Chapter 1

Shattering Culture: An Introduction

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HOW DOES culture matter in American medicine and health care? This query motivated the ethnographic studies of healthcare institutions and psychiatric clinics that are the heart of this volume.

Why Attend to Culture in Medicine and Health Care Now?

For many decades, American medicine and its institutions of patient care have attended to the cultural distinctiveness of patients and carried out missions to redress inequalities in access to medical services for the poor, for ethnic and racial minorities, and for new immigrants and refugees. However, despite years of effort to institutionalize culturally sensitive and competent care and to reach out to serve and provide equitable care to minority patients, two highly consequential federal policy studies, Mental Health: Culture, Race, and Ethnicity and Unequal Treatment, released in 2001 and 2002–2003, respectively, reported persistent inequalities and disparities in treatment by culture, race, and ethnicity over a wide range of psychiatric and medical specialties (Smedley, Stith, and Nelson 2003; Surgeon General 2001). Studies funded by the National Institutes of Health over the past two decades also found that unequal medical and psychiatric treatment cannot be explained by differences in access or by individual patient characteristics alone, thereby leading researchers and
policymakers to seek explanations in subtle and complex psychological, social, and cultural processes in interactions between patients and their doctors and health-care institutions. The public discussions generated by these two policy discussions on “culture counts” and “unequal treatment” remain profoundly vibrant and relevant in health policy and medical circles today.

This book reports on findings from a study carried out in Greater Boston, in which we explored the role of culture in contemporary worlds of medicine and psychiatry as practiced in environments of increasingly complex cultural and demographic diversity. With the publication of these reports, the concept of culture came to have a newfound caché in American medicine in the twenty-first century. The social milieu generating this dynamism in the meaning and importance of culture is the dramatic transformation in the demographic landscape of American society. The new immigration over the past several decades has intensified American cultural diversity and increased complex formulations of racial and ethnic identities (Lee and Bean 2010). We define this as the emergence of cultural environments of hyperdiversity (see chapter 2, this volume).

The chapters in this book discuss the various ways culture is used and given meaning in psychiatry and mental health care in clinical settings in Greater Boston. Our research documented how ideas about culture, ethnicity, immigration, diversity, disparities, and inequalities are shaped in and by American medicine and its institutions of patient care, research and training, and health policy, thereby influencing clinical ideologies, forming clinical practices, and generating programs to deliver quality care that is regarded as culturally appropriate, sensitive, or competent. We sought to understand the roles and meanings of culture from the perspective of clinicians and health-care staff who treat patients from diverse cultural backgrounds and who find culture relevant in their daily clinical work, asking them to reflect not only on patient culture but also on the culture of psychiatry and medicine and of their clinics—in other words, organizational culture.

We framed our research with two overarching queries: How does American medicine respond to cultural diversity? Does culture make a difference in American health care and in mental health care? We began the research with three broad issues in mind. First, we wondered about the extent to which notions of ethnicity and culture, popular in the 1960s when community clinics were being established as part of the Great Society agenda, remain present in the way doctors and clinics use culture and think about how culture counts; the extent to which the language of cultural competence in contemporary medicine relies on ideas of an earlier era, of coherent ethnic communities sharing coherent cultures; and whether these older models of ethnicity are still regarded as useful guides for clinicians and those who organize care in today’s culturally diverse
medical settings. Second, we wondered about the extent to which ideas of race, ethnicity, and culture are shaped by changing demographics and the new immigration (for a review, see Suárez-Orozco, Suárez-Orozco, and Qin 2005 and Kasinitz et al. 2008), and whether newer ideas of culture that no longer assume coherent systems of meaning and experience have found their way into the discourses, practices, and policies of American medicine and psychiatry. Third, and most fundamental to our research, we consider how the culture of medicine and in particular the culture of psychiatry adapt and respond to these changes and how broad symbolic systems that support American medicine and its subspecialties interact with the dynamic and changing meanings of ethnicity, race, and culture that have evolved over the past two decades.

