How Culture Is Considered in Evaluations of Psychopathology

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A mail survey was conducted to explore how mental health professionals take culture into account in their evaluations of psychopathology and to assess their reported attitudes toward the role of culture in their work. The respondents were 118 licensed social workers, psychologists, and psychiatrists from the state of California. Their reported attitudes and behavior represent a culturally sensitive position. For example, 83% of the sample indicated that they consider culture for most or all of their culturally different patients. A total of 96 therapists provided brief case summaries describing how they took culture into account for a given patient. A qualitative analysis revealed that culture is considered throughout the evaluation and treatment process. Furthermore, 35 case summaries referred to changes in the therapists' clinical evaluations as a result of considering culture. All but three of the case summaries indicated that clinicians judged the problems to be less severe or less pathological when thought to be cultural in nature. The risk of dismissing actual psychopathology as culturally normative behavior is considered.

In considering culture in the evaluation of patients from diverse cultural backgrounds, clinicians are faced with the following dilemma. On one hand, they have been instructed to be familiar with cultural differences in the definition and expression of psychopathology. For example, several authors have written that hearing voices of a religious nature may be culturally appropriate for Mexican Americans (Jones and Korchin, 1982; Levine and Padilla, 1980; Torrey, 1972). Therefore, it is argued that clinicians should be aware of this purported culture-specific behavior and not judge it to be representative of psychotic symptomatology. On the other hand, clinicians have been warned that by considering purported cultural differences, they may be at risk to judge abnormal behavior as normal behavior for a specific group (Lewis et al., 1979; Thomas and Sallen, 1972). Lewis and her colleagues (1979), for instance, indicate that clear cases of psychopathology among black adolescents were overlooked or judged as not needing mental health services. They argued that clinicians may have interpreted the specific behavior as normative for black adolescents from low-income, urban environments. Thus, if the practitioner considers cultural differences in evaluating a culturally different patient and judges the patient to be less disturbed, then the practitioner is at risk of inappropriately minimizing or dismissing psychopathology. Conversely, if the practitioner does not consider cultural differences, he or she may be at risk of misinterpreting normal behavior as pathological.

In an attempt to seek guidance on how to differentiate between culturally normative behavior and psychopathology, clinicians may turn to the research literature. A close examination of the research, however, reveals that there are very few well-documented instances of cultural differences in the definition of psychopathology or in the expression of psychopathology for the major cultural groups in the United States. This literature is primarily based on case studies, clinical observations, and limited research studies. For example, the notion that hearing voices is more culturally acceptable for Mexican-Americans is based on anecdotal evidence (Phillipus, 1971) and on one very limited study of high school students (Torrey, 1972). A review of potential cultural differences between blacks and whites (Adebimpe, 1981) also indicates that there have been very few studies from which to draw any firm conclusions. And a recent overview of cultural issues in the assessment of Asian-Americans is primarily based on clinical observations (Chin, 1983). At best, the cross-cultural psychopathology research suggests that there may be some culture-specific symptomatology. Given the very limited nature of this research, however, no empirically based guidelines can yet be drawn as to when culture should be considered for specific cultural groups.

Researchers can assist practitioners with the noted dilemma by conducting systematic studies of psychopathology across cultures. Epidemiologic studies are most certainly needed, such as those being conducted through the Epidemiologic Catchment Area Project (Hough et al., 1983; Regier et al., 1984). As well, studies of the phenomenology, course, and outcome of mental

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...disorders across cultural groups are needed. Westermeyer (1986) outlines a number of other areas within the study of cross-cultural diagnosis that require further research, including diagnostic reliability and validity, folk diagnosis, and personality assessment.

Whatever the specific topic or research strategy, it is important that these investigations go beyond identifying ethnic or racial differences. Racial and/or ethnic group differences provide some clues as to where possible cultural differences lie, but we cannot assume that such group differences represent cultural differences. The cultural backgrounds of the comparison groups should be assessed and found to differ if any identified symptom differences can be appropriately attributed to cultural factors.

A second research approach that might prove helpful is the study of clinicians’ evaluations of patients from culturally diverse groups. This approach assesses whether therapists take into account culture when evaluating such patients and, if so, the extent to which such considerations affect their clinical and diagnostic judgments. Although there are no definitive data to indicate when culture should or should not be considered, by studying the clinical judgment process researchers may be able to determine when cultural norms are properly and improperly applied. By comparing times when distinct cultural norms are used in the clinical judgment process with times when no distinct cultural norms are used, researchers will then be able to examine whether the application of distinct norms affects (either positively or negatively) the quality of the patient’s care. Consider the following hypothetical situation. A clinician reports that he or she took into account culture in assessing a Chinese-American patient who presented physical complaints. In so doing, the therapist noted that somatic complaints are a culturally acceptable way of expressing distress and that it is unlikely that there is any organic basis to the physical complaints. Consequently, the therapist judged the patient as having a psychological disorder and as not requiring a medical examination. In this case, the researcher can argue that the decision not to refer the patient for a medical examination because of the purported cultural nature of the presenting problem is representative of poor treatment. Even if one cultural group is predisposed to somatization, the failure to refer the patient for a physical examination may result in a physical disorder going undetected and untreated.

The present research takes the clinical judgment approach in studying the role of culture in mental health evaluations. A mail survey was conducted and therapists were asked to describe briefly one case in which they took culture into account. In order to assess the impact cultural considerations had on their evaluations, therapists were also asked if their evaluations would have differed had they not considered culture, and if so, how. One major purpose of this study, therefore, is to examine clinicians’ report of how they consider culture. There is a great deal of literature pointing out the need to consider culture, but there are no data to indicate how clinicians are considering culture. For example, the study conducted by Lewis et al. (1979) suggests that one reason clinicians overlooked pathology in black adolescents may have been that they attributed the problems to sociocultural factors. There was no assessment of whether such sociocultural attributions were made, however.

In regard to how culture is considered, a number of specific topics are addressed in the present research. First of all, this study attempts to identify where in the evaluation process culture is considered. For example, does it occur in the diagnostic formulation, in the way in which an interview is conducted, or in other aspects of the evaluation process? Also of significance is whether considering culture leads to any change in the perceived diagnosis or in the judged severity of the presenting problem(s). It is not known whether cultural considerations lead to judging the presenting problem as representing more, less, or equal amounts of disturbance. A final way in which taking into account culture may influence evaluations is by increasing the number of resources practitioners consult. Assuming practitioners are unfamiliar with a patient’s cultural background, they may be more likely to consult with colleagues or with the patient’s family to help them identify how culture interfaces with psychopathology. It should be noted that, because this study is based on clinicians’ recall of one case, the collective responses can not be thought to represent exactly how culture is considered in clinical practice. Social desirability, selective recall, time, and other factors are likely to influence clinicians’ responses. Nevertheless, the responses should provide an indication of the range of processes used in the consideration of culture.

A second major purpose of the present research is to assess therapists’ attitudes toward the role of culture in the evaluation of culturally diverse patients. At present, there are no data to indicate whether therapists agree with the notion that culture must be taken into account. Specifically, clinicians will be asked if they think that taking into account culture is important and if they believe that culture affects the expression of psychopathology.

Methods

Respondents

A total of 118 clinicians participated in this study. Among the respondents were 49 masters level social
workers, 43 doctoral level psychologists, 3 masters level psychologists, and 23 psychiatrists. Mostly men (73 men and 45 women) and mostly Anglos (N = 84) comprised the sample. Other self-designated ethnic/racial groups included Jewish (N = 9), black (N = 3), Asian (N = 1), Chicano (N = 1), and other (N = 9). All but one social worker reported having a clinical license. As a group the respondents described themselves as actively engaged in clinical activities and as quite experienced. They reported spending 70% of their time in clinically related work and having an average of 19 years of postdegree clinical experience. In terms of caseload, 58% see primarily adults, 31% see both adults and children, and 10% see primarily children. On the average, clinicians reported that 27% of their patients were from culturally diverse backgrounds.

Procedures

Mental health professionals practicing in California were randomly selected from the national directories of three major professions: psychiatry (American Psychiatric Association [APA], 1980), psychology (Council for the National Register of Health Providers in Psychology, 1980), and social work (National Association of Social Workers [NASW], 1976). One hundred professionals were chosen from each directory. Those practicing in California were selected because culturally different groups comprise a large percentage of this state’s population. It was thought that this would increase the likelihood that the surveyed professionals would have contact with patients of diverse cultural backgrounds.

The identified practitioners were mailed a questionnaire and were informed in a cover letter that the purpose of the survey was to a) assess the extent to which therapists take into account culture and b) examine qualitatively the process by which clinicians may consider cultural factors. The initial mailing consisted of 300 questionnaires and a stamped return envelope. Questionnaires were precoded according to each specific profession. Alternates within each profession were randomly selected to replace any mailings returned as undeliverable. The alternates were continuously selected to replace undelivered questionnaires until a determined cutoff date was reached. Preceding the cutoff date, 11 questionnaires were returned as undeliverable, and no further alternates were selected. The final number of deliverable questionnaires was 289. Two weeks after the initial mailing a reminder post card was sent to all subjects who had not returned their questionnaire. One month later, a final questionnaire was sent accompanied by a brief cover letter requesting that they reconsider the survey and return a completed questionnaire at their earliest convenience.

Instrument

The questionnaire contained three parts, which respectively assessed a) clinicians’ attitudes toward culture, b) how clinicians report taking culture into account, and c) clinicians’ personal and professional background. The attitude section was composed of two questions, each accompanied by a distinct rating scale. The first question was, “Do culturally diverse groups differ in their expression of mental health disorders?” The five response alternatives ranged from “symptom expression does not differ across groups for any disorder” (1) to “symptom expression differs for all disorders across groups” (5). The second question was, “How important do you think it is to take into account cultural factors in the evaluation and diagnosis of culturally diverse patients?” A 9-point bipolar rating scale anchored by “Not at all important” (1) and “Extremely important” (9) accompanied this question.

One fixed alternative question and two open-ended questions were used to assess the extent that clinicians consider culture in their evaluations and how they do so. The fixed alternative question was, “To what extent do you take into account cultural factors in evaluating and diagnosing culturally diverse patients?” The rating scale was composed of the following: “I never take into account cultural factors” (1), “Only for a few culturally diverse patients” (2), “For some culturally diverse patients” (3), “For most culturally diverse patients” (4), and “For all culturally diverse patients” (5). The open-ended questions instructed the respondents to a) describe a time when they took into account culture while evaluating and/or diagnosing a culturally diverse patient, paying particular attention to how culture was taken into account, and b) to consider whether their evaluation or diagnosis would have been the same or different had they not considered culture.

The third part of the instrument contained a one-page demographic inventory, which requested information such as gender, ethnic origin, professional background, years of clinical experience, and licensure status. After this, space was provided for the clinicians to indicate whether they wished a summary of the study’s findings and to provide any comment about the study.

Coding of Open-Ended Responses

Two ratings were made of the responses to the open-ended questions. The first rating identified where culture was considered in the evaluation. After examining the responses to a pilot survey, the following
Categories and their definitions were developed: a) understanding the problem, a fuller appreciation of the presenting problem or disorder with no mention of any change in regard to the evaluation or treatment; b) clinical judgment, nondiagnostic judgments such as the severity and prognosis of the disorder; c) diagnostic formulation, classification of the symptoms into diagnostic categories; d) treatment goal definition, determination of what aspect of the disorder or problem should receive attention; e) general treatment, the type of intervention provided and/or manner in which the clinician interacts with the patient; and f) other, any response that does not fit in the above categories.

It is important to note that these aspects of the evaluation-treatment process are interrelated. For example, clinicians need to understand presenting problems before making judgments regarding severity, prognosis, or diagnosis, and certainly before treating patients. It is possible then for the “understanding” category to apply to most if not all case summaries. Other categories may overlap as well. Although more than one response category could apply to a given case summary, clinicians in general emphasized one part of the evaluation-treatment process more than another. In categorizing each vignette the raters focused on that part of the evaluation-treatment process that appeared to be most influenced by cultural considerations.

The second general rating pertained to whether taking culture into account affected the clinician’s perception of the disorder’s severity. Three categories were derived: a) the problem or disorder was judged to be less severe or pathological given that culture was considered, b) the problem or disorder was judged to be more severe or pathological given that culture was considered, and c) there was no report of any change in the clinician’s perception of severity.

The authors served as the raters of the open-ended responses. Given that this was a descriptive study with no specific hypotheses, the likelihood that any biases of the authors would affect the ratings was thought to be minimal. Before rating the responses, the raters practiced their coding with responses obtained through a pilot study. The reliability of the raters’ judgments was assessed by determining the percentage of the ratings in which both raters agreed. The intrarater agreement for the first rating was 86.4% (83 of 96) and 97.9% (94 of 96) for the second rating. For those discrepant ratings, the raters jointly reexamined the clinicians’ responses and came to an agreement on which category best applied to those responses.

Two other tabulations were made of the open-ended responses. The second author identified the race/ethnicity of the reported case and the type of consultation sought by the therapist in assessing the significance of culture. In regard to the latter, whenever the therapist specifically mentioned seeking information regarding cultural material, then the rater identified whether the source of this information fell into one of six categories: patient, patient’s family, clergy, readings, colleagues, and faith healer. Given that the coding of the patient’s ethnicity/race and the source of information appeared to be straightforward, the reliability of the rater’s judgments was not assessed.

Results and Discussion

Attitudes toward Cultural Factors

Clinicians reported that they highly value culture in their evaluations of culturally diverse patients. Thirty-nine percent of the sample rated culture to be extremely important (9) in their evaluations, which in fact represents the modal response. The group mean of 7.5 on the 1 to 9 rating scale further indicates the strong level of support culture received. In addition, clinicians reported that they believe that symptom expression differs for some disorders across culturally diverse groups. This represents both the mean (3.2 on a 1 to 5 scale) and the modal response (68.4% of the sample). This finding indicates that the sampled clinicians acknowledge that culture influences the way in which some disorders are expressed. Overall, clinicians’ reported attitudes represent a culturally sensitive position regarding the assessment of psychopathology.

The Extent to Which Culture Is Considered

Before examining the manner in which culture is considered, it is important to first assess the extent to which culture is considered. Fifty-one percent of the therapists indicated that they take into account cultural factors in their evaluations for all culturally diverse patients, and 32.3% indicated that they consider culture for most culturally diverse patients. In all, 83% of the sampled therapists reported taking culture into account for most or all of their culturally different patients. This finding is consistent with the reported attitudes; therapists rate themselves as generally being culturally sensitive.

How Culture Is Considered

The ways in which clinicians consider culture are examined in the 96 brief case reports provided by the respondents. (Twenty-two respondents did not provide a case report and are excluded from the following analyses.) The cases represent a range of racial/ethnic groups: 35 Hispanics, 23 Asians, 15 blacks, six American Indians, five from the Middle East, 10 others, and two unidentified. Both men and women are well
represented: 43 women, 52 men, and in one case the patient’s gender was not identified. Finally, the presenting problems reflect a range of psychopathology, from acute stress reactions and marital discord to psychotic disorders. (See López and Hernandez [in press] for a discussion of the specific types of presenting problems for Hispanic cases.)

The examination of how culture is considered in these case descriptions addresses three specific questions: a) where in the evaluation process is culture noted? b) what effect does considering culture have on the clinicians’ perceptions of problem or disorder severity? and c) do therapists report consulting other resources to assess the cultural nature of the problems? Frequency data will be reported for the responses to each of these questions. In addition, case descriptions representing the major response categories will be provided for purposes of illustration.

Where culture is noted. Based on the cases provided by the clinicians, culture is being considered at various times throughout the evaluation and even into the treatment. An initial evaluative process in which culture was considered pertains to more fully understanding the patient’s problem. This occurred for 13.5% (N = 13) of the cases. The following example illustrates this.

“A Korean teenager. His family’s description of his bizarre, schizophrenic-like behavior was that he was retarded and thus could not be presented socially. He was a family disgrace. It was important to consider the family’s culturally determined rejection [because it] was increasing the withdrawal and isolating behavior of the patient. The family was able to accept their son’s problem as an illness—[they] probably [would] never accept retardation. The cultural factors were important in understanding the family’s ideas about retardation. They helped in understanding part of the psychodynamics.”

For this case and others like it there was no mention of the way in which the increased understanding affected the clinical judgment or treatment process. Nonetheless, it appeared to be an important consideration of culture given that several clinicians reported doing so.

Culture was also reported to be considered during the clinical judgment process (21.8% or N = 20)—when clinicians were forming their nondiagnostic impressions of the presenting problems. An example of the way that culture is taken into account at this time is provided in the following edited case description.

“American Indian youngster—Navaho—was involved in an acting out incident at his school. The thrust of much of my work with this youngster was to help him make appropriate assertions to his peers. I had to take into consideration his social experience and background. [Had I not taken cultural factors into account] I would have seen him as more disturbed and withdrawn than he actually was.”

A related but different process pertains to the diagnostic formulation, which was reported in 15.6% (N = 15) of the cases. By considering culture, some clinicians altered their diagnoses of the patient. The following case illustrates such a change.

“I can think of one black woman from the South who presented with what she called hallucinations. I know there is a higher incidence of hallucinations in this ethnic group so I gave them less significance than I would have had she been white. In other words I saw them as hysterical rather than schizophrenic.”

Although this example is similar to the clinical judgment example in that the perceived severity differs given cultural factors, it goes beyond the clinical judgment example by considering specific diagnostic impressions. In spite of the fact that clinicians were specifically asked to provide examples of evaluations, a relatively large number of cases (36.5%) were rated as pertaining to treatment. A small proportion of these cases (N = 6) focused on treatment goal definition whereas the larger proportion (N = 29) focused on other aspects of treatment. The following edited case report concerns treatment goal definition.

“[The client is] a 30-year-old male homosexual with a lover. Both individuals have outside sexual relationships. Reason for entering therapy is because of relationship problems. With treatment the issues that were relevant were power and control . . . . The open sexual relationships were not of particular relevance and continued after solving the primary relationship issues between the couple. [Had cultural factors not been considered] undue emphasis would have been placed on the outside sexual contacts either as a symptom of problems or in changing this aspect of the relationship as part of the solution. Understanding the gay subculture assisted in not falsely identifying a problem which did not exist.”

This case points out how cultural considerations can influence what is and is not defined as the problem. A more general aspect of treatment is illustrated in the next case example.

“An elderly Burmese-Chinese man with Parkinson’s disease experienced profound depression which required admission to an inpatient psychiatric unit. Due to the patient’s condition (incontinence, need to be fed which was exacerbated by his depression), the hospital staff, which was not attuned to the patient’s culture, recommended that he be placed in a skilled nursing facility. The patient was strenuously opposed, as well as his family, since “abandonment” to a facility was alien to their culture. We arranged for the...
nursing care and other services to be provided in the patient’s home."

In this example, culture was considered in the manner in which treatment was provided, not in the manner in which the disorder was assessed. Other treatment-related cases referred to providing more supportive therapy, including an extended family member in family therapy, and being less challenging of perceived resistances.

A heterogeneous set of cases comprised the remaining category of the evaluation and treatment process, which was named "other responses"; it contained 13.5% (N = 13) of the cases. Given the wide range of cases, this category will not be considered further.

Overall, the most salient characteristic of these findings is that clinicians reported many cases that focused on some aspect of treatment. It is unclear why this occurred, given that the study was clearly presented as pertaining to the evaluation process. One plausible explanation is that clinicians may be more likely to consider cultural factors in the treatment phase than in the evaluation phase. In fact, two clinicians made this comment. This interpretation, however, runs counter to clinicians’ strong endorsement that they take culture into account in their evaluations of culturally diverse patients. Perhaps clinicians think that they consider culture regularly in their evaluations but are hard pressed to describe an example when asked to do so. A number of factors may enter into this, including the possibility that they may think they consider culture in their evaluations more than they actually do.

Turning to the evaluation process, it is worth pointing out that clinicians reported considering culture across all noted evaluative phases—from gaining insight into the problem to the diagnostic process. No one aspect of the evaluation predominated. This suggests that, when clinicians take culture into account, they do so across several aspects of their clinical evaluations.

The effect of considering culture on clinical judgments and diagnoses. Of the 96 cases, only 35 referred to any change in the perception of the disorder as a result of considering culture. The other 61 cases referred almost exclusively to nonevaluation categories, such as treatment-related, understanding, and other response. There was almost no mention of clinical judgments or diagnoses among these cases.

Examining the 35 case reports in which considering culture did have an impact on the clinicians’ perceptions of severity or diagnosis, clinicians almost unanimously (N = 32) reported judging the problem to be less severe or pathological. An example of such a case description follows:

"In my work with a particular Hispanic female, my judgment of her ego-strength or self-image was quite different than it would have been had I not taken into account cultural patterns which "condoned" the male being unfaithful and having other relationships. Accepting this practice is not considered a deviant choice in a female of the Hispanic culture."

For this patient, the therapist implies that he perceives the patient’s self-image to be more normal because acceptance of the husband’s affairs is purportedly normative cultural behavior.

Only on three occasions was the patient judged to have a more severe disorder or more serious problem. One such example is presented below:

"A 60-year-old Mexican alcoholic VA outpatient. Dependency needs with (his) family members were huge. If he were Anglo-Saxon, an attempt to deal with alcohol dependency alone might have had a chance of success."

In this case description, it appears that the therapist believes culture in some way has a negative impact on the perceived prognosis of the disorder.

Given that clinicians reported that they almost exclusively adjusted their evaluations in the direction of less pathology or severity, it would appear that they were acting appropriately in considering culture. At least this is consistent with the literature, which instructs clinicians to consider that what may be deviant for the majority culture may be normative for another culture. A close examination of the way that clinicians knew the particular symptoms or behaviors were culturally based for these patients provides little data to indicate that they appropriately considered culture.

Reported consultation in the assessment of cultural factors. Knowing that the vast majority of the clinicians were not of the same cultural background of the cases reported, it is important to examine how they knew some symptom, problem, or behavior was culturally based. Of the 96 cases, 10 therapists reported seeking some type of consultation. In a few cases, more than one resource was used. Some clinicians actively engaged the patient’s family (N = 4) and/or the patient (N = 3) in describing values and practices adhered to by their cultural group. Others consulted priests; on one occasion an Irish priest was contacted regarding an Irish-American patient and on another occasion an Italian priest was contacted regarding an Italian-American patient. Two other therapists reported consulting with a colleague who either spoke the patient’s native language and was able to provide an independent evaluation, or who was from the patient’s cultural background and could provide some insight into the culture. Readings were also reported as being helpful in two cases. One therapist noted that
he consulted a folk healer who was also treating the patient.

Although it is clear that some clinicians sought assistance in their assessment of the cultural factors relevant to the case, the more striking observation is that 86 of the 96 clinicians did not report how they knew some behavior or symptom was culturally based. This finding may be the result of numerous factors. First of all, the respondents were not asked to report this information and therefore did not report it. Second they may not have allowed themselves sufficient time to indicate why they considered some symptom or behavior to be cultural in nature. A third plausible explanation is that clinicians failed to properly assess the cultural significance of the particular symptom or behavior. In other words, therapists may have assumed that specific cultural notions applied to their patient with little corroborating evidence other than the patient’s race or ethnicity.

Even though it is difficult to determine the extent to which clinicians failed to assess the cultural factors pertinent to their cases, the quality of some of the case reports suggest that cultural factors were not assessed in a number of cases. For example, three of the already cited case reports suggest that the specific cultural basis to the problems was not properly evaluated; how did the therapist know than an extramarital affair was culturally acceptable to the Hispanic woman, or that reported hallucinatory experiences were more representative of hysterical symptoms for the black woman, or that the drinking problem of the Mexican-American man had a poor prognosis? If the therapists indeed failed to properly assess the cultural basis of the symptoms, they might have been at risk to dismiss a significant problem in the Hispanic woman's life, to dismiss the black woman's psychotic symptomatology, and to misjudge the prognosis of the Mexican-American's drinking problem. These potentially inaccurate evaluations could adversely affect the type of care provided to these patients.

Methodological Considerations

Before considering the implications of this research, it is important to discuss some methodological factors that may have contributed to the findings. One such factor is the representativeness of the sample. Reported mail survey response rates vary considerably for mental health professionals, from a low of 20% (Abramowitz et al., 1976) to over 50% (Bernstein and Lecomte, 1982). The response rate of the present study, 40.8%, was a little better than what might be considered average for these surveys (approximately 35%). Also, the obtained response rate is consistent with the average return rate (42%) for general mail surveys judged not to be salient to the respondent (Heberlein and Baumgartner, 1978). Therefore, the response rate alone does not suggest any particular sample biases.

One possible sample bias is that therapists who value culture are overrepresented in the sample. One way of indirectly testing this hypothesis is to examine the number of minority therapists who responded. One might expect minority therapists to be particularly sensitive to cultural issues and therefore participate in greater numbers than their proportion among California therapists would indicate. Only five therapists, or 4.5% of the sample, identified themselves as Asian, black, or Hispanic. Although no specific data are available regarding the racial/ethnic background of psychiatrists, clinical psychologists, and clinical social workers practicing in California, available data suggest that 4.5% does not reflect an overrepresentation of minority mental health professionals in the sample. In 1980, racial/ethnic minorities comprised 16.1% of all NASW members in California who reported their racial/ethnic background. Also in 1980, 7.7% of the APA’s general membership identified themselves as being of minority background. With regard to psychology, the American Psychological Association estimated that in 1978–1979, 3.1% of their U.S. resident doctoral clinical psychology members were minorities (Russo et al., 1981). Given the large Hispanic and Asian population in California, it is likely that the national figures underestimated the number of ethnic minority psychiatrists and psychologists practicing in California. Considering the noted percentages, minority group therapists are not overrepresented among the sample.

Another way of assessing whether culturally sensitive clinicians are overrepresented in the sample is to examine clinicians’ report of their clientele’s cultural background. One might expect that clinicians who are seeing a relatively large percentage of culturally diverse patients might be more likely to participate in the study. The data do not support this hypothesis. More than half of the respondents (52.3%) reported having 15% or fewer clients from different cultural backgrounds. Furthermore, over two thirds of the sample (68.5%) reported having caseloads with 30% or fewer culturally diverse patients. Given that 33% of the 1980 California population were identified as racial/ethnic minorities (U.S. Census Bureau, 1985), less than one third of the sampled clinicians report

3 Lucero, P. Personal communication. NASW, Silver Springs, MD. Figures for minorities include the following racial/ethnic groups: American Indian, Asian-American, black, Chicano/Mexican-American, Puerto Rican, and other Hispanic.

4 Thomas, R. Personal communication. APA, Washington, DC. Figures are based on the following self-identified groups: Native American, Mexican, Puerto Rican, other Spanish, Asian (Filipino), Asian (Oriental), and black.
having larger percentages of culturally different patients than are represented in the state population.

It is also important to consider that cultural diversity was broadly defined in this study. Therefore, the figures reported by clinicians may reflect their consideration of other groups that they perceive to be culturally different (e.g., Italian-Americans, Jews, gays and lesbians, Persians). So their actual percentage of clientele from racial/ethnic minority groups as defined by the census (i.e., American Indian, Asian, black, Hispanic, and other) may in fact be lower than they reported. Given the available data, there seems to be little indication that clinicians who are likely to value culture in their practice are overrepresented in the sample.

Another methodological factor that should be considered is social desirability. Therapists may have answered the attitudinal questions in a manner reflecting more positively on their cultural sensitivity than is actually the case. Moreover, they may have chosen cases that they believed demonstrated greater cultural responsiveness. As a result, the case examples may reflect how clinicians consider culture for selective patients.

Research and Clinical Implications

Given the exploratory nature of this research, it is difficult to draw any definitive conclusions. Nevertheless, the findings have several research implications. Of particular importance are the results that pertain to the impact that considering culture has on therapists' evaluations; clinicians may be at risk to dismiss pathology as being representative of culturally normative behavior. The prevalence of this type of error is unknown; however, the fact that it may exist has significance for the study of clinical judgment bias. Recent reviews in this area have noted the consistent lack of support for biases against minority patients (Abramowitz and Murray, 1983; Sattler, 1977). The paradigm used in this area of research usually presents therapists with vignettes or brief case histories of a minority group patient in one condition and a majority group patient in the other condition. The clinicians are instructed to make a number of clinical judgments including degree of disturbance and prognosis. Previous investigators have defined bias as judging the minority patient as more disturbed than the majority patient—an overpathologizing bias (López, 1983). The findings of the present study suggest that investigators be open to the possibility that clinicians may also judge the problems of the culturally diverse patients to represent less pathology than the problems of patients from the majority culture—a potential minimizing bias (López, 1983).

A second research implication is that more data are needed to assess the way in which clinicians decide that some symptom or behavior is cultural in nature. The present study assumes that the absence of reporting a cultural assessment may indicate that no such assessment was conducted. Although this may be true in some cases, it may not be true in others. A more direct assessment of how clinicians determine what are cultural factors and how they then apply these notions is needed.

Also, future research is needed to examine prospectively the role of culture in evaluations and therapy. A prospective study might be able to obtain a more representative sample of clinicians’ consideration of culture in evaluations and treatment than the present study, which is limited by factors such as selective recall, social desirability, and time limitations.

In terms of clinical implications, it is clear that the sampled clinicians acknowledge the importance of culture, both in their attitudes and in their reported behavior. It is less clear that they appropriately consider culture. The message that we would like to communicate to practitioners is that, although it is important to consider culture, it is important to do it well. Oftentimes the literature pertaining to cultural groups informs the clinician of specific cultural characteristics that pertain to specific cultural groups. Although this information can be helpful, it can also be misapplied. Cultural groups are very heterogeneous and members are at different levels of acculturation and of different socioeconomic strata. Furthermore, the frequently noted cultural factors are poorly grounded in empirical research. It is important for clinicians to learn as much as possible about different cultural groups, but it is unlikely that they will be able to learn the many subtleties of any given group. Therefore, it may be equally important for them to learn how to properly assess the patient’s cultural background and its relationship to the clinical picture. As reported by some of the respondents to the survey, finding out from the patient, family, significant others, or colleagues what they view as cultural and pathological is crucial. The more data one collects from these resources, the fewer assumptions one will have to make as to what is and is not cultural.

Conclusion

Given the growing size of cultural minority groups in the United States, it is important that researchers and clinicians more thoroughly examine the role cultural factors play in the pathogenesis and treatment/evaluation of mental disorders. Such research will contribute to our understanding of psychopathology not only in culture-specific groups, but also in the general population. Moreover, this research should
contribute to the provision of quality mental health services to cultural minority groups.

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