MENTAL HEALTH SERVICES FOR AFRICAN AMERICANS: A CULTURAL/RACIAL PERSPECTIVE*

SERVIÇOS DE SAÚDE MENTAL PARA AFRO-AMERICANOS: UMA PERSPECTIVA CULTURAL/RACIAL

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Abstract: African Americans have made consistent progress toward first class citizenship since l 965. Nonetheless, mental health services for this population have been biased, incomplete, and deficient because similarities to Euro-Americans have been emphasized while differences were largely ignored. This article addresses some differences including cultural/racial identity and the cultural self that affect assessment, psychiatric diagnoses, and psychotherapy or other interventions. An assessment-intervention model illustrates how cultural information can inform service delivery to African Americans. This model exemplifies one application of cultural psychology that can contribute to a change in professional practice, training, and research for a multicultural society. Suggested guidelines emerging from this model point toward areas to be emphasized in service delivery and research.

Key-words: African American; Mental health; Services.

INTRODUCTION

Mental health services for African Americans have been reactive to socio-political events in the United States that have emphasized similarities between approximately 81millionpersons of color, including 37 million African Americans, and approximately 200 million European Americans. These services have been characterized by bias affecting the availability, utilization, and quality of assessment, clinical diagnoses, and subsequent psychotherapy or other interventions. This paper emphasizes African American cultural/racial differences that affect the reliability and validity of assessment procedures, psychiatric diagnoses, and effectiveness of psychotherapy and other standard interventions. All of these services require an infusion of cultural/racial components and/or explicit design and presentation within an Africentric perspective. This paper suggests that an understanding of identity and self as products of culture and race are essential ingredients for improving the quality of mental health services. An assessmentintervention model illustrates a systematic approach to credible and beneficial mental health services for African Americans and indicates areas for emphasis in services, service delivery, research, and training.

SOCIOPOLITICS AND MENTAL HEALTH SERVICES

Slavery in the United States provided a legacy of extreme inequality, victimization, and powerlessness for a predominantly Southern ru-

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ral population. Following the Civil War in 1865, segregation and Jim Crow laws continued and supported oppression and expectations for verbal/physical abuse and injury from Euro-Americans. Moreover, a depth ofindividual personal hurt and despair resulted in transgenerational emotional scars now called Post Traumatic Stress Disorder. Beginning in the 1940s, migration from the rural South to Northern and Western urban areas occurred for economic reasons. The Civil Rights Movement provided legal challenges to de jure segregation accompanied by non-violent direct action protests, the Black Power Movement, and landmark legislation in the form ofthe Civil Rights and Voting Rights Acts in the 1960s.

The education and training of professional psychologists to provide competent mental health services was predicated on a Euro-American perspective designed to represent the interests of that population (DANA, 1998a; DANA & MAY, 1986). Clinical psychology programs began to provide research-based training primarily for middle-class males of Euro-American origins during the 1940s. A Counseling Psychology training model in 1964 provided increased access for diverse cultural/racial students and presaged a conspicuous development of publication outlets for research on multicultural populations. A practitioner-scholart~iningmodel in 1973 counter elitism in clinical psychologyby focusing attention on social problems and non-middle class populations. However, over time all training models became increasingly tuition-driven and similar in content and objectives. African American students were generally discouraged in many programs as late as the 1970s.

Mental hospital patients were de-institutionalized to the community beginning in the 1950s and by the middle of the 1960s mental health centers promised community treatment for these persons. This was an era of intense social activism and legal challenges to second-class citizenship. However, the violence of race riots and assassinations evidenced a continuation of oppression. Community mental health center services to the poor, underserved, and chronically mentally ill did not exclude African Americans per se although the available services were inadequate and underutilized because of financial, institutional, and cultural barriers. African Americans found more comfortable, credible, and relevant services in churches, hospital emergency settings, or from community persons. Professional services in culture-specific agencies began in the 1970s and provided models for cultural competence that have continued to be available in the 1990s.

During the late 1970s, psychiatry was remedicalized to share a common medical frame of reference that included biological causation and a diagnostic classification system (DANA & MAY, 1986,1987). Pharmacological interventions were emphasized and an earlierbiopsychosocial model of mental illness was abandoned. This new biological model of mental illness was presented in the 1980 American Psychiatric Association, Diagnostic and Statistical Manual (DSM-III). Psychologists increasingly employed behavioral and cognitive therapies developed for EuroAmericans with all clients. These events were followed the Health Maintenance Organization Act of 1973. Over 100 managed care companies rapidly became responsible for mental health care that was viewed as inseparable from health care. Funding for treatment of cultual/racial groups was scarce and new federal monies were increasingly used to train primary care physicians.

