April 23, 2006

Dear Students,

As you wind down this semester the Diversity Committee would like to provide you with some resources to take with you. As part of our ongoing commitment to the diversity climate of our school and profession we have begun to compile materials that reflect the values of social work in our complex urban environment. This is a project in progress, however, we are providing you with a copy of our initial collection of materials in hopes you will find the information useful and informative. Please note that we are aware the material enclosed does not represent all possible aspects of diversity, nor does it represent any official views of the School of Social Work. Material was provided by individual students and faculty. We welcome any comments regarding this resource (amyamada@usc.edu). Have a great summer!

Best wishes,

Ann Marie Yamada, Ph.D.
School of Social Work Diversity Committee Chair

Enclosure (1)
You finally decide to get help and then you're punished for it pigeonholed into a diagnosis, shamed, labeled, and discriminated against for life. The stigma can be worse than the illness.

Stigma is about disrespect:
It hurts, punishes and diminishes people.
It harms and undermines all relationships.
It appears in behavior, language, attitude and tone of voice.
It happens even when we don't mean it.

<table>
<thead>
<tr>
<th>Disrespectful Language:</th>
<th>Respectful Language:</th>
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</thead>
<tbody>
<tr>
<td>Crazy, lunatic, deficient, wacko, loony tune, psycho etc.</td>
<td>Mental illness or psychiatric disability</td>
</tr>
<tr>
<td>Manic depressive (when referring to a person)</td>
<td>Person with bipolar disorder or manic depressive illness</td>
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<tr>
<td>Schizophrenic</td>
<td>Person who has schizophrenia</td>
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<tr>
<td>Handicapped person</td>
<td>Person with a disability</td>
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<tr>
<td>Slow, low functioning</td>
<td>Person who has cognitive difficulties</td>
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<tr>
<td>Normal</td>
<td>Non-disabled person</td>
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Some Rules of Thumb:

- Don't focus on a disability. Focus instead on issues that affect the quality of life for everyone, e.g., accessible transportation, housing, affordable health care, etc.

- Don't portray successful persons with disabilities as superhumans. This carries expectations for others and is patronizing to those who make various achievements.

- Don't sensationalize a disability. This means not using terms such as "afflicted with," "suffers from," "victim of," and so on.

- Don't use generic labels such as "the retarded," "our mentally ill," etc.

- Don't use psychiatric diagnoses as metaphors for other situations, e.g., a "schizophrenic situation." This is not only stigmatizing, but inaccurate.

- Do put people first, not their disabilities. Say for example, "person with schizophrenia" rather than "schizophrenic."

- Do emphasize abilities, not limitations. Terms that are condescending must be avoided.

http://www.dcf.state.fl.us/dcfflash/jun05/stigma.shtml
http://www.stopstigma.samhsa.gov/topics_materials/organizations.htm
http://www.adscenter.org/topics_materials/f-orgs.htm
LGBTQQ Terminology

**Ally:** A heterosexual or LGBT person who supports LGBT people.

**Bisexual:** A person who is emotionally, physically, spiritually, and sexually attracted to members of more than one gender.

**Biological Sex:** A binary system (male/female) set by the medical establishment, usually based on reproductive organs.

**Closeted:** One who has not "come out of the closet" or who has come out to only a few people. One who may not be comfortable enough with their own sexuality to share it with others.

**Coming Out:** The life-long process of discovering, defining, and proclaiming ones (non-heterosexual) sexuality.

**Cross Dressing:** The act of wearing the clothing of the "opposite" sex for performance, sexual encounters, or comfort. Generally, the term cross dresser is preferred to transvestite.

**Drag:** Queen, a person who consciously performs femininity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting; King, a person who consciously performs masculinity, sometimes in an exaggerated/theatrical manner, usually in a show or theatre setting.

**Dyke:** Derogatory slang terms used to identify lesbians. This term has been embraced and reinvented as a positive, proud, political identifier when used by lesbians among and about themselves.

**Faggot:** Derogatory slang used to identify gay men, which has been embraced and reclaimed as a positive, proud, political identifier when used by gay men among and about themselves.

**Gay:** Usually, but not always, refers to homosexual men. Also used as an umbrella term for the LGBT community.

**Gender Identity:** How a person perceives and what they call themselves; may or may not agree with societal gender roles outlines for their sex; typically masculine/feminine. Coincides with what doctors and/or society have prescribed for that person or can also refer to a multitude of expression like femme, boy, faggot, leather, androgynous, leather, etc.

**Genderqueer:** Any LGBT person whose gender presentation is an intentional mixture of gender signifiers, usually a political identity in support of transgender persons and against the binary gender system.

**Heterosexual:** A person who has emotional, physical, spiritual, and sexual attractions to persons of the "opposite sex". The sexuality that dominant discourse prescribes.
**Heterosexual Privilege:** Advantages that come with heterosexuality in this society and culture; i.e. Marriage and all the benefits that go along with it, acceptance from family, safety, and acceptance in their chosen career field.

**Heterosexism:** The belief that all people are heterosexual, the assumption and/or belief that heterosexual relationships and behavior are superior, and the actions based on this assumption.

**Homosexual:** A person who has emotional, physical, spiritual, and sexual attraction to persons of the "same sex". More of a medical term, it is considered an outdated term when referring to gay people or communities.

**Homophobia:** Fear, anger, discomfort, intolerance, or lack of acceptance toward LGBT people, or experiencing these feelings about one's own non-heterosexual preference.

**Intersexed:** People born with ambiguous genitals, formerly referred to as hermaphrodites. Most intersexed people do not possess "both" sets of genitals, rather a blending or a different appearance that is medically unacceptable to most doctors. Intersexuality is fairly common. Many who identify as intersexed believe that early childhood surgical intervention is not only unnecessary but cruel and advocate counseling and support for children and families.

**Lesbian:** A woman who has emotional, physical, spiritual, and sexual attractions to other women.

**Lifestyle:** How a person chooses to live and behave. Being LGBT is not a choice, and therefore is not considered a lifestyle (i.e. yuppie, vegan, hobbies, rural/urban, etc.).

**Outing:** To declare a person's identity publicly; people can out themselves, or someone can out them either with or without their permission.

**Rainbow Flag:** In 1978, San Francisco artist Gilbert Baker designed a flag for the city's Gay Freedom celebration and LGBT movements worldwide have since adopted it as a symbol of gay identity and pride. It has six stripes in the traditional form, but can be seen as streamers, etc., which run in the order of red, orange, yellow, green, blue, purple. The flag also symbolizes diversity within unity.

**Questioning:** The process of exploring one's own sexual identity, including but not limited to one's upbringing, expectations from others (family, friends, church, etc.), and inner motivation.

**Queer:** Derogatory slang terms used to identify LGBT people. This term has been embraced and reinvented as a positive, proud, political identifier when used by LGBT people among and about themselves.

**Sexual Orientation:** To whom a person is erotically attracted. Not to be confused with sexual preference: What a person likes to do sexually.
**Transgender:** An umbrella term for people who transgress society's view of gender and biological sex as necessarily fixed, unmoving, and following from one's biological sex. They view gender on a spectrum, rather than a polarized, either/or construct. This can range from identification to cross dressing, to undergoing hormone therapy, to sex reassignment surgery and/or to other forms of dress/presentation. Transgender people can include transsexuals, cross-dressers, drag kings/queens, masculine women, feminine men, and all those who defy what society tells them is appropriate for their "gender". Political trans activists seek to create more space around gender, and to create a space and a society where the choice of gender expression/presentation is safe, sane, and consensual.

**Transsexual:** A person whose core gender identity is "opposite" their assigned sex. Transsexuals may live as the opposite sex, undergo hormone therapy, and/or have sex reassignment surgery to "match" their bodies with their gender identity.

**Transvestite:** A person who cross-dresses for erotic pleasure or relaxation.

**Pink Triangle:** This was a symbol used by the Nazi's to label gay men in the concentration camps. It has since been adopted as a symbol of identity and pride.

**Black Triangle:** This was a symbol used by the Nazi's to label lesbians and other women deemed 'antisocial' in the concentration camps. It has since been adopted as a symbol of identity and pride.

*Adapted by Jessica Van Tuyl from the University of Ohio's LGBT Programs Center
Website at: [http://www.ohio.edu/lgbt/resources/educate_def.cfm](http://www.ohio.edu/lgbt/resources/educate_def.cfm)*
African Americans

Approximately 12% of the U.S. population -- 33.9 million people -- identify themselves as African American. The African American population is increasing in diversity as immigrants arrive from many African and Caribbean countries. Over half of the Nation's African Americans population (53%) live in the South; 37% reside in the Northeast and Midwest combined; 10% live in the West. In 1997, nearly one-fourth of all African American earned more than $50,000 a year. Yet, as a whole, when compared to other racial and ethnic groups living in the U.S., African Americans continue to be relatively poor. In 1999, about 22% of African American families lived in poverty, compared to 13% for the United States as a whole and 8% for non-Hispanic white Americans.

Need for Mental Health Care

Whether African Americans differ from whites in the rate of mental illness cannot be answered simply. For African Americans living in the community, overall rates of mental illness appear to be similar to those of non-Hispanic whites. Differences do arise when assessing the prevalence of specific illnesses. For example:

African Americans may be less likely to suffer from major depression and more likely to suffer from phobias than are non-Hispanic whites. Somatization is more common among African Americans (15%) than among whites (9%). Moreover, African Americans experience culture-bound syndromes such as isolated sleep paralysis, an inability to move while falling asleep or waking up, and falling out, a sudden collapse sometimes preceded by dizziness.

While non-Hispanic whites are nearly twice as likely as African Americans to commit suicide, suicide rates among young black men are as high as those of young white men. Moreover, from 1980 - 1995, the suicide rate among African Americans ages 10 to 14 increased 233%, compared to 120% of comparable non-Hispanic whites.

African Americans are over-represented in high-need populations that are particularly at risk for mental illnesses:

- People who are homeless. While representing only 12% of the U.S. population, African Americans make up about 40% of the homeless population.
- People who are incarcerated. Nearly half of all prisoners in State and Federal jurisdictions and almost 40% of juveniles in legal custody are African Americans.
- Children in foster care and the child welfare system. African American children and youth constitute about 45% of children in public foster care and more than half of all children waiting to be adopted.
- People exposed to violence. African Americans of all ages are more likely to be victims of serious violent crime than are non-Hispanic whites. One study reported that over 25% of African American youth exposed to violence met diagnostic criteria for post-traumatic stress disorder (PTSD). Among Vietnam War veterans, 21% of black veterans, compared to 14% of non-Hispanic white veterans, suffer from PTSD, apparently because of the greater exposure of blacks to war-zone trauma.
Availability of Mental Health Services
The public mental health safety net of hospitals, community health centers, and local health departments are vital to many African Americans, especially to those in high-need populations. African Americans account for only 2% of psychiatrists, 2% of psychologists, and 4% of social workers in the United States.

Access to Mental Health Services
Nearly 1 in 4 African Americans is uninsured, compared to 16% of the U.S. population. Rates of employer-based health coverage are just over 50% for employed African Americans, compared to over 70% for employed non-Hispanic whites. Medicaid covers nearly 21% of African Americans.

Use of Mental Health Services
Overall, only one-third of Americans with a mental illness or a mental health problem get care. Yet, the percentage of African Americans receiving needed care is only half that of non-Hispanic whites. One study reported that nearly 60% of older African American adults were not receiving needed services.

African Americans are more likely to use emergency services or to seek treatment from a primary care provider than from a mental health specialist. Moreover, they may use alternative therapies more than do whites.

African Americans of all ages are under represented in outpatient treatment but overrepresented in inpatient treatment. Few African American children receive treatment in privately funded psychiatric hospitals, but many receive treatment in publically funded residential treatment centers for emotionally disturbed youth.