The terms shattering culture and cultural environments of hyperdiversity (or, simply, hyperdiversity), from which we draw our title, emerged directly from our ethnographic investigations and observations. Hyperdiversity, as Seth Hannah discusses in chapter 2, identifies our nation’s dynamic population transition to a complex and mosaic-like mix of national origin, ethnicity, race, immigration status and nativity. Shattering Culture, our title, popped out as we analyzed our interviews and observations. The title identifies the uncertainty that arises in these cultural environments of hyperdiversity in which broad identity-based indicators of cultural difference are often too blunt to capture current social and individual identities. The new immigration and the new ethnic-racial mix in younger generations of Americans and immigrants have shattered bounded communities and the cultural meanings of the old social categories of ethnicity and race, as cultural identities have increasingly become more complex, dynamic, fluid, and evolving. Census categories of the race and ethnicity pentad are gradually breaking apart in a dynamic and ever-evolving fashion (Asian, black, Hispanic, Native American and Pacific Islander, and white, with mixed race added in this decade). Thus the certainty of these official cultural categories, the result of so much health and other government policy research, is shattered (Prewitt 2005, 2009; Saulny 2011).

The politically important cultural categories of race and ethnicity have been fundamental to promoting civil rights, to assessing inequalities and disparities “in health, education, housing, and civil rights protection, and to identifying underrepresented minorities” (Saulny 2011, A1). And yet they now seem, at least in popular culture, to be social labels and analytic categories of another era and to have diminished political potency and meaning (CDC 2011). Shattering culture also names efforts of clinicians and support staff who attend to emergent and contextually dependent patterns of social categorization and ways individuals appropriate and use cultural difference. For example, language, income, and insurance status were often considered as important cultural categories that rivaled or exceeded race and ethnicity. In using the term shattering culture, we do
not intend to discard culture as a concept with which to think and make
sense of the world of medicine and of social life, but rather to note that
the certainty about the value of older cultural categories of race and eth-
nicity, used often in establishing social policies for equality and the
common good, is shattered.

In the following sections of this chapter, we discuss psychiatry’s import
for understanding the meanings and uses of culture in medicine and
responses to cultural diversity today, and follow with an exploration of
the issues framed by, and in conversation with, the two highly signifi-
cant national health policy discussions of this century—culture counts in
mental health care and unequal treatment and disparities in healthcare.
We present a discussion of the demographic landscape of Boston and its
uniqueness and a description of our research design, clinical sites, and
the sample characteristics of our participants. We conclude with a brief
preview of the chapters.

**Anthropology in Psychiatric Clinical Settings**

Why psychiatry? Culture has long been a fundamental analytic category
with political and policy caché in psychiatry and mental health services, as
well as among academic research communities. Questions about whether
mental illnesses vary across cultures, and about how to adapt psychiatric
services—including diagnosis, therapeutics, and the organization of care—
for the various needs of distinctive cultures and subcultures, have been
central issues of concern for nearly the whole of modern psychiatry (see
Anderson, Jenson, and Keller 2011; Kleinman and Good 1986). Historically
rooted in engagements with cultures around the globe since colonial eras
(Pols 2011; Anderson, Jenson, and Keller 2011; Good and Good 2010;
Jenkins and Barrett 2004), psychiatry has held a fascination for cultural dif-
ference in how mental illness is expressed, experienced, and understood
(Good and Good 1980). Psychiatry is the medical discipline most often charged with teaching cultural competence
and cultural sensitivity to medical students, residents, and other clinical trainees, and the specialty most concerned with language barriers and clinician-patient matching (Willen, Bullon, and Good 2010; chapters 3 and 5, this volume). In addition, psychiatrists are most frequently turned to by physicians from other specialties for cultural consultations.7