Managed care expanded during the 1990s to cover more than 100 million persons in only four surviving companies. The variety and accessibility of all mental health services were dramatically reduced for all persons and persons of color were offered only those services designed for Euro-Americans (DANA, 1998b). Many earlier segregated service settings were consolidated with mainstream agencies and access to providers of the same race/ethnicity or primary language became increasingly infeasible for most persons despite a research literature suggesting that matching improved retention of clients and intervention outcomes.

AFRICAN AMERICAN COMMUNITY

This history would be incomplete without an orientation to the present that includes some discussion of introductory premises and basic terminology as well as some special circumstances in the African American community. Race, culture, and ethnicity are identity constellations used throughout this paper that overlap in some components but have essentially different meanings and are complex terms that have been politicized, burdened with surplus meaning, and affected by racism.

Race has not been defined scientifically or used adequately as a concept. As a consequence, comparative group research is often misinterpreted or misrepresented due to limited sampling within groups and the use of race as a political category has resulted in invidious and destructive group comparisons. Race, however, supercedes all other experiences for persons of color in the United States and thereby is a designation of choice and pride for many persons, an insistence upon

acknowledgment of a history of oppression as well as justice and equity. Many African Americans prefer the term racial identity because racial status has been the index of acceptance in White America. Increasing knowledge ofthe psychological, physical, cultural, and sociopolitical components of racial identity led to the development of instruments to measure racial identity.

The African American psychological community has been divided in preference for either cultural identity and ethnicity or race due to the scientific shortcomings of race as a designation. Ethnicity has been defined as "enculturation of intergenerational values and beliefs from one's cultural heritage (BURlEW et al., 2000, p.174). Ethnicity is a group term while culture is embodied in the individual as the cultural self as a consequence of acculturation. What it is to be a group member-a collocation of values, beliefs, language, behaviors, customs, symbolsmay be contrasted with what it is to be a persona selective incorporation of cultural values, mediated by personality, life circumstances, and acculturation. Stage or typology processes and outcomes of acquiring racial identity as well as the processes and outcomes of acculturation blend and comingle with group culture and the individual cultural self-to compose racial identity and cultural identity. The political issue of Afrocentrism/Africentrism divides the African American community in the United States and is best represented by the relative emphasis given by individuals in their daily lives to racial identity or cultural identity. Racial identity has been focused on racial consciousness, a collective interpretation of group experience that includes grievances concerning the disadvantaged status and continuing power differentials. Racial identity is considered to be essential for health by externalizing stress. Racial consciousness typically includes the militancy encompassing the psychological and sociopolitical dimensions invoked by the terms Afrocentrism/Afncentrism as well as a pathologization of acquiescence or acceptance of a Euro-American construction of reality by African Americans.

REDUCING BIAS IN CONTEMPORARY MENTAL HEALTH SERVICES

Bias is apparent in the attitudes and behaviors of service providers, the service delivery process, psychiatric diagnoses, tests, and interventions (DANA, 1998c). Research substantiating prejudice and racism among providers is available. For example, psychiatrists and residents who used identical patient data except for race, found that the African Amencan was less able to benefit from psychotherapy because he was "less articulate, competent, introspective, self-critical, sophisticated about mental health centers, and psychologically minded" (GELLER, 1988, p. 124). Stereotyping has also been documented among professionals from diverse cultural/racial groups. European Amencan providers minimize differences and may be unwittingly ethnocentric as evidenced by labeling Afncan American group differences as deficits. Bias has also been uncovered to survey findings, hospital admissions, and during encoding of data and distortions in information retrieval during diagnostic decision-making. Bias can be reduced in clinicians, service delivery style, assessment, psychiatric diagnosis, and interventions by instruction rn the limitations ofthese AngloAmerican constructions of reality.

Training to reduce bias could also have a salutary effect on perceived competence since more than one-halfofpsychologists in a recent national survey dbd not feel competent to provide services for their Afncan American clients. Bias and/or insufficient training are difficult to separate, although cultural competence evaluations have suggested that Euro-American clinicians have more modest multicultural skills than, for example, African Americans. Moreover, these Euro-American clinicians did not report strong awareness and relationship skills, a deficiency associated with poor application of multicultural skills.

