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PSYCHOTHERAPY AND ETHNIC MINORITIES

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Let us begin with a demographic fact: Members of ethnic minority groups are neither major users of traditional psychotherapy nor purveyors of psychotherapy in anything like their proportion in the population. Indeed, it is relatively rare, statistically speaking, for African-Americans, Hispanics, and Native American Indians to use psychotherapy in the formal sense in which the term is ordinarily used. The same statement can be made for most forms of private or third-party supported services in the field of mental health including treatment for alcohol addiction, drug addiction, serious mental disorders, and mental retardation (Albee, 1977, 1979; Marmor, 1975; National Mental Health Association, 1986; President's Commission on Mental Health, 1978; Sue, 1988).

This pattern of usage should not be confused with levels of need or help-seeking for emotional problems. In general, ethnic minorities experience a higher proportion of poverty and social stressors typically regarded as antecedents of psychiatric and psychological disorders than Whites. Measured by numerous social indicators of economic stability and benefit, ethnic minorities as a group are seriously disadvantaged relative to Whites

(Health Resources Administration, 1980; Heckler, 1986; *Healthy People 2000*, 1990). While studies of race differences in psychological distress find African-Americans are no greater than Whites in *average* stress levels, non-Whites are twice as likely to report *extreme* levels of stress as a function of *greater exposure* to stress (Kessler, 1979; Kessler & Neighbors, 1986; Neighbors, 1984). Poverty, substandard housing, educational disadvantages, and problems of discrimination are all stressful events that are often associated with emotional problems and are increasing in the lives of ethnic minorities.

The potential impact of the conditions of poverty has been documented in studies relating stressful economic life events to changes in health and mental health status (Catalano & Dooley, 1983; Dohrenwend, 1990; Haan, Kaplan & Camacho, 1987). For example, it was found that environmental stress resulted in greater psychological distress for lower socioeconomic status (SES) African-Americans as compared with middle SES and lower SES Whites (Ulbrich, Warheit, & Zimmerman, 1989). The study illustrated that lower socioeconomic status African-Americans were more vulnerable to discrete events of stress as opposed to chronic strain. Although the poorer African-Americans in this study were able to cope better with the chronic stress of their economic deprivation, it was the daily hassles that accompany that poverty that most affected their emotional status.

Yet, in spite of the preponderance of these events in their lives, ethnic minorities are often underserved by high quality mental health resources (Wu & Windle, 1980). Studies of mental health utilization patterns of African-Americans indicate a higher usage of public rather than private mental health facilities (Mays, Caldwell & Jackson, 1991; Smith, 1981). Reliance on public facilities, marked by the instability of programs caused by financial constraints, federal budget reductions, sporadic state funding, and categorical rather than discretionary funding mechanisms, often results in second-rate care when compared with private facility services (Edwards & Mitchell, 1987). Services in private mental health facilities, in contrast to public facilities, are distinguished by choice of provider, stability of treatment regimes, choice in types of treatment approaches, specialists, long-term treatment programs, and better trained service providers.

For a variety of reasons some members of ethnic minority groups will choose to use informal rather than formal sources of help for emotional problems (see Flaskerud, 1986; Mays, Caldwell, & Jackson, 1991; Neighbors & Jackson, 1984). Help is often sought from family physicians, herbalists, acupuncturists, *curanderos*, root doctors, clergy, the church and other family members (Flaskerud, 1986). Family, friends, and traditional healers are sought not only because they share a world view of the person, but also

because inaccessibility, costs, waiting time, distance, stigma, or cultural insensitivity in traditional psychotherapy services have rendered those services unappealing.

Whereas the disparity between the mental health service needs and usage patterns of formal traditional services of ethnic minorities is explained by some as a function of culture and differences in expectations on the part of this population, the disparity is also due to neglect and a failure of the profession of psychology to develop and promote relevant and adequate mental health services for this population. Several studies have found that use of community mental health center services by ethnic minorities is significantly enhanced when the centers are placed near the population (Flaskerud, 1986; Sue & Morishima, 1982); when language and ethnic/racial matches in staff personnel are offered (Flaskerud, 1986; Sue & Morishima, 1982; Zane, Sue, Castro & George, 1982); when therapy that is active, supportive, immediate, and directive is available (Sue & Morishima, 1982; Lin, 1983; Flaskerud, 1986); and when provision of referral to services for social, economic, legal and medical problems are incorporated (Dworkin & Adams, 1987; Flaskerud, 1986). Undoubtedly, ethnic minorities will use mental health services when the services are accessible, culturally relevant, and comprehensive.