Appropriateness and Outcomes of Mental Health Services
While few clinical trials have evaluated the response of African Americans to evidence-based treatment, the limited data available suggest that, for the most part, African Americans respond favorably to treatment. However, there is cause for concern about the appropriateness of some diagnostic and treatment procedures. For example, when compared to whites who exhibit the same symptoms, African Americans tend to be diagnosed more frequently with schizophrenia and less frequently with affective disorders. In addition, one study found that 27% of blacks compared to 44% of whites received antidepressant medication. Moreover, the newer SSRI medications that have fewer side effects are prescribed less often to African Americans than to whites. Finally, even though data suggest that blacks may metabolize psychiatric medications more slowly than whites, blacks often receive higher dosages than do whites, leading to more severe side effects. As a result, they may stop taking medications at a greater rate than whites with similar diagnoses.

http://www.mentalhealth.samhsa.gov/cre/default.asp
Asian Americans/Pacific Islanders

Approximately 4% of the U.S. population – over 11 million people – identify themselves as Asian Americans or Pacific Islanders (AA/PIs). The AA/PI population is expected to double in the next 25 years. About 54% of AA/PIs live in western States, especially California and Hawaii. 18% live in the Northeast, 17% in the South, and 11% in the Midwest.

The AA/PI category is extremely diverse, with about 43 different ethnic subgroups. While the majority of AA/PIs were born outside of the U.S., a large proportion of Chinese and Japanese Americans are 4th and 5th generation Americans. Since the mid-1960s, the AA/PI population has grown rapidly with high rates of immigration from China, India, the Philippines, Korea, Vietnam, and Southeast Asia. Most Pacific Islanders are not immigrants, but are descendants of the original inhabitants of land taken over by the United States – Hawaii, Tonga, Guam, American Samoa, the Northern Mariana Islands, the Marshall Islands, the Caroline Islands, and Palau.

AA/PIs speak over 100 languages and dialects, and about 35% live in households where there is limited English proficiency in those over age 13. Some subgroups have more limited English proficiency than others: 61% of Hmong-, 56% of Cambodian-, 52% of Laotian-, 44% of Vietnamese-, 41% of Korean-, and 40% of Chinese-American households are linguistically isolated.

There is a range of educational attainment in the AA/PI population. In 2000, 44% of Asian American adults had a college or professional degree compared to 28% of white Americans. 58% of South Asian Americans (from India, Pakistan, Bangladesh, and Sri Lanka) fell into this group. In contrast, in 1990 only 12% of Hawaiians and 10% of other Pacific Islanders had completed college, and 2 out of 3 Cambodian-, Hmong-, and Laotian-American adults had not completed high school.

The average family income for AA/PIs is higher than the national average. However, AA/PIs still have a lower per capita income and higher rate of poverty than non-Hispanic white Americans. In 1990, about 14% of the whole AA/PI group was living in poverty, compared to 13.5% of all Americans, and 9% of non-Hispanic whites. Among subgroups, poverty rates ranged from a low of 6% for Filipino Americans to a high of 64% among Hmong Americans.

Need for Mental Health Care

Our knowledge of the mental health needs of AA/PIs is limited. National epidemiological studies have included few AA/PIs or people whose English is limited. The largest study to focus on AA/PIs (i.e., the CAPES study) examined the prevalence of mood disorders in a predominantly immigrant Chinese American sample. This study found lifetime and one-year prevalence rates for depression of about 7% and 3%, respectively. These rates are roughly equal to general rates found in the same urban area.

While overall prevalence rates of diagnosable mental illnesses among AA/PIs appear similar to those of the white population, when symptom scales are used, AA/PIs show higher levels of depressive symptoms than do white Americans. Furthermore, Chinese Americans are more likely to exhibit somatic complaints of depression than are African Americans or non-Hispanic whites. Small studies of symptoms of emotional distress have found few differences between AAPI youth and white youth.

AA/PIs may experience culture-bound syndromes such as neurasthenia and hwa-byung. Neurasthenia is characterized by fatigue, weakness, poor concentration, memory loss, irritability, aches and pains, and sleep disturbances. Hwa-byung, or "suppressed anger syndrome," is characterized by symptoms such as constriction in the chest, palpitations, flushing, headache, dysphoria, anxiety, and poor concentration.

Compared to the suicide rate of white Americans (12.8 per 100,000 per year), the rates for Filipino (3.5), Chinese (8.3), and Japanese (9.1) Americans are substantially lower. However, Native Hawaiian adolescents have a higher risk of suicide than other adolescents in Hawaii, and older Asian American women have the
highest suicide rate of all women over age 65 in the United States. There is also a growing concern about increasing suicide rates in the Pacific Basin.

**High-Need Populations**
AAPIs are not overrepresented among high-need, vulnerable populations such as people who are homeless, incarcerated, or have substance abuse problems. However, they are heavily represented among refugees. Many Southeast Asian refugees are at risk for post-traumatic stress disorder (PTSD) associated with trauma experienced before and after immigration to the U.S. One study found that 70% of Southeast Asian refugees receiving mental health care met diagnostic criteria for PTSD. In a study of Cambodian adolescents who survived Pol Pot's concentration camps, nearly half experienced PTSD and 41% suffered from depression 10 years after leaving Cambodia.

**Availability of Mental Health Services**
Nearly 1 out of 2 AAPIs will have difficulty accessing mental health treatment because they do not speak English or cannot find services that meet their language needs. Approximately 70 AAPI providers are available for every 100,000 AAPIs in the U.S., compared to 173 per 100,000 whites. No reliable information is available regarding the Asian language capabilities of mental health providers in the U.S.

**Access to Mental Health Services**
Overall about 21% of AAPIs lack health insurance, compared to 16% of all Americans. The rate of Medicaid coverage for eligible AAPI families is well below that of whites. For example, among families with incomes below 200% of the Federal poverty level, whites are twice as likely as Chinese Americans to enroll in Medicaid. It has been suggested that lower Medicaid participation rates are, in part, due to widespread but mistaken concerns among immigrants that enrolling in Medicaid jeopardizes applications for citizenship.

**Use of Mental Health Services**
AAPIs appear to have the extremely low utilization of mental health services relative to other U.S. populations. For example, in the CAPES study, only 17% of those experiencing problems sought care. Among AAPIs who use services, severity of disturbance tends to be high, perhaps because AAPIs tend to delay seeking treatment until symptoms reach crisis proportions. While more research is needed, shame and stigma are believed to figure prominently in the lower utilization rates of AAPI communities. AAPIs tend to use complementary therapies at rates equal to or higher than white Americans.

**Appropriateness and Outcomes of Mental Health Services**
Few studies examine the response of minorities to mental health treatment. One study found that AAPI clients had poorer short-term outcomes and less satisfaction with individual psychotherapy than did white Americans. Another study found that older Chinese Americans with symptoms of depression responded to cognitive-behavior therapy as did other multietnic populations. AAPI/PI clients matched with therapists of the same ethnicity are less likely to drop out of treatment than those without an ethnic match. Preliminary studies suggest that AAPIs respond clinically to psychotropic medicines in a manner similar to white Americans but at lower average dosages. Research is needed to identify key components of culturally appropriate services for AAPIs.

http://www.mentalhealth.samhsa.gov/cre/default.asp

Latinos/Hispanic Americans

The Hispanic/Latino American population is characterized by its rapid growth. Approximately 35.3 million people now self-identify as Hispanic Americans. The number is expected to increase to 97 million by 2050 – nearly one-fourth of the U.S. population. Mexican Americans comprise almost two-thirds of Hispanic Americans, with the remainder being of Puerto Rican, Cuban, South American, Central American, Dominican, and Spanish origin.

Latinos are highly concentrated in the U.S. Southwest. 60% live in California, Arizona, New Mexico, Colorado, and Texas. However, from 1990 to 2000, the number of Latinos more than doubled in Arkansas (170%), North Carolina (129%), Georgia (120%), Nebraska (108%), and Tennessee (105%).

Overall, only 56% of Latinos 25 years-of-age and over have graduated from high school, compared to 83% of the total U.S. population. However, academic achievement varies considerably among Hispanic subgroups. 70% of Cuban Americans, 64% of Puerto Ricans, and 50% of Mexican Americans 25 years-of-age and over have graduated from high school.

The economic status of Hispanic Americans parallels their educational status. The poverty rates are 14% respectively for Cuban Americans, 31% for Puerto Ricans, and 27% for Mexican Americans, compared to 13.5% of all Americans.

Need for Mental Health Care

Generally speaking, the rate of mental disorders among Hispanic Americans living in the community is similar to that of non-Hispanic white Americans. However,

- Adult Mexican immigrants have lower rates of mental disorders than Mexican Americans born in the United States, and adult Puerto Ricans living on the island tend to have lower rates of depressions than Puerto Ricans living on the mainland.
- Studies have found that Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Hispanic white youth.
- Regarding elder Hispanic Americans, one study found over 26% of its sample were depressed, but depression was related to physical health; only 5.5% of those without physical health problems said they were depressed.
- Culture-bound syndromes seen in Hispanic Americans include susto (fright), nervios (nerves), mal de ojo (evil eye), and ataque de nervios. Symptoms of an ataque may include screaming uncontrollably, crying, trembling, verbal or physical aggression, dissociative experiences, seizure-like or fainting episodes, and suicidal gestures.
- In 1997, Latinos had a suicide rate of about 6% compared to 13% for non-Hispanic whites. However, in a national survey of high school students, Hispanic adolescents reported more suicidal ideation and attempts proportionally than non-Hispanic whites and blacks.

High-Need Populations

Hispanics are relatively under-represented among people who are homeless or children in foster care. However, they are present in high numbers in other high-need populations.

- People who are incarcerated. 9% of Hispanic Americans, compared to 3% of non-Hispanic white Americans, are incarcerated. Latino men are nearly four times as likely as white men to be imprisoned at some point during their lifetimes.
- Vietnam War Veterans. Latinos who served in Vietnam were at higher risk for war-related post-traumatic stress disorder than were black and non-Hispanic white veterans.
• Refugees. Many refugees from Central America experienced considerable civil war-related trauma in their homelands. Studies have found rates of post-traumatic stress disorder among Central America refugee patients ranging from 33 to 60%.

• Individuals with Alcohol and Drug Problems. In general, Hispanic Americans have rates of alcohol use similar to non-Hispanic whites. However, Hispanic women/Latinas have unusually low rates of alcohol and other drug use, while Latino men have relatively high rates. Rates of substance abuse are higher among U.S.-born Mexican Americans compared to Mexican-born immigrants. Specifically, substance abuse rates are twice as high for U.S.-born Mexican American men than for Mexican-born men, but seven times higher for U.S.-born Mexican American women than for Mexican-born women.

**Availability of Mental Health Services**

In 1990, about 40% of Hispanics either did not speak English at all or did not speak it well. While the percentage of Spanish-speaking mental health professionals is not known, only about 1% of licensed psychologists who are also members of the American Psychological Association identify themselves as Hispanic. Moreover, there are only 29 Hispanic mental health professionals for every 100,000 Hispanics in the United States, compared to 173 non-Hispanic white providers per 100,000.

**Access to Mental Health Services**

Nationally, 37 percent of Hispanics are uninsured, compared to 16% for all Americans. This high number is driven mostly by Hispanics' lack of employer-based coverage – only 43% compared to 73% for non-Hispanic whites. Medicaid and other public coverage reaches 18% of Hispanics.

**Use of Mental Health Services**

Among Hispanic Americans with a mental disorder, fewer than 1 in 11 contact mental health specialists, while fewer than 1 in 5 contact general health care providers. Among Hispanic immigrants with mental disorders, fewer than 1 in 20 use services from mental health specialists, while fewer than 1 in 10 use services from general health care providers.

Precise estimates of the use of complementary therapies by Hispanic Americans do not exist. One study found that only 4% of its Mexican American sample consulted a curandero, herbalista, or other folk medicine practitioner within the past year, while percentages from other studies have ranged from 7 to 44%. The use of folk remedies is more common than consultation with a folk healer, and these remedies are generally used to complement mainstream care.