ASSESSOR/THERAPIST

Mental health professionals can be encouraged to understand their own cultural identifications as well as cultural racial identities of other persons and recommended supplements include a self-examination of one's own identity using formal developmental theories or a social learning model. In addition to an examination of identity attitudes and developmental stages, selfstudy can be directed using genograms to increase student awareness of ethnic differences across several generations. Supervision for Anglo American students, particularlyby African American clinicians, is also required to facilitate understanding ofthe consequences for African American clients of differences in cultural facial perspectives. Sustained living experiences in a novel cultural context of interest are also needed to provide a more genume introducbon to life in segregated or culture-specific communities that may have enduring consequences. For example, participation in Washington, D.C. non-violent restaurant sit-downs

during the summer of 1947 opened new vistas for me and subsequently determined occupational choice and shaped my professional interests and identity.

SERVICE DELIVERY STYLE

Use of an acceptable social etiquette for deliveryofservices can increase client satisfaction and reduce anxiety among service providers (DANA, 1993). However, until recently, a service delivery style, or social etiquette predicated on medical service delivery, was used for all clients This style is task-onented and relatively impersonal. The establishment of rapport and a level of comfort that permits many persons of color to accept services may be difficult if not impossible using this style.

Before accepting services, an increasing number of Afncan Amencans seek affirmation of a clinician'shumanity, cultural knowledge, and relative freedom from prejudice and stereotypy. Moreover, clinicians should communicate an understanding ofthe pervasive effects of racism and discrimination in the daily lives oftheir clients as further evidence of credibility. GIBBS (1985) has describedmicrostages of a process of "sizing up and checking out" the service provider, particularlyprevalent among persons who are developing or consolidating an Africentric racial identity. This process begins with appraisal, a guarded, superficial, and often aloof, pre-commitment stance during which the client looks to the clinician for signs of genuineness, personal authenticity, and approachability. If satisfied, the client proceeds to explore and even challenge the clinician's personal qualifications, beliefs and values to document culturally-relevant experiences that can help to equalize racial or background differences. Following achievement of partial identification, overtures toward a more personal relationship require sensitive and flexible responding from the clinician. Developing loyalty and personal regard for the clinician reduces defensiveness and can lead to engagement by the client with subsequent assessment or treatment. However, it should be recognized that some African Americans in process of becoming Africentric will express strong preferences for an African American clinician that should be honored whenever feasible.

ASSESSMENT

Psychological tests used for clinical diagnosis and personality description were developed for a mainstream, largely middle-class, Euro-American population (DANA, 1993). When administered to diverse clients without corrections for cultural and/orracial identity, these tests may be pejorative and/or pathologizing. Such tests are called Anglo emics and are applied as etics without adequate demonstrations of equivalence (DANA, 2000a, 1 998a, 1993). These standard tests are used not only in the United States but have been exported worldwide as a consequence of minimizing or ignoring cross-cultural differences. Although research on these tests can be designed to establish cross-cultural equivalence in language, format, and content; to date, the findings indicate only very modest equivalencies in language and format without substantial evidence for construct validity.

For African Americans born in the United States or English-speaking countries, standard English can be assumed and translation oftests is not necessary. However, equivalence of personality or psychopathology constructs may not be assumed because these standard tests were developed primarily or exclusively for EuroAmericans and normed primarily on this population. There is no unequivocal evidence that the constructs in these tests are applicable to African Americans, either in the sense of including the range of relevant constructs or the meaningfulness ofthese constructs.

As a consequence of heterogeneity in the African American population, it is necessary to use moderator variables for racial identity status prior to administration of standard tests for personality or psychopathology. Standard tests can pathologize African Americans on the basis of confounding developing racial identity, cultural distinctiveness, or social class with DSM symptoms and diagnostic categories. Moreover, Africentric personality characteristics, cultural identity components, and psychopathology indicators can differ radically from the dimensions on standard tests. Interpretation of these tests is dependent not only on adequate, representative norms stratified by social class, but on available sources of information on racial/cultural identity, cultural beliefs, and personality characteristics.

