURE

The organization elects a president to a two-year term. The board of directors consists of a past president, president, and president-elect, along with a secretary, treasurer, four regional representatives, presiding elder, and parliamentarian.

COMMITTEE STRUCTURE

Committees are structured into three main clusters: advancing knowledge, community, and organizational maintenance. Located within the advancing knowledge cluster are professional development, the Committee to Advance African Psychology, the African Psychology Institute, Black Mental Health Month, and the Leadership Institute. The community cluster supports social action, testing and education, legislative education, health, and the African American Family Preservation and Revitalization committee. The final cluster comprises membership, the Committee on International Relations, chapter development, student affairs, and information technology. Additionally, there are seven standing committees: Ethics, Rules, National Convention, Personnel, Fiscal Affairs, Publications, and Reparations.

PUBLICATIONS

The Association of Black Psychologists has three regular publications: *PSYCHDiscourse; ABPsi*

NewsJournal, a monthly or bimonthly newsletter; and the *Journal of Black Psychology,* a professional quarterly journal of qualitative and quantitative research.

—Harvette Armonda Grey

See also African/Black Psychology; African Americans

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ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER

Attention-deficit/hyperactivity disorder (ADHD) is one of the most frequently diagnosed disorders among children and adolescents. It is a lifelong condition that is estimated to affect 3% to 5% of school-age children. The disorder is characterized by core symptoms that include age-inappropriate levels of concentration, attention, distractibility, and impulsive behavior. For example, affected children seem unable to sit still, always appear to be daydreaming, or cannot focus on tasks long enough to finish. Children may exhibit a range of characteristics and varying levels of severity. Behaviors associated with ADHD are classified into three subtypes: predominantly inattentive, predominantly hyperactive-impulsive, and combined. Because ADHD often affects functioning in multiple settings, such as home, school, and peer relations, it may have a negative, long-term impact on academic and vocational performance and on social-emotional development.

A number of controversies surround ADHD: whether it exists as a distinct disorder, whether it can be accurately identified, and what the most effective treatments are. For people of color, there are also concerns about stigma associated with diagnostic labels, the rate at which ethnic groups are identified with ADHD, and access to appropriate treatment. Extant research focuses primarily on Caucasian, male, and middle-class populations, with limited consideration of gender, race, ethnicity, culture, and socioeconomic status.

CAUSES AND MAJOR CHARACTERISTICS

Comprehensive considerations of race, ethnicity, gender, and culture have generally been overlooked in the understanding of ADHD. Among individuals with ADHD, the core symptoms, such as distractibility or inattentiveness, are biologically influenced. There is no single known cause of ADHD. It occurs more frequently in individuals who have a family history of the disorder and more frequently in children who are exposed to prenatal insult, obstetrical complications, or high levels of lead. The disorder was once viewed as a neurological condition primarily involving attention, but it is now understood as a neurological condition primarily involving self-control and behavioral inhibition. Cultural environment is important because it determines how well or how poorly an individual functions, and it influences how behavior will be understood and treated. Parenting styles and educational methods do not cause ADHD, but they often play a role in effective treatment.

Studies examining the prevalence of ADHD or the proportion of individuals with ADHD in specific ethnic groups have reported conflicting results. The use of different assessment instruments and methods of diagnosis may account for the conflicting findings as much as any true differences in the rate of ADHD among ethnic groups. For example, rates of ADHD based on teacher ratings of children's behavior indicate higher rates among African American and Hispanic American children compared with European American and Asian American children. However, the observer's judgment about the quality of the child's behavior has been shown to be influenced by ethnicity, socioeconomic status, and student and teacher expectations.

Attention-deficit/hyperactivity disorder is a lifelong condition that is identified more often in boys. It is estimated that boys are three times more likely to be affected than girls, although ADHD may not be as easily recognized in girls. Boys are more likely to demonstrate disruptive and impulsive behavior that gets the attention of parents and teachers. Girls are more likely to demonstrate inattentiveness, depression, and academic problems that may be overlooked. Consequently, girls are more likely to be identified later than boys and less likely to receive treatment.

Until recently, ADHD was most often diagnosed during childhood. It is now known that ADHD continues into adulthood, although symptoms can change from childhood to adulthood. Hyperactivity, aggressiveness, impulsive behavior, and distractibility are more common among children. In older adolescents and adults, inattentiveness, impatience, and restlessness are more common with lessened hyperactivity, partly because of coping strategies that are learned with life experience.

Attention-deficit/hyperactivity disorder frequently coexists with other disorders, including disruptive behavioral disorders, specific learning disabilities, anxiety, depression, and tic disorders. A large proportion of adults with ADHD may also experience depression, anxiety, and major mood disorders. When ADHD goes untreated, substance abuse occurs in nearly half the people affected.

ASSESSMENT

Criteria for a diagnosis of ADHD includes the onset or beginning of symptoms before age seven, the presence of at least six inattentive or six hyperactive symptoms for at least six months, and significantly lowered performance in two or more areas of the child's life (e.g., difficulty at home and at school). Children may be mistakenly identified with ADHD because many of the key characteristics are typical for children of certain ages, and a diagnosis may be made based on poor information after a brief assessment. In addition, culture influences the expectations and behavioral norms of family, schools, and communities. What is acceptable and adaptive behavior from one cultural or ethnic group to another varies. People from different cultural and ethnic groups may also have different beliefs and attitudes about illness, helping professions, and trust in large institutions, as well as preferred community supports and healers.