Psychiatry is also the medical specialty that reflects most deeply on its own internal variety and diversity of professional cultures, such as acknowledging the tension between universalism and cultural specificity, as well as the competition among psychodynamic, cultural, biological, neuroscience, and—most recently—genetic approaches to making sense of mental illness, designing therapeutics, and understanding humankind (Luhrmann 2000; Jenkins 2011; Lewis-Fernandez, personal correspondence, March 2011). For example, today’s leading cultural psychiatrists8 are shaping cultural ideologies for ethnic specific clinics, creating cultures of clinical practice oriented toward culturally diverse patient populations served, and actively undertaking cross cultural research. They are creating one dimension of psychiatry’s culture of the twenty-first century by developing new diagnostic definitions and illustrative cases where patient culture matters in treatment, for the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM) 5.0.9 They also debate the merits of universalism and cultural specificity in patient care, exploring ways to balance these two impulses in American psychiatry “that allow one to transcend difference and seek affinities across cultural boundaries.”10 Thus the drive toward encompassing cultural particularism into universalism (a culturally constructed notion as well) at the heart of today’s cultural psychiatry is not surprising. As Roberto Lewis-Fernandez, a leading cultural psychiatrist speaking about the work of the DSM 5.011 working group on culture says, “I am not anti-universalism, but for a more informed universalism.”

Similar to many other fields in medicine, psychiatry is also under stress from current financial constraints and chaotic coverage and payment plans, as well as from an explosion in documentation practices and technological modes of regulation and oversight (see chapters 10 and 11, this volume). Thus for those interested in how medicine is responding to cultural diversity today, psychiatry is a field that is good to think with.

Culture Counts and Unequal Treatment

Psychiatry has long been concerned with cultural differences in access and use of mental health services and in treatment outcomes. Beginning in the 1960s, research began to show differences in access to care, treatment quality, and outcomes for racial and ethnic minorities in the United States, leading to debates among psychiatrists, policymakers, and other activists about the potential explanations for these troubling differences
(Sue 1977). Some took the particularistic position that culture counts, arguing that cultural barriers to treatment caused unequal outcomes. They viewed the experience and expression of mental illness as fundamentally different across diverse racial and ethnic groups and argued these differences must be taken into account to provide effective and equitable treatment for all (Sue 1998; Satcher 2001; Chang 2003). Researchers also proposed that inferior care could be caused by racism or bias on the part of individual providers or the system itself (Smedley, Stith, and Nelson 2003). Others looked to more universalistic explanations, that racial and ethnic differences in access to psychiatric care, quality of care, and treatment outcomes are due to universal aspects of mental illness, and that individual characteristics such as social class, poverty, and lifestyle choices are disproportionately present in different groups (Chang 2003).

These concerns with differences in mental health care by race and ethnicity of over thirty years ago were motivated in part by the identity politics of the 1960s and the social movements promoting equality for racial and ethnic groups in the United States, defined by the U.S. Census pentad, as white, African American, Asian, Hispanic/Latino, and Native American and Pacific Islanders (Hannah 2011). They were also motivated by a global deinstitutionalization movement to close the mental hospitals and asylums and replace them with community mental health and outpatient services. These two movements transformed American psychiatric treatment from long-term hospitalization or asylum care (Goffman 1961) to short-term stays, outpatient medication, and culturally sensitive and tailored treatment at many community mental health centers. Thus the politics of designing culturally appropriate care radically changed with the changes in treatment modalities and settings, and culture, race, and ethnicity became politically significant to building services designed to serve minority populations.