** Appropriateness and Outcomes of Mental Health Services**

Few studies on the response of Latinos to mental health care are available. One randomized study found that members of low-income, Spanish-speaking families were more likely to suffer a significant exacerbation of symptoms of schizophrenia in highly structured family therapy than in the less structured case management. Several studies have found that bilingual patients are evaluated differently when interviewed in English as opposed to Spanish. One small study found that Hispanic Americans with bipolar disorder are more likely to be misdiagnosed with schizophrenia than are non-Hispanic white Americans.

One national study found that only 24% of Hispanics with depression and anxiety received appropriate care, compared to 34% of whites. Another study found that Latinos who visited a general medical doctor were less than half as likely as whites to receive either a diagnosis of depression or antidepressant medicine.

http://www.mentalhealth.samhsa.gov/cre/default.asp

Native American Indians

Approximately 1.5% of the U.S. population -- 4.1 million Americans -- identify themselves as having American Indian or Alaska Native (AI/AN) heritage. The Federal government currently recognizes 561 different AI/AN tribes and there are many other tribes that are not officially recognized. AI/ANs speak over 200 indigenous languages. Approximately 280,000 speak a language other than English at home; more than half of Alaska Natives who are Eskimos speak either Inuit or Yupik. Most American Indians live in Western states, with 42% in rural areas compared to 23% of whites. In 1980, most American Indians lived on reservations or trust lands, compared to only 20% today. Over 50% now live in urban, suburban, or rural non-reservation areas. In 1980, only 56% of AI/ANs 25-years-old and over had graduated from high school. By 1990, this percentage had increased to 66%, but it was still below the 75% rate for the Nation as a whole. In 1998, AI/AN men and women were roughly twice as likely as whites to be unemployed. In 1999, about 26% of AI/ANs lived in poverty, compared to 13% for the United States as a whole and 8% of white Americans.

Need for Mental Health Care

No large-scale epidemiological studies of AI/ANs have yet been published. The results of one such study which will provide considerable information about the prevalence of mental disorders among the AIAN population are expected in the near future. One small study with a 20-year follow-up found the lifetime prevalence of mental disorders to be 70%.

The Great Smoky Mountain Study found that AI children had similar rates of disorder (17%) compared to white children (19%). AI children had lower rates of tics (2 vs. 4%) and higher rates of substance abuse (1 vs. 0.1%). Almost all of the latter was accounted for by alcohol use among 13-year-old AI children.

Large-scale studies of mental disorders among older American Indians are lacking, but smaller studies have found rates of depression ranging from 10 to 30%.

The prevalence rate of suicide for AI/ANs is 1.5 times the national rate. AI/AN males ages 15 to 24 account for two-thirds of all AI/AN suicides. Violent deaths -- unintentional injuries, homicide, and suicide -- account for 75% of all mortality in the second decade of life for AI/ANs.

High-Need Populations

AI/ANs are over-represented among high need populations including the following:

- People who are homeless. While representing less than 2% of the U.S. population, it is estimated that AI/ANs constitute 8% of Americans who are homeless.
- People who are incarcerated. In 1997, an estimated 1 out of every 25 AI/AN adults were in the criminal justice system. A 1998 study found that 1 out of every 2 adolescents in a Northern Plains reservation juvenile detention facility had a substance abuse or mental health disorder. Many of these youth had multiple disorders.
- People with alcohol and drug problems. Prevalence rates for current alcohol abuse and/or dependence among Northern Plains and Southwestern Vietnam veterans have been estimated to be as high as 70% compared to 11 - 32% of their white, black, and Japanese American counterparts. The estimated rate of alcohol-related deaths for AI/ANs as a whole is much higher than it is for the general population.
People exposed to trauma. The rate of violent victimization of AI/ANs is more than twice the national average. The higher rate of traumatic exposure results in a 22% rate of PTSD for AI/ANs, compared to 8% in the general U.S. population. The American Indian Vietnam Veterans Project found lifetime prevalence of PTSD to be 45 to 57% among AI veterans, rates significantly higher than among other Vietnam veterans.

Children in foster care. Until 1978 when Congress passed the Indian Child Welfare Act to end "a pattern of discrimination against American Indians," an estimated 25 to 30% of AI/AN children had been removed from their families. By 1999, AI/AN children accounted for only 1% of children in foster care.

Availability of Mental Health Services
Approximately 101 AI/AN mental health professionals are available per 100,000 AIANs, compared to 173 per 100,000 for whites. In 1996, only about 29 psychiatrists in the U.S. were of AIAN heritage.

Access to Mental Health Services
The Indian Health Service (IHS) is the Federal agency responsible for providing health care to Native populations. However, only 20% of AIs report access to IHS clinics, which are located mainly on reservations.

Medicaid is the primary insurer for 25% of AI/ANs. Only about 50% of AI/ANs have employer-based insurance coverage, compared to 72% of whites. 24% of AI/ANs do not have health insurance, compared to 16% of the U.S. population.

Use of Mental Health Services
Representative community studies of AI/ANs have not been published, so little is known about the use of mental health services among those with established need. Smaller studies found that, off AI adults with a mental disorder, 32% received mental health or substance abuse services, about the same as the U.S. population as a whole. Among Cherokee children with a mental disorder, only 1 in 7 received professional mental health treatment, a rate similar to the non-AI sample. Cherokee children were more likely than white children to receive treatment through the juvenile justice system and inpatient facilities. AI/ANs appear to use alternative therapies at rates equal to or greater than whites.

Appropriateness and Outcomes of Mental Health Services
Few AI/AN have been included in the controlled clinical trials used to develop treatment guidelines for the major mental disorders.

http://www.mentalhealth.samhsa.gov/cre/default.asp
Multicultural

- Association for Multicultural Counseling and Development
  5999 Stevenson Avenue
  Alexandria, VA 22304
  Tel: 703-823-9800 or 800-347-6647
  http://www.counseling.org

- Center for Multicultural Human Services
  701 West Broad Street
  Suite 305
  Falls Church, VA 22046
  Tel: 703-533-3302
  Fax: 703-237-2083
  http://www.cmhsweb.org

- Cross Cultural Health Care Program
  270 So. Hanford St., Suite 100
  Seattle, WA 98134
  Tel: 206-860-0329
  http://www.xculture.org

- National Center for Cultural Competence
  Georgetown University
  Child Development Center
  3307 M Street, NW, Suite 401
  Washington, DC 20007-3935
  Toll free: 800-788-2066
  Tel: 202-687-5387
  Fax: 202-687-8899
  http://www.gucll.georgetown.edu/ncce/

- National Minority AIDS Council
  1931 13th Street, NW
  Washington, DC 20009-4432
  Tel: 202-483-6622
  Fax: 202-483-1155
  http://www.nmac.org

- Office of Minority Health Resource Center
  U.S. Department of Health and Human Services
  P.O. Box 37337
  Washington, DC 20013-7337
  Tel: 800-444-6472
  http://www.omhrc.gov
Multicultural

APA Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. American Psychological Association, 1998

Abstract:
(from the introduction) There is increasing motivation among psychologists to understand culture and ethnicity factors in order to provide appropriate psychological services to ethnic and culturally diverse populations is attributable, in part, to the growing political and social presence of diverse cultural groups, both within APA and in the larger society. New sets of values, beliefs, and cultural expectations have been introduced into educational, political, business, and healthcare systems by the physical presence of these groups. The issues of language and culture do impact on the provision of appropriate psychological services


Keywords:
CUL/cultural competency/Goals/Health/Minority/Research

Abstract:
Past research supported by the Agency for Healthcare Research and Quality has helped identify and explain the reasons for disparities in delivering health care to minority populations

http://www.mentalhealth.samhsa.gov/cre/default.asp
Homophobia and Heterosexism in Social Workers

Cathy S. Berkman and Gail Zinberg

Evidence suggests that social workers may be biased when dealing with gay and lesbian populations. The study discussed in this article attempted to measure the extent of homophobia and heterosexist bias and their correlates in a cohort of 187 social workers using the Index of Attitudes toward Homosexuality, the Attitudes toward Lesbians and Gay Men Scales, and a newly created scale to measure heterosexist bias. We found that 10 percent of respondents were homophobic and that a majority were heterosexist. Levels of homophobia and heterosexism were negatively correlated with amount of social contact with homosexual men and women. Religiosity was associated with higher levels of homophobia and heterosexism, and having been in psychotherapy was associated with more positive attitudes toward gay men and lesbians. Amount of education on topics related to homosexuality was not correlated with levels of homophobia and heterosexism.

Key words: gay men; heterosexism; homophobia; lesbians; social workers

Social workers, although trained to put aside biases and to respect the diversity of cultures reflected in client populations, are susceptible to absorbing the explicit and implicit biases held by mainstream society. Gay male and lesbian populations have historically been seen not simply as different from but as somehow less than their heterosexual counterparts. Evidence suggests that social workers may be biased when dealing with gay and lesbian populations. The problems these populations experience when encountering heterosexual social workers are partially related to social work's often unconscious bias and partially to an information deficit concerning the gay and lesbian communities and the unique difficulties that homosexual men and women encounter living in a predominantly heterosexual society.

Although homosexual clients are apt to bring many of the same problems to counseling as heterosexual clients, these problems are often exacerbated both by the heterosexual bias (or "heterosexism") of the mainstream culture and by the real or imagined heterosexism of those to whom they turn for help. The study discussed in this article was designed to determine the nature of heterosexual social workers' attitudes toward gay men and lesbians. We also hoped to
understand how these attitudes are related to gender, contact with gay men and lesbians, education about homosexuality, and religiosity.

**Review of the Literature**

Until 1973 the American Psychiatric Association (APA), which has historically determined the nomenclature and diagnostic criteria for clinical social work, regarded homosexuality as a psychopathology. At that time, 37 percent of the members of the APA opposed depathologization (Bayer, 1987). Homosexuality as pathology was replaced in 1973 with "ego-dystonic homosexuality," a concept that defined dissatisfaction with same-sex orientation as illness. In 1988 ego-dystonic homosexuality as well was removed from the *Diagnostic and Statistical Manual of Mental Disorders* (Haldeman, 1991). Homosexuality is still a classification category in the International Classification of Diseases (World Health Organization, 1997).

Although homosexuality has ceased to be regarded as a mental illness, heterosexuality continues to be referred to as the norm, and homosexuality is still often inadvertently discussed within the context of pathology (Morin, 1977; Rudolph, 1988). Negative attitudes toward homosexuality exist on a continuum from homophobia to heterosexism. Homophobia is traditionally defined as "fear, disgust, anger, discomfort and aversion that individuals experience in dealing with gay people" (Hudson & Ricketts, 1980, p. 358) or as a "dread of being in close quarters with homosexuals" (Weinberg, 1972, p. 4). The term has come to be more broadly defined as "any belief system which supports negative myths and stereotypes about homosexual people" (Morin & Garfinkle, 1978, p. 30) and "any of the variety of negative attitudes which arise from fear or dislike of homosexuality" (Martin, 1982, p. 341).

Heterosexism is "a belief system that values heterosexuality as superior to and/or more 'natural' than homosexuality" (Morin, 1977, p. 629). Heterosexual bias is a more subtle concept than homophobia and entails the belief that heterosexuality is normative and that nonheterosexuality is deviant and intrinsically less desirable. Heterosexism is often manifested by individuals who would not be considered as being blatantly homophobic or holding negative attitudes. This often subtle heterosexism permeates the culture in which social institutions and social work practice are built.

Rudolph (1989) demonstrated heterosexism among mental health practitioners; his sample of master’s- and doctoral-level clinicians and clinicians in training clearly held strongly positive attitudes about homosexuals in areas such as civil liberties, psychological character, and morality, yet had negative attitudes when addressing the suitability of homosexuals in sensitive professional positions. Garfinkle and Morin (1978) found that psychologists rating case studies of hypothetical clients that were identical except for sexual orientation perceived the homosexual clients as less healthy than the heterosexual clients. Glenn and Russell’s (1986) study of counseling psychology trainees found a heterosexual bias in ratings of hypothetical clients.