There is no single psychological, educational, or medical test for ADHD. To accurately identify ADHD, a multisource (information obtained from multiple individuals) and multimethod (information obtained using many methods) process is necessary. Information from the child, parents, teachers, and others familiar with the child in different settings helps to assess the child's behavior compared with other children of the same developmental stage and cultural context.

Methods used in assessment may include interviews, behavior rating scales, and psychological testing. The use of rating scales and psychological tests is limited by how well the scales and tests have been designed for use with racial and ethnic groups and by possible rater or examiner bias. Rating scales that focus on specific core symptoms are helpful in identifying the child's behavior in different settings. Rating scales that focus on a wide range of behavior, attitudes, and feelings are helpful in making an accurate diagnosis and determining whether there are other coexisting problems. As a group, African American children are often rated with more ADHD behaviors and with more severe symptoms, which may be the result of bias or actual behavioral differences from other groups. Although psychological and educational tests are helpful in identifying academic and learning disabilities, their appropriate use with ethnic and racial groups requires an understanding of possible bias in test construction and interpretation.

TREATMENT

There are three basic types of treatment for ADHD: medication, behavioral intervention, and combined or multimodal intervention. Medications such as Ritalin are considered by medical professionals to be the most effective treatment for the core symptoms of ADHD. The use of medication is controversial because of concerns about the abuse and misuse of these drugs and because little is known about their long-term effect (i.e., longer than 14 months) on development. Possible racial and ethnic differences in how these medications are processed by the body have not been conclusively demonstrated.

Behavioral or psychosocial interventions include parent education, social skills training, structured positive reinforcement for appropriate behavior in school and at home, and counseling for organizational and socialization strategies. These treatments are more effective than medication in improving academic, vocational, and social functioning, but they are not as effective as medication in reducing the core ADHD symptoms. Ethnic groups may prefer psychosocial interventions over medication. Ethnicity and socioeconomic status may influence the motivation for various treatments.

Multimodal approaches combine medication and behavioral treatments to address ADHD symptoms and academic and social problems. Combined approaches work best when family, teachers, and other professionals coordinate their efforts to ensure consistency from one setting to another.

Although ADHD is not specifically designated under the Individuals With Disabilities Education Act, some children and adolescents may be eligible for special education services depending on the severity of their symptoms and the presence of specific learning disabilities. Many families of color are suspicious of in-school services because of stigma and because of the disproportionate representation of African American and Hispanic youth, especially males, in special education. Youth and adults may be eligible for school and workplace accommodations under Section 504 of the Rehabilitation Act and under the Americans With Disabilities Act.

—Cheryl C. Munday

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ATTRIBUTION

Attributions involve making causal explanations for events or outcomes, particularly the behaviors that led to those events or outcomes. These explanations may be made by the individuals who experienced the events directly (self-attributions), or explanations may be given for why events or outcomes happened to other individuals (social attributions).

Individuals tend to take personal credit for successful outcomes by making attributions that reflect characteristics that are internal and stable to them (e.g., positive personality characteristics), whereas they tend to deflect blame for failure outcomes by making attributions that reflect external elements of the situation or context (e.g., the task was too hard). These self-serving attributions are important because they have been linked to psychological and physical health indexes such as self-esteem and immune functioning. Moreover, these self-serving attributions, though prevalent in all cultural groups, are typically stronger in Western (versus Eastern) cultures.

In explaining outcomes that happen to others, more pronounced cultural differences are found, particularly for failure outcomes. Individuals from Western cultures tend to make dispositional attributions to explain the unsuccessful outcomes of others (e.g., "She didn't get the job because she is not smart enough"), whereas individuals from Eastern cultures tend to make attributions that reflect situational constraints or pressures (e.g., "She was late for the meeting because she was caring for an ailing parent"). These social attributions are important because they can lead to stereotyping and discrimination when individuals, particularly those from Western cultures, make attributions within a multicultural society.

SELF-ATTRIBUTIONS

Self-attributions can be classified according to three dimensions: internality, stability, and globality. *Internality* is present when an outcome is an attribute of the self (e.g., ability, effort) rather than outside the self (e.g., difficulty of task, other people). *Stability* is present when an outcome is consistently present (e.g., an immutable personality trait) rather than temporary (e.g., effort). *Globality* is present when an outcome is cross-situational (i.e., occurs on many situations) rather than situation specific (i.e., occurs only in the target situation). Attributing negative or failure outcomes to internal, stable, and global causes (e.g., one's own personality) is referred to as a *depressive* or *pessimistic attributional style.*

Because the underlying attributions suggest the cause will be present in a multitude of situations in the future, individuals will experience feelings of helplessness, lowered self-esteem, and expectations that future failures are likely to reoccur. In contrast, attributing negative outcomes to internal, unstable, and specific causes (e.g., lack of effort) suggests that one's behavior can be altered to eliminate or reduce

the negative outcome (e.g., if one just works harder). Conversely, attributing positive outcomes to internal, stable, and global causes (e.g., one's own personality) is referred to as an *optimistic* or *stress-buffering attributional style.* This attributional style (also referred to as having "positive illusions") is generally associated with heightened self-esteem and expectations that successful outcomes are likely to reoccur in the future.