For example, it has been documented that the emotional experience of becoming Africentric has been confounded with psychopathology on the MMPI leading to misdiagnosis (DANA, 1993). Modest but significant variance in MMPI F. 4, 6, 8, and 9 scale scores from a normal population is associated with the development of racial identity measured on standard moderator variables. The 4-9 codetype has been equated with antisocial personality attributes while significant

elevations on F. 6, and 8 occur not only with distress and distrust but also with serious psychological disturbance.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM-IV)

Clinical diagnosis of mental illness has been an established psychiatric prerogative since the publication of the first DSM in 1952. The DSM is another Anglo American emic that has been exported, particularly since DSM-III in 1980. Nonetheless, mental health and mental illness are primarily constructions of behaviors and emotional expressions that are culturally recognized and accepted. Specific symptoms, syndromes, and diagnostic entities appear with remarkable consistency and regularity within particular cultu~l contexts. This recognition led to preparation oftwo volumes of cultural considerations for each DSM-IV diagnostic category MEZZICH, KLEINMAN, FABREGA, & ^PARRON (1996). The contents of these volumes were only parenthetically addressed subsequently in the 1994 DSM-IV by an outline for cultural formulations and a glossary of culture-bound disorders. There has been a consistent effort to educate users of DSM-IV in the preparation of cultural formulations although practitioners and agencies have been reluctant to incorporate this information in diagnostic evaluations of d^leirmulticultu^Ial clients.

The DSM exhibits a culture-specific dualism or mind-body dichotomy that presents an illness model described by pain reports, bodily experiences, psychological dysfunctions and worry, social role functioning, and care-seeking. In addition, the DSM accepts the Euro-American "acquired consciousness that interferes with total absorption in lived experiences" (KLEINMAN, 1988, p.50). WARD (1994) suggested that the "human potentials for various states of consciousness are culturally conditioned" (p.60) and there is some consensus that the "normal" consciousness for most African Americans constitutes an altered state for Euro-Americans. Alteration of consciousness is a survival technique that provides focused attention, unreflective responsiveness to crisis, and a heightened potential for accessing spiritual contents. The

DSM illness model cannot reconcile an acquired consciousness that requires a mind-body dualism with an altered consciousness predicated on a monism in which mind and body are inseparable.

When African Americans construct their own diagnostic systems of ordered and disordered personality functioning, the perspective from their own reality does not overlap with DSM. For example, AKsAR (1991) believes that racism experienced in a pathological oppressive society provides the genesis for disorders referred to as alien self, self destructive, anti-self, and organic. A second example, the Africentric Azibo Nosology describes 18 disorders (AZIBO, 1989).

INTERVENTIONS

Standard mental health interventions include both psychotherapies and medications developed by mainstream Anglo-Americans and provided essentially without alterations or modifications to the 34% of clients with culturally and racially diverse origins. In a seminal but seldom cited paper, SUINN (1985) described the deficiencies of Anglo American role definitions of psychodynamic, humanistic-existential, and behavioral-cognitive psychotherapeutic approaches for multicultural populations. In retrospect, it is not surprising that available services were underutilized because these services were not explicitly or systematically designed for diverse populations (DANA, 1998a, 1998b).

Cultural formulations, however, are only an interim remedy that can focus professional consciousness on the Anglo-American emic shortcomings of the manual. Nonetheless, the use of cultural formulations in the preparation of DSM-IV diagnoses can improve the goodnessof-fit with available interventions categorized as culture-general (etic), culture-specific (emic), and combined culture-general and culture-specific. Culture-general interventions are credible and beneficial for many problems and diagnoses presented by African Americans. In addition, however, the service provider must have an acceptable service delivery style. Combined interventions contain both culturally recognizable and mainstream components and require a cultural/racial identity description. These interventions are most useful for persons who are low in acculturation and comfort with white society and high on racial identity. Existing mainstream interventions can be modified on the basis of acculturation and racial identity information. For example, interventions focused on social skill development, social assertiveness, and problemsolving can employ cultural elements such as the family, church, and other social support networks for empowerment. Racial matching of clients and providers will often be helpful to implement combined interventions. Culturespecific interventions are often necessary for Africentric persons with

transgenerational problems resulting from oppression, or stress from current discrimination, or distress caused by the process of developing a racial identity.

AN ASSESSMENT-INTERVENTION MODEL

Any attempt to reconstitute mental health services for a multicultural society necessitates more than reduction of bias per se. A systematic approach to multicultural assessment and intervention is also required. A model in the form of a flow chart was developed to focus research, training, and practice within these areas (DANA, 2000a). When applied to African Americans, questions can be addressed at various points in the assessment-intervention process to emphasize the relevance of assessment instruments, increase the reliability and accuracy of clinical diagnoses, and foster the use of more credible and beneficial intervention services.