Most studies of homophobia have been conducted with samples of undergraduates (for example, Glassner & Owen, 1976; Hansen, 1982b; Millham, San Miguel, & Kellogg, 1976; O’Hare, Williams, & Ezovski, 1996) and other mental health professionals (Buhker, 1989; Hayes & Gelso, 1993; Pagotun-Ad & Clair, 1986; Rudolph, 1989; Smith, 1993). We are aware of only two studies that examined the nature and extent of homophobia among social workers. Both studies found that almost one-third of social workers with MSW degrees were homophobic (Wisniewski & Toomey, 1987), and one study found that social workers were more homophobic than psychologists and other mental health professionals (De Crescenzo, 1984).

There is concern that inadequate attention is given to homosexuality in social work education (Hidalgo, 1992; Murphy, 1992) and that social workers and counselors who maintain homophobic attitudes are less effective, if not actually harmful, in delivering social services to gay and lesbian clients (Dulany & Kelly, 1982; Greene, 1994; Rudolph, 1988). The consequences of these homophobic or heterosexist attitudes may be reflected in client evaluations. Rudolph reported that the source of dissatisfaction with treatment in the gay and lesbian populations was often the counselors’ heterosexual bias.
However, these findings are based on data from the 1970s and may not reflect current practice. It is clearly necessary to explore the extent of bias with more recent research because of changes that might have occurred over the past two decades as a result of the gay rights movement and the AIDS epidemic. Describing the extent of social workers' bias and its correlates is critical to understanding how bias affects clients and to modifying social work education and training to change negative attitudes.

Methods

Purpose of the Study

The study discussed in this article included a large probability sample of social workers that has greater generalizability than the two previous studies of homophobia in social workers that relied on nonprobability samples. We used three standardized measures of homophobia, including one that distinguishes between attitudes toward gay men and lesbians, as well as an original scale that measures the more subtle attitude of heterosexism. The classification of contacts by type of relationship enabled us to test the contact theory of reduced prejudice against members of a minority group resulting from equal-status contact (Allport, 1954). We also included measures of a variety of factors that might be correlated with these attitudes. Because there have been relatively rapid changes on the societal level in issues related to homosexuality, including the gay rights movement, the AIDS epidemic, and the rise in political opposition to gay rights, it is important to have timely empirical findings on this issue.

On the basis of the results of previous studies, we expected to find that heterosexual bias among social workers would be negatively correlated with education about homosexual issues (Glenn & Russell, 1986; Iyriboz & Carter, 1986; Rudolph, 1989; Serdahely & Ziemba, 1984; Uribe & Harbeck, 1991; Wells, 1991) and contact with gay men and lesbians (Glassner & Owen, 1976; Herek & Glunt, 1993; Lance, 1987; Milham et al., 1976; Pagonon-An & Clair, 1986). The relationship between gender and homophobia was also of interest because of conflicting reports in the literature (see review by Kite, 1984). We also explored the association established between religiosity and homophobia (for example, Herek & Glunt, 1993). The following hypotheses were tested:

1. Male social workers are more homophobic and heterosexist than female social workers.
2. Homophobia and heterosexism are greater when the gender of the respondent is the same as the gender of the target group.
3. There is a negative correlation between the number of relationship categories with a gay or lesbian acquaintance and levels of homophobia and heterosexism.
4. There is an association between the type of relationship with gay men and lesbians known and degree of homophobia and heterosexism.
5. There is a negative correlation between the extent of contact with gay men and lesbians, especially in peer relationships, and levels of homophobia and heterosexism.
6. There is a negative correlation between the amount of education on topics related to homosexuality and levels of homophobia and heterosexism.
7. Social workers who are less religious are less homophobic and heterosexist.

Sample

The target population for this study was heterosexual social workers holding MSW degrees. The study population was members of NASW in January 1994 who had MSW degrees. The sample frame was a random sample of 1,000 names randomly selected from NASW members in the United States. Questionnaires were sent to a systematic random sample of 376 respondents, including 188 men and 188 women. Anonymity was guaranteed, and a self-addressed stamped envelope was enclosed. The response rate was 54 percent, with a total of 202 returned questionnaires, of which 189 met the eligibility criteria of heterosexual orientation as determined by an item in the questionnaire regarding sexual orientation. Two respondents were dropped from the sample because of improperly completed responses to questions.
measuring attitudes toward homosexuality. However, dropping these respondents did not change the sociodemographic characteristics of the sample or the overall response to any outcome measures (for example, means or proportions) that could be scored.

Most of the 187 participants were female (72.2 percent), and the mean age was 46 years (SD = nine years). The respondents were predominantly white (91.4 percent), and the remainder were primarily African American (5.3 percent), Latino (1.2 percent), Asian (0.5 percent), and "other" (0.5 percent); 1.1 percent did not answer the question. Over two-thirds were married (70.1 percent), and the remainder were divorced or separated (13.4 percent), never married (7.5 percent), in a committed relationship (6.4 percent), or widowed (2.1 percent); one respondent did not provide a clear answer to this question. Many (71.1 percent) reported having children. The median household income was in the $65,000 to $80,000 category.

Measures
Hudson and Ricketts’s (1980) Index of Attitudes toward Homosexuality (IAH) measures homophobia as an affective response of nonhomosexual people toward homosexual men and women. It follows Weinberg’s (1972) definition of homophobia and thus differs from previous measures, which focused on attitudes toward homosexuality rather than homosexual people and on affective responses rather than cognitive or emotional responses. The IAH scale was chosen for its high reliability (.90) and good content and factorial validity.

The items include statements such as "I would feel comfortable working closely with a male homosexual" and "I would feel disappointed if I learned that my child was homosexual." Participants were asked to respond to each of the 23 statements using a five-point Likert scale ranging from 0 = strongly agree to 4 = strongly disagree, with 2 = neither agree nor disagree. We modified several items for greater relevance to the target population of social workers; the original instrument had been administered to undergraduate college students. For example, the item "I would like to have my parents know that I had gay friends" was modified to read "I would like my colleagues to know that I had gay friends." Negative items were reverse scored. Two items were dropped from the scale because they appeared to be ambiguous for the purpose of this study: "I would feel uncomfortable if I learned that my spouse or partner was attracted to members of his or her sex" and "I would feel uncomfortable kissing a close friend of my sex in public." The theoretical score range of this reduced scale is 0 to 92, with a higher score reflecting a greater level of homophobia. The reliability of the IAH in this sample, as calculated with Cronbach’s alpha, was .94. A score of 0 to 22 indicates a high-grade nonhomophbic, 23 to 45 a low-grade nonhomophbic, 46 to 69 a low-grade homophbic, and 70 to 92 a high-grade homophbic.

Herek’s (1988) Attitudes toward Lesbians and Gay Men (ATLG) comprises two subscales: a 10-item Attitudes toward Lesbians (ATL) scale and a 10-item Attitudes toward Gay Men (ATG) scale. Sample items in the ATLG scale include “A woman’s homosexuality should not be a cause for job discrimination” and “Lesbians just can’t fit into our society.” Sample items in the ATG scale include “The idea of male homosexual marriage seems ridiculous to me” and “Male homosexuality is merely a different kind of lifestyle that should not be condemned.” These two scales were originally administered with nine-point Likert-type response categories (Herek, 1988) and also with three-point response categories (Herek & Glunt, 1993). We modified the items to be rated according to the same five-point response categories as the IAH. The items were coded from 1 to 5, and negative items were reverse scored. We dropped one item from each of the ATL and ATG scales because of similarity to other items in the questionnaire. Each nine-item scale had a theoretical score range of 0 to 45, with a higher score reflecting a more homophobic attitude. For the present study, the internal consistency (alpha) coefficients were .90 for the ATG scale and .92 for the ATL scale.

An original 13-item scale was designed to measure heterosexism. We also scored this scale using the five-point response categories used for the IAH and ATLG scales. Negative items were reverse scored. Scores is 13 to 65, with a greater level of heterosexism as higher.

The Marlowe-Crowne Scale (Crowne & Marlowe) was used to determine the degree of responding the tendency to accept a research question. The range of this scale is 0 to 70, with a higher score reflecting a greater response set.

We created the Revised Marlowe-Crowne Scale (CRMCS), which is a measure of social desirability. This scale includes questions about norms and values, such as: "I always tell the truth," "I am a good person," and "I try to be helpful to others." The CRMCS has a range of 0 to 100, with a higher score indicating a greater tendency to respond in a socially desirable manner.

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were reverse scored. The theoretical range of scores is 13 to 65, with a higher score reflecting a greater level of heterosexism. The Cronbach's alpha is .82.

The Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960) was included to determine the degree of response bias by as-
sessing the tendency to respond in a culturally acceptable manner. The theoretical scoring range of this scale is 10 to 20, with a higher score reflecting a greater socially desirable response set.

We created the Relationship Categories Known Scale, which lists 22 types of relationship and asks respondents to indicate whether they are acquainted with at least one person in that category who is or might be gay or lesbian. This list includes spouse, former spouse, lovers, former lovers, parents, children, siblings, friends, neighbors, classmates, supervisors, colleagues, clients, teachers, employers, employees, interns, secretaries, messengers, hairdressers, shopkeepers, and others (write-in category). The scores were determined by summing one point for each relationship category in which the respondent knew someone who was gay or lesbian. The scale has a theoretical scoring range of 0 to 22.

The following subscales were also created: Categories of Relatives Known Scale (parents, children, siblings), Categories of Peers Known Scale (friends, neighbors, classmates, and colleagues), Categories of Superiors Known Scale (supervisors, teachers, and employers), Categories of Clients and Subordinates Known Scale (clients, employees, interns, and secretaries), and Categories of Distant Persons Known Scale (messengers, hairdressers, and shopkeepers). Clients were included in the category with subordinates because social workers are actually or perceived to be in a position of authority over clients. The intercorrelations between the pairs of subscales indicated that the relatives subscale was very weakly and not significantly correlated with the other subscales, but that there were moderate or strong correlations between each of the other pairs of subscales.

We created the Contact with Homosexuals Scale by asking respondents whether they had a great deal of contact, a moderate amount of contact, a little contact, or no contact with at least one gay or lesbian person in each of the 22 categories of relationship. The scores were determined by summing the responses to these items; a higher score reflected a greater amount of contact. Subscales of the contact scales were created according to the same categories as the Relationship Categories Known subscales.

We created an Education Scale to measure the amount of education that respondents had received on topics related to homosexuality either in an MSW program or subsequently. Topics included HIV/AIDS, family issues, psychopathology, transference and countertransference, parenting, public policy, human development, substance abuse, and others. Participants were asked to indicate the amount of education they had received on each topic on a scale ranging from 0 = none to 3 = a great deal. The theoretical scoring range of this scale is 0 to 81, with a higher score reflecting a greater amount of education on issues related to homosexuality. The Cronbach's alpha is .69.

To measure sociodemographic characteristics, participants were asked what their highest social work degree was, the year it was received, the number of years as a social worker, and current work capacity. Religiosity was measured by asking respondents to indicate true or false to the statement, "Religion is an extremely important aspect of my life." Respondents were also asked whether they had undergone any form of psychotherapy either currently or in the past.

Results

According to norms established by Hudson and Ricketts (1980), slightly more than one-quarter (26.7 percent) of the respondents were high-grade nonhomophobic, 62.0 percent were low-grade nonhomophobic, 10.7 percent were low-grade homophobic, and only one respondent (0.5 percent) was high-grade homophobic.

Normative cutoff points are not available for the ATL, ATG, and Heterosexism scales; however, the item mean scores for these scales are informative (Table 1). The item means for the ATG and Heterosexism scales indicate that, on average, respondents agreed, but not strongly, with the positive statements about gay men and
all homosexual people, respectively. The item mean for the ATL scale indicated that, on average, respondents were midway between agreeing and strongly agreeing with positive statements about lesbians.

**Gender Differences**

Men were more homophobic than women on each of the three scales measuring homophobia, although these differences were not statistically significant. A significantly greater degree of homophobia was expressed by both genders toward gay men (ATG scale) than toward lesbians (ATL scale), but this difference was virtually the same for both genders. The concordance of gender did not appear to be a factor, and the differential between men and women was slightly greater in relation to lesbians than gay men.