Cross-cultural differences in attributional styles are explained by a cultural emphasis on individualism versus collectivism. Because individuals in Western cultures focus on the person as the source of negative and positive outcomes, one would expect these individuals to make more dispositional than situational attributions for their own behavior. Because individuals in Eastern cultures focus on the individual as rooted in the social environment, one would expect these individuals to make more situational than dispositional attributions for their own behavior. Research has shown that a self-serving attributional bias is relatively universal, though it is weaker in Eastern cultures.

There is a tendency, however, for some minority group members within the United States to experience attributional ambiguity for outcomes. This occurs when a minority group member is unsure whether an outcome is the result of his or her own personal characteristics or group membership. For successful outcomes, such as being hired for a job, individuals might wonder whether they were hired because of their perceived abilities (e.g., an internal, stable attribution) or because of perceived affirmative action policies (e.g., an external attribution). For unsuccessful outcomes, such as not being hired for a job, individuals might wonder whether they were not hired because they were unqualified (i.e., they did not have the abilities for the job) or because "they are African American." Thus, no clear self-serving attributions are made.

SOCIAL ATTRIBUTIONS

Similar cultural theories of individualism and collectivism can be used to explain cultural differences in the attributions that individuals make about the behavior of others. Differences in social attributions are largely a function of where individuals focus their attention. Individuals from Western cultures have a tendency to emphasize the traits and abilities of others at the expense of situational characteristics (e.g., how hard a task was) when making attributions for behavior, particularly for negative outcomes. Individuals from Eastern cultures have a tendency to emphasize attributions as tempered by situational or contextual influences, such as the social-role obligations and social pressures that an individual is experiencing. Cultural differences in attributional thinking do not appear because there is an absence of dispositional thinking in Eastern cultures. However, Eastern cultures view dispositions as more malleable, and they are more sensitive to the fact that individuals behave differently under different circumstances.

Attributions that individuals make about the behavior of members from other groups (specifically, different cultural groups) are important because they can foster stereotypes and lead to discrimination. Attributions made by an individual (referred to as the *judge*) from a specific cultural group (referred to as the *in-group*) about the negative outcomes experienced by members (referred to as the *target*) of a different cultural group (referred to as the *out-group*) typically reflect negative personality characteristics and engender feelings of anger. For example, a Caucasian juror may attribute the criminal behavior of an African American defendant to the aggressive nature of the target individual. Conversely, attributions made for the behavior of a fellow in-group member are more likely to be situationally based and engender feelings of sympathy. For example, a Caucasian juror is more likely to attribute the criminal behavior (e.g., robbery) of a Caucasian defendant to extenuating circumstances, such as financial need. The implications of these attributions can be profound in the courtroom and beyond. The assignment of personality attributions for behavior is more strongly associated with judgments of guilt and retaliatory behaviors than the assignment of situationally based attributions for behavior.

Attributions provide an expectation about behavior. Behaviors leading to negative outcomes that are consistent with existing stereotypes are attributed to internal, stable, and global causes (e.g., negative personality traits). Behaviors leading to positive outcomes that are not consistent with existing stereotypes are attributed to external, unstable, and situation-specific causes (e.g., luck) or to internal, unstable, and situation-specific causes (e.g., "they [African Americans] happened to work hard in this one instance"). It has been found, for example, that the perceived successes of African Americans (and women, for that matter) are attributed more to luck and task ease than the perceived successes of Caucasians (particularly men).

A model of the effect of stereotypes on social judgments can be proposed to explain these social attributions. A target individual's behavior is first compared with a salient group stereotype that the judge (or the individual perceiving the behavior) has. Next, the target behavior is determined to be either consistent or inconsistent with the prevailing group stereotype. An observed behavior that is consistent with the group stereotype will lead to attributions that are ability or personality based. A behavior that is inconsistent with the group stereotype will lead to attributions that largely reflect luck or task ease.

For example, assume that a Caucasian high school student (the judge) has just learned that a fellow Hispanic classmate (the target) has been admitted to Harvard University (the target behavior or outcome). Further, assume that the Caucasian student holds the stereotype that Hispanics are lazy. Because the Hispanic student's target behavior is inconsistent with the Caucasian student's group stereotype, the latter will largely attribute the behavior to causes such as luck or affirmative action. However, if this Caucasian student holds the stereotype that Hispanics are hard-working, the same target behavior will be viewed as consistent with the stereotype and attributed to the ability of the target Hispanic. Thus, the attributions that individuals have—and ultimately, the discriminatory behaviors that individuals may engage in as a consequence of these attributions—begin with stereotypes. Nowhere is this more prominent than int the stereotypes that individuals hold about different cultural groups.

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FURTHER READING

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