The real problem is that the overwhelming majority of ethnic minorities do not have high quality psychotherapeutic services for the treatment of their mental health problems. Moreover, given the continuing increase in the population of ethnic group members in the United States and rising costs of health care, it is apparent that the bulk of these people will not enjoy such services in the foreseeable future if our profession does not change. While a segment of this population will always choose an informal source of help for its problems, the vast majority, if adequate and appropriate services were available, would take advantage of such formal services. It is to this group that the profession must respond.

These facts have been documented often enough so they need not delay us very long from considering some of the reasons for this lack of use or coverage. The most detailed examination of these issues was contained in the report of the President's (Carter) Commission on Mental Health (1978).

WHO?

Who are the underserved? They are identified repeatedly in several different places in the Carter report: children, adolescents, and the elderly.

Together, these three groups represent "more than half" of the nation's population—and a disproportionately large number of these underserved groups are ethnic minorities. Elsewhere there is discussion of underserved minority groups as a whole—including 22 million Black Americans, 12 million Hispanic Americans, 3 million Asian and Pacific Island Americans, and 1 million American Indians and Alaska natives. All of these groups are underserved or, in many instances, inappropriately served, by persons insensitive to cultural differences or incompetent in appropriate languages.

While these identified groups (totaling 38 million persons) clearly overlap somewhat with the three specific age groups identified as underserved, we are not yet at the end of the statistical complexities. Five million seasonal and migrant farm workers are largely excluded from mental health care. Elsewhere in the report of the Commission (1978) we discover that women also often do not receive appropriate care in the mental health system. Neither do persons who live in rural America, or in small towns, or in the poor sections of American cities. Neither do 10 million persons with alcohol-related problems, nor an unspecified number of persons who misuse psychoactive drugs, nor the very large number of children and parents affected by child abuse, nor 2 million children with severe learning disabilities, nor 40 million physically handicapped Americans, nor 6 million persons who are mentally retarded. While the Carter Commission made some very brave statements about "recent improvements" in the availability of mental health care in this society, it seems clear that this improved care must have been available largely to those groups not identified as being underserved—who could only be well educated, White, and living in the affluent sections and suburbs of major American cities!

The Commission (1978) also heard that migrant farm workers, largely drawn from minority groups, had the most abysmal care in both the areas of physical health and mental health. Similarly, Marmor's (1975) study, *America's Psychiatrists*, found that psychiatrists practicing psychotherapy in private offices saw very few persons from ethnic minority groups. Ethnic minority males were least frequently seen. All these statements apply even more profoundly to ethnic minority children.

In 1986 and two presidents later, the U.S. Secretary of Health (Heckler) Task Force on Black and Minority Health reiterated many of the same findings, although some indicators of health and mental health were worse. The task force found that among African-Americans, approximately 40–47% of total annual deaths were calculated to be excess deaths. Homicides and accidental deaths accounted for 35% of these excess deaths in African-Americans under the age of 45 years and 19% in the under-70 age group. While not quite as high, the same pattern was true for Hispanics

and, in particular, Native Americans. No other cause of mortality so greatly differentiated African-Americans from other Americans as did homicide. Although technically, homicide is often viewed as a matter for the health arena, the prevention and cessation of violence and altering the nature of violence are clearly within the realm of psychological interventions.

Thirteen years after the President's Commission and five after the Heckler report, the conditions of health and mental health for ethnic minorities have improved for a few but worsened for many. *Healthy People 2000* (1990) cites a whole range of data supporting this conclusion. African-Americans have significantly higher rates of coronary deaths; African-American women, Hispanic women, Native American women, and men with high blood pressure (most likely African-American) are found to have a high prevalence of obesity (from poor diets). Growth retardation among low-income children is more common among African-American children, Hispanic children, Asian and Pacific Islander children. Baby bottle tooth decay is often associated with the failure to breast feed or the short duration of breast feeding, and these are more common among ethnic minority groups. Ethnic minority groups are more likely to smoke cigarettes (Southeast Asian men are highest) and youth of low socioeconomic status more commonly start smoking early. Smoking during pregnancy is more common, as is the use of smokeless tobacco, among ethnic minorities. Motor vehicle crash deaths are startlingly high among Native American men, and cirrhosis is high among this group, as well as among African-American males. The heavy use of alcohol and the use of other drugs is more common among ethnic minorities. Premature pregnancy, mostly unintended, is high among African-American and Hispanic adolescent girls. Young Black men and young Hispanic men are the most common targets for homicide. Deaths by motor vehicular accidents and by drowning are more common among minority males. The prevalence of dental caries, untreated caries, and gingivitis is especially common among ethnic minorities. Infant mortality, fetal deaths, maternal mortality, low birth weight infants, and failure to receive prenatal care all affect ethnic minority groups disproportionately. African-American and Hispanic women are less likely to receive breast exams, mammograms, or Pap tests. Chronic disabling conditions and reduced life expectancy are problems associated with ethnic minority group status in the United States.

