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Cultural and Contextual Influences in Mental Health Help Seeking: A Focus on Ethnic Minority Youth

Ana Mari Cauce
University of Washington

Melanie Domenech-Rodríguez
Utah State University

Matthew Paradise
University of North Carolina at Greensboro

Bryan N. Cochran, Jennifer Munyi Shea, Debra Srebnik, and Nazli Baydar
University of Washington

In this article, a mental health help-seeking model is offered as a framework for understanding cultural and contextual factors that affect ethnic minority adolescents' pathways into mental health services. The effects of culture and context are profound across the entire help-seeking pathway, from problem identification to choice of treatment providers. The authors argue that an understanding of these help-seeking pathways provides insights into ethnic group differences in mental health care utilization and that further research in this area is needed.

Theorists and researchers in developmental psychopathology have expressed an appreciation for the role that extraindividual influences play in human development. Numerous studies have demonstrated that family, peers, school, neighborhood, and community play a central role in the emotional lives of young people. An exclusive focus on the individual in the study of etiology or course of behavioral disorders may soon become obsolete. Social scientists have come to acknowledge that every individual exists within a complex set of environmental systems and that these systems affect his or her psychological well being at a fundamental level.

Bronfenbrenner (1979) articulated the notion that the social environment consists of multiple spheres of influence, each defined by its proximity to the individual. The most proximal influence is the family, followed by contexts such as neighborhood, school, and community that play immediate and important roles in the lives of youth. At the most distal level, the macrosystem is where culture and other contextual influences operate. In theory, this environmental outer layer may have a profound impact on children and their adjustment, but its effects are subtle, elusive, and difficult to capture with the traditional techniques used for studying psychological phenomena. Bronfenbrenner's model explicitly allows for interactions between these systems of influence, and more recent attempts to extend this model place such interactions at the center rather than the periphery of child development (Cicchetti & Aber, 1998; García Coll et al., 1996). In practice, however, the effects of culture have often been poorly incorporated into this broader emphasis on context, and few studies have focused on the complex interactions between culture and other contexts that so often characterize the lives of youth at risk for emotional and behavioral disorders.

This article issues a call for research that specifically focuses on the pathways by which adolescents seek help for mental health problems. A focus on help seeking, rather than simply help getting, more fully accounts for the role of culture and context. It also recognizes that these factors influence every aspect of behavioral and emotional disorders, from problem definition to whether and how adolescents and their families participate in treatment. We begin the article with an attempt to clarify the knotty definitional issues inherent in dealing with constructs that have often been loosely conceptualized and even more vaguely defined. We then move on to make a more concrete case for the importance of culture and context in understanding the mental health help-seeking pathways for adolescents. We end with ideas for future research.

Definitional Issues: Race, Ethnicity, Culture, Context, and Adolescence

The first challenge in an undertaking of this sort arises out of loose terminology. Four constructs central to the discussion of this article, race, ethnicity, culture, and context, must first be defined. Yet their definitions are elusive at best, and sometimes tautological. Moreover, conceptions of race and ethnicity are continually transforming. Evidence of this is seen in the multitude of publications dealing with race and ethnicity, each having to define the terms for use in their particular study or review. Definitions of race and ethnicity are inherently contextual. A noteworthy example of this is seen in the U.S. Census Bureau (2000) changes to the census instrument to adapt to more currently held notions of race and ethnicity.

Ana Mari Cauce, Bryan N. Cochran, and Jennifer Munyi Shea, Department of Psychology, University of Washington; Melanie Domenech-Rodríguez, Department of Psychology, Utah State University; Matthew Paradise, Department of Psychology, University of North Carolina at Greensboro; Debra Srebnik, Department of Psychiatry, University of Washington; Nazli Baydar, School of Nursing, University of Washington.

Correspondence concerning this article should be addressed to Ana Mari Cauce, Department of Psychology, Box 351525, University of Washington, Seattle, Washington 98195. E-mail: cauce@uswashington.edu

Historically, race distinctions were seen as biologically based (Williams, 1997), whereas ethnicity was viewed as a marker for culture (Guerra & Jagers, 1998). However, recent research in the social sciences, and biological sciences especially, indicate that the biological foundation of race is a persistent myth. Referring specifically to the biological or genetic roots of race and ethnicity, Francis Collins, Director of the Human Genome Project, has unequivocally stated, "Racial designations and ethnicity have no scientific basis" (Zwillich, 2001, p. 2). Still, race is a difficult construct to give up. It provides a convenient and powerful organizing structure for the examination of inequality, injustice, and discrimination in this country. It also remains central to the formation of identity (Williams, 1997). For the purposes of this article, we use *race* and *ethnicity* interchangeably to describe distinctions among the five major race–ethnic groups identified by the U.S. Census: White European Americans, African Americans, Asian Americans/Pacific Islanders, Native Americans, and Latino/Hispanics.

Few studies define culture beyond an indication of race–ethnicity, and most of the research we cite in support of cultural influences on help seeking have used race–ethnicity as the marker for culture. There are clear limitations to this approach, but there would be virtually no literature to draw on if we required a more elaborate or differentiated definition of culture (see Cauce, Coronado, & Watson, 1998, for a full discussion of this issue).