There were no significant differences in mean scores on the IAH and ATG and ATL scales according to age, marital status, being a parent, income, highest graduate degree (MSW or doctorate), or whether primary work capacity was in direct service provision.

Scores on the Heterosexism Scale indicated that men were significantly more heterosexist than women. Age was also associated with scores on the Heterosexism Scale, with younger respondents having lower scores (age 28 to 40 = 26.8, age 41 to 50 = 28.6, age 51 to 70 = 30.4, p < .05).

There were weak but significant positive correlations between the Crowne–Marlowe Scale and the IAH and ATG and ATL scales. The correlation between the Crowne–Marlowe Scale and the Heterosexism Scale was not significant. However, the direction of these correlations was opposite to that which would be expected if a socially desirable set was influencing responses to the items on the homophobia scales. These analyses increase our confidence in the validity of scores on the four attitude scales.

**Categories of Relationships with Gay Men and Lesbians**

We tested the first hypothesis by analyzing the intercorrelations between the Relationship Categories Known Scale and subscales with each of the four attitude scales. We found a negative correlation between the number of relationship categories with a homosexual acquaintance and levels of homophobia and heterosexism (Table 2). The strongest correlations were seen for the total Relationship Categories Known Scale, with strong correlations for the Categories of Peers Known Scale and the Categories of Distant Persons Known Scale. It appears that relationships with peers and superiors had a more positive influence on levels of homophobia and heterosexism than did relationships with people of a lower status. The low correlation with relatives known may result from the extremely low mean for this subscale.

| Table 1 |
| Social Workers' Mean Scores on Scales Measuring Attitudes toward Homosexuality and Heterosexism, by Gender (N = 187) |

<table>
<thead>
<tr>
<th>Gender</th>
<th>IAH</th>
<th>ATL</th>
<th>ATG</th>
<th>Heterosexism Scale</th>
<th>ATG–ATL*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men (n = 52)</td>
<td>31.7</td>
<td>15.5</td>
<td>19.6</td>
<td>30.5</td>
<td>4.1***</td>
</tr>
<tr>
<td>Women (n = 135)</td>
<td>29.6</td>
<td>13.8</td>
<td>18.1</td>
<td>27.9</td>
<td>4.3***</td>
</tr>
<tr>
<td>Men–women</td>
<td>2.1</td>
<td>1.7</td>
<td>1.5</td>
<td>2.6*</td>
<td>4.2***</td>
</tr>
<tr>
<td>Total sample</td>
<td>30.2</td>
<td>14.3</td>
<td>18.5</td>
<td>28.6</td>
<td>4.2***</td>
</tr>
<tr>
<td>Item means for total sample</td>
<td>1.3</td>
<td>1.6</td>
<td>2.1</td>
<td>2.2</td>
<td></td>
</tr>
</tbody>
</table>

Notes: IAH = Index of Attitudes toward Homosexuality (Hudson & Ricketts, 1980); ATL = Attitudes toward Lesbians scale (Herok, 1988); ATG = Attitudes toward Gay Men scale (Herok, 1988). Range for IAH items was 0 to 4; range for the other scale items was 1 to 5, with the low score representing less homophobia or heterosexism.

*Paired t test on difference between means for the ATG and the ATL scales.

*Independent samples t test on difference between means for men and women.

*p < .05. ***p < .001.

| Table 2 |
| Correlation Coefficients Subscales with Scales |

| Variables |
| Relationship Categories Known Scale and subscales with each of the four attitude scales. We found a negative correlation between the number of relationship categories with a homosexual acquaintance and levels of homophobia and heterosexism (Table 2). The strongest correlations were seen for the total Relationship Categories Known Scale, with strong correlations for the Categories of Peers Known Scale and the Categories of Distant Persons Known Scale. It appears that relationships with peers and superiors had a more positive influence on levels of homophobia and heterosexism than did relationships with people of a lower status. The low correlation with relatives known may result from the extremely low mean for this subscale.

**Amount of Contact with**

The patterns seen in the number of gay men and women were closely related to the Contact with the attitude scales (Table 1). The Contact Categories Known Scale was stronger in relation to the other three attitude scales.

**Education on Topics Related**

The hypothesis that received on topics related to the attitude scales was not statistically significant. The ATL, ATG, and IAH scales were all weak and not significant. Respondents had a mean of 31.7, indicating that they were not significantly different.

**Religiosity and Psychology**

Analyses of the relationship between religiosity and homophobia were...
Table 2
Correlation Coefficients for the Relationship Categories, Contact, and Education Scales and Subscales with Scales Measuring Attitudes toward Homosexuality and Heterosexism (N = 187)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$M$</th>
<th>IAH</th>
<th>ATL</th>
<th>ATG</th>
<th>Heterosexism Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Categories Known Scale</td>
<td>5.02</td>
<td>-.41***</td>
<td>-36***</td>
<td>-29***</td>
<td>-36***</td>
</tr>
<tr>
<td>Categories of Relatives Known Scale</td>
<td>.09</td>
<td>-.05</td>
<td>-.00</td>
<td>-.02</td>
<td>-.05</td>
</tr>
<tr>
<td>Categories of Peers Known Scale</td>
<td>2.26</td>
<td>-.34***</td>
<td>-26***</td>
<td>-31***</td>
<td>-33***</td>
</tr>
<tr>
<td>Categories of Superiors Known Scale</td>
<td>.66</td>
<td>-.27***</td>
<td>-15**</td>
<td>-.22**</td>
<td>-20**</td>
</tr>
<tr>
<td>Categories of Clients and Subordinates Known Scale</td>
<td>1.12</td>
<td>-.21**</td>
<td>-18**</td>
<td>-.23***</td>
<td>-23***</td>
</tr>
<tr>
<td>Categories of Distant Persons Known Scale</td>
<td>.59</td>
<td>-.30***</td>
<td>-26***</td>
<td>-26***</td>
<td>-26***</td>
</tr>
<tr>
<td>Contact with Homosexuals Scale</td>
<td>8.81</td>
<td>-.42***</td>
<td>-24***</td>
<td>-34***</td>
<td>-38***</td>
</tr>
<tr>
<td>Relatives Contact Scale</td>
<td>.26</td>
<td>-.14</td>
<td>-.05</td>
<td>-.07</td>
<td>-.09</td>
</tr>
<tr>
<td>Peers Contact Scale</td>
<td>4.12</td>
<td>-.42***</td>
<td>-25***</td>
<td>-34***</td>
<td>-39***</td>
</tr>
<tr>
<td>Superiors Contact Scale</td>
<td>.98</td>
<td>-.24***</td>
<td>-11**</td>
<td>-.18**</td>
<td>-17**</td>
</tr>
<tr>
<td>Clients and Subordinates Contact Scale</td>
<td>2.21</td>
<td>-.26**</td>
<td>-.16**</td>
<td>-.22**</td>
<td>-29***</td>
</tr>
<tr>
<td>Distant Persons Contact Scale</td>
<td>.81</td>
<td>-.32***</td>
<td>-22**</td>
<td>-.29***</td>
<td>-28***</td>
</tr>
<tr>
<td>Education Scale</td>
<td>26.4</td>
<td>0.02</td>
<td>0.08</td>
<td>0.03</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Notes: IAH = Index of Attitudes toward Homosexuals Scale (Hudson & Ricketts, 1980); ATL = Attitudes toward Lesbians scale (Herek, 1988); ATG = Attitudes toward Gay Men scale (1988). The means for Relationship Categories Known Scale and the Contact with Homosexuals scale are slightly higher than the sums of the subscale means because of the inclusion of “other” in the total scale.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Amount of Contact with Gay Men and Lesbians

The patterns seen in the correlations between the number of gay men and lesbians known and the attitude scales were very similar to those seen between the Contact with Homosexuals Scale and the attitude scales (Table 2). As with the Relationship Categories Known Scale, correlations tend to be weaker in relation to the ATL scale compared to the other three attitude scales.

Education on Topics Related to Homosexuality

The hypothesis that amount of education received on topics related to homosexuality is negatively correlated with homophobia and heterosexism was not supported. The correlations between the Education Scale and the IAH and the ATL, ATG, and Heterosexism scales were all weak and not significant (Table 2). Respondents had a mean scale score of 26.4, although there was wide variability in scores ($SD = 15.7$). The item mean score was 1.1 ($SD = .31$), indicating that most respondents had only “a little” education on any of the 27 topics.

Religiosity and Psychotherapy

Analyses of the relationship between religiosity and homophobia were based on a priori reports in the literature, whereas analysis of the relationship between psychotherapy and homophobia was exploratory. We found that both religiosity and psychotherapy were associated with homophobia and heterosexism as measured by the four attitude scales (Table 3).

The mean scores for each of the four attitude scales were significantly greater, indicating a higher level of homophobia and heterosexism, for social workers who responded that religion was an extremely important aspect of their lives. Respondents who were currently undergoing or had undergone some form of psychotherapy in the past had significantly lower mean scores on each of the attitude scales, an indication of lower levels of homophobia and heterosexism among these individuals.

Hierarchical Regression

Hierarchical regression models were estimated by regressing each of the attitude scales on the independent variables examined in the analyses shown in Tables 1 through 3 and potential modifying variables. We found that either the Relationship Categories Known Scale or the Contact with Homosexuals Scale, but not both, was significant in each of the models. The Edu-
Table 2
Mean Scores on the Scales Measuring Attitudes toward Homosexuality and Heterosexism, by Religiosity and Psychotherapy Measures (N = 187)

<table>
<thead>
<tr>
<th>Measure</th>
<th>IAH</th>
<th>ATL</th>
<th>ATG</th>
<th>Heterosexism Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religiosity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33.4***</td>
<td>16.2***</td>
<td>20.6***</td>
<td>30.6***</td>
</tr>
<tr>
<td>No</td>
<td>26.8</td>
<td>12.4</td>
<td>16.4</td>
<td>26.5</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27.9***</td>
<td>13.4**</td>
<td>17.4***</td>
<td>27.6**</td>
</tr>
<tr>
<td>No</td>
<td>36.6</td>
<td>16.8</td>
<td>21.7</td>
<td>31.5</td>
</tr>
</tbody>
</table>

Notes: IAH = Index of Attitudes toward Homosexuals (Hudson & Ricketts, 1980); ATL = Attitudes toward Lesbians scale (Herek, 1988); ATG = Attitudes toward Gay Men scale (Herek, 1988). Results of t-tests: *p < .05, **p < .01, ***p < .001.

The heterosexism scale had a small but significant effect in the model estimated for the IAH and was not significant in any of the other models. Having undergone psychotherapy reduced the homophobia score on each of the attitude scales by approximately 5 percent (for the Heterosexism Scale) to 9 percent (for the ATG Scale) of the theoretical range, depending on the scale. Social workers who responded that religion was extremely important to them had homophobia scores on each of the attitude scales that were 4 percent (for the IAH Scale) to 9 percent (for the ATG Scale) higher than those who said religion was not very important.

Discussion

We found that the overwhelming majority (almost 90 percent) of these social workers were not homophobic. Social workers in this study were significantly less homophobic ($\chi^2(3, N = 264) = 229.98, p < .001$) than those who participated in Wisniewski and Toomey's (1987) study. Compared with a national sample of adults who were asked five of the items in the ATG scale (Herek & Glunt, 1993), social workers in our sample were significantly less homophobic on all five items ($\chi^2(2, N = 1,138 to 1,189)$ ranged from 67.12 to 327.25, $p < .001$). However, in addition to the approximately 10 percent who were homophobic, a majority of respondents had heterosexist attitudes. A score of 13 on the Heterosexism Scale represents the absence of heterosexist attitudes, and the mean for this study was over 15 points higher. Although further work in establishing the reliability, validity, and meaningful cut points for the Heterosexism Scale is necessary, the face and content validity of this scale lend credence to the importance of this finding.