As health psychology grows in importance as a new subfield within psychology, mounting evidence supports the critical role of lifestyle and behavioral components in health and mental health status. Central to almost every problem that psychology can treat is the reduction of stress. In spite of the overwhelming evidence that damaging environmental stressors

are experienced by many ethnic group members, the presence of violence, and the impact of the conditions of poverty on their psyches, traditional psychotherapy looks inside the sufferer for an answer. As Albee (1990) stated in an address at a substance abuse prevention meeting:

> Problems are not inside the person. Problems are inside an unjust society. . . . We should ask ourselves what are the causes of poverty, low self-esteem, boredom and hopelessness. If we focus only on counseling to change self-esteem, we may fail to identify the causes.

The "who" so in need of services are often the socially marginal people in our society—victims of poverty, prejudice, homelessness, involuntary unemployment, exploitation and other damages brought on by our society.

Brown et al. (1990–1991) present an excellent analysis of how society contributes to the condition of ethnic minorities. In the past 20 years, there has been a restructuring of the labor market. In the United States, our economic base has shifted from one of a labor-intensive goods production to a highly technical information-processing market. One result, according to Brown et al. (1990–1991), has been the closing or relocation of manufacturing plants. America's urban centers were most affected because large numbers of inner-city ethnic minorities were employed in the low-skill, goods-producing occupations. While the American economy has benefitted from its change to less labor-intensive jobs by switching to high technologic, automated outputs, it has left large numbers of inner-city ethnic minorities unable to move into this employment sector. The sectors experiencing growth in the current economy are high-technology manufacturing, administrative support, and advanced services. All require high levels of education and skills. Yet the federal government, particularly during the Reagan administration, cut and eventually ended job training programs and reduced educational loan and scholarship programs. Clearly, "a look inside" will not be the sole remedy for many of the mental health problems faced by ethnic minorities, who were left "marginal" because of the switch to a high technologically oriented society.

WHY?

Bias

What are some of the reasons for the lack of availability of high quality mental health services or the patterns of psychotherapy utilization by ethnic minority group members? Clearly it is not because of the lack of mental health problems, because we know from epidemiological studies that sig-

nificantly high rates of emotional distress are found among African-Americans and Hispanics (Myers et al., 1984). Such epidemiologic findings reflect, of course, a diagnostic system based on criteria developed largely by Western, White, middle-class, male psychiatrists.

As Mays (1985) pointed out, the descriptive criteria used to diagnose emotional disorders have a strong bias influenced by Euro-American values emphasizing the importance of individualism, competition, and separateness. A number of ethnic minority cultures hold different values and stress different behaviors, and therefore their members are more likely to get diagnosed as different or disturbed. In many Native American cultures, for example, cooperation is far more important than competition; Hawaiian children do poorly in competitive intellectual pursuits. Indeed, the average IQ of Hawaiian children is lower than that of the children of any other minority group, not because Hawaiian children are unintelligent, but because the measures used are inappropriate.

The Larry P. case (Lambert, 1981) in California established the inappropriateness of individual intelligence tests, like the Binet, for classifying minority children, a disproportionate number of whom are placed in classes for the "mildly retarded." Their performance on other measures of social adaptability often exceeded White norms. Jane Mercer (1973) has reported a careful study of the social role performance of children with IQs below 69 in the schools of Riverside, California. She compared Anglo (White middle-class) children with Black and Mexican-American children. Basically she found that the Anglo children called *educable mentally retarded* (EMR) were failing in their social roles. Children from the two other ethnic groups classified as EMR were less likely to be failing socially. Most important, she found a low correlation between behavior described as adaptive or competent and measured intelligence. Sixty percent of the Chicano (Mexican-American) children who had "failed" their intelligence test were able to pass a measure of good adaptive behavior. They were competent. Ninety percent of the African-American children in this same EMR group were also able to pass a measure of adaptive behavior.