Disentangling culture from context presents an even more complex challenge because one is so often used in defining the other. To a large extent, culture develops as a result of specific contextual demands. One cannot speak about a Navajo culture outside of a life that began on the great Western plains with its unique geographic features, animal and plant life, and the challenges to survival that these posed. Conversely, culture has been defined from a more relativistic point of view as a social context in which people share social norms, beliefs, values, language, and institutions (Guerra & Jagers, 1998). Human development then occurs within a cultural context, and individuals learn to make sense of the outside world within a cultural framework. Hence, culture *is* one of the contexts that adolescents emerge from, and context can be thought of as a collection of cultural dimensions. One is a subset of the other, although it is not clear which is the overriding or broader construct. For the sake of conceptual clarity, when we refer specifically to culture in this article, it is in order to elucidate ethnic group differences in the process of help seeking. In contrast, when we refer to context more generally, we refer to contextual features not necessarily tied to culture, such as socioeconomic status (SES), gender roles, or regional differences. This is not to say that in the real world these are always possible to tease out or pull apart. For example, in this country the confound between SES and culture is sizable, and to the degree that certain ethnic minority cultures represent, in part, adaptations to challenging socioeconomic conditions, controlling for one to examine the influence of the other may not be meaningful.

Compared with the fuzzy constructs of race, ethnicity, culture, and context, adolescence, with its clear biological markers associated with puberty, would seem to be much easier to define. Virtually every culture differentiates between childhood and adulthood (Crockett, 1997). Yet there are notable cross-cultural variations in the age at which the adolescent transition is believed to begin, when this transition ends, and whether it exists as a discrete period with distinctive tasks and tangible outcomes.

The ethnographic work of Linda Burton and colleagues suggests that although inner-city African American youths surely go through puberty, the concept of adolescence as a discrete stage between childhood and adulthood may not apply. A host of factors including structural inconsistencies in the definition of adolescent roles, age-condensed families and blurred intergenerational boundaries, an accelerated life course, and culture-specific definitions of successful developmental outcomes combine to place many adolescents either in adultlike or developmentally ambiguous roles from very early ages. This puts into question the existence of a distinct transition period between child- and adulthood. In contrast, African American youth who grow up in suburbs with access to ample economic resources do not fit this profile and are afforded the "luxury" of an adolescence (Burton, Obeidallah, & Allison, 1996).

For Native Americans, adolescence is a time of changing roles and responsibilities, but the traditional endpoint is not autonomy but rather increasing dependence on the family. This sharply contrasts with more conventional developmental theories that list individuation as a major task of adolescence (Red Horse, 1982). Similar to many urban African American youth, East Indian youth in the United States do not experience an adolescence that closely resembles typical adolescence in the United States. Only boys have the opportunity to engage in the exploration often considered the sine qua non of this transitional time (Saraswathi, 1999).

In sum, the constructs of culture and context are open to multiple interpretations, and they are interrelated to such a profound extent that it becomes difficult in practice to separate the definition of one from the experience of another. Likewise, our understanding of adolescence, and the developmental context it represents, varies by culture and socioeconomic context. The interrelated nature of these constructs serves only to emphasize the importance of considering culture and context in research studies involving minority adolescents and makes the call for research in this area even more urgent.

In the following sections, we present a model of adolescent help seeking that begins with problem definition, moves to the decision to seek help, and ends with selection of a treatment service or service provider. These three steps in the help-seeking pathway serve as the organizing framework for examining what we know about the role of culture and context in this process. Given the dearth of research in this area, our presentation draws a rough sketch rather than a detailed portrait. At times we might use findings from one ethnic group to suggest that there are cultural influences on how mental health problems are defined and draw on research with a different ethnic minority group to illustrate cultural differences in selection of treatment service. This does not mean that the various ethnic groups are interchangeable or that their pattern of help seeking differs from the White majority in similar ways. An in-depth and comprehensive review is simply not possible at this time. Thus, we end with recommended research questions that might help us to better incorporate culture and context into our work on mental health services. Such research may lead to a more comprehensive review in the future.

Help-Seeking Pathways for Adolescents

Data recently presented at the Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service, 2000) suggested that more than 7 out of 10 American adolescents who suffer from mental health problems are receiving no services. This problem was identified as even worse among minority adolescents. For example, more than 80% of Latino adolescents with mental health issues do not receive care (Zwillich, 2000). Without actual need taken into account, research suggests that African American children are more likely to receive mental health treatment than White children (Cohen & Hesselbart, 1993; Costello & Janiszewski, 1990), whereas Latino, Asian American, and Native American youth are less likely to receive treatment (Bui & Takeuchi, 1992).

Help-seeking research has traditionally focused on rates of mental health treatment or service utilization and these were assumed to be the logical outcome of seeking help. More recently, however, there has been a growing recognition that both the science of developmental psychopathology and the needs of policymakers concerned with children and youth are better served by research focusing on the more protracted *process* of help seeking. A focus on the help-seeking process broadens the scope of research to begin with the time when a problem is first noticed.

In examining the help-seeking pathways of minority adolescents in particular, we borrow from a model presented by Srebnik, Cauce, and Baydar (1996), who in turn drew from the work of Anderson and Newman (1973), Goldsmith, Jackson, and Hough (1988), and Pescosolido (1992). As outlined earlier, this model describes three identifiable stages along the help-seeking pathway: problem recognition, the decision to seek help, and the selection of a help provider. This model is illustrated in Figure 1. As this figure shows, the three steps in our model are interrelated. We discuss them in order, but the help-seeking process seldom occurs in an orderly fashion. For example, a mother's definition of her adolescent's behavior problem may change after she seeks out help. Thus, we include double-headed arrows between each of these three steps.

Two key factors, epidemiologically assessed need and perceived need, lead to problem recognition. We argue that context and culture affect both of these. Culture and context also affect coercive and voluntary processes, which lead to the decision to seek help. Finally, we make the case that whether adolescents and their families progress to the stage of service selection and whom they turn to for help or receive help from—informal network members, collateral services, or formal mental health services—are largely determined by culture and context.