Gender Differences

Although a number of studies found higher levels of homophobia in men than in women (for example, Glassner & Owen, 1976; Hansen, 1982b; Herek, 1994, 1988; Herek & Glunt, 1993; Kite, 1984; Millham, San Miguel, & Kellogg, 1976; Weinberger & Millham, 1979), our finding that level of homophobia did not differ according to gender was consistent with more recent reports (O'Hare et al., 1996; Royse & Birge, 1987; Royse, Dhooper, & Hatch, 1987), including a meta-analysis of 24 studies (Kite, 1984), and with the study of homophobia in social workers (Wisniewski & Toomey, 1987). The Heterosexism Scale did indicate that women were significantly less heterosexist than men. We also found that levels of homophobia were significantly greater in relation to gay men than lesbians, and this was the case for both men and women. This result may be due to less rigid views about sexuality in relation to women than men; stereotypes about predatory sexual behavior and pedophilia in gay men; and, more recently, fear of AIDS.

We replicated the finding of higher levels of homophobia in relation to gay men among heterosexual men e.g., example, Herek, 1994, 1976; Yarber & Koss, 1983; our difference was not significantly higher among homophobes. Although Herek levels of homophobia were not significantly higher among gay men, we have not found no significant difference.

Age

Our finding of no significant differences in levels of homophobia by age is in agreement with previous studies (Herek, 1994). We found no significant difference among young people.

Knowing a Gay or LESBIAN

We confirmed previous findings that persons who knew a gay or lesbian were less homophobic than those who did not. Not everyone in the sample had known a gay or lesbian, but those who did know one were significantly less homophobic than those who did not.

It is possible that the correlation between knowing a gay or lesbian and decreased homophobia suggests that the higher levels of homophobia found in the general population may be due to lack of exposure. When people do not know anyone who is gay, they may have more negative attitudes toward gay people, and this may contribute to the higher levels of homophobia found in these communities.
heterosexual men compared with women (for example, Herek, 1988; Kite, 1984; Millham et al., 1976; Yarber & Yee, 1983), although this difference was not significant. We did not find a higher level of homophobia in relation to lesbians among heterosexual women compared with men. Although Herek (1988) did find higher levels of homophobia toward lesbians among his female respondents, the magnitude of this difference was smaller than seen in relation to gay men, and he noted that previous studies have often found no differences between male and female respondents in attitudes toward lesbians.

**Age**

Our finding of no significant differences in levels of homophobia by age is supported by previous studies (Herek & Glunt, 1993). Our finding of significantly lower levels of heterosexism among younger respondents remains to be replicated.

**Knowing a Gay or Lesbian Individual**

We confirmed previous reports of a negative association between knowing a gay or lesbian person and homophobia (Allport, 1954; Hansen, 1982b; Herek & Glunt, 1993; Lance, 1987; Millham et al., 1976; O’Hare et al., 1996; Pagtolun-An & Clair, 1986). By examining findings according to the type of relationship, we found that the number of types of homosexual relatives and amount of contact with them were not related to level of homophobia or heterosexism, although this may be due to the extremely low numbers of homosexual relatives reported. Our data supported Allport’s (1954) findings that prejudicial attitudes are reduced when there is peer contact with members of the minority group. Marmor (1980) suggested that interactions with gay men and lesbians provided information that reduced ignorance and minimized negative stereotypes.

It is possible that there is a reverse causal direction and that people with lower homophobia and heterosexism choose to have friends who are homosexual more often than do those who are homophobic or heterosexual. It is unlikely that this temporal sequence entirely explains this correlation for two reasons: First, the three other relationships that make up the Categories of Peers Known Subscale are not voluntary.

Second, having a friend who is gay or lesbian accounts for only half of the scale score for over 90 percent of the respondents and only one-third of the scale score for almost two-thirds of the respondents. Similarly, amount of contact with a friend who is homosexual accounts for only half of the scale score for over 80 percent of the respondents and only one-third of the scale score for almost half the respondents.

A possible shortcoming is the way the measures of number of types of relationships with a homosexual person and amount of contact were constructed. These variables did not count the total number of people known who were gay or lesbian or the total amount of contact with homosexual individuals. Rather, these items determined whether or not there was at least one person in that relationship category who was homosexual and the amount of contact with that individual. Although this method does not measure the number known or amount of contact, the scores may be valid as indicators of the relative differences in these measures between respondents, and more important, the relationships with the attitude scales may be correctly reflected. Future research that includes measures of the total number of gay men and lesbians known by the respondent and the amount of contact with those individuals is necessary to resolve this issue.

**Education on Gay and Lesbian Issues**

Our finding of no association between social workers’ attitudes and education was at first surprising in view of previous research that indicated that education has been effective in changing attitudes (Anderson, 1981; Christensen & Sorensen, 1994; Lyribo & Carter, 1986; Rudolph, 1989; Serdahely & Ziemba, 1984; Uribe & Harbeck, 1991; Wells, 1991). It should be noted that many of these studies did not use an experimental design, did not have appropriate comparison groups, and measured only short-term effects of the targeted educational intervention in which participants, often undergraduates, were most likely aware of the goals of the intervention. Although it is possible that our measure of education may not be sensitive to
factors that are salient to homophobia and heterosexism, it appears that whatever education is received is of negligible long-range effectiveness.

Religiosity

The meaning of the association between attitudes and religiosity is complex. Previous studies have found that people who are more religious, have more conservative religious beliefs, and attend church frequently are more homophobic (Cameron & Ross, 1981; Glassner & Owen, 1976; Hansen, 1982a; Herek & Glunt, 1993). Allport and Ross (1967) made a distinction between extrinsic and intrinsic orientations to religion. An extrinsic orientation reflects a conventional, instrumental approach, whereas an intrinsic orientation reflects an internal, meaning-based approach. They found that an extrinsic orientation tends to be positively associated with prejudice, whereas an intrinsic orientation stresses love, tolerance, and acceptance of differences.

Herek (1987) explored the association between religion and attitudes toward gay men and lesbians and found no significant correlation between intrinsic versus extrinsic orientation and homophobia. Instead, degree of orthodoxy, whether extrinsic or intrinsic, was positively correlated with homophobia. Our measure of religiosity was based on a single item that did not allow us to fully explain the nature of the association with homophobia and heterosexism. Future studies would benefit from a more comprehensive conceptualization and measurement of religion, including denomination and religiosity, to understand their meaning in relation to attitudes toward homosexual people.

Having Been in Psychotherapy

The association between having been in psychotherapy and more positive attitudes toward gay men and lesbians was intriguing. This association was based on an exploratory analysis for which there was no a priori hypothesis. It is possible that psychotherapy leads to questioning and subsequently reducing one’s biases toward gay men and lesbians, either consciously or unconsciously. Alternatively, social workers who are more open-minded about homosexuality may also be more receptive to engaging in psychotherapy. Understanding the dynamics of this association will require more extensive study and may provide clues to methods for reducing homophobia and heterosexism.

Study Limitations

The response rate of 54 percent, although respectable for a mail survey, raises concern about selection bias and the generalizability of the results. There is also a possibility of misclassification of sexual orientation of respondents on the basis of self-report, despite the guarantee of anonymity. This possibility is more likely to result in underestimation of the levels of homophobia and heterosexism.

Effects on Treatment

The existence of homophobia in social workers who work with AIDS patients (Wiener & Siegel, 1990) and the high prevalence of social workers who indicate their reluctance to work with people with AIDS (Dhooper, Royse, & Tran, 1987–88) are of particular concern. But the existence of negative attitudes toward gay men and lesbians in professional social workers is troubling regardless of a client’s HIV status.

Hayes and Gelso (1993) found that homophobia in male counselors predicted their discomfort with gay male clients and that even moderate levels of homophobia can interfere with counseling. Homophobia affects transference and countertransference and may lead to inappropriate choices of treatment modality and treatment goals (Caban, 1988; De Crescenzo, 1984; Gelso & Carter, 1985; Singer & Luborsky, 1977). Greene (1994) noted that therapists may commit errors in the treatment of homosexual clients that can occur along a continuum ranging from minimizing the importance of the client’s sexual orientation and the negative effects of heterosexism (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Youngstrom, 1991) to viewing homosexual orientation as the pathological underlying cause of all of the client’s problems (Garnets et al., 1991; Markowitz, 1991). The long history of antimale bias and loss of acceptance of gay men and lesbians in American society is related to the higher rates of substance abuse, and among this population (Rudolph, 1988, 1982). It is important to respond to client needs but also to understand the role of homophobia and heterosexism.

Increased Visibility

The finding that so many social workers scored the importance of social work in schools of social work with such high visibility from within and from the discipline is encouraging. Social work schools should take a lead role in increasing the visibility of professional social workers and systematically encourage involvement in organizations for the visibility of social workers. Social work students should be especially vigilant and advocate for increased visibility.

Education and Training

to the higher rates of depression, anxiety, substance abuse, and other psychological distress among this population (Morrow, 1993; Rudolph, 1988, 1989; Ziebold & Mongeon, 1982). It is important that social workers not only respond to clients in an unbiased manner but also understand how such biases may have contributed to the problems with which clients are coping.

**Increased Visibility of Gay Men and Lesbians**

The finding that social contact is correlated with homophobia and heterosexism underscores the importance of greater visibility of gay men and lesbians among social workers, both in schools of social work and in the workplace. Herek (1984) suggested that interactions among equal-status individuals with common goals should lead to a decrease in heterosexism. Schools and agencies alike can encourage more visibility from within by advocating gay-positive and lesbian-positive policies that directly and indirectly encourage visibility. For example, providing job-related benefits to same-sex domestic partners of faculty or staff not only would be an incentive to gay men and lesbians to be open about their sexual orientation, but also would make a powerful statement to all individuals at that institution. Visibility can be encouraged within social work schools through the existence of on-campus gay and lesbian organizations for students that provide on-campus visibility as well as student speakers to social work classes. Social workers need to be especially vigilant in opposing the ways, overt and covert, that visibility is discouraged.

**Education and Training**

Numerous suggestions have been made regarding the need for more training and education about gay and lesbian issues for mental health professionals (Buhike, 1989; Cabaj, 1988; Garnets et al., 1991; Graham, Rawlings, Halpern, & Hermes, 1984; Greene, 1994; Murphy, 1992; Proctor & Groze, 1994; Youngstrom, 1991) and social workers in particular (Dulancy & Kelly, 1982; Gramick, 1983; Morrow, 1993). Herek (1991) suggested several possible reasons that might explain the effectiveness of educational programs in changing attitudes toward homosexuality and proposed further research directed toward understanding which factors resulted in the attitude change.

A formal policy on the inclusion of sexual orientation content in social work education is itself a relatively recent phenomenon. The Council on Social Work Education (CSWE) Curriculum Policy Statement in 1983 formally mandated schools of social work to address the area of sexual orientation (Murphy, 1992). Hidalgo (1992) emphasized the importance of integrating content on a wide range of topics related to homosexuality throughout all areas of the curriculum, including not only practice but also administration, human behavior, policy, research, and field work. Forristor (1992) suggested several modalities for integrating content on homosexuality into direct practice courses.

Several authors (for example, Gramick, 1983; Morrow, 1993) have advised social workers to have self-awareness of their own homophobia and how it affects their practice with clients. Murphy (1992) maintained that mental health professionals should be taught that it is unethical for them to work with homosexual clients unless they have a positive view about homosexual lifestyles. She advocated that professional organizations such as NASW and CSWE become forums for ensuring that statements regarding the need to educate social workers about the concerns of gay men and lesbians are adhered to, that openly homosexual individuals are elected to offices within these organizations, that the CSWE accreditation board review the curriculum to determine the adequacy of information on gay and lesbian topics, and that content on homosexuality be included in licensing exams.

**Conclusion**

Research should be undertaken so that the profession may better understand how education about homosexuality might reduce homophobia and heterosexism. Social workers need to learn about the format and content that are most effective in communicating a lasting message. Research is also needed to understand how negative attitudes toward gay men and lesbians are related to service delivery outcomes, including effectiveness and client satisfaction.
References


Cathy S. Berkman, PhD, ACSW, is assistant professor, Fordham University Graduate School of Social Service, 113 West 60 Street, New York, NY, 10023; e-mail: berkman@mary.fordham.edu.