Mercer suggests that the educable mentally retarded should be divided into three groups. The first group would include those children damaged by identifiable organic factors (a relatively small group); the second would be those retarded because of the operation of polygenic inheritance; the third would be those who were culturally different from the norm. It is in this third group that objective measures of intelligence and objective measures of adaptive competent behavior do not agree. She found that at least half of the Mexican-American adults who might have been classed as mentally retarded in school were leading effective competent lives: They

had married, were gainfully employed, and were adapting successfully to their environment. Few had psychotherapy.

In regard to Asian Americans, considerable debate has taken place concerning assertiveness (Sue & Morishima, 1982). Studies have identified, in particular, Chinese and Japanese as "quiet, verbally inhibited and non-assertive" (Zane, Sue, Hu, & Kwon, 1991). Researchers have concluded that this behavior is the culprit in problems ranging from limited occupational mobility to dating patterns with lower preference for Asian males by Asian women (see Zane, Sue et al., 1991). Although the studies were indeed able to document that the Asians were less assertive than Whites, they missed what is probably a fairer question of whether they are less likely to perform such behaviors if necessitated in certain social roles. As Zane and his group established, Asians report being able to behave as assertively as Whites, although they may experience greater anxiety and guilt over such behavior.

The psychotherapist who attempts to use anxiety management to assist such individuals without a full appreciation of the cultural undertones may miss the mark. As Zane, Sue et al. (1991) point out, the assumption of most anxiety management programs is that the anxiety has an *irrational* or *maladaptive* learning base. Once the therapist is able to extinguish or expose this faulty premise, anxiety reduction will occur. When the basis for such anxiety is the result of cultural conflict, the question raised is whether an assumption of irrationality is a meaningful one. Building on the work of Sue (1983), in which he describes cultural conflicts that involve two equally valid sets of values clashing with each other, attempting to expose one as irrational is futile. Rather the experience of anxiety and guilt is one that would be indicative of a bicultural functioning, which is a positive attitude!

Access

Psychotherapy as traditionally practiced is largely a middle-class phenomenon, and psychotherapists tend to congregate in middle-class communities and neighborhoods. Even though there are more psychotherapists per capita in Washington, DC than anywhere else in the world, nearly all of them can be found in the White areas of Northwest Washington and in suburbia. More than 20 years ago, William Ryan (1969), in a major study of mental health care in Boston, demonstrated clearly the unavailability of mental health services, including psychotherapy, to the poor and disadvantaged. He found that five groups: multi-problem families, the elderly, persons discharged from state hospitals, children in need of residential care, and adolescents—mostly ethnic minorities—had almost no access to men-

tal health facilities in a city that had more mental health resources than any other in the nation. He reported that the typical psychotherapy recipient was a White, non-Catholic, college-educated woman between the ages of 30 and 40 who was likely to live in one of three contiguous census districts in upper-middle-class Boston.

Services available to persons who are poor and/or members of minority groups are most likely to be in tax-supported agencies where less adequately trained therapists are available or are from underfunded tax-supported social agencies or probation departments where staff are in short supply.

Shortage of Minority Professionals

A factor influencing the use of psychotherapy by ethnic minority group members is the limited availability of bilingual and bicultural professionals, particularly minority therapists (Casas, 1985). It is not hard to empathize with those beset with both the ordinary stresses of life as well as with the extra stresses of being victims of prejudice and discrimination. That they may hesitate or refuse to talk about their troubles with Anglo therapists is understandable when some may view these therapists as representatives of the culture that has caused many of their problems.

The numbers of African-American and Hispanic psychotherapists is extremely small because of the long existing barriers to education for ethnic minority group members. This bias was particularly acute in the field of psychology. Graduate programs in psychology were long closed to members of ethnic minority groups (and also to women). Between 1879 and 1920, of ten thousand doctorates awarded in psychology, only eleven were earned by Black scholars. Between 1920 and 1966, the ten most prestigious departments of psychology awarded a grand total of eight doctorates to African-American candidates while granting a total of 3,767 PhDs during this period (see Albee, 1969).