Figure 1 does not explicitly have a place for culture and context because culture and context surround all the constructs in the model. Adolescents and families respond to mental health problems and concerns within the context of the larger social environment that may both guide and push them toward or away from various types of services. African American adolescents with social and emotional disorders are more likely to end up in the juvenile justice system than White adolescents with similar problems (Comer & Hill, 1985; Kaplan & Busner, 1992). They are also more likely than White adolescents to enter mental health care through law enforcement or involuntary commitment, even when levels of symptomatology are taken into account (Fabrega, Ulrich, & Mezzich, 1993; Snowden & Cheun, 1990; Takeuchi, Bui, & Kim, 1993). In contrast, Native American youth with behavioral problems are more likely to go without any treatment or to be removed from their homes by a government agency (Beiser & Manson, 1987; Berlin, 1983). These differences are not simply a matter of personal or family decisions or choices; neither are they merely a reflection of cultural differences. They arise out of a dynamic interaction between individual and family choice, cultural values and beliefs regarding mental health and help seeking, and contextual and systemic factors such as the availability of services within the community and social networks that can provide referrals to them.

Problem Recognition and Definition

Help seeking cannot begin in earnest until a problem or mental health need is recognized. This need can be defined in one of two ways: as an epidemiologically defined need or as a subjective or perceived need. According to epidemiological definitions, the prevalence of serious emotional and behavioral disorders in chil-

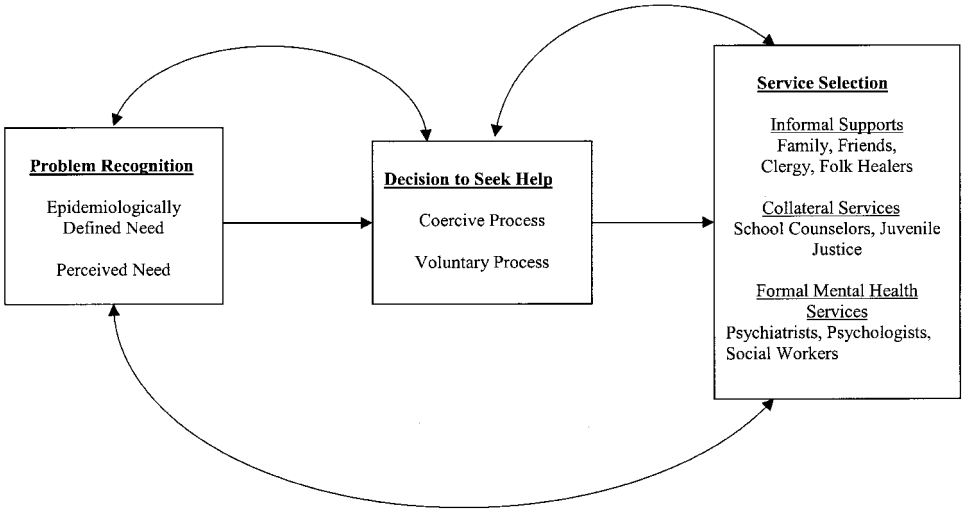

Figure 1. A model for mental health help seeking.

dren at any given time has been estimated at 17–22% (Costello, 1989), and it increases to over 30% by late adolescence (Reinherz et al., 1993; Shaffer, Fisher, Dulcan, & Davies, 1996). However, these rates go down significantly when meaningful functional impairment is used as a criterion. When assessed need is defined more restrictively using both diagnosis and functional impairment, between 5 and 10% of youth are found both to have a diagnosis and to show significant difficulties in day-to-day living (Bird et al., 1988; Costello, 1989).

One study, unique in its assessment of functional impairment, estimated the prevalence of serious emotional disorders in a community sample of youths to be 6.7% (Trupin, Low, Forsyth-Stephens, Tarico, & Cox, 1980). Especially relevant to this discussion, this rate varied widely by ethnicity, with American Indians showing a markedly higher rate (18%) than African Americans (7%), Whites (4%), and Asian Americans (1.6%).

The introduction of functional impairment into the formal assessment of psychopathology allows for a better accommodation of the inherent subjectivity in problem recognition and definition by the adolescent or family members. More precisely, the identification and definition of a child or adolescent's mental health problems, as well as decisions about help seeking and service selection, are largely determined by the mother, in consultation with others, including her child (Burns, Angold, & Costello, 1992; Combs Orme, Chernoff, & Kager, 1991). The symptom-focused approach typically taken by clinicians is often incongruent with the way parents or their equivalents look at their children's problem. An adolescent's truancy or problems at school, for example, are more apt to capture the attention of his or her family members than "symptoms" such as anger, frustration, or hopelessness (Pottick, Lerman, & Micchelli, 1992).

Although not systematically investigated, there has been much conjecture that ethnic and cultural groups differ on questions as basic as what is perceived to be a mental health problem (Fabrega et al., 1993; D. W. Sue, 1994). It makes sense that contextual and cultural factors likely underlie, at least to some extent, the differences between epidemiologically assessed need and perceived need across ethnic groups.

Epidemiologically defined need is typically assessed using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Disorder categories in the *DSM* were developed from available theories of abnormal behavior, and these categories have evolved in tandem with both the growing understanding of mental illness and broader social and cultural changes in America. An example of this evolution was demonstrated when the category for homosexuality as a diagnosis was removed in the third edition of the *DSM* (*DSM–III*; American Psychiatric Association, 1974). Nonetheless, this accommodation of broader social and political change has not always been complete.

Although the fourth edition (*DSM–IV*) and fourth edition, text revision version (*DSM–IV–TR*; American Psychiatric Association, 1994, 2000) more explicitly recognize contextual and cultural factors in diagnosis, they continue to address these issues in a fragmented fashion through two separate sections and an appendix (Cervantes & Arroyo, 1995). There is also notable variation in the quality of the cultural information in these sections. The section describing cultural aspects of mood disorders, for example, is nicely elaborated and discusses the presentation of symptoms, as well as differences in the perceptions of severity of symptoms, across cultural groups. Other sections, such as the one on pervasive developmental disorders, offer no cultural information at all. Yet both mood disorders and pervasive developmental disorders exist across all ethnic and racial groups.