Gail Zinberg, MSW, is director, Youth Empowerment Support Services, GLBT Youth, Columbia and Greene Counties, NY. The authors acknowledge the contributions of Priscilla Johnson, Carol Resse, and Priscilla Woods to this study.

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OUT OF TOUCH
When Parents and Children Lose Contact
After Divorce
GEORGE L. GREIF

"A powerful book that captures the complexity of a common and many-sided domestic drama... The narratives are vivid enough to detail the many twists and turns that lead one parent to 'lose touch' and Greif's analysis is rich enough to stand alone. Together, complemented by insightful policy recommendations, they make for a book that anyone who has personal or professional interest in what happens to families after divorce will want to read"—Theodore Cohen. "I found the concrete self-help actions based on 180 responses and the interviews conducted to be most helpful both as a social worker and a single parent"—Susan C. Tebb. $25.00, 240 pp.

ENSURING INEQUALITY
The Structural Transformation of the African American Family
DONNA L. FRANKLIN
FOREWORD BY WILLIAM JULIUS WILSON

"Why are so many African-American children growing up in mother-led families? From a nuanced historical perspective, Donna Franklin offers no-holds-barred answers to this question. Conservatives and liberals alike will find things in her argument with which to agree—and disagree. She brings a provocative new perspective to America's pressing debates about poverty, fatherlessness, and how to (really) reform welfare"—Thea Skorup "Intellectually fascinating... Rejects the view that the rise of single parenthood is a new, modern development, and shows that the change in family structure is traceable to a cumulative story which started in slavery... A well-crafted, closely reasoned, and well-documented narrative that challenges conventional understanding of the plight of African American families"—Martin Klein. $27.50, 251 pp.
MULTICULTURALISM

INTRODUCTION

Multiculturalism has been described as a "movement...whose goal is to elevate and celebrate diverse ethnic backgrounds" (Johnson, 2000). Multiculturalism as a concept is both challenging and provocative. Responses to multiculturalism vary, depending on socioeconomic factors, political environments, and individual orientation to cultural pluralism. The reactions to multiculturalism range from valuing it for its contributions to society, acceptance as a de facto status of development within our society, suspicion of its roots and its intention, to outright rejection by those who find it a threat. Factors that affect an individual's response to multiculturalism include, but are not limited to, concerns about empowerment, social status and placement within society, availability and distribution of resources, and political acceptance or rejection of the concept. For social workers, multiculturalism is a reality within which the profession is practiced and always offers an opportunity for personal and professional growth.

Currently, the challenge to understand and accept cultural differences in the United States is more difficult due to misconceptions and xenophobia created by fear of terrorism and immigration of people from countries in which English is not the national language and its people are predominantly of color. In contrast to the European immigration in the late 19th and early 20th centuries, the majority of the foreign-born population in the United States in 2000 came from Mexico, the Asia-Pacific countries (India, Philippines, China, and Vietnam), Central America, and the Caribbean islands.

![Diagram showing the ten source countries with the largest populations in the United States as percentages of the total foreign-born population: 2000](image)


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BACKGROUND

In recent years, the United States has been attracting over a million immigrants annually. This has resulted in a country that is religiously, racially, and linguistically increasingly more diverse. Additionally, intermarriage among different racial, ethnic, and religious groups has added complexity to categorizing groups or identifying cultural characteristics. International and cross-cultural adoptions add another nuance to the multicultural layers of society. Together, the cultural tapestry of the United States has increased the need to understand how society at large has changed and how these changes enrich, challenge, and strain society, and concomitantly the need for services, political awareness, and tolerance. American society has tended to be very precise about racial divisions and identification, and mixed-race people complicate this framework. For example, Hispanics are not a racial category and may, in fact, be of many—usually mixed—racial backgrounds. The United States won’t have any categorized racial or ethnic majority at some point between 2050 and 2100. This trend is bound to aggravate tensions over issues like immigration, affirmative action, political power, and competition for resources. “They are simmering now in disputes over what government benefits to allow legal immigrants, whether to make English the country’s official language, and how to ensure opportunities for minority Americans without discriminating against others” (Lawrence, 1997).

INTERNATIONAL EXPERIENCE WITH MULTICULTURALISM

Diversity characterizes the great majority of the countries in the world. With the end of the cold war and the dominance of two world powers, claims for recognition based on ethnicity, religion, or cultural background have become increasingly stronger. Tragedies such as the genocides in Bosnia and Rwanda have heightened individual country concerns regarding the power relationships among its various ethnic and religious subgroups. A few countries, notably Australia, Canada, and Sweden, have adopted multiculturalism as its response to cultural and ethnic diversity. The position of these three countries is that “multiculturalism emphasizes that acknowledging the existence of ethnic diversity and ensuring the rights of individuals to retain their culture should go hand in hand with enjoying full access to, participation in, and adhesion to, constitutional principles and commonly shared values prevailing in the society. By acknowledging the rights of individuals and groups and ensuring their equitable access to society, advocates of multiculturalism also maintain that such a policy benefits both individuals and the larger society by reducing pressures, and ultimately, social conflicts based on disadvantage and inequality. In Australia, there is a further contention that cultural diversity actually provides an important national resource for foreign economic, political and cultural relations” (UNESCO, 1995).
MULTICULTURALISM IN THE UNITED STATES

Historically, "multiculturalism" came into public use in the United States during the 1980s in the context of public school curricula reform. Specifically, the argument was made that the content of classes in history, literature, social studies, and other areas reflected what came to be called a "Euro-centric" bias. Few, if any, women or people of color, or people from outside the Western European traditions appeared prominently in the curricula of schools in the United States. This material absence was also interpreted as a value judgment that reinforced unhealthy ethnocentric and racist attitudes. Multiculturalism, in response to these criticisms, has evolved as a movement with the goal to elevate and celebrate diverse ethnic backgrounds. It is reflected in educational programs that include historical contributions by people of color; in the use of multiple languages in public life, including prevalent and visible use of sign language (as on voting ballots, public announcements, all official public meetings, televised events, and religious services); and in corporate programs designed to work more effectively with workers from diverse backgrounds.

Multiculturalism has been seen by some as part of a solution to a long history of ethnic and racial oppression in the United States. The increasing demands by minority groups for recognition and equality, often linked to the concept of multiculturalism, has led to an expansion of diversity from traditional racial and ethnic divisions to include gender, social class, religion, and spiritual belief, sexual orientation, age, and physical and mental ability. Social conservatives have criticized the movement as a devaluation of what they regard as an essential core of standards and wisdom traced to Western white civilization. Concerns have been raised that the movement will lead to societal chaos and loss of control as well as provide more options for aberrant behavior and non-conformity. Other critics are concerned that the movement diminishes patriotism, inhibits national identity, corrupts the country's language base, and undermines the moral standards that regulate behavior.

LANGUAGE

Language is a central issue of contention among proponents and opponents of multiculturalism, and increasingly, religion is coming into this sphere. Language is a very important component of culture since it provides a sense of unity. There is no official status granted to English in the United States, although it is unquestionably the dominant language. Attempts to render English official and restrict use of other languages in public services, including education, have been declared unconstitutional by the Supreme Court, as infringing on the civil rights of citizens (Law v. Nichols, 414 U.S. 563). Supporters of English as the national language are opposed to publicly supported bilingual education or bilingual communication on the basis of the latter's undermining influence on national identity and acculturation. Supporters of bilingual or multi-lingual communication contend that support of foreign language communication enhances, rather than diminishes, understanding and acceptance of American values and participation in political discourse. In education, bilingual communication supporters also contend that it ensures that children are helped to keep pace with their English-speaking peers in educational achievement while mastering English, rather than becoming victims of a learning gap. NASW recognizes the potential broad negative impact of English-only legislation and considers the use of a variety of languages as a right and a resource that is closely aligned with the ethical principles of service and social justice (NASW, 1999).

CULTURAL PRACTICES, RELIGIOUS BELIEFS, AND SECULARISM

The United States, as an industrial society, is highly secularized, although also characterized by strong religious power in public discourse and actions. Science has replaced religion as the primary approach to understanding the natural world, and religion has become a source of social control. However, substantial numbers of the established population and new immigrants retain cultural and religious beliefs that are fundamental to their lives and wish to see them reflected in public law and public display. The separation of state and church is a heatedly contested topic and a politically charged issue reflected in the debate over prayer in school, abortion rights, and display of religious symbols on public lands and buildings.

Cultural characteristics such as religious practices or distinctive style of dress identify members of particular ethnic or religious communities. Dress codes associated with particular religions, (e.g., Islam or Orthodox Judaism), have sparked a movement to curtail their use in public schools. Requests to celebrate Islamic, Jewish, or Christian cultural observances at work sites have met with resistance and raise charges of non-observance of the separation of church and state. Cultural identifiers also include rules that govern marriage and other forms of social connection that affect the boundaries that separate peoples of different ethnicities.
Cultural identifiers are important because they decline in number and effectiveness, so does the ethnic identity associated with them. Social workers who work with immigrants from distinctly non-European ethnic backgrounds are abundantly aware of the “push-pull” and often conflictive family relationships that arise as children learn the language of their new country, customs, and styles of dress that are different from the ones practiced at home.

Religion also creates controversies regarding science and authority. One of the concepts, fundamentalism, has been described as “the struggle against modernism by religious groups who claim the continued relevancy of earlier time periods for models of truth and value and reject what they perceive as forms of secularism. Such groups are often characterized by a strict authoritarianism that disallows individual variations from the defined (scriptural) norm of faith” (Johnson, 2000). Within Christianity, fundamentalism is a Protestant view that affirms the absolute and unerring authority of the Bible, rules out scientific or critical study of the scriptures, denies the theory of evolution, and holds that alternate religious views within or outside Christianity are false. Within Islam, fundamentalists advocate a mystical view of Islamic values and seek to restore the primacy of religious-based law. They oppose the secular ethos that, in their view, characterizes not only non-Muslim West but also Muslim nation-states. They seek a community in which religion and politics are intertwined, and seek official recognition of Islamic Law as the source of social control and authority.

**ISSUES FOR SOCIAL WORKERS**

Social work has had extensive experience relating to issues associated with diversity and multiculturalism. While the arguments for and against acceptance of multiculturalism as an organizing and systemic principle for our society continue to be debated, social work values diversity and promotes cultural competence as important social work tools. The profession has been taught to understand and respect various cultures, and provide culturally relevant programs and services. The NASW Code of Ethics, intended to serve as a guide to the everyday professional conduct of social workers, includes the principle that “social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and differences among people and cultural groups” (NASW, 1999). In 2001, NASW expanded further on its commitment to the issues of diversity and cultural competence by developing the Standards of Cultural Competence in Social Work Practice. In 2002, NASW’s Practice Update on Cultural Competence (NASW, August 2002) summarized the Association’s policies and guidance regarding culturally competent social work practice and described the efforts being made to help social workers become more effective in their practices.

Social workers are particularly tasked with facilitating the interactive social processes between societies’ status quo populations and those groups seeking acceptance and recognition. The effectiveness of social workers seeking to facilitate relevant social interactions among groups, between groups, between individuals and communities, and between individuals and the social systems and structures requires constant self-evaluation and active efforts to keep their professional knowledge and skills current. The concept of multiculturalism is complex and fraught with controversies regarding American identity, acceptance of differences, and individual rights. The projected acceleration of the diverse make-up of the United States requires sensitivity, self-awareness, and excellent cross-cultural skills to help resolve controversies and achieve positive transformations of communities and society.

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California Religious Demographics

Religious Profiles of Sample California Counties

Every decade, the Glenmary Research Center publishes a profile of the religious affiliations of residents in every county in the United States. This is the major source of information that is currently available for identifying the relative sizes of the nation's many faith traditions and for tracking long-term trends in religious affiliation. We have used information from the Glenmary Research Center to create religious profiles for a representative sample of California counties.