The first Black PhD, Francis Cecil Sumner, was awarded the degree from Clark University in 1920. While a graduate student at Clark, he wrote letters to local newspapers pointing out that Americans should not be represented by the press as "self-appointed paragons of virtue" in contrast to the papers' portrayal of Germany's barbaric and immoral culture. He argued that Americans were not aware of nor concerned about the social injustices and widespread discrimination toward Blacks. For this, he was required by his University to apologize in a letter to the newspaper for his "disloyalty to his native country." Sumner, like many later Black PhDs, had to teach in Black colleges because of the reluctance of White colleges and universities to employ members of minority groups.

Similar problems have been faced by Hispanic young people seeking graduate studies in psychology. Carlos Albizu-Miranda, a giant in Puerto Rican psychology, returned to his native island to open his own school to train Puerto Rican psychologists-therapists, and a large majority of Puerto Rican psychotherapists have done their work at the school he founded there.

The early history of the American Psychological Association is replete with examples of racism and racist and sexist discrimination. The most convincing evidence of race differences in ability came from the psychological testing of soldiers during World War I. APA President Robert Yerkes and his consultant, Edward Lee Thorndike (another President of APA), were largely responsible, although it was a book by Carl Brigham (1923) of Princeton University that brought the "evidence" to the educated public. Brigham's book, (based on the Army's tests of soldiers), found a clear-cut relationship between the proportion of Nordic, Alpine, and Mediterranean blood and performance on intelligence tests. The book was praised by the chairman of the U.S. Senate Committee considering immigration law change. Brigham says, near the end of his "scientific" review:

> We must face a possibility of racial admixture here that is infinitely worse than that faced by any European country today, for we are incorporating the negro [sic] into our racial stock, while all of Europe is comparatively free from this taint. . . . The decline of American intelligence will be more rapid . . . owing to the presence here of the negro. (pp. 209–210)

A laudatory foreword to the book was written by APA President Yerkes. (It may be of some historical interest to note that Brigham designed the Scholastic Aptitude Test and served as Secretary of the College Entrance Examining Board. Later he was elected Secretary of APA.)

Because the Army IQ tests had shown that Jews, Negroes, Spanish-Mexicans, Poles, Italians, French Canadians, and other "brunette nationalities" performed at the feebleminded level in at least 80 percent of the cases, the immigration laws were changed to defend (rather late in the day) the purity of the native-born White Protestants. As Kamin (1974) points out, "There is nowhere in the records of the Congressional hearings—nowhere—a single remark by a single representative of the psychological profession to the effect that the results of the Army testing program were in any way being abused or misinterpreted" (p. 24). (For a fuller account of the racist beliefs of early American and British psychologists like Galton, Spearman, Pearson, Burt, G. S. Hall, Yerkes, Terman, see Albee, 1982; Fernando, 1988; Mays, 1985.)

Lest we forget, Fernando (1988) reminds us that, while overt scientific

racism is clearly not in vogue, there was a resurgence of a "scientific racism" evidenced in the theories of race in the 1970s. One such example is Jensen's (1969) genetic explanation for IQ differences between Blacks and Whites. Considering his idea far from dead, Jensen (1984) defended his position in a commentary to a 1984 book titled, *Race, Social Class and Individual Differences in IQ* by Sandra Scarr.

It was not until the Civil Rights movement of the 1960s and the establishment of the Association of Black Psychologists (as well as the Hispanic Psychological Association, the American Indian Psychological Association, and the Asian-American Psychological Association) that American mainstream psychology was forced to confront its racism in issues involving admissions to graduate training and governance activities by the American Psychological Association. Finally in 1980, the American Psychological Association incorporated into its governance structure a Board of Ethnic Minority Affairs (BEMA) and in 1986 a Division-Society for the Psychological Study of Ethnic Minority Issues.

The supply of ethnic minority psychologists increased moderately in the 1970s and 1980s but is still far below the proportion in this population. With the U.S. population approximately 12 percent African-American and 7 percent Hispanic, only 2 percent of psychologists earning the PhD in recent years are African-American and fewer than 1-1/2 percent are Hispanic. The status of available psychological providers who are American Indians is worse and the future looks equally bleak. La Fromboise (1988) calculated that in 1976 there was 1 psychologist of any ethnic background for every 43,000 American Indians. By 1985, with 180 master's- and doctorate-level self-identified American Indian psychologists, the rate was increased to 1 American Indian professional for every 8,333 Indian persons. She contrasts this to a 1 in 2,213 rate of available psychologists for the general population. Due to the small number of American Indian psychologists to serve as role models, few students consider psychology as a career. This lack of career choice is exacerbated by tribal priorities that stress medical and legal careers (La Fromboise, 1988).

