Culture Counts

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The biggest difference between Yankees and Southerners is attitude… In the north, eccentric relatives are hidden away in a back room when company comes to visit. In the south, not only do we enjoy our eccentrics, we sit them in a place of honor, rocking on the front porch, and invite the entire town over …
~ Julia Sugarbaker, *Designing Women*

INTRODUCTION

All public education has some form of basic objectives ensuring that students will receive a quality education. Teachers are bound by law to follow these objectives and, when meeting these requirements, have little or no time to introduce any additional, interesting topics. Texas is no exception. Preparing students for the Texas Essential Knowledge Skills (TEKS) completely fills every minute of class. My dilemma is to follow the *Mental Health* TEKS while encouraging my students' interest and motivation to learn material and ideas not included in the TEKS. Unfortunately, my experience teaching college level Life Span Psychology is that students are very eager to delve into abnormal psychology, but have little enthusiasm for classes dealing with what is considered "normal" behavior. This lack of enthusiasm is also present in high school students. Since most students do not realize that mental health deals with not only normal but also abnormal mental conditions, they express a rather less than enthusiastic desire to sign up for this new elective. No doubt, changing the title to *Mental Illness* would greatly increase the number of students requesting this class. Not having this luxury creates a problem. Electives are determined by student requests. How can the study of normal behavior and coping skills compete with schizophrenia, obsessive-compulsive disorder, anti-social personality, or better yet, sexual dysfunction? Having heard all my life that a good defense is a strong offense, I have taken this advice to heart and modified the curriculum to appeal to each student. At first glance this seems a task of Herculean proportions or at least a trick from a magician's hat. Abrah Cadabra, with one simple twist, this class takes on personal appeal.

My twist is to approach the curriculum through a culturally diverse viewpoint. I will try to make this class appealing by asking my students to look at the required topics through their own cultural experiences, perceptions, and needs.

> A major finding … is that racial and ethnical minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity…. Most minority groups are less likely than whites to use services, and they receive poorer quality mental health care, despite having similar community rates of mental disorders…(This) means that minority communities have a higher proportion of individuals with unmet mental health needs. (Mental Health: Culture, Race, and Ethnicity [MHCRE] 3)

Dr. Arthur Kleinman is among one of the first researchers to view culture and psychopathology together. As he notes, Lopez states that Kleinman provided the first step in

understanding "the social world within mental illness… Researchers in cross-cultural psychology identified ways in which culture shapes distress and disorder" (Lopez 572). Cultural psychopathology's goal is to examine the effects of culture on mental health, illness, and the importance of culture on mental health services (MHCRE 25).

The paraphrase at the top of this paper from a popular '80s television sitcom draws attention to the importance of cultural perception of mental health and illness, known as *cultural relativism.* Behavior considered slightly eccentric in one culture may be completely unacceptable in another. Furthermore, within certain cultures, even speaking of the symptoms of mental health disorders is tantamount to being ostracized by family and society. Cultural values and attitudes are extremely difficulty to modify, and many people who would seek out mental health treatment will not do so, due to cultural beliefs. Therefore, knowledgeable health care practitioners should have the ability to ask appropriate and relevant questions of the patient resulting in useful health-care seeking behavior and correct medical intervention. Because Houston is a highly culturally diverse city, physicians and other health care professionals practicing in here should gain a working understanding of all these cultures if they are to provide total health care for their patients.

A growing health care issue is care for the mentally ill. Studies such as the 1991 Epidemiologic Catchment Area (ECA) and the 1995 National Comorbidity Survey (NCS) agree that up to one half of American adults will have a mental disorder in their lifetime and the majority of these patients will be treated by non-psychiatric specialists such as family practice and internist physicians, nurses, and social workers (Fortinash and Holoday-Worret 9).

As the majority of my students plan to enter the health care profession as nurses and nurse practitioners, the importance of understanding cultural attitudes toward mental health disabilities is a major reason to write this curriculum unit. The modern nurse must master sophisticated knowledge of pathology, diagnosis, referral of mental disorders, and knowledge of multicultural health care. As upper classmen--juniors and seniors--these students have proven not only their desire to enter the health care profession, but also the ability and maturity to study various topics of mental health and illness.

UNIT OVERVIEW

This curriculum will be divided into four parts: characteristics, causes, effects, and treatments of mental illness in a variety of cultures. The characteristics section reveals a culture's overall perspective on abnormal mental conditions. The second section on causes will address cultural views as to the genesis of mental illness. The third section on effects will then address both stigma and acceptance of mental illness as shaped by different cultures. Finally, culturally acceptable and promoted treatment for mental illness will be discussed. This curriculum supports a project-based learning environment, encouraging students to step into the role of researcher and later teacher. Using project- based learning also allows the teacher to change roles, becoming a facilitator or consultant in research rather than maintaining a traditional role. Additionally, this type of learning stimulates increased student involvement and investment in their project. In addition to the initial goal of learning about cultural diversity in mental health, as a teacher preparing students for the highly competitive post-secondary academic environment, also of major importance is the encouragement of a technological learning situation incorporating research and the use of multimedia technology and speaking skills. My students are primarily English as Second Language (ESL) speakers, requiring practice before attaining confidence in the use of English when speaking before an audience. It is my hope that with more practice will be greater familiarity and ultimately, anxiety reduction in a stressful situation.

Houghton Mifflin's Project-Based Learning Space states that "Project-based learning is a comprehensive instructional approach to engage students in sustained, cooperative investigation."