On a more basic level, the focus on diagnosis and disease rather than on the experience of the individual may illustrate the Western bias toward "scientific objectivism" (Parron, 1997, p. 157). The fact that the family or individual's perception of need is central to the help-seeking model is one of its greatest conceptual strengths.

Some cultures may simply be more accepting of certain psychiatric symptoms (Alegria et al., 1991). Intercultural differences have also been found in parents' "distress thresholds" with respect to their children's mental health problems (Weisz & Weiss, 1991). Here, culture may influence whether a problem is defined as mental health related or not. Nonmainstream cultures offer an abundance of alternative explanations for odd or undesirable behavior. Supernatural, spiritual, religious, moral, and balance theories (hot vs. cold) of emotion and behavior may be particularly prominent among African American and Native American families with strong ethnic affiliations (Cheung & Snowden, 1990).

Contextual issues also play an important role in problem perception and recognition. Parents may be more likely to consult others about their child's emotional or behavior problems when their anxiety is high (Mechanic, 1978). Likewise, when parents are themselves under stress and struggling to get by, a scenario more likely for poor, minority families, parenting suffers and parents may become harsher and less warm toward their children (McLoyd, 1995). They may also be less sensitive to their children's distress. The relative burden of care placed on a family has also been found to influence subjective need, with parents shouldering greater burdens less apt to notice psychological problems in their adolescents (Brannan, Heflinger, & Bickmann, 1995).

Social norms for which behaviors are undesirable, deviant, or worthy of concern are another important contextual factor that has bearing on problem perception. Many behavioral rating scales, such as the Child Behavior Checklist (Achenbach, 1991a) and the Youth Self-Report (Achenbach, 1991b), which are both ubiquitous in the literature, ask parents or adolescents to define their symptoms or problems in terms of whether they occur "more often" or "less often" than for a typical, similarly aged child. Yet the behaviors of "typical" children may vary with neighborhood context. In a neighborhood in which aggression is common, a parent may not define his or her teenage son's weekend fighting as outside the norm. In particularly harsh contexts, for example, behavior that would otherwise contribute to a clinical diagnosis (e.g., running away) might be more accurately viewed as adaptive (Paradise et al., 2001).

Problem recognition and identification make up the first step in the help-seeking pathway, and it is clear that cultural and contextual factors play a key role with respect to both epidemiologically assessed need and perceived need. Still, standardized instruments for assessing epidemiological need give few guidelines for the consideration of culture and context in making a diagnosis, and we are only beginning to understand how these same factors affect perceived need. A deeper understanding of these factors is not only important in order to better approximate the true prevalence of mental health service needs for adolescents, it is also crucial to understanding the relationship between objective and subjective

need and their impact, both alone and in tandem, on the decision to seek help.

The "Decision" to Seek Help

Service utilization is, not surprisingly, closely linked to problem recognition (Leaf et al., 1985). One large study of multiethnic adolescents found that those who met criteria for emotional disturbance were much more likely to seek out mental health professionals than were nondisturbed adolescents (Offer, Howard, Schonert, & Ostrov, 1991). Another study found that youth with both a diagnosis and a functional impairment were about seven times more likely to receive treatment than those without a diagnosis or impairment (Leaf, Bruce, & Tischler, 1986). Still, the correspondence between need and action is neither direct nor reliable. One study of suicidal ideation among adolescents found it to be negatively related to seeking professional help (Saunders, Resnick, Hoberman, & Blum, 1994).

Help seeking is most likely to occur when a mental health problem is recognized as undesirable and when it is deemed not apt to go away on its own. The first is relatively easy for parents or adolescents to assess, although they may not always agree on the nature and severity of the problem. The second condition, whether a problem is likely to remit without seeking help, is more difficult to evaluate, especially during the adolescent years, when some degree of antisocial behavior and emotional instability may be considered normative (Moffit, Caspi, Dickson, Silva, & Stanton, 1996). Many, if not most, adolescents have at some point disobeyed their parents, lied to authority figures, or used alcohol or drugs.

Further complicating an assessment of whether problems warrant professional attention is the fact that the developmental stage of adolescence is characterized by change (Holmbeck et al., 2000). Traditionally, this period has been described as one of flux, transition, and disequilibrium (Cicchetti & Toth, 1996). So it is not too surprising that many parents decide to ignore some behavior problems, expecting they will dissipate or disappear over the course of normal development.

Perhaps in part because of the tendency to leave well (or not so well) enough alone, the evidence suggests that most adolescents with serious mental health problems do not receive adequate treatment (Burns, 1991; Costello & Janiszewski, 1990; Koot & Verhulst, 1992; Realmuto, Bernstein, Maglothin, & Pandey, 1992; Offord et al., 1987). The relatively small portion (6–20%) of those in need who receive mental health services speaks to the many obstacles that exist between the individual youth in need and his or her decision to seek help. An additional obstacle noted with regard to adolescents specifically is the lack of services targeted specifically for this age group (Holmbeck et al., 2000; U.S. Public Health Service, 1999). These treatment barriers cut across social and economic boundaries and interact with cultural and contextual factors. These interactions in turn produce ethnic group differences in whether help is sought and where it is received.

Even after a problem is recognized as undesirable and there is a genuine desire on the part of the adolescent, family member, or both to change it, the decision about whether and how to seek help varies by culture and context. At a basic level, there is a belief in some cultures that the best way to deal with psychological problems is to avoid thinking about them. Some Asian American groups believe it is best not to dwell on upsetting thoughts or events (Cheng, Leong, & Geist, 1993). In this same vein, African American adolescents may be encouraged to simply use willpower to overcome adversity and to "tough out" difficult situations (Broman, 1996). African American adolescent boys, in particular, speak of "chilling" or dampening down on negative affect as a way to cope with anger or stress (Poulin et al., 1997).