In Table 1, we show the percentage of practicing minority mental health professionals across the four disciplines of psychiatry, psychology, social work, and nursing as compiled by the Heckler report (1986) from 1980 data. Table 2 specifically presents the pool of clinical psychologists available that is equally as unrepresentative. Later data (see Table 3) compiled by the American Psychological Association show race of 1989 PhDs by subfields. Out of a total of 1,491 PhDs awarded in Clinical and Counseling psychology, ethnic minorities received only 161 degrees. One step taken by the Board of Ethnic Minority Affairs of the American Psychological

TABLE 1
Percentages of Practicing Professionals by Race/Ethnicity

Profession	Non-Minority	Black	American Indian	Asian/Pacific Islander	Hispanic	Unknown
Psychologists	95.6	1.4	0.2	1.1	0.7	0.9
Psychiatrists	69.4	1.5	0.4	5.6	2.5	20.7
Social Workers	88.5	5.8	NA	1.6	1.8	2.2
Nurses	91.5	3.7	0.3	2.0	1.2	1.3

Note: Primary data sources are membership surveys of the American Psychological Association (1982), American Psychiatric Association (1977), National Association of Social Workers (1982), a Health Resources and Services Administration survey of registered nurses (1980), and a National League for Nursing survey of 1980–1981 graduations of minority students from basic baccalaureate nursing programs. From *Report of the Secretary's Task Force on Black and Minority Health* by M. M. Heckler, 1986, U.S. Department of Health and Human Services, Washington, DC: U.S. Government Printing Office.

Association to assist ethnic minorities to receive ethnically sensitive and culturally appropriate treatment has been the drafting of the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (Myers, Wohlford, Guzman, & Echemendia, 1991).

In addition to the unavailability of minority psychotherapists, there are further problems affecting the availability of help for members of minority groups. Thirty years ago, the American Medical Association was often quoted as saying that the country did not need more physicians because no American lived more than a few miles from the nearest doctor. This was a small comfort to the residents of Harlem who, though they lived only five miles from Park Avenue, might as well have lived five light years away for all the help they might receive.

Clearly psychotherapy can be considered an intervention used by societies that are industrialized and subgroups who are relatively affluent.

TABLE 2
Numbers and Percentages of Clinical Psychologists in the United States by Race/Ethnicity and by Graduate Degree

Racial/Ethnic Group	PhD		Master's	
	Number	Percent	Number	Percent
Nonminority	15,885	96.2	2,360	94.9
African-American	159	1.0	38	1.5
Hispanic	164	1.0	19	0.8
American Indian	182	1.1	29	1.2
Asian/Pacific Islander	6	0.4	8	0.3
Unknown	123	0.7	32	1.3
Total	16,519	100	2,486	100

Note: Data from *Report of the Secretary's Task Force on Black and Minority Health* by M. M. Heckler, 1986, U.S. Department of Health and Human Services, Washington, DC: U.S. Government Printing Office.

TABLE 3
Number of 1989 PhDs Awarded in Psychology by Subfield and Race/Ethnicity

Racial/ Ethnic Group	Subfields		
	Clinical	Counseling	School
Total, all races[a]	1,021	470	98
American Indian	2	4	0
Asian	23	6	0
Black	44	15	4
Hispanic	47	10	6
Other ethnic	10	4	2
Total ethnic minorities	126	39	12

Note: Data from National Research Council, 1990, *1990 Summary Report: Doctorate Recipients from United States Universities*. Table compiled by Office of Demographic, Employment, and Education Research, American Psychological Association, June, 1990.
[a]Excludes degrees awarded to students who are foreign citizens.

Recent papers at the 1990 Vermont Conference on the Primary Prevention of Psychopathology (Albee, Bond, & Monsey, 1992) by Sefa-Dedeh of Ghana and by El-Mouelly from Egypt as well as reports by psychologists and psychiatrists from Pakistan (Arshad), India (Sonty), and Eastern Europe (Sek) present a picture of massive human social problems untouched by psychotherapy. In spite of the impossibility of reaching more than a handful of the billions of people who live in Third World countries in Africa, Asia, and elsewhere, many university psychology departments in countries of the Third World are embarking on the training of psychotherapists.

WHAT IS NEEDED?