Themes from this earlier era continue to be central today in reports on culture counts and unequal treatment reflecting a renewed concern about the burden of mental illness for racial and ethnic minorities and inequalities in treatment. Many of the same academics who were advocates for minority mental health in the 1960s and 1970s participated in the production of these twenty-first century reports and remain leading advocates today. In 1999, the Surgeon General released a mental health report that identified the disease burden of mental illness and access to mental health care as an area of growing concern for the United States, but framed the issue in universal terms, neglecting to report on differences in prevalence, treatment, and care for racial and ethnic minorities. Academic experts in minority mental health, often members of the groups they study, regarded the exclusion of analyses by culture, race, and ethnicity as deplorable, as did the federal employees most engaged in policies promoting mental health care for ethnic and racial minorities (see Chang, Good, and Good
They successfully lobbied for a new consensus report, *Mental Health: Culture, Race, and Ethnicity, A Supplement to the Surgeon General’s Report on Mental Health* (Surgeon General 2001), which highlighted the importance of race and ethnicity, declaring that culture counts. They documented ways culture counts in mental health care and health policy through empirical studies, identifying by culture, race, and ethnicity the unequal burden of mental illness, unequal use and access to treatment, and disparities and inequalities in diagnosis, medication, therapeutics and quality of care (Chang et al. 2003; Chang 2003; Surgeon General 2001). “Culture Counts” fast became a rallying cry for those promoting programs for minority mental health. The phrase resonates well with the long tradition of using culture as a fundamental albeit diffuse analytic category in psychiatry, justifying attention to cultural variation in the experience and expression of illness and legitimizing investment in culturally tailored mental health services and culturally competent care.¹³

Nonetheless, a tension between impulses to privilege cultural distinctiveness versus universal commonalities is common as well in research that does attend to minority mental health and analytic categories of race and ethnicity.¹⁴ Chang characterizes this divide as research that “privileges universal common risk factors, such as poverty, to explain group difference in mental illness versus . . . that which privileges group specific cultures, histories, and lived experience—such as racism [or colonialism] to explain group differences in mental illness” (Chang 2003, 379).¹⁵ Despite these differences among researchers in minority mental health, culture counts continues to expand the relevance and develop new meanings of culture in psychiatry.

The Culture Counts movement was given further public exposure and its policy relevance enhanced by the publication of the Institute of Medicine’s report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2002–2003). The report presented a vast overview of National Institutes of Health (NIH) research from the decade of the 1990s that documented differences in treatment by race and ethnicity across a wide spectrum of medical and psychiatric conditions (Ayanian et al. 1999; Ayanian et al. 1993; Bach et al. 1999; Smedley, Stith, and Nelson 2003; Good et al. 2003; Waters 2008). For example, in psychiatry, differences were documented in diagnosis and medication practices, black men receiving misdiagnoses of greater severity more frequently than white men or women, and more frequently being prescribed older rather than newer psychopharmaceuticals.¹⁶

This genre of highly influential NIH research was nurtured by the successful political movements and ethnic-identity health-care politics of the late 1980s and early 1990s (Epstein 2007). In particular, the women’s health movement and its congressional advocates, Patricia Schoeder and Olympia Snowe, successfully called for research on the diseases of
women and minorities and explanations for differences by gender, race, and ethnicity in medical treatment for major disorders such as heart disease. In 1990, the force of law mandated inclusion of minorities and women in NIH-funded research (Kelty, Bates, and Pinn 2007, 130), bringing a virtual sea change in the research culture of NIH and along with it the findings of disparities in medical treatment.

Building on recent NIH research and motivated by its congressional charge, notably led by the Black Congressional Caucus, Unequal Treatment continued the critique of solely universalistic explanations for racial and ethnic differences in mental health care, providing evidence for a series of provocative and revolutionary arguments. It also demonstrated that differences in care for racial and ethnic minorities exist, even after taking into account universal, individual factors such as insurance status, access to care, and lifestyle choices. The authors referred to these remaining differences as disparities in care, which they tied to other more pernicious factors, such as clinician bias or racism. This dramatically shifted the terms of the debate away from the cultural characteristics of racial and ethnic minority members themselves to the culture and institutions of medicine itself—its individual clinicians and health-care providers, on medical education, training, research, and institutions of patient care—as sources of disparities in care.