Attitudes about mental health services such as receptivity to care, anticipated and real negative consequences from others, self-consciousness, and stigma tolerance have also been linked to mental health help seeking and to utilization of formal mental health services (Barker & Adelman, 1994; Fischer & Turner, 1970; Leaf et al., 1986). Though the evidence is scant, there is reason to believe that culture affects these attitudes. For example, in many East Asian cultures, outside help is regarded as a source of shame or "loss of face" (Cheung & Snowden, 1990; Leaf et al., 1986; S. Sue, 1988; Takeuchi et al., 1993)

Although we are just beginning to understand the impact of culture on the decision to seek treatment, it seems quite clear that race plays a role in whether adolescents are coerced into treatment. Problem recognition and help seeking may be linked not out of a family member's concern for the adolescent but instead through more coercive processes. For example, a grandmother might be instructed at a school conference that either she place her granddaughter in a mental health treatment program or her granddaughter will be expelled from school. Likewise, mental health treatment may be imposed on an adolescent by the courts, as an alternative to sentencing or as a necessary part of probation. Among adults, Pescosolido, Brooks Gardner, and Lubell (1998) found that almost a quarter of all client contacts with mental health professionals were a function of mandated referrals. Although there are no similar estimates of the number of adolescents in mandated treatment, anecdotal evidence suggests that this is also the case.

It is still too early to come to firm conclusions about the role of culture in adolescent mental health help seeking, but developmental issues associated with adolescence appear to be of paramount importance. These include the need for privacy so typical of adolescents, their push for autonomy and self-reliance, and the fragile self-identity associated with the teenage years. Left to their own initiative, very few adolescents actively seek help, even from informal sources like friends or families.

In one multiethnic, but predominantly White, sample of 7th to 12th graders, more than two thirds did not seek help, despite problems such as depression, suicidal thoughts, and substance use (Dubow, Lovko, & Kausch, 1990). The importance of self-reliance was the most often cited reason for not seeking help, followed by beliefs that problems were too personal to share with others, and other concerns about confidentiality. In one study, when adolescents from diverse ethnic groups were given various options about their preferred way of handling an emotional problem, youths rated help seeking as their least preferred coping strategy (Copeland & Hess, 1995). Other studies have also reported low rates of adolescent-initiated help seeking, and few or no ethnic differences have been found (Boldero & Fallon, 1995; Copeland & Hess, 1995).

Gender is also an important consideration in the decision to seek help. Both early and late adolescent girls report more positive attitudes toward help seeking than similarly aged boys (Cook, 1984; Garland & Zigler, 1994; Kuhl, Jarkon-Horlick, & Morrissey,

1997). Compared with male adolescents, who tend to devalue expression of affect, female adolescents also use more emotion-focused coping techniques, including mobilizing social support and seeking out help from others to solve their problems (Copeland & Hess, 1995). These differences are likely contextually based, the product of norms in the larger social environment, including family, friends, and the media, which encourage and reward girls for exhibiting fears and worries and reward boys for being tough, courageous, and independent (Stefic & Lorr, 1974).

Economic considerations are also implicated in decisions about mental health service utilization, although their role is not well understood. One study, which excluded coercive referrals, found that family income was unrelated to professional contact for mental health problems among a multiethnic sample of youths (McMiller & Weisz, 1996). Two other studies suggest that there is a curvilinear relationship between SES and mental health service utilization (Cohen & Hesselbart, 1993; Koot & Verhulst, 1992). In these studies, youth from very low and very high SES backgrounds were more likely than working class youth to utilize mental health services. This pattern has been attributed primarily to greater access to funding. Middle and upper income youth are typically privately insured, whereas lower income youth may receive Medicaid benefits that provide coverage for mental health treatment. In contrast, working-class families may not have mental health coverage. The link between poverty and mental health service utilization may be especially strong for minority adolescents. One study found that almost 90% of African American youths in the mental health system were poor (Hoberman, 1992).

Thus, another possible explanation for cross-cultural discrepancies in mental health service utilization comes from the overrepresentation of ethnic minorities among the poor. Poverty leads to an increased chance of being in contact with a broad network of social service agencies that might readily identify mental health problems and refer individuals for treatment (T. Y. Lin, Tardiff, Donetz, & Gorecky, 1978; Takeuchi et al., 1993). Indeed, mental health referrals tend to come from other non-mental-health related social service agencies for individuals in poverty, whereas referrals more often come from family and friends for those with greater financial means (e.g., Gove & Howell, 1974; Neighbors & Jackson, 1984).

Finally, the very nature of the problem is another important, and at times overlooked, contextual factor that affects the decision to seek help. Among adolescents, conflicts with family members are less likely to lead to help seeking, for example, than other interpersonal problems (Boldero & Fallon, 1995). The reluctance of adolescents to seek help for problems within the family may prove especially difficult for teenage daughters of immigrant parents, regardless of ethnicity. A large-scale study of children of immigrants found that, after acculturation and language were controlled for, daughters were more likely to indicate that they had conflicts with parents, due in part to more restrictive parental standards. Parent–child conflict was, in turn, related to greater depressive symptoms (Portes & Rumbaut, 2001).

In sum, recognition of a mental health problem increases the likelihood that adolescents or their parents will seek help for that problem, but problem identification does not guarantee that help seeking will take place. Race and ethnicity undoubtedly play a role in whether adolescents are coerced into treatment, but there is surprisingly little research examining the role of ethnicity or culture on voluntary help seeking. We simply know more about other contextual factors that may affect the decision to seek help. These include factors that are confounded with ethnicity, such as SES, and others that are not, such as gender. Perhaps the most troubling finding comes from the growing body of research that suggests that even after recognizing their problems, adolescents are extremely reluctant to seek help. This is important to keep in mind as we examine the issue of service selection, or what types of treatment adolescents are most apt to receive.