Learning revolves around real-world projects (Bradford 12.) As students seek solutions to project problems they use skills such as collecting and analyzing data, reaching conclusions from their data, communication skills with team members, and finally creating the actual tangible project (Houghton Mifflin). The student is given more responsibility for creating the driving question as well as the final product. This freedom offers the student opportunity to be in a realistic problem-solving situation that ultimately creates a concrete report, model, or task. This project can be presented to classmates and critiqued by peers providing feedback that increases knowledge for both the creator and the entire class (Houghton Mifflin). For further information regarding project-based learning consult references for this topic.

My curriculum unit is designed for the first four to six weeks of a semester-long class. The introduction will ask students to write their expectations of the content for a class titled *Mental Health*. Utilizing class discussion about student expectations, we will then progress to the questions, "What are mental health and mental illness and what factors effect our mental health?" The relevancy of this class to each student will be addressed through the readings and discussion of ECA and NCS research studies as students are far more vested in learning about topics useful in the real world.

A brief history of mental health, which is required by TEKS, will encourage students to comprehend the strides taken over many years in the understanding of mental illness. Beginning with Roman law and progressing through current times, students will research the care given to the mentally ill. Class discussion will include the differences between voluntary admission, emergency commitment, judicial commitment, preventive and mandatory outpatient treatment, and finally review patient confidentiality and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To encourage interest and assist students in the synthesis of knowledge, the use of films demonstrating the change in attitudes toward the mentally ill will include viewing *The Snake Pit, One Flew Over the Cuckoo's Nest, Out of Darkness,* and *A Beautiful Mind.* These films deal with portrayals of mental illness since World War II. In addition to the change in the media's attitudes toward mental illness, students will be exposed to a variety of diagnoses and treatment modalities that will be discussed the last portion of the class. Each film will be assigned to a group to create a presentation. The project will be in the form of a television talk show format in which various viewpoints of the characters from the film will be represented. These personas include a host, patient, family member, mental health specialist, and a private citizen to discuss their experiences with mental illness. The purpose of this project is to encourage dialectic thought by increasing the understanding of each viewpoint, but also to encourage empathy for others and the synthesis of their knowledge to create the final project.

The next area of exploration will be cultural diversity. Asking students to name the various cultures represented in our classroom, our school, and finally among the patients we have encountered in hospital rotations, students will come to the conclusion that Houston is indeed, a culturally diverse city. Both students and teacher will take the Heritage Assessment Tool (Specter 295-297). This assessment asks questions about an individual's own cultural identity. Following the key allows students to realize that they too are ethnocentric. Forming groups and jig-sawing information, the class will share pertinent terminology such as acculturation, assimilation, ethnicity, ethnocentrism and xenophobia. Each group will be asked to offer examples encountered in their personal lives, demonstrating these terms through real world application. We will then refer to our own ethnocentricity and come to the realization that as a health care provider we must be aware of our own cultural biases. Research into cultural attitudes toward mental illness among African, Asian, Hispanic, Arabic, European, Native American people, as well as the elderly, will be assigned. A teacher-created web quest incorporating research and articles will be the foundation for a multi-media presentation of each culture and its

effects on mental health and illness. A primary source for research will be the Surgeon General's Report: *Mental Health: Culture, Race, and Ethnicity.*

The final topics of this curriculum will deal with specific psychiatric disorders including anxiety, mood, personality, substance-related, dementia, cognitive and eating disorders, in addition to schizophrenias. Each topic will be assigned to a group to produce a presentation that includes symptoms, treatment modalities, prognosis, and current outcome in regard to minorities and cultures.

After completion of these unit projects, my students will approach Harris County Mental Health Mental Services (MHMS) and the Greater Houston Area Health Education Center (AHEC) regarding their needs for creating cultural diversified brochures about available mental health services. The brochures will be written in Spanish and Vietnamese, since my students are bilingual. This final project concludes my project-based learning unit and fulfils a real world application that is needed in our diverse community.

Teaching this amount and depth of information in one semester is challenging. However, utilizing a project-based curriculum will, as explained earlier, encourage student vestment in the creation of projects and ultimately, achieve greater learning. Previous use of this teaching strategy has allowed me to assess a greater degree of topic knowledge. This method encourages students to research in greater detail areas of personal interest, thereby creating an opportunity for greater individual and class learning. The ultimate goal of this curriculum is for each student to build a sound foundation for better understanding culturally diverse patients.

RISK FACTORS FOR MENTAL ILLNESS IN THE HISPANIC CULTURE

Culture is defined by most psychology and sociology texts as a common heritage or beliefs, norms, and values. Ethnicity is defined as a common heritage shared by a particular group (Zenner 393). When referring to heritage we must look at the similarities in language, rituals, music and food. As such, Hispanic Americans share all these factors but are composed of four main groups: Mexican, Puerto Rican, Cuban, and Central American. If one assumes that Hispanics have a common ancestry, one may also leap to the generalization that all Hispanics share the same culture. L. Cooper-Patrick's explanation of cultural identity as referring to the culture with which someone identifies and to which standards of behavior are adapted is dynamic. The immigrant comes to America with his own culture and becomes acculturated within the new host country's dominant culture (583). This is not a one-way process; both cultures are modified. Simply look at the variety of Mexican food found in Texas, as an example.