Drawing from theories in social psychology on bias and stereotyping (Van Ryn 2002; Dovidio et al. 2008), Unequal Treatment emphasized personal bias and stereotyping within medicine as explanatory of disparities; yet it also implicated the broader culture of medicine and the medical gaze (Good et al. 2003; Good 1995a, 2001, 2007; Good and Hannah 2010; Good et al. 1990; Good et al. 1999). It recommended policies and interventions to redress clinician bias and to reduce disparities and inequalities in care by race and ethnicity. This shift in emphasis (and perhaps blame) from patient culture, race, and ethnicity to the culture of medicine found its way into twenty-first century NIH research agendas as well as into policies of health-care institutions and clinics. Centers for disparities research were soon established in many academic medical centers and teaching hospitals throughout the country, thereby following earlier developments of entrepreneurial adventures in cultural competence and diversity training that grew in response to the increasing cultural diversity of patient populations (Lo and Stacey 2008; Lakes, Lopez, and Garro 2006; Lopez 1997; Betancourt 2003, 2006; Guarnaccia and Rodriguez 1996; Kleinman and Benson 2006).

The cultural categories salient in these two national discussions—culture, race, and ethnicity for mental health, and race and ethnicity (and at times social class and gender) for disparities—have profoundly influenced the actions of health-care institutions and their clinicians and staff, shaping practices designed to respond to the increasing cultural hyper-
diversity of patient populations and to reduce health-care and health disparities among disadvantaged ethnic and racial minorities. Culture counts and unequal treatment became the dominant policy themes defining in large measure the role culture plays in all its many meanings in medicine and psychiatry today.

However, the analytic categories of race and ethnicity underlying these dominant policy themes are being challenged by recent demographic trends that have brought increased immigration to the United States from around the world and exceptional residential mobility and racial and ethnic diversity in neighborhoods and cities and even rural communities across the country. Clinics once designed to serve primarily one ethnic community or a few neighborhood ethnic groups are now faced with a complex array of individuals from different and multiple ethnic backgrounds, speaking different languages, holding nuanced cultural perspectives, from different social classes, and with complicated historical experiences as well as racial and ethnic identities. These changes, which we refer to in this book as hyperdiversity, call for an expanded investigation of how culture counts in American mental health care. Culture may count in contemporary medicine and psychiatry, but in ways not well captured by the analytic research and policy categories that have relied solely on the mandated pentad of the national census. Cultural differences are vast among members of each of the major census categories, and each medical institution and profession has a unique cultural character and institutional history that powerfully shapes care in ways unrelated to simple definitions of race and ethnicity.

Curiously, the concept of culture as an analytic concept has increasingly been questioned by some anthropologists, just as health-care institutions and clinicians have increasingly routinized concepts and uses of culture as means for improving quality of care and reducing disparities, and as health-services researchers use culture as an independent variable to explain differences in health status and disparities in medical treatment. Anthropologists have grown concerned about the risks of essentializing societies (either as cultures plural, or subgroups within societies as subcultures) (Abu-Lughod 1991). A good deal of anthropological scholarship in recent years emphasizes how cultural communities and forms of cultural identity are variable, situational, dynamic, and embedded in struggles for power and control over resources. Our discussions of culture, both patients’ culture and the culture of medicine, reflect the debates in anthropology (Goodale 2009; Marcus and Fischer 1999). Rather than throwing out the culture concept or judging it as outdated and of scant value, the chapters in this book caution against essentializing patient or ethnic group culture but acknowledge that culture, as well as ethnicity and race, continue to hold pragmatic significance for many people, and as such, requires continued attention from clinicians and social scientists.
Researching Psychiatry in Hyperdiverse Boston

Greater Boston, historically a major hub of immigration, continues to be a gateway city. Boston is historically unique as well in the distinctive boundary profiles of its ethnic communities and their links to the city’s various health-care institutions—its community clinics, its hospitals, and its academic medical centers, which for decades had been publicly perceived as ethnically and religiously flavored. Strikingly, Boston’s demographic transformation over the past three decades has dissolved many boundaries of ethnicity and religion that for generations characterized the culture and politics of Greater Boston and its segregated neighborhoods, ethnically defined (Blustone and Stevenson 2000).\textsuperscript{17} No longer predominantly Yankee, Brahman, Irish, Italian, African American, and Chinese; no longer just Catholic, Protestant, and Jewish; no longer black, white, and a little Asian; Boston’s population of the twenty-first century has become a mosaic, a world city representing the diversity of the globe,\textsuperscript{18} or what we refer to as a cultural environment of hyperdiversity.