While the history of psychotherapy derives from many sources, it is safe to say that a major tap root leading to the growth of modern traditional psychotherapy was the work of Freud. Freud treated middle-class White women in Vienna who, as a consequence of the repressive patriarchal culture of the time, had symptoms rooted in repressed sexuality. Freud's "discovery" of the unconscious, of unconscious motivation, repression, and the ego mechanisms opened many compartments of the human mind that led to excited explorations by his followers and by subsequent therapists. Other chapters in this volume provide rich background in the history of various therapies. Let it suffice for us to assert that therapy is largely available to the middle class, especially women, and not to ethnic minorities and to other disadvantaged groups for economic, cultural, and social reasons. In this respect it is no different from many other forms of human services and health care.

Most of the 40 million Americans who are not covered by any kind of health insurance are drawn from the ranks of the poor ethnic minorities. Concomitant with inescapable poverty and powerlessness is a higher-than-average incidence of a great range of physical and mental disorders. If minority groups suffer so disproportionately from untreated physical illnesses and have little or no protection, we should not be surprised that they suffer too from untreated mental disorders as psychotherapy has come to be part of the health care system, and persons without coverage through health insurance or other group protection cannot afford its high cost.

The view that social, economic and political conditions are primary factors in the psychological problems of ethnic minorities calls for a reorienting of mental health services to create less stressful environments (Cannon & Locke, 1977). This approach advocates a public health prevention model in which psychological problems will be reduced through the prevention and eradication of factors that contribute to poverty, substandard and nonexistent housing, low self-esteem, and lack of personal competence and power.

Albee (1981; 1990) designed a model supporting the basic principles of a public health model—involving the host, the agent, and the environment.

$$\text{Reducing incidence} = \frac{\text{organic factors} + \text{stress} + \text{exploitation}}{\text{coping skills} + \text{self-esteem} + \text{support system}}$$

The factors above the line in the diagram represent noxious agents that contribute to psychopathology. The factors below the line are ways we can strengthen the resistance of the host and thus prevent or ameliorate the behavior. In Albee's model, the equation can be applied to either a population or an individual. Within the context of primary prevention, the focus would be the population. The goal would be either to decrease the components in the numerator or to increase the components in the denominator.

Nobles (1986; 1990) advocates an "Afrocentric prevention model" of psychotherapy for African-Americans that emphasizes empowerment and Black identity. Nobles believes the primary function of culture is to give individuals patterns for interpreting reality. Then, culture has the responsibility for determining what should be prevented or promoted as normal and abnormal human behavior. According to Nobles, culture gives to individuals and communities several critical elements—self-worth, legiti-

macy, spiritual rejuvenation, power, self-determination, and bonding that effective prevention programs must replicate.

Several other culture-specific psychotherapy models have been developed since the mid 1970s with the emergence of more ethnic minority professionals into the field (Mays & Comas-Diaz, 1988; see Jackson, 1990). Yet the effectiveness of many of these models is limited by their relationships to our current payor system. For those ethnic minorities able to afford mental health services through private insurance, they can choose either an ethnic provider and or a model of psychotherapy that is culturally specific. But for the vast majority of ethnic minorities in need of mental health services, without changes in who provides the services, the structure of financing of those services, the orientation of the interventions, and a focus on the underlying social conditions producing the mental health problems, these models will be unattainable.

Bataille (1989) advocates a multifaceted and adaptable psychotherapy of the future. She envisions a practice of psychotherapy in which exclusivity of practice in an office or hospital will be the exception rather than the rule. Instead, therapy will expand to become environmental, interventions will be woven more intricately into the client's life. This could include home, school or worksite visits, or interacting with informal sources of emotional support.

Public psychotherapy in the 1990s and in psychology's next 100 years will require some tough decision making on the part of our profession. Psychology as a profession—if it is to remain a credible and ethical body—must develop adequate, relevant, and effective models of public psychotherapy that meet the needs of all consumers. Psychotherapy as delivered in our current health and mental health care system must become a relic encased in our traveling exhibits. We need a payor system that will sustain and champion diverse methods such as community support systems rather than focusing only on outpatient psychotherapy (Anthony & Blanch, 1989; Kupers, 1981; Parrish & Lieberman, 1977). The system will need to include a flexibility that allows for the reimbursement of supportive activities. This can only be accommodated through a transformation of our current system of mental health care. The possibility of such a transformation will be a direct function of psychology's ability and commitment to work to create a public mental health system that will be responsive to all in need of mental health services.

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