commonalities as well as differences among ethnic groups, there are even variations in lifestyles including health behaviors within *each* ethnic group among its members. To concede that this *one* model at its theoretical stage of development can be *the* model to serve as the framework for the development of curricula from a multiethnic perspective to provide the knowledge and skills to all students is difficult.

Demonstration projects using the framework and other strategies identified by Abbott would permit researchers to examine the process and outcome for students and faculty who participate in curricula which uses the empowerment model as compared to those in the traditional programs. Positive results would increase the validity of calling for the widespread use of the empowerment model to improve the psychology programs and ultimately produce professionals with the ability to provide quality services to multiethnic populations.

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Critique

The United States has a poor record in meeting the mental health needs of its minority populations. By focusing on individual pathology and relying on the white male as norm, practitioners have provided an ethnocentric and ineffective means of treating their culturally diverse clients. No longer can mental health problems be regarded only in terms of disabling mental illnesses and identified psychiatric disorders. They must also embody harm to mental health linked with perpetual poverty and unemployment and the institutionalized discrimination that happens on the basis of race or ethnicity, age, sex, social class, and mental or physical handicap. In its report, the President's Commission on Mental Health indicated that mental health services and programs must focus on the diversity of groups in U.S. society and satisfy the groups in terms of their special needs.[1]

Traditionally, and from an assimilationist position, ethnic minorities have been viewed as espousing an external (vis-à-vis internal) focus of control (i.e., a fatalistic orientation), unable to delay gratification, and as immoral, unintelligent, and uneducable. The failure of traditional psychology in treating minority clients has resulted in the development of psychologies exclusive to particular ethnic minorities

(e.g., Chicano psychology, black psychology).[2] Such sociocultural psychologies have been more effective as frameworks for mental health practices and programs than traditional therapy. Moreover, a sociocultural psychology is more scientific, parsimonious, and universal than traditional white Euroamerican systems of psychology laboring under the assumption that mental health and behavior is best explained by variables within individuals.[3] Under the guise of neutrality, traditional psychology intervention has been oppressing rather than liberating. For example, a major flaw in psychoanalysis is that it sometimes creates the problem that it is designed to eliminate.

Structural rather than individual factors provide the key to the etiology of mental illness for ethnic minorities. In addition to the various forms of institutionalized discrimination, unemployment, insufficient education, impoverished housing, and slum community environments are not only conducive to stress-producing circumstances but are also barricades to effective psychological services. "People who are deprived by reason of race or poverty have a higher incidence of all kinds of illness."[4] These factors are associated with changes in the incidence and prevalence of mental illness by population categories, and must be taken into account in preventative programs. Besides racial and ethnic minorities, recent immigrants, the poor, the elderly, and women are high-risk populations for the development of mental disorders because of their exposure to extraordinary stress, their lack of opportunity for participating in the creation of knowledge and gaining a measure of control over their social environment, inadequate institutional and community supports to sustain them during periods of difficulty, and pressures resulting from contradictory role expectations.

Mental health needs vary by cultural groups and by one's position relative to others in society. Each ethnic minority category has a unique narrative, a particular status within society, and specific patterns of adaptation and accommodation regarding society. One cannot assume that effective mental health practices for majority groups will be sufficient for minority groups.

Mental health is a community concern and cannot be restricted to the expertise of professionals. Community groups are useful support systems for individuals who need to eliminate their self-doubts and misery and rebuild their confidence, composure, and faith. They help people who, for whatever reason, do not seem to benefit from "official" therapy. Through interaction with others with similar problems, community support groups provide individuals with new insights and

relationships and perhaps a more objective view of themselves. In the field of mental health, professional expertise is not conclusive unless it embodies the experiences and practical knowledge of consumers of services.[5] Group therapy is appropriately based on the wealth of data which show family strife as a serious threat to the mental well being of its members. Family therapy can be an efficacious preventative measure for potentially explosive, violent home environments.

Primary responsibility for the insensitivity of mental health services to minority clients can be placed on our educational institution. Training programs should include bilingual instructors with a thorough awareness of diverse segments of our population. Minority clients tend to trust agencies with therapists who identify with their group. Clearly, the presence of people like oneself contributes to trust. The President's Commission on Mental Health has recommended that advocacy teams for the representation of the mentally ill be established and that each state constitute a "Bill of Rights" for all mentally disabled persons.[6] The Commission also called for erasing discrimination against mental disability in present Medicaid and Medicare laws and recommended that any future national health insurance program not sever mental illness from the scope of its objectives.[7]

The empowerment model is needed to furnish a back-drop for a radical change in our nation's mental health care. As Abbott suggested, perhaps the major goal of mental health treatment is for clients to gain a greater sense of mastery over their fate—a formidable task, especially when a national commission could impart doubt about whether depression and paranoia were abnormal when found among individuals who reside in barrios and ghettos.[8] The President's Commission recognized that paranoia and depression were severely detrimental to the mental well being of Chicanos and blacks as well as other minorities and poor whites and emphasized that no one should experience such adverse conditions requiring such adaptations.[9] The voices of minorities must be heard for the nation's benefit.

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Notes

[1]President's Commission on Mental Health. *The Report to the President*. (Washington, D.C.: U.S. Government Printing Office, 1978).

[2]J. Martinez, Jr., ed. *Chicano Psychology*. (New York: Academic Press, 1977). R.I. Jones, ed. *Black Psychology*. (New York: Harper & Row, 1972).

[3]R. Diaz-Guerrero. 1977. "A Sociocultural Psychology." pp. 17-27 in J. J.L. Martinez, Jr., ed. *Chicano Psychology*. (New York: Academic Press, 1977) 17-27.

[4]Jack R. Ewalt. "The Birth of the Community Mental Health Movement." *An Assessment of the Mental Health Movement*. Walter Barton, ed. (Lexington, MA: Lexington Books, 1977) 18.

[5]Charles V. Willie. "The President's Commission on Mental Health—A Minority Report on Minorities." *New England Sociologist*. Vol. 1 (Fall, 1978) 13-22.

[6]President's Commission on Mental Health.

[7]Ibid.

[8]Joint Commission on Mental Illness and Health. *Action for Mental Health*. (New York: Wiley, 1961).

[9]President's Commission on Mental Health.