Service Selection

Service selection is defined as where or to whom adolescents and their families turn after identifying a problem and deciding to seek help. Finding help should logically flow from these first two steps, but it is seldom easy or straightforward, especially for adolescents. Adolescents are neither children nor adults, and it is often unclear which treatment centers are available to them. Relevant treatment eligibility criteria such as age vary not only from state to state but from agency to agency within the same state or city. There is also variability in the rules and regulations about whether adolescents can be treated without parental consent. This hodgepodge of treatment criteria creates a great deal of confusion for adolescents and their parents at a time already marked by distress.

It is no wonder so few youths actually receive services from specialty mental health treatment providers. A study by Burns and colleagues (1995) found that less than half (40%) of all youth who both met criteria for a psychiatric diagnosis and demonstrated functional impairment received services from the mental health treatment sector. In contrast, over 70% of these young people received some sort of services from the school system. Other locations in which youth received services include the primary health care settings (11%), the child welfare system (16%), and the juvenile justice system (4%). The consensus seems to be that schools and other collateral services not explicitly set up to address mental health problems have become the primary providers of treatment for children and youth requiring mental health treatment (Hoagwood & Jensen, 1997).

Parodoxically, though only a relatively small proportion of youth in need actually receive mental health services, some troubled youth receive treatment in multiple settings. In one study, of youth receiving substance abuse services, 21% were also receiving mental health services, 45% were receiving child welfare services, and 10% were involved in the juvenile justice system (Trupin, Forsyth-Stephens, & Low, 1991). Another study reported that the rate of youth referred to mental health services was 3.25 times higher for those in the juvenile justice system compared with other youth with similar problems (VanderStoep, 1992). Given minority youth's overrepresentation in many of these settings, it is quite likely that whereas some in need receive no services are all, others become tangled in multiple service systems.

The complex network of treatment providers and pathways into treatment that exists for youth becomes even more chaotic when one recognizes that many, if not most, attempts to get help for social and behavioral problems happen within the informal sphere of family and friends. For ethnic minorities, this process takes place within the context of the family's social network, which often includes a range of informal consultants, extended family

members, friends, and ethnic-traditional and religious healers (Cauce & Srebnik, 1989).

Social networks may facilitate or inhibit help seeking and service selection, depending on their sociocultural norms around help seeking. In tightly meshed networks, when norms are not congruent with those of formal service settings, the individual is discouraged or prevented from seeking that type of help. Furthermore, in cultures in which strong and interlocking community and familial networks are the norm, individuals and families may not seek out formal mental health services because their needs are met within the network (A. Horwitz, 1987; McKinlay, 1973; Tata & Leong, 1994). Because of the strong influence of these networks on real decisions about treatment, context and culture may have their greatest impact at the point of service selection.

For both genders and across ethnic groups, when adolescents themselves report mental health problems or distress to another person, it is most often to a family member or friend. Nonetheless, ethnic groups do seem to differ in whom specifically they choose to disclose to. With social and emotional problems, White adolescents appear to turn to friends more often, whereas Mexican American and African American youth are more apt to involve relatives or immediate members of the family (Munsch & Wampler, 1993; Offer et al., 1991).

It is startling that there has been so little research examining the roles of peers as referral sources, particularly given the critical role that peers play in the emotional lives of adolescents. Although the literature does not speak directly to the dimension of help seeking, one study, demonstrating that adolescents with a friend who had contact with a mental health professional were more apt to receive treatment themselves, offers a tantalizing suggestion that peers are central here (K. M. Lin, Masuda, & Tazuma, 1982).

When ethnic minority parents decide where their children should get help, they seem less likely than White parents to choose formal mental health providers. In one study of families who eventually came into contact with a mental health agency related to their children's socioemotional problems, White parents were more likely to have contacted mental health professionals themselves than African American or Latino parents. This was the case for both initial contacts and percentage of total preclinic contacts (McMiller & Weisz, 1996). There is some evidence that African American families in particular have little faith in the usefulness of psychotherapeutic interventions and some fear that contact with a mental health provider will result in institutionalization of their child (Takeuchi et al., 1993). For many Asian American families, formal mental treatment is used only as a last resort when children or adolescents have psychological problems, and every attempt is made to deal with the problem within the family before getting outside help (K. Lin, Inui, Kleinman, & Womack, 1992).

Given the reluctance of minority parents to seek help from formal mental health treatment providers, such as psychiatrists, social workers, or psychologists, access to treatment for minority youth is often facilitated by individuals outside of the mental health system. These individuals, acting as gatekeepers, provide a less threatening connection to mental health services for minority groups. Gatekeepers may include personnel or officials from schools, churches, community agencies, or known and respected members of the community familiar with the mental health system. Informal community supports such as folk healers may also be consulted, although less is known about the nature and use of this kind of indigenous help and how it may influence an individual or family's connection with conventional mental health services (Cheung & Snowden, 1990; Tata & Leong, 1994).

Cultural and ethnic differences between provider and client are another important consideration when looking at patterns of service use among ethnic minorities. Mental health agencies and individual providers who represent the "majority" may lack the cultural competence necessary for effective outreach and service provision. This inadequacy may affect adolescents or their families' decision to seek mental health services, their ability to secure services, their selection of services, their satisfaction with services, and their likelihood of staying in treatment. Indeed, lack of cultural competence on the part of treatment providers may be one of the most formidable barriers to mental health service use for minority adolescents and their families (Leaf et al, 1986; Meinhardt & Vega, 1987; S. Sue, 1988; Takeuchi et al., 1993).