A first question indicates the opportunity for etic instruments when they become available in the future to be used for universal diagnosis and treatments. These instruments do not exist at the present time because the standard instruments are assumed to be universal in the absence of convincing theory and research.

At present, it is necessary to proceed to Question 2- cultural/racial orientation. Most African Americans are assimilated, bicultural, or marginal in cultural orientation status. Traditional African Americans would be immigrants from various African countries, Haiti, and elsewhere in various stages of acculturation. However, African Americans who have adopted an Africentric worldview (NOBLES, 1980) are attempting to restore a sense of traditionality in their lives by an emergent racial identity. An Africentric worldview embodies psychobehavioral modalities of groupness/sameness/commonality, includes values and customs relevant to cooperation, collective responsibility, and interdependence, and an ethos of tribal survival and oneness with nature. It makes sense to consider the addition of an Africentric cultural orientation to include these persons. Such an addition would emphasize the necessity for assessment ofthese persons using an acceptable service delivery style, culture-specific instruments, and test interpretations that incorporated an Africentric perspective and used an identity-specific conceptualization. Marginal African Americans are trapped by the "victim system" created by poverty and racism and constitute a subculture focused on living/surviving in the present, using cooperation and obedience to authority for power, suppressing feelings, toughness, and belief in luck or magic. Bicultural African Americans know the rules for good functioning in both social contexts, although they may be more comfortable in one milieu. Assimilated refers to African Americans who are more comfortable in the Anglo-American world.

Standard tests may be used for assimilated and bicultural persons (see Question 5), although individuals with an Africentric identity may strongly prefer African American emic tests administered by an African American clinician using an appropriate service delivery style. A large number of emic tests are currently available for African Americans (JONES, 1996), although very few emic tests now exist for other cultural/ racial groups in the United States (Question 4).

In addition to these culture-specific tests, measures of racial identity (See Burlew et al., 2000) include the Developmental Inventory of Black Consciousness and the Racial Identity Attitude Scale. Africentric personality is described by the African Self-Consciousness Scale while African American cultural identity can be measured by the African American Acculturation Scale (AAAS).

For traditional persons, however, neither the African American emic tests nor standard Anglo emics will be appropriate. If a diagnosis is necessary, aninterviewbyabilingual, culturally competent service provider should lead to the preparation of a cultural formulation. If adiagnosis is unnecessary because issues accompanying acculturation rather than pathology are salient, then a conceptualization that leads to a culturespecific intervention, preferably from a culturally competent service provider fluent in the client's first language, is desirable.

Question 6 is focused on "cross-cultural interaction stress" or stressors from mainstream society, regardless of whether standard or culture-specific instruments have been used. These stressors are both a byproduct and legacy of racism. These stressors continue to have "pervasive, institutionalized, insidious" effects that may require interventions similar to those applied with survivors oftorture (COMAS-DIAZ, 1999). This question is of particular importance because almost all Anglo-American clinicians have ignored the impact of the contemporary and transgenerational effects of racism in providing services to African Americans. This ignorance stems from the essence of White privilege, an absence of discriminatory interpersonal experiences coupled with easy access to societal opportunities that are largely restricted or denied

to African Americans. This unearned privilege has been described as "an invisible knapsack of assets that an entitled group can refer to on a regular basis to more effectively negotiate their daily lives" (ROBINSON, 1999, p.76). Perceived racism stimulates distrust and fear and daily life can become traumatogenic for PostTraumatic Stress Disorder. CLARK, ANDERSON, CLARK, & WILLIAMS (1999) developed a contextual model o fthe bi opsycho so ci al effects of racism that includes perception, coping responses, psychological and physiological consequences, and health outcomes. The impact of racism must always be considered in assessment of African Americans, regardless of whether or not it is presenting problem or a contributing factor to psychopathology. In other words, Question 6 always requires documentation ofthe impact and effects of racism upon the client. This information is essential for all interventions. If a diagnosis is required, a cultural formulation should be developed to ensure that treatment addresses these presenting issues by incorporating cultural components. If a diagnosis is unnecessary, the subsequent intervention can be directed at the presenting stressors by affirming and strengthening cultural/racial identity.