Since 1970, Greater Boston has transformed from an environment in which blacks and whites made up 98 percent of the population to one in which whites are nearly the minority and Hispanics and Asians, combined, outnumber blacks. As figure 1.1 shows, the white population in Suffolk County\textsuperscript{19} has declined from 84 percent in 1970 to just 52 percent in 2009 as immigration has rapidly increased and whites have continued their relocation to the suburbs (see also figure 1.2). As figure 1.3 shows, the foreign-born population in Suffolk County has doubled, from 13 percent in 1970 to nearly 26 percent in 2009. The black population in Suffolk County has grown moderately, increasing from 14 percent in 1970 to 20 percent in 2010, but its geographic distribution and ethnic composition has changed dramatically. Approximately half are now immigrants or children of immigrants from a growing number of countries in the Caribbean, Africa, and elsewhere\textsuperscript{20} and, as figure 1.4 shows, now live in an expanding area south of the city from Roxbury through Dorchester, down to Mattapan, Roslindale, and Hyde Park. The Hispanic/Latino population has grown tremendously, increasing from just 3 percent in 1970 to 20 percent in 2010. A racially and ethnically diverse population of immigrants and refugees from throughout Latin America as well as American citizens originally from Puerto Rico, the Hispanic/Latino population is geographically widespread throughout Greater Boston and, as figure 1.5 shows, is particularly concentrated in cities and neighborhoods such as East Boston, Chelsea, and Jamaica Plain, where they are majorities or near majorities. The Asian population has also grown rapidly, increasing from less than 1 percent in 1970 to more than 8 percent in
2010, and as figure 1.6 shows, is no longer confined to Chinatown in central Boston. The Asian population has shifted in recent years to suburban areas, but significant ethnic enclaves exist; many Vietnamese live in Dorchester, and many Cambodians have settled in Lowell, outside Suffolk County.

As a result of these demographic shifts, the cultural identities of ethnic-specific clinics of past decades have changed radically, as have the ethnic and nativity profiles of both health-care staff and patient populations. Mission statements and ideologies of hospitals and medical centers have greater cultural flexibility, adapting to demographic changes by adding new culturally tailored services and languages as they appeal to an often rapidly changing demographic profile of new immigrant patients in their catchment areas while they continue to provide health-care services to more stable neighborhood populations (Hunter and Park 2010).
Figure 1.2 Percentage White in Suffolk County, 1970 to 2000

Source: Authors’ compilation based on data from the U.S. Census Neighborhood Change Database (NCDB) 1970–2000 (GeoLytics 2010). Maps created with GeoLytics software. Note: White population, with the exception of 1970, is non-Hispanic.

Figure 1.3 Percentage Foreign-Born in Suffolk County, 1970 to 2009

Source: Authors’ calculations based on data from the U.S. Census Bureau (2010).
Figure 1.4  Percentage Black in Suffolk County, 1970 to 2000

Source: Authors’ compilation based on data from the U.S. Census Neighborhood Change Database (NCDB) 1970–2000 (GeoLytics 2010). Maps created with GeoLytics software. Note: Black population, with the exception of 1970, is non-Hispanic.