Just as Hispanic Americans have diverse ancestries, there are diverse reasons for immigration. Gil and Vega report that the cause of migration will have a major impact on the experiences immigrants face in the United States. If war or terrorism instigated the immigration, the risk of post-traumatic stress disorder (PTST) rises significantly (440). Even with immigration without human rights violation, the process is made more difficult due to lack of money and documentation. As a result, the stress of immigration is increased by restriction of possible jobs and fear of deportation. "Many Hispanic immigrants are unskilled laborers or displaced agricultural workers who lack the social and economical resources to ease their adjustment…" (MHCRE 130).

The Hispanic culture is one of family orientation. Hispanic families are very close and usually consist of not only a nuclear family but also an extended family. Often children remain at home until marriage, and the extended family network promotes cultural tradition or identity, which proves to be a resilience factor. Resilience is the ability to cope with adversity. Multiple texts state that positive coping abilities include supportive families, temperament, intelligence, education, social competency, and spirituality.

Hispanics tend to have less formal education than whites. According to the 2000 United States Census Bureau (USCB) only 56 percent of twenty-five year-olds have graduated from high school and 11 percent from college. Kaufman reports that Hispanics born outside of the U.S. between the ages of 16 to 24 have a greater than twice the rate for dropping out of school than American born Hispanics. Seventy percent of Cuban Americans have graduated from high school, 64% of Puerto Rican Americans and 50% of Mexican Americans are high school graduates (USCB 2002d). The Census Bureau reports that 25 percent of Cuban Americans are college graduates, equal to the graduation rate of Americans overall. Eleven percent of Puerto Rican and 7 percent Mexican origin immigrates are college graduates. These statistics are important as educational level is a strong indicator for socioeconomic status. USCB further reports that Cuban Americans are more affluent than Puerto Rican and Mexican Americans. Thirty-one percent of Puerto Rican Americans, 27 percent of Mexican Americans and 14 percent of Cuban Americans are living in poverty. The unemployment rate is 7 percent for both Puerto Rican and Mexican and 5 percent for Cuban Americans. The stratification of Hispanic cultural subgroups will affect not only the rates of mental illness, but also treatment seeking behaviors between Cuban Americans and other Hispanic subcultures:

> The burden of illness in the United States is higher in racial and ethnic minorities than whites… Higher rates of physical (somatic) disorders among racial and ethnic minorities hold significant implications for mental health. For example, minority individuals who do not have mental disorders are at higher risk for developing problems such as depression and anxiety because chronic physical illness is a risk factor for mental disorders. (MHCRE 30)

Hispanic Americans suffer from greater ill health than white Americans. According to the Department of Health and Human Services (DHHS) the death rate from diabetes is twice the rate for whites. Twenty percent of newly diagnosed tuberculosis cases are Latino although Hispanics are a small percentage of total U.S. population. Latinos also suffer from higher rates of hypertension and obesity. A surprising factor is that Hispanic Americans have a lower infant mortality rate than white Americans.

When ill, many Hispanics are treated by traditional healers known as curandero or santero. These healers use herbs for therapeutic treatments for both physical and mental complaints. In addition, these practitioners use fortune telling or readings, observation, and exorcism to treat their clients.

"Historical and socio-cultural factors suggest that, as a group, Latinos are in great need of mental health services… In addition, historical and social subgroup differences create differential needs within Latino groups" (MHCRE 133). Long known are risk factors for mental health problems including violence, poverty, inadequate education, racism and discrimination. The Hispanic immigrant having both lower educational and economic status is at risk for mental health disorders. Research studies including adults, children and adolescents, the elderly and high-need populations such as Vietnam War Veterans, refugees, drug and alcohol dependent, and the incarcerated will be the topics of student's research.

The ECA study reports Mexican Americans have no difference in the rates of mental illness than white Americans. However, a significant finding was the rate of depression and phobias between Mexican-born and U.S.-born Mexican Americans. Twenty-five percent of Mexican immigrants report a mental and/or substance disorder as compared to forty-eight percent of U.S.-born Mexican Americans. At first glance this research seems to support that the process of acculturation may lead to a significant increase in mental disorders. Further research is necessary to determine if it is the acculturation process or rather discrimination, poverty, and other negative stressors that minorities encounter on a daily basis.

A 1999 study conducted by Glover sites Hispanic children in Texas report greater anxiety-related problem behaviors such as delinquency than white students. Higher rates of depression are found among Mexican-origin youth paralleling adult studies. Findings from research seem to point to a correlation between number of years residing in the United States and an elevated risk for mental health disorders. Drug use and suicidal ideation is also higher for adolescents living in America than those living in Mexico. These statistics support the finding that Hispanic children and adolescents are at a higher risk than white American children to develop mental health problems (47-50).

Elderly Hispanic Americans are no exception. Studies report that Hispanic adults over the age of sixty without physical health problems have a much lower percentage of reported depression. However, with physical health problems, the rate is similar to that of younger Hispanic adults. Again, one must question further if having physical illness means that these adults have access to reporting their depression verses adults that are not seeking medical care.

Poverty has long been reported as increasing the risk for mental health problems. Findings from studies conducted on lower socioeconomic neighborhoods have the greater risk for delinquency. Unfortunately the outlook for Hispanic Americans is not positive. Male Hispanics are four times more likely to be incarcerated than white American males. Indeed the rate for female Hispanic Americans is twice that for white American females, and Hispanic adolescents make up 18 percent of incarcerated juvenile offenders. The rate of mental disorders is higher among all incarcerated populations (U.S. Bureau of Justice Statistics).

Studies of post-traumatic stress disorder (PTSD) in Viet Nam War Veterans found Hispanics Americans to be greater than both white and African American veterans. Recent research finds that Puerto Rican American veterans have the highest rates of PTSD than other Hispanic Americans in similar war related stress exposure. Further research is necessary to explain theses findings but researchers hypothesize that these statistics may be related to "differences in symptom reporting (and) may reflect features of expressive style rather than different levels of illness (or) greater exposure to violence and trauma prior to entering the military" (MHCRE 139).

Many Central American Hispanic Immigrants come to America as refugees from terror and human rights violations. However, most do not receive official refugee status from the government. These individuals are at higher risk for PTSD and depression. Cervantes' study found half of Central Americans subjects "were consistent with a diagnosis of PTSD" (MHCRE 140) verses less than twenty-five percent of recent Mexican American immigrants. The findings support the fact that Central American Hispanics having experienced violence and terror prior to immigration are a high-risk group for mental health problems.

Research on substance abuse finds a high correlation between mental disorders and substance abuse. Cunradi reports Hispanic males of Mexican decent are at higher risk to use substances than white males. More alcohol abuse is found among Mexican American verses white American males. Place of birth is again a factor in risk for substance disorders. U.S.-born Mexican American males are twice as likely to abuse substances as Mexican-born males. This rate is also true for U.S.-born Mexican American youth. Gender difference was far more significant. U.S.-born Mexican American women have a seven times greater risk factor for substance abuse than Mexican born immigrant women (1492-1498).

The final high risk population to be studied is the homeless. Due to the high rate of poverty among Hispanic Americans, one would expect a large number of Hispanic Americans to be represented in this population. The good news is that studies by The National Survey of Homeless Assistance Providers and Clients report that Hispanic Americans are "underrepresented among those without shelter" (MHCRE 139). Furthermore, fewer Hispanic children are found in

foster care. The close-knit Hispanic American family and community are strong resilience factors for those placed in very potentially stressful mental health risk environments.

Studies of mental health problems of Hispanic Americans find that Hispanics have higher rates of depression than whites. Puerto Ricans living in New York have a higher rate of depressive symptoms than Cuban and Mexican Americans (Moscicki et al 136). Kleinman states that cultures vary in the meanings of illness. Included are attitudes and beliefs that a particular culture holds toward an illness. The illness may be either/or physical or mental, and the culture determines if sympathy, stigma, cause, and the type of person who suffers from it (MHCRE 137).

> Cultural meanings of illness have real consequences in terms of whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help (mental health specialist, primary care provider, clergy, and/or traditional healer), the pathways they take to get services, and how well they fare in treatment (MHCRE 26).

Culture is important in the expression of symptoms. Many Hispanic Americans report somatic or physical symptoms. Puerto Rican Americans have higher rates of somatic complaints than do Mexican Americans. Culture-bound syndromes for Latinos are *susto* (fright) *nervios* (nerves) and *mal de ojo* (evil eye). Caribbean Latinos have a culture bound syndrome, *ataques de nervios*. Ataques de nervios symptoms include "screaming, crying, trembling, verbal or physical aggression and in some cases, seizure-like or fainting episodes, and suicidal gestures" (MHCRRE 138). *Ataques de nervios* can also be found in lower rates in other Hispanic Americans. Patients report that episodes are experienced in close conjunction with major life problems.

Koss-Chioino (1992) explains presenting problems can be interpreted in "multiple levels; the mental health view, the folk-healing view, and the patient or client's view" (MHCRE 138). Symptoms of depression may be expressed by the client to a mental health specialist as either a loss or gain of appetite, difficulty with memory, hallucinations or feelings of sadness and desperation. The same patient will complain to the Spiritualist of back and leg aches, and fear. After consulting the mental health specialist the client will explain symptoms as "disordered or out-of-control mind, behavior or lifestyle. The Spiritualist will explain the complaint as an obsession" (Koss-Chioino 198). However, if asked the cause of the patient's complaints before consultation with either the traditional or medical health care provider, the patient may explain complaints are due to family problems (Koss-Chioino 198). Therefore, the provider must be familiar with the Hispanic American culture to be able to provide appropriate care.

Although studies repeatedly place Hispanic Americans at higher risk for mental disorders, the suicide rate of Hispanics Americans is less that half that for white Americans. A survey by the Center for Disease Control and Prevention (CDC) reports that Hispanic Americans grades nine through twelve responded with greater suicidal ideation and parasuicides than either white or African American students. These statistics reveal a greater distress level among Hispanic American youth and a high need for mental health intervention.

Repeated research reveals depressing statistics for mental health among Hispanic Americans; further research reveals successful Hispanic American coping methods. Hispanics face adversity from poverty and discrimination, but according to the Suarez-Orozco study of 1995, Hispanic Americans have a "dual frame of reference" (140). Although many live in poverty and violence, when using their family's back in their country of origin to assess their lives, they see an improvement in their socioeconomic status. Their viewpoint is one of seeing what they now have verses U.S.-born Hispanics whose viewpoint is what they do not have (MHCRE 140).

A second strength is the desire to succeed. Again the closely-knit family is the source for this coping method. The need to succeed is due to wanting to assist their extended families back in

the countries of origin. The third strength is also found within the Hispanic American family. The families tend to band together to support any member with a physical or mental illness. Hispanic families tend to use faith as a coping method giving a sense of hope in the worst of circumstances. An example is the following quotation given by the sister of a patient suffering from severe mental illness:

> We all have an invisible doctor that we do not see, no? This doctor is God…We must keep in mind that a (human) doctor is inspired by God and that He will give us something that will help us. We must also keep in mind who really does the curing is God, and that God can cure us of anything we have, material or spiritual. (MHCRE 141)

Mexican Americans explain schizophrenia is caused by *nervios*. The term *nervios* removes blame from the patient and reduces criticism by the family and society. "Mexican American families living with a relative who has schizophrenia are not only less likely to be critical, but also those who are Spanish-speaking immigrants have been found to be high in warmth" (MHCRE 141). The combination of Hispanic warmth, spirituality, and conception of mental illness help the mentally ill family member.

Doctors Benjamin Druss and Robert Rosenheck as well as multiple studies report that Americans regardless of ethnocultural background will utilize alternative sources of health care in addition to seeking mainstream health care (MHCRE 709). Various studies of Mexican Americans report 7 percent to 44 percent use the services of curanderos, herbalista, or other folk medicine practitioners. MHCRE reports that the use of folk remedies is higher than consulting the curanderos because the remedies are commonly known. These remedies are used in addition to mainstream medical treatments. Such an example is the use of folk remedies for asthma in a Puerto Rican community while understanding and utilizing mainstream medical treatments (143).

An unusual project combining traditional mental health care practitioners and espiritistas (Puerto Rican folk healers) allowed traditional care providers to visit the healer's practice or centro (Koss-Chioino 133). The espiritistas also were included in case studies of patients by the traditional health care providers. Each group stated that the program increased understanding of their perspective therapy and encouraged their coordination of care in the client's interest. Additionally the traditional health care providers learned that folk care may have been stigmatized by the church and that many Hispanics will not admit to the use of folk remedies (Koss-Chioino 133).

In conclusion Hispanic American mental health needs are not being met at this time. The need for culturally responsive therapy for Hispanic Americans requires health care providers access the "world of their patients and families. Doing so will suggest ways practitioners can integrate effectively the social and cultural context of their Latino patients with their own worlds to provide effective care" (MHCRE 147).

RISK FACTORS FOR MENTAL ILLNESS IN AFRICAN AMERICAN CULTURE

The majority of African Americans were forcibly brought to America as slaves, viewed as personal property not as human beings. Even after emancipation, discrimination and poverty were daily experiences. Laws known as Jim Crow or "black codes" continued to segregate the races and to "perpetuate an inferior status for African Americans" (MHCRE 67). Such a history is rift with risk factors for mental illness. Statistics however, reveal rates for mental illness are similar to that for white Americans (MHCRE 67–68) presenting proof that African Americans are a very resilient people.

How did this group of people, facing over two centuries of prejudice and economic hardship, not only survive but rise within a society that rejected and blocked every attempt to improve their social status? African Americans utilize a variety of successful coping measures. Perhaps the

most important is the African American family. Most African Americans have very strong family ties and this extended family provides both monetary and emotional support. Although one-parent homes are more commonly found among African Americans than white Americans, the number of African American families, regardless of socioeconomics, open their hearts and homes, providing family foster care for the displaced child.

Religion or spirituality also rates highly as a successful coping method. Statistics report that eighty-five percent of Africans view themselves as religious (Taylor 89). Survey respondents report that prayer is a fundamental coping mechanism for life's adversities. Being involved in religious organizations also provides a successful social network to buffer the injustices of prejudice. Within the African American culture family, friends, neighbors, and congregations are expected to provide support for any individual in need. Such a strong emotional network reduces risk factors for mental illness in this population.

Factors that place African Americans at risk for mental health problems include unemployment, homelessness, violence and crime, substance abuse, and substandard education (Wilson 15). Lack of education is a very strong indicator for potential mental health issues. Without education, employment prospects become very limited, reducing the potential for earnings above the poverty level. Statistics obtained by the United States Census Bureau, 2001c, report that the percentage of African Americans graduating from high school is equal to that of white Americans. Seventeen per cent of African Americans earn a bachelor's or graduate degree as compared with twenty-six per cent for the general population. However, income statistics are not so optimistic. Overall, African Americans are an economically poor ethnicity.

Twenty-two percent of African Americans live in poverty in comparison with ten per cent of the overall population (U. S. Census Bureau). Socioeconomic stratification places African American at opposing ends of the economical scale. The rate for African Americans living in severe poverty is three times that of white Americans and children and adolescents are highly represented in this statistic. However, one positive statistic is that most families move out of the poverty level. Unfortunately the hard working family is quickly replaced by other families (O'Hare 10). The duration of poverty is also longer for African American families as compared to white American families.

"African American poverty is associated with family structure. African American children in particular, are especially likely to live in single-parent, mother-only families" (Statistical Abstract of the United States). Research studies do not agree to the extent of symptoms or diagnosis of mental illness between African Americans and white American children. However, the Surgeon's General's report on mental health (DHHS, 1996) found that African American children impaired by a mental health problem had received no mental health services in the previous six months. This statistic is quite disturbing as it foretells the contingency of mental health problems into adulthood. Not only are the mental health needs of African American children not being met, the statistics regarding physical health needs is no better.

The Department of Health and Human Services found that mortality rates for African Americans are higher than for white Americans. Increased morbidity includes rates three times as high for diabetes, double for prostate cancer, forty per cent higher for heart disease, HIV and AIDS rates are seven times as great, breast cancer higher and infant mortality twice that of white Americans. As physical health needs are not currently being met, and physical illness is a comorbidity factor, African Americans risk for mental health disorders are higher than that of white Americans.

The ECA research survey reports a greater amount of cognitive impairment among elderly African Americans than other ethnic groups and this impairment is highly correlated with lack of

education rather than socioeconomic factors. Additionally, depression in elderly African Americans is similar to white Americans, elevated when paired with physical illness.

Stigma frequently prevents the seeking of treatment for mental health problems. Clients may seek mental health treatment by verbalizing somatic complaints (MHCRE 61). Somatization is fifteen per cent more common among African Americans than in white Americans. Another pathway for treatment is through culture-bound syndromes. The Diagnostic and Statistical Manuel of Mental Disorders, Fourth Edition (DSM-IV) reports two culture-bound syndromes associated with African Americans. The first is isolated sleep paralysis. The presenting symptom is the inability to move when awaking or falling asleep. The second syndrome is termed "falling out" and refers to dizziness followed by sudden collapse. Such somatic symptoms generally result in care given by a primary care giver rather than a mental health specialist. Many anthropologists view these syndromes "as a rich indigenous tradition of ways for African Americans to express psychiatric distress and other forms of emotion" (MHCRE 61).

Suicide is a most serious attempt for seeking assistance for mental health disorders. African Americans are only half as likely to commit suicide as white Americans. However, this favorable statistic becomes less positive when the suicide rate for young African American males is examined. The rate rises to the same rate as for young, white American males. "The rates of suicide for African Americans ages ten to fourteen increased 233 percent as compared with a 120 percent increase in young white American suicides" (MHCRE 61).

As previously stated, prejudice and discrimination have high correlation with risk factors for mental illness. The long history of negative stereotyping of African Americans has led to a generalized feeling of mistrust for authority (MHCRE 8). Such mistrust will also discourage this population from seeking assistance from white American mental health care providers.

The combination of these research reports presents a depressing picture for African Americans. Within high-need populations, foster care, incarceration, homelessness, and exposure to violence, African Americans represent an ethnic majority. African American children are greatly affected by poverty and violence. Forty-five percent of children in foster care are African American. The majorities of these children have experienced abuse or neglect and have a history of multiple placements in the foster care system. This lack of stability places these children at high risk for mental illness and studies substantiate this finding. Forty-two percent of children in welfare programs meet criteria for a mental disorder (MHCRE 62).

Another group over represented by African Americans is the homeless. Jencks' study finds that forty-four per cent of the homeless were African Americans (61). Studies further reveal that homeless rates and mental illness are highly positively correlated. Schizophrenia is eleven to thirteen per cent higher in the homeless than in the general population. Mood disorders in the homeless affect up to thirty per cent verses eight per cent of the general population (Koegel et al 1090)

The prison population has a high rate for mental illness regardless of culture. Again, African Americans comprise nearly half of the incarcerated population. Both incarcerated African and white Americans are eight times as likely to have mental disorders as non-incarcerated Americans. Additionally, incarcerated African Americans having mental illness are less likely to actually receive treatment for their mental health disorder than white prisoners (U. S. Bureau of Justice Statistics).

Exposure to violence increases the risk for mental illness and again, African Americans are over represented as an ethnic group. Griffen and Bell state that African Americans of all ages are more likely to be victims of violent crime and are at greater risk for knowing someone who has been a victim of violence (2269). Fitzpatrick and Boldizar report a high correlation between

violence and mental illness. "Over one-fourth of African American youth who had been exposed to violence have symptoms severe enough to warrant a diagnosis of PTSD" (Fitzpatrick and Boldizar 426). To further support these statistics, African American veterans have a higher rate of PTSD than white American veterans although they only composed ten percent of the total U. S. soldiers in the Vietnam War. Researchers explain this difference is due to African Americans soldiers receiving greater exposure to war-zone trauma than their white American colleagues (MHCRE 62).

Multiple research reports reveal that African Americans are in great need for mental health services. Barriers to receiving this care include lack of insurance, cultural stigma, and type of treatment modality. Much change must occur to combat these barriers.

Brown's statistics reveal that one-fourth of African Americans do not have health insurance as African Americans frequently are employed in jobs that do not provide health care benefits (MHCRE 63). Even with insurance covering mental health services, African Americans still do not seek treatment as do white Americans. These findings lead to the second barrier, cultural stigma.

Despite public service announcements, studies show African Americans report fearing mental health treatment 2.5 times greater than white Americans (Sussman 188). According to the NCS, sixteen percent of African Americans having a mood disorder saw a mental health specialist. Additionally, Stanley Sue reports that African Americans are also more likely to prematurely terminate medical care (795). This factor may be explained by Akutsu's finding that African Americans receiving mental health treatment are frequently court mandated (63). Sussman also finds that African American parents do not use medical terminology such as attention deficit/hyperactivity disorder (AD/HD) when describing their children (188). Zylstra further states that in the elderly population, African Americans were not as knowledgeable about symptoms of depression as are white Americans (66). Additionally, African Americans responded to Cooper-Patrick's survey that in addition to stigma, spirituality also affects treatment seeking behavior (433). A case study supporting this emphasis placed on spirituality over main stream psychiatric care is found in MHCRE. Joan, a 50 year old African American attempted suicide and was rushed to the emergency room. She complained of difficulty sleeping and auditory hallucinations in which the voices instructed her to kill herself. Joan had previously been in treatment for psychotic depression and with both traditional and drug therapy was able to return to society. During an interview, Joan revealed that she contacted an itinerant minister, and after payment, received holy oil. The minister then told her she was cured and to stop taking her medication. Her suicide attempt was the result of this advice. Spirituality is very important to African Americans and unfortunately con artists take advantage of these strong beliefs often without thought to the life-threatening consequences of their actions (MHCRE 65).

The final barrier to be discussed is treatment modality. African Americans, like all members of the human species, prefer familiarity over the exotic or different. Multiple studies support this hypothesis regardless of whether choosing food, a mate, or our personal health care professional. African Americans prefer African American health care providers, and also report that the amount of time spent by the professional with the patient is of major importance in establishing patient-professional trust (Keith 62). African Americans comprise only two per cent of practicing psychiatrists, two per cent of psychologists, and four per cent of social workers. Therefore, most African American clients will not be successful in obtaining care from an African American mental health care specialist.

Mainstream psychiatric treatment modalities including cognitive-behavior therapy appear to be equally successful for either African Americans or white Americans (Treadwell et al 377). However, Sue's study found African Americans treated by the Los Angeles County mental health

system did not improve as significantly as other minorities and white Americans (796). Exposure therapy in particular, proved to be ineffectual treatment for panic attacks. Furthermore, African Americans are less likely to be diagnosed and treated with antidepressants, and when medicated are not prescribed selective serotonin reuptake inhibitors (SSRI). Older medications are far more easily discontinued without side effects allowing patients to discontinue medication without notifying their physicians. Medication non-compliance is offered as a plausible explanation for the large numbers of African Americans treated in emergency room and inpatient facilities (MHCRE 66).

Physicians must be made aware that African Americans metabolize some antidepressants and anti-psychotics more slowly, resulting in more severe side effects (Livingston, et al. 175). Regardless, African Americans receive higher doses of antipsychotic medications than white Americans (Segel, et al. 284). Higher dosages produce short-term side effects including stiffness, jitteriness, and muscle cramps and long-term tardive dyskinesia. These symptoms can be quite frightening and may well result in patient discontinuation of medication.

Ultimately, African Americans are in need of mental health services. Over-representation of African American ethnicity in high-risk mental health populations and the decreased number of African Americans seeking treatment for mental health disorders must be addressed by general care providers as well as mental health care specialists. Health care providers must ultimately meet these needs by becoming more culturally aware, building patient-caregiver trust, and incorporating traditional and ethnic coping methods.

LESSON PLANS

These lesson plans are examples of the various types of activities that will be used to teach this unit. They do not necessarily follow in chronological order.

Patient Rights

Objectives

Students will utilize their knowledge of mental illness and the law to determine specific patient rights violations.

Students will identify ethical practices; describe legal aspects and issues of malpractice, negligence, and liability (TEKS 4A, 4C).

Materials

Video: *One Flew Over the Cuckoo's Nest*
TV, DVD or video player
Exit Ticket

Procedure

Having seen mental illness and mental hospitals portrayed from the viewpoint of the 1940s in the film, *The Snake Pit*, we will now leap forward to the 1960s and view the movie, *One Flew Over the Cuckoo's Nest*. Produced in 1975, the movie is based on the novel of the same name written in 1962.

As the video will take the entire period, I frequently use an exit ticket as my method of evaluation. An exit ticket is a quick evaluation method for a participation grade. To exit the class, each student must list three things that they learned from the movie. If they are able to do so, they receive a 100 for a daily grade.

Patient Rights - Part Two

Objectives

Students will utilize their knowledge of mental illness and the law to determine specific patient rights violations and identify abusive situations (TEKS 5A).

Students will identify ethical practices; describe legal aspects and issues of malpractice, negligence, and liability (TEKS 4A, 4C).

Students will practice the concept of teaming (TEKS 3B).

Students will identify maladaptive conditions such as paranoia, schizophrenia, and aggression; research and describe treatment options (TEKS 1H, 1I).

Materials

Pencil and paper
Projector with attached computer
Slides quoting students exit ticket answers
Slide of scenario
Slides of main character's names

Procedure

Using power point, project various statements from the previous day's exit tickets and encourage students to discuss the importance of what their classmate's learned from viewing the video. Remind the class of changes in treatment and laws governing the mentally ill. Project the following slide. Have students form groups of four or five members and discuss the following situation:

> As a nurse you are a patient rights advocate and work in the mental hospital portrayed in the movie *One Flew over the Cuckoo's Nest*. Do you feel that any patient rights violations have occurred? The timer is set for fifteen minutes of discussion.

Slide 2:

> Your group will now have another fifteen minutes to write a report in which you describe any patient rights violations observed to the Joint Commission of Hospital Accreditation.
>
> Grades will be assigned by your ability to pair any applicable legal torts with specific situations.

After each group turns in their report, show a slide with each major character's name and have students determine a diagnosis and give examples of behavior that justifies the diagnosis. Encourage students through discussion, to come to a mutual agreement as to diagnosis.

Mental Illness in the 1990s

Objectives

Students will identify maladaptive conditions such as paranoia, schizophrenia, and aggression (TEKS 1H).

Students will identify societal perspectives related to mental health; identify socioeconomic factors that influence mental health and care (TEKS 1C, 1F).

Students will practice the concept of teaming (TEKS 3B).

Project members will use dialectic thinking to portray assigned characters.

Students will use creative thinking to synthesize knowledge to produce the assigned project.

Materials

Video: *Out of Darkness: Schizophrenia*
VHS, DVD, TV
Exit Tickets

Procedure

Explain that the purpose of viewing the video is two fold. The first objective is to observe family dynamics when dealing with a mentally ill family member. The second objective is to observe the general populations' response to the mentally ill. Allow one hour and forty-five minutes to view the entire movie.

Ask students to answer their exit ticket questions without discussing the movie. Instruct students to write on their exit tickets the character that they feel the greatest and least amount of empathy towards. Then have students answer the following questions on their exit ticket:

1. Does Polly's mental illness significantly affect normal family dynamics? Give one example supporting your answer.
2. What are three things that you learned about mental illness from this movie?

Students must complete their exit tickets to leave the room, and this allows the teacher to give a daily participation grade.

After class, review the characters chosen by the students as most and least empathized character. Select six students as group members for the video project and assign each student to represent the character that they felt the least empathy with. Taking on this character's viewpoints encourages students to use dialectic thinking skills.

Mental Illness in the 1990s - Part Two

Objectives

See Mental Illness in the Nineties, Part One

Materials

Hand out explaining the project
Character assignments
Video camera and tape
Slide projector with attached computer

Procedure

Display the assignment for students to begin as soon as they are seated. Have students write a two-page essay using standard persuasive writing style. They are to justify their choices of most and least empathetic characters in the movie, *Out of Darkness: Schizophrenia*. Evaluation will be according to Chavez's English Department's standard writing rubric. I recommend that you utilize your English Department's rubric allowing reinforcement for the English Department's standards of writing.

Separate the six members comprising the project group. Congratulate them on being chosen for a special project, and due to their selection, they are exempt from the class's writing assignment. Give out the Talk Show Project Handout, rubric, and character assignments. Have the students read the project topic, and begin discussing how they want to complete the project. While the group is brainstorming ideas for implementation of the project, return to the class and monitor their activity.

Allow time for discussion before returning to review the handouts with the project group. Answer any questions and explain that they are to portray their assigned character to their best ability. As guests on a popular talk show, they must respond to the host's questions from their character's viewpoint. They are to dress, behave, and speak in character. They are to use class time to organize their talk show and use the first part of the next class to practice and video tape the presentation. The premier of the talk show will be during the last half of the next class period.

Talk Show Project

Driving Question

Does mental illness have an impact on family dynamics and society as a whole?

Introduction

Mental illness is a part of all societies. It is a major concern not just for medical professionals but also the general public. Mental illness and mental health care receives frequent public attention through the media. Talk shows, movies, as well as newspapers all deal with mental illness and its effects on the family, community, and our society. Your project is to use a talk show format to present the impact of mental illness on the individual family and community.

Assignment

Your group will role-play the characters from the movie: *Out of Darkness: Schizophrenia*. You have been invited by a popular, nationally syndicated talk show to discuss how mental illness has impacted your life. In addition to portraying these characters, you also wish to educate the general population about this devastating illness. However, as time is money on national TV, you are only scheduled for 15 minutes of airtime.

Characters	**Responsibilities**
1. Host	• develop an introduction about the day's topic • introduce characters • develop interesting challenging questions to assist your guests with individual viewpoint • maintain control over the direction of the dialogue
2. Polly	• depict the disease and treatment modalities • verbalize feelings resulting from prejudice and ignorance of mental illness • explain needs as she returns to society
3. Polly's Mother	• the emotional and physical strain of having a mentally ill child • dealing with mental health system, family, and society • impact of her daughter's treatment
4. Polly's Sister	• growing up in the shadow of mental illness
5. Registered Nurse Practitioner	• dealing with mentally ill patients and their families • assisting the patient returning to society
6. Polly's Boyfriend	• how schizophrenia is viewed by the general public

Cultural Diversity

Objective

The student will identify and describe cultural diversity in specific minority populations including origin, treatment, and stigma towards mental illness.

The student will identify high-risk populations for mental illness and identify socioeconomic factors influencing the use of mental health resources.

Materials

The Heritage Assessment Tool
Cultural Terminology Handout
Cultural Project Assignment Handout
Computer Lab for 3 weeks
UBS memory sticks for projects or network to save presentations

Procedure

Students and teacher will take the Heritage Assessment Tool. Following the key, students will add up their "yes" answers. Every yes answer is counted as 1 point. A score of 15 or above is indicative of identification with a traditional heritage.

Have students look at the Cultural Terminology Handout and assign each group a term. Instruct groups to look up the definitions for their assigned term, discuss the definition and apply it towards situations in life. You will have twenty minutes to do this. After calling time, each group will "teach" their term and give examples of its application to the class. By jig sawing the information, the entire class will be given the information without having to look up each term. Terms include acculturation, assimilation, ethnicity, ethnocentrism, xenophobia, and socialization.

After the terminology has been discussed, assign groups to research the minority cultures that are applicable to your students. As Chavez High School's population is predominately Hispanic, African-American, and Asian, I want my students to research these cultures in addition to Arabic and Native American as these cultures view mental illness quite differently from traditional medical perspectives. Each group will receive two copies of *Mental Health: Culture, Race, and Ethnicity* as well as U.S. Government sites for Census, research studies, and University Library Sites such as University of California, Berkley's Folk Medicine web site. Explain to students that you do not want slides of massive amounts of data. I am more interested in the significance of these statistics as they impact mental health in a particular population. Students will have three weeks to research their culture and create a power point presentation for their classmates.

A required report by the principal researcher (group leader) of each member's contribution to the project will be due at the end of the week. Each student will give a self-evaluation of their activity for daily grades. The final project will be given three major grades for each student; multimedia grade, individual public speaking grade, and an information grade. I use the speech teacher's public presentation rubric, a technology rubric and a project knowledge rubric found on Conect.com. Once on the site, a teacher may modify the basic rubric to meet individual needs or may use rubistar.com to create their own rubric. I have made arrangements with our Communications and Business Computers Information Systems teachers to allow this project as major grades in their classes. These teachers also volunteered to be guest evaluators during the project presentations.

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