Question 7 inquires whether or not a diagnosis is required. If yes, then a cultural formulation will increase the probability of a combined treatment. If no diagnosis is necessary, a culturespecific intervention for specific problems of oppression or for problems that are amenable to a specific intervention such as psychotherapy designed for this population. One example of Africentric psychotherapy applies theory within a consistently ernic approach (KARENGA, 1997).

MENTAL HEALTH PREREQUISITES FOR A MULTICULTURAL SOCIETY

This review has suggested that a cultural/ racial perspective for designing and delivering acceptable mental health service to African Americans is consistent with democratic principles in a multicultural society. For African Americans, this perspective can promise a more acceptable standard of care in mental health services. However, any significant amelioration of available mental health services for African American clients has not occurred to date, partially because managed has failed to acknowledge individual differences and cultural/racial differences (DANA, 1998b).

Of greater importance, the mental health establishment has been slow to recognize the magnitude of cultural/racial differences in consciousness, emotionality, spirituality, self, symptomatology, problems-in-living, and a history of racism, discrimination, and continuing oppression. These salient differences have been somewhat obscured by the diversity and heterogeneity of the African American population, particularly in racial identity development and cultural orientation status. The mental health establishment has only been willing to address similarities while consistently minimizing differences and has ignored individual preferences for services or service providers within this heterogeneous population. As a consequence of this continuing dilemma, African Americans remain underserved because they are less likely to seek help than EuroAmericans (SNOWDEN, 1999). Snowden's data suggests that the historic contention that African Americans resort to emergency room care in crisis may be explained by differential access to mental health care. When one considers, in addition, the disproportionate representation of African Americans injails, prisons, mental hospitals and among the homeless population, their vulnerability to disservice and to inappropriate or ineffective services is emphasized.

The, heartland of cultural/racial differences is the self. Differences in the selfbetween Anglo Americans and other cultural/racial groups has remained relatively unrecognized among mental health providers and by managed care service delivery systems (DANA, 2000b,1998d). These selfdifferences emphasize what is important and meaningful to the individual and include boundaries ofthe self that are more permeable, more inclusive, and contain contents that are unique for each cultural/racial group. For African Americans, the family, extended family and other individuals are included. Spirituality generally occupies a large portion of the self and there is an interrelatedness among components that emphasizes responsibilities for other persons. The intervention example described in Table 4 addresses aspects ofthe self that are excluded from standard mental health services.

Recognition ofthese differences must be accompanied by a willingness to address mental health problems on the basis of these differences during assessment, clinical diagnosis using the DSM-IV and psychotherapy in a context of many other interventions. Training for professional psychologists that is multicultural rather than monocultural is necessary. For example, I teach a two semester graduate assessment course that includes Anglo Americans as only one of many cultural/racial groups that students must be competent to assess and understand. This focus inevitably

highlights the emic nature of standard tests and examines not only the methodology of test construction and validation but also indicates the limitations of interpretation inherent in these tests when they are applied to persons from various cultural/ racial populations.

However, training in multicultural assessment alone is not sufficient. A concomitant examination of research methodology and statistics should focus on culture as figure rather than ground, proximal rather than distal, and central rather than peripheral. In statistics, MALGADY (1996) has suggested reversing the Null Hypothesis in a context of reexamining methodology (DANA, 2000c) to provide the beginnings of cultural psychology forprofessional psychological practice.

Resumo: Os afro-americanos vêm progredindo muito em direcào a uma verdadeira cidadania desde 1965. Contudo, os serviços de saúde mental para essa população têm sido tendenciosos, incompletos e deficientes, porque as similaridades com os curo-americanos têm sido enfatizadas, ao passo que as diferenças têm sido largamente ignoradas. Este artigo aborda algumas dessas diferenças, incluindo a identidade cultural/racial e o 'eu cultural' que afetam a avaliação, os diagnósticos psiquiátricos e a psico-terapia ou outras intervençoes. Um modelo de avaliação-intervenção ilustra como a informação cultural pode melhorar o atendimento aos afro-americanos. Esse modelo exemplifica uma aplicação de psicologia cultural que pode contribuir para uma mudança na prática profissional, no treinamento e na pesquisa dentro de uma sociedade multicultural. Sugestões de diretrizes que emergem desse modelo apontam para áreas que necessitam ser enfatizadas no atendimento e na pesquisa.

Palavras-chave: Afro-americanos; Saúde mental; Serviços.

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ANEXO