Figure 1.5  Percentage Hispanic/Latino in Suffolk County, 1970 to 2000

Source: Authors’ compilation based on data from the U.S. Census Neighborhood Change Database (NCDB) 1970–2000 (GeoLytics 2010). Maps created with GeoLytics software. Note: Hispanic population includes respondents of any race.
Many community clinics in Boston and neighboring towns are charged not only with providing care for established immigrant populations who have settled in their catchment area, but also with serving as a primary supportive institution for newly arrived refugees from a wide diversity of nations. Hub-and-spoke health-care systems, where the medical center is the hub and the community clinics are satellites (or feeders to the hub) dot Boston and its environs. These systems provide tertiary and high-technology medical care as well as ambulatory and primary care at the academic medical centers, plus primary care and outpatient services, including mental health services, at the community clinics. These organizational features pattern medical and psychiatric care throughout the Boston area and strongly influenced our research possibilities and site selections.

Greater Boston is also a major political player in the culture counts movement in mental health care and in the disparities movement to reduce inequalities in health status and treatment. In 2005, Mayor Thomas Menino charged the city’s health-care institutions to redress disparities in health status and in healthcare following the publication of Unequal Treatment. As reported by Stephen Smith in the Boston Globe on June 23, 2005,

Mayor Thomas M. Menino of Boston will unveil a comprehensive initiative this morning designed to address what public health authorities
regard as the city’s most pressing medical issue: the intractable differences in health status between the races. As part of the 1 million dollar effort the city will help pay for hospitals to begin detailed tracking of racial and ethnic differences in the care patients receive, and it will underwrite training designed to make physicians more culturally sensitive. (B1)

Much of the research underpinning *Unequal Treatment* was produced by scholars from Boston’s medical schools (Boston University, Harvard Medical School, Tufts Medical Center, and other institutions), and, building on their influence in national policy, centers for disparities research and cultural competence were established in Boston’s academic medical centers (see Betancourt 2003, 2006; Ayanian et al. 1993; Ayanian et al. 1999; McGuire et al. 2006; Good et al. 2003). In addition, efforts to respond to the needs of new immigrant populations led Boston’s clinical and hospital worlds to emphasize care designed to be culturally competent, sensitive, and appropriate.

**Clinics, Clinicians, and Health-Care Staff**

The anthropologists, sociologists, and psychiatrists who have written the chapters of *Shattering Culture* present innovative analyses of the work of culture and how it is invoked in the academic and community medical institutions and psychiatric clinics of Greater Boston. This interdisciplinary group of scholars conducted ethnographic observations and interviews with clinicians, health-care staff, and patients.

The research began with mapping current mental health services and clinical sites in Boston and environs, noting demographic and cultural transitions over the past three decades in each clinic’s locales and patient populations, and transformations in clinical cultures, ownership, and governance.21 We then created a typology of current clinics and psychiatric services: generic clinics and inpatient services, offering a range of interpreter and chaplain services, with universalistic identities and ideologies of care—the “we take everyone” sites; clinics with culturally specific identities and tailored services, such as the Latino clinic, staffed by Spanish-speaking clinicians and support staff; and community clinics identified by geographic neighborhood or place, offering a wide variety of language- and culturally specific care designed to serve highly diverse populations, including new immigrants. In phase one of the study, field methodologies were anthropological, including ethnographic observation and participant observation, as well as focused, open-ended interviews with clinicians and other health-care staff, and with patients and their physicians. Anthropological hanging out in a given research site often produces the best ethnographic field work, yet such methods are rarely tolerated in clinical settings. Thus, we chose clinical sites for our most intensive
research where generous and frankly curious colleagues smoothed the way for this difficult field work.

We interviewed 192 health-care staff recruited from all ranks: psychiatrists, psychiatric residents, psychologists, social workers, nurses, front desk workers, clinic managers, interpreters, chaplains, patient advocates, and security guards. Our initial interview opened with a long question introducing core topics for our discussions, which usually lasted for an hour or longer. We interviewed some clinicians or staff more than once.

[Introductory Script] We are interested in asking you some questions about the role of culture in the practice of medicine. We are trying to understand the experience of treating patients with various cultural backgrounds and practices, but we are also very interested in the culture of clinical practice itself: the way that your clinic is organized, how your day-to-day work is structured, the types of rules and procedures that are in place. We are interested in patient culture and what is sometimes referred to as organizational culture. Keep this in mind as we progress through the interview.