Our intention is to highlight the fact that the religious affiliations of California residents assume very different patterns in various regions of the state. All statistics are self-reported by denominational "headquarters" and/or associations. Critics of the Glenmary report argue that this procedure may limit the reliability of statistics, because different definitions of membership may be utilized by leaders in various religious traditions.

Los Angeles County's Ten Largest Faith Groups in 2000

<table>
<thead>
<tr>
<th>Religious Group</th>
<th>Number of temples, churches, mosques, or synagogues</th>
<th>Number of adherents</th>
<th>% of total population</th>
<th>% of total adherents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>278</td>
<td>3,806,377</td>
<td>40</td>
<td>68.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>202</td>
<td>564,700</td>
<td>5.9</td>
<td>10.2</td>
</tr>
<tr>
<td>S. Baptist Conv.</td>
<td>312</td>
<td>111,634</td>
<td>1.2</td>
<td>2</td>
</tr>
<tr>
<td>Mormon</td>
<td>239</td>
<td>97,347</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Muslim</td>
<td>48</td>
<td>92,919</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>American Baptist</td>
<td>211</td>
<td>73,217</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Independent Charismatic</td>
<td>11</td>
<td>71,500</td>
<td>0.8</td>
<td>1.3</td>
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<td>Assembly of God</td>
<td>260</td>
<td>64,327</td>
<td>0.7</td>
<td>1.2</td>
</tr>
<tr>
<td>United Methodist</td>
<td>177</td>
<td>54,676</td>
<td>0.6</td>
<td>1</td>
</tr>
<tr>
<td>Intl Four Square Gospel</td>
<td>225</td>
<td>52,362</td>
<td>0.6</td>
<td>0.9</td>
</tr>
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</table>

Selected Non-Christian Religious Traditions in Los Angeles County: 2000

<table>
<thead>
<tr>
<th>Religious Group</th>
<th>Number of temples, mosques, or synagogues</th>
<th>Number of adherents</th>
<th>% of total population</th>
<th>% of total adherents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahai'</td>
<td>44</td>
<td>6,346</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>Hindu</td>
<td>37</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>Muslim</td>
<td>48</td>
<td>92,919</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Jewish</td>
<td>202</td>
<td>564,700</td>
<td>5.9</td>
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</tr>
<tr>
<td>Sikh</td>
<td>14</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>Buddhist</td>
<td>145</td>
<td>NA*</td>
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* Data not available
Los Angeles is the most religiously diverse city in the world

At a meeting sponsored by the Center for Religion and Civic Culture, a politically active Protestant denominational leader expressed frustration: "It's wrong to say there is a Los Angeles religious community," he argued. "In fact, we're incredibly fragmented. I'm often introduced to people who I'm told are important religious figures in Los Angeles. To tell you the truth, I've never heard of most of them."

The frustration expressed by this denominational executive probably could not have been avoided as Los Angeles has bypassed London and New York as the world's most religiously pluralist metropolitan region. More than 600 separate faith communities have established religious centers in Los Angeles neighborhoods, and these communities conduct their affairs in a large number of different languages and in a large number of racial/ethnic enclaves. Most of their clergy are strangers to one another.

During the 1920s and 1930s Los Angeles was a bastion of Anglo Protestantism, reflecting the values of Midwestern parishioners who had been carried to the Southland on the Southern Pacific Railroad. Well into the 1970s, Protestant denominational leaders enjoyed comfortable, influential ties with the city is still strong "downtown business establishment," which itself was largely Protestant.

The Immigration Act of 1965, however, created the condition for a radically different religious future for the City of Angels-a future that would anoint Roman Catholicism as the area's dominant religious group. Today Roman Catholicism is the single largest faith tradition in Los Angeles County, with 294 parishes and 3,631,368 adherents. Among Christians, 71% are Catholics. Between 1980 and 1997, Roman Catholicism experienced a 26% growth.

According to Louis Velasquez, director of the Los Angeles Archdiocese Office of Hispanic Ministry, approximately 70% of Roman Catholics in Los Angeles County are Latino, mostly immigrants from Mexico and Central America. Father Gregory Courier, speaking for the three-county Los Angeles Archdiocese, suggests that as many as one million undocumented immigrant Catholics probably remain uncounted. Sixty percent of these Latino Catholics, Velasquez says, speak Spanish as their primary language. Spanish masses are held at over two thirds of the Archdiocese's 287 parishes, and in most of these parishes, Spanish language masses make up about 80% of the total number of masses offered.

An additional 10% of Roman Catholics in Los Angeles County are Asian, weighted toward first and second generation immigrants from East Asia, especially from Korea and the Philippines. Nine percent are African-American.

Today only 26% of the County's Christians are Protestant, and Los Angeles County Protestantism is no longer led by mainline Protestant denominations such as the Presbyterian Church USA, the United Church of Christ, the Disciples of Christ, American Baptist, Evangelical Lutheran Church in America, the United Methodist Church, and the Episcopal Church. Only 29% are mainliners-successors of the region's previous mainline "Protestant Establishment." Although the mainline denominations have experienced decline during the past three decades within Los Angeles County, there are now signs that that decline may be bottoming out. Between 1990 and 1997, for example, the Episcopal Church and the Evangelical Lutheran Church in America have apparently experienced growth, even as the United Methodist Church and the Presbyterian Church USA have continued their descent.

Among Protestants, 55% are evangelical and 16% are Pentecostal. In 1906, in what is now the Little Tokyo district of Los Angeles, a revival held on Azusa Street launched an international Pentecostal movement-a movement that, at the end of the century, is being energized by a surge of Latino converts. Latino Pentecostalism is the major growth area of Southland Protestantism. In the City of Los Angeles, there are about 1,000 Latino Pentecostal churches. According to a recent national survey by the Tomas Rivera Center, although about 77% of Latinos continue to be affiliated with Roman Catholicism, the momentum is toward affiliation with Pentecostalism. That momentum is apparent all over the central areas of the city, where neighborhoods housing Latino immigrants host storefront Pentecostal churches, sometimes at a density of two or three to a block.

Los Angeles County's Jewish community appears to be experiencing a slight growth, from approximately 503,000 in the mid-to-late 1980s to approximately 599,000 in 1997. Of these, approximately 34% are affiliated with temples and synagogues. In 1990, Jews made up 10.3% of the population that identified with Judeo-Christian traditions.

There are roughly 30,000 Iranian Jews in Los Angeles. Most live in Los Angeles's exclusive West Side. Eighty-five percent are self-employed. Their employment is concentrated in sales, technology, and administrative support services. After their arrival in Los Angeles, about 90% of Iranian Jews maintain their pre-immigration level of religious practice.

According to anecdotal reports, attendance at Buddhist temples and meditation centers is rapidly growing in Los Angeles County. There are currently 131 Buddhist temples and meditation centers in Los Angeles County.

Islam is also on the rise, making Southern California the third largest concentration of practicing Muslims in the United States, with 58 mosques, community centers, and study centers in Los Angeles County. According to J. Gordon Melton, who regularly charts the growth and decline of the nation's faith traditions, 40% of American Buddhists and Muslims reside in Southern California. In Los Angeles County, there are 6 Bahai worship centers, 18 Hindu temples, 16 Shinto worship centers, and 28 Tenrikyo churches and fellowships.

Southern California is the largest growth area in the United States for the Church of Jesus Christ of Latter Day Saints. Nevertheless, Mormonism in Los Angeles County experienced a slight decline between 1990 and 1997-from 103,286 to 96,300 members, probably because of an outflow of members to the Inland Empire.
Think Before You Speak
Interacting & Etiquette

PEOPLE WHO USE WHEELCHAIRS
- Always ask the person using the wheelchair if he or she would like assistance before you help.
- Don't lean on a person's wheelchair. It is part of their personal space.
- Don't discourage children from asking questions about the person or why they use a wheelchair.
- If the conversation lasts more than a few minutes, sit or kneel to get to eye level.

PEOPLE WHO ARE VISUALLY IMPAIRED
- Ask the person if he or she wants help in getting about. When providing assistance, don't grab and start tugging — allow the person to take your arm, bent at the elbow.

PEOPLE WHO HAVE SPEECH DIFFICULTIES
- Give whole, unhurried attention to the person.
- Keep your manner encouraging, rather than correcting.
- Rather than speak for the person, allow extra time and give help when needed.

PEOPLE WHO ARE HEARING IMPAIRED
- If necessary, get the person's attention with a wave of the hand or light tap on the shoulder.
- Don't be embarrassed about communication via paper and pencil.
- Speak clearly and slowly but without exaggerating. Don't shout! Use body language or facial expression to help.

When necessary, ask questions that require short answers or a nod or shake of the head.
- Don't pretend to understand when you don't. Repeat what you do understand; the person's repetition will clue you in and guide you.
- Look for communication aids like pictures or symbols.

Try to maintain eye contact. Allow for a clear view of your face — the person may be lip reading. Don't speak directly into the ear.

How to Say It
Say person who has
Instead of crippled or on crutches
Say person with
Instead of victim or handicapped
Say a disability
Instead of disabled or handicapped
Say cerebral palsy
Instead of polio, C.P., or paralytic
Say speech
Instead of retarded
Say seizure disorder
Instead of epileptic
Say Down Syndrome
Instead of mongoloid
Say short stature
Instead of dwarf or midget
Say without speech or nonverbal
Instead of mute or hard of hearing
Say deaf or hearing impaired
Instead of hard of hearing
Say visually impaired
Instead of blind
Say developmentally delayed
Instead of slow
Say emotional disorder or mental illness
Instead of crazy or insane
Say hearing disability
Instead of hearing disabled
Say handicapped
Instead of normal or healthy
Say mobility impaired
Instead of lame
Say cerebral
Instead of handi-cap
Say seizure
Instead of his
Say congenital disability
Instead of birth defect
Say uses a wheelchair
Instead of confined to a wheelchair
Say non-ambulatory
Instead of wheelchair-bound
Say physical disability
Instead of crippled or lame
Say paralyzed
Instead of invalid or paralytic
Say has hemiplegia (one-sided paralysis)
Instead of hemiplegic
Say has quadriplegia (paralysis of all limbs)
Instead of quadriplegic
Say has paraplegia (lower body paralysis)
Instead of paraplegic
People with disabilities have the same rights as everyone else—the right to fall in love, marry, hold down a job, acquire an education, etc. Above all, they have a right to self-esteem. To insure these rights, people with disabilities should be referred to in terms that acknowledge the ability, merit, and dignity of the individual. By making an effort to become sensitive to, and aware of, the language we use, we create an atmosphere of mutual respect. This brochure will give you some ideas for using “People First” language.

If you saw a person using a wheelchair unable to negotiate the stairs of a building, would you say:

“There is a handicapped person unable to find a ramp”
or would you say: “There is a person using a wheelchair who is handicapped by an inaccessible building”?

LEARNING THE LANGUAGE

- Speak of the person first, then the disability.
- Emphasize abilities, not limitations.
  “He uses a wheelchair.”
  “She walks with crutches.”
- Understand that although a disability may have been caused by a disease, the disability itself is not a disease and is not contagious.
- Don’t label people as part of a disability group—say “people with disabilities” not “the disabled.”
- Don’t patronize or give excessive praise or attention.
- Don’t say, “Isn’t it wonderful how he has overcome his disability?” People live with a disability—they have to overcome attitudinal, social, architectural, educational, transportation and employment barriers—not the disability.
- Be aware that choice and independence are important. Ask a person with a disability if s/he wants assistance before you help. Your help may not be wanted or needed.
- Treat adults with disabilities as adults. Call the person by his or her first name only when extending that familiarity to all others present. Make eye contact and speak directly to the person, not a companion or interpreter. Do not give the person a nickname s/he does not usually use; say “Bill,” not “Billy.”
- Be aware of the distinction between disability and handicap: A disability is a functional limitation that interferes with a person’s ability to walk, hear, talk, learn, etc. A handicap is a physical or attitudinal constraint that is imposed upon a person. Use handicap to describe a situation or barrier imposed by society, the environment or oneself.
- Be considerate of the extra time it might take for a person to get things said or done.