These same factors appear to play a role even when youth choose treatment providers on their own. In a study of late adolescents at college, Mexican Americans were found to utilize college counseling center services less often than White students. They also indicated less willingness to seek help from counselors. However, when these students did seek out a counselor, those Mexican Americans who demonstrated a high commitment to Latino cultural values also expressed a strong preference for same-ethnicity counselors, who might be more sensitive to their needs (Sanchez & King, 1986).

This study underscores the difficulties that arise when conducting research on help seeking at the interface of ethnicity, culture, and context. Ethnicity was an important predictor of who sought help from the counseling center, but it was cultural values that shaped the context in which Mexican American students sought help (i.e., their preference for a Mexican American therapist).

It is also important to recognize that in addition to the cultural factors that affect treatment selection, the broader context within which the service system exists can also either facilitate or deter entry into mental health treatment. Mental health service providers often point to adolescent or family resistance to help seeking and treatment, but families perceive lack of transportation, long waiting lines, inflexible hours, and distance from home as much more important barriers (Goldsmith et al., 1988; Leaf et al., 1986; Trupin et al., 1991). Given their reduced access to specific resources, ethnic minority and low-income families are likely to be affected disproportionately by these kinds of barriers to treatment (Cheung & Snowden, 1990; Leaf et al., 1986; Takeuchi et al., 1993).

Future Directions for Research on Adolescent Help Seeking

In this article we have presented a model of adolescent mental health help seeking that involves three steps: problem recognition, the decision to seek help, and service selection. We then examined the impact of culture and context on each, with a special focus on how these might inform ethnic group differences. Although the literature on help seeking is incomplete at best, the available studies suggest that both culture and context play an important part in each step of the process. From the start, culture and context affect how problems are defined, whether help is sought, and where it is received. Especially noteworthy is the evidence that

obtaining services from the mental health sector for an adolescent's behavior problem is often a last choice for many ethnic minority parents or their children. Once a problem is recognized and the decision to seek help is made, ethnic minorities most often turn to extended family or friends for solutions. This broader social network may in turn facilitate or hinder connections with more formal sources of mental health treatment, but we know surprisingly little about this process or how it works.

This three-part model of help seeking has served as a heuristic device for our presentation of evidence in support of cultural and contextual influences on the ways in which adolescents come to receive mental health services. It is important to reiterate, however, that these stages are not necessarily sequential or discrete and that it is not unusual for individuals to describe their getting help for a mental health problem as simply "muddling through."

This notion of muddling through is best articulated by Pescosolido (1992; Pescosolido et al., 1998). Instead of viewing help seeking in dichotomous and restricted terms, Pescosolido et al. noted that "social influence processes marked by social network contacts replace the isolated, individualistic, decision-making image as the mechanism through which illness careers move" (p. 277). For example, an African American mother of a seemingly depressed adolescent may consult her own mother, her sister, her best friend, and the family priest to get their opinions on whether her daughter's problem is serious or worthy of attention. Each conversation may alternately increase or decrease her level of worry and corresponding commitment to seek help. Even if these initial contacts help the mother to move from early problem recognition toward a desire to take action, another round of consultations may take place about what to do next. She might begin by consulting a school counselor or she may begin by talking to a primary care provider. These conversations may be, for the mother, all that is necessary to address the problem, or these consultations may end up in referral to a mental health center. There may also be yet another round of consultations before the referral is accepted or rejected. We believe that culture and context are potentially significant factors at each point in this trajectory.

Research on the pathways that adolescents take into mental health treatment is vastly underdeveloped, and we know very little about how this multilayered process unfolds for young people. We know even less about help seeking for ethnic minority adolescents and their families. Nonetheless, this is an especially good time for such work to take place. Here we have reviewed the extant literature and provided a model to help break down the help-seeking process. Pescosolido (1992; Pescosolido et al., 1998) has provided us with a promising theoretical framework to inform research in this area. Moreover, the last 20 years have seen various epidemiological studies that have helped tremendously in developing the instrumentation necessary to undertake further research (see Bird, 1996, for a description of this work). Valid and reliable measures for tracking the mental health service utilization of children and adolescents from diverse cultural backgrounds are also available (Burns et al., 1992; Costello, Burns, Angold, & Leaf, 1993). In addition, we now have some basic measures that allow us to assess ethnic or cultural identity and socialization (Phinney, 2000; Phinney, Madden, & Ong, 2000; Johnson & Hunter, in press). Hence the pieces are in place for the next step.

The sparseness of work in this area is so great that no single direction for future research is necessarily more compelling than another direction. Most ambitious would be a study that actually follows a sample of multiethnic youth from the earliest stage of problem identification, tracking their progress to the point of service utilization or truncation of the help-seeking pathway. This could best be done by identifying a sample at risk for the development of mental health problems. Thus far our understanding of the pathway for help seeking among adolescents comes from either retrospective studies or those that ask youth what they would do *if* they needed help in the future. A prospective study of help seeking would do a much better job of helping identify factors that either facilitate or hinder mental health service utilization among youth in general and ethnic minority youth more specifically.

Alternatively, there are a host of questions that could be asked about the impact of context and culture within each step of our help-seeking model. For illustrative purposes, we conclude by identifying one key question in each step of the process that we believe to be in special need of attention.

Targets for Future Research

Question 1: How Does the Relationship Between Epidemiologically Assessed Need for Mental Health Service, Functional Impairment, and Subjective Perception of Need Differ for Ethnic Minority Adolescents and Their Parents?

We know that congruence between these factors increases the likelihood that help seeking will take place, but we know very little about what factors lead to this congruence. One hypothesis worthy of examination is that congruence between epidemiologically assessed need, functional impairment, and subjective perception of need is less likely for minority adolescents than those from the majority culture.

In an article outlining the lessons she has learned from working with multiethnic adolescents from different cultures in different contexts, Mitchell (1996) described these contextual factors as akin to matrushkas, the Russian doll sets that are nested one within another. You open one doll and another, virtually identical but smaller, is nested within. Open that one and there's another, smaller yet, and so forth. This is a vivid illustration of how we, as individuals, are literally enveloped by context and culture. The illustration, however, is clearest for majority children who are of Anglo-American background. For these youth, the layers are relatively congruent in the norms and values they promote, teach, and reinforce. Most majority White parents are safe in assuming that the tools used to assess their son or daughter's need for mental health services have been developed on the basis of cultural norms they ascribe to and for populations that match their own. They can also assume their adolescent child's therapist will have some sense of what's normative or deviant for youths growing up in neighborhoods and families like their own. This is true even when the provider is a person of color, because exposure to the majority White culture is so often a requisite for achieving positions of power and influence in this society.

For minority youth, however, contextual asynchrony is often the rule. A diagram of the relationship between their contextual influences would look more like a square box, nested within a sphere, packed inside a pyramid. Burton and Jarrett (2000) recounted in vivid detail how an African American adolescent could be given a

great deal of responsibility at home and rewarded for acting decisively and in an adultlike manner. Yet when she behaved in the same manner at school, she would be viewed as bossy and difficult. In a similar way, an adolescent Puerto Rican girl who is praised at home for remaining close to her mother and not wanting to move out to attend college may find this closeness defined as *enmeshment* and problematic by a school counselor. Given that the contexts that surround minority youth continually scrape against each other, their relatively low utilization of conventional mental health services, at least on a voluntary basis, may make a great deal of sense. The asynchrony between specific cultural definitions of mental health problems and those used within the formal mental health system may create a difficult-to-bridge gap between many minority youth and mainstream treatment providers. The greater attention in the *DSM–IV* and *DSM–IV–TR* to cultural factors suggests some growing recognition of this fact, but systematic examination of this question, especially with regard to minority adolescents, has not been undertaken.

Question 2: What Role Do Religious or Spiritual Gatekeepers Play in Referring Ethnic Minority Adolescents to Mental Health Services?

In many minority cultures, prayer and spirituality are used as coping strategies (Acosta, 1984; Manson, 1986; Veroff, Douvan, & Kulka, 1981), and the role of the church and spiritual advisers as sources of support during times of distress appears central. Still, we know little about how these support systems operate. For example, following the Indian Health Care Improvement Act of 1976 (Indian Health Service, Department of Health and Human Services, 1990) some American Indian communities initiated recognition and funding of traditional healing for mental health services, but little is known regarding the linkages of these services systems to the formal service systems or about their effectiveness. We need better research to determine the extent to which mental health needs are being adequately addressed within spiritual and religious communities and the types of problems that clergy or spiritual leaders are most likely to refer to conventional mental health providers.

Question 3: How Does Comorbidity Affect Mental Health Treatment Selection for Minority Youth?

When ethnic minority adolescents do receive mental health treatment, they are likely to receive it in combination with other services. This has been attributed to the relatively high number of coercive referrals for ethnic minority youth, especially for African Americans, and to their greater involvement with social services more generally. However, the high rates of clinical co-morbidity between psychiatric symptoms, delinquency, substance abuse, school problems, and abuse or neglect may be another explanation for this widespread cross-system service utilization. During adolescence, problem behaviors co-occur with such regularity that developmental theorists talk about a problem behavior syndrome (Donovan, Jessor, & Costa, 1988; Jessor, 1992).

Developmental psychopathologists also recognize this overlap among behavior problems, substance use, and mental health and point out that similar pathways can lead to multiple outcomes (i.e., *multifinality*) and that different pathways can lead to the same disorder (i.e., *equifinality*). Still, the bulk of psychopathology researchers today continue to concentrate on the development and treatment of discrete disorders, often excluding those individuals with comorbid conditions from their research. Consequently, there is an extensive knowledge base about the course of depression, the course of conduct disorder, and the course of substance abuse, but far less is known about the interactive effects of various combinations of the three. Further, because counts of service utilization for the same youth are often duplicated across providers (e.g., mental health, juvenile justice, school system), reliable prevalence estimates for comorbidity remain elusive. Given that minority youth appear more likely to receive treatment from multiple agencies once in the system, the impact of comorbidity on service utilization may prove to be especially important for understanding these youths' help-seeking pathways (Trupin, Forsyth-Stephens, & Low, 1991).

Conclusion

Several years ago it was estimated that by the year 2000, 40% of the mental health service delivery population would be ethnic minorities (Yeh, Takeuchi, & Sue, 1994). Many of these are adolescents. Still, policy aimed at increasing access to mental health services for ethnically diverse youth has been formulated in a virtual vacuum, and our lack of knowledge about the process of help seeking among these youths continues today. This dearth of research has forced policymakers and treatment providers alike to make dubious extrapolations from research with adults, with younger children, or with primarily majority samples.

In the last several years an increasing amount of attention has been placed on developing a culturally competent mental health delivery system. Perceptions of mental service providers as culturally insensitive surely play a role in why ethnic minority families are reluctant to select them as the service of choice for their adolescent children. However, more than three quarters of all adolescents and families who identify a problem drop out of the help-seeking pathway before they even come into contact with a mental health service provider, and this process appears to be even more common for ethnic minority youths and their families. Understanding the process by which ethnic minority adolescents and their families identify problems, seek help, and engage in treatment should consequently be a top priority for those concerned with service provision. Culturally competent mental health services quickly become irrelevant if ethnic minority adolescents do not find their way into them.

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