We analyzed interviews by deep reading and then, with the aid of data analysis software Atlas.ti©, we compared responses by site, profession, gender, and ethnicity. The clinical settings are described and presented in table 1.1; tables 1.2 through 1.4 present characteristics of interviewees. Across these clinical settings, we find a mosaic of difference by nativity, ethnicity, race, and language among clinicians and health-care staff, reflecting greater Boston’s contemporary ethnic diversity.

_Academic Medical Center Hub 1 (AMC1)_ is central to Boston’s huge global reaching hub-and-spoke system. The academic medical center we refer to as AMC1 or the “mother ship” has cultural and interpreter services designed for both its global patients and for Greater Boston’s patient populations. The granite walls of the main hospital lobby are engraved with uplifting statements about patient rights in twenty languages. AMC1’s mission statement, revised in 2007 in response to Mayor Menino’s charge, reads, “Guided by the needs of our patients and their families, we aim to deliver the very best health care . . . and to improve the health and well-being of the diverse communities we serve.” We carried out observations and interviews with clinicians and staff at the hub in the acute psychiatric inpatient unit, in the psychiatric emergency department, and in the psychiatric outpatient department; we also interviewed interpreters and chaplains who served both psychiatric patients as well as other patients. Among the clinicians and staff interviewed, 75 percent self-identified as white, 9 percent as black, 5 percent as Asian American, 4 percent as multiracial, and 9 percent as Hispanic/Latino.
Table 1.1  Medical Sites and Psychiatric Clinics

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Medical Center 1 (AMC1)</td>
<td>Inpatient psychiatric unit</td>
</tr>
<tr>
<td></td>
<td>Outpatient psychiatric service</td>
</tr>
<tr>
<td></td>
<td>Acute psychiatric service</td>
</tr>
<tr>
<td></td>
<td>(emergency department)</td>
</tr>
<tr>
<td>Academic Medical Center 2 (AMC2)</td>
<td>Outpatient Latino mental health clinic</td>
</tr>
<tr>
<td></td>
<td>Psychiatric outpatient service</td>
</tr>
<tr>
<td></td>
<td>Psychiatry residency training settings</td>
</tr>
<tr>
<td>Private Psychiatric Hospital (PPH)</td>
<td>Inpatient psychiatric unit</td>
</tr>
<tr>
<td>Neighborhood Community Health Center (NCHC)</td>
<td>Outpatient mental health services</td>
</tr>
<tr>
<td>Region Medical Center (RMC)</td>
<td>Outpatient and inpatient psychiatric services</td>
</tr>
</tbody>
</table>

Source: Authors’ compilation.

Table 1.2  Phase 1: Number of Clinician and Staff Interviews by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Sites</td>
<td>192</td>
</tr>
<tr>
<td>Academic Medical Center 1 (AMC1)</td>
<td>79</td>
</tr>
<tr>
<td>Academic Medical Center 2 (AMC2)</td>
<td>56</td>
</tr>
<tr>
<td>Neighborhood Community Health Center (NCHC)</td>
<td>24</td>
</tr>
<tr>
<td>Regional Medical Center (RMC)</td>
<td>19</td>
</tr>
<tr>
<td>Private Psychiatric Hospital (PPH)</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: Authors’ compilation.

The Neighborhood Community Clinic, a satellite of AMC1, has a long history of serving a highly diverse although constantly changing population of immigrants and minorities, and today its community is an environment characterized by ethnic and racial hyperdiversity. Its mental health clinic was established in 1978 in response to a fire that destroyed much of the small town. Its local outreach programs serve the poor and recent immigrants from many countries, including refugees fleeing political violence. Its patient population is very diverse, as is its mental health service staff. As a satellite community clinic, its staff complain at times—using a pejorative phrase commonly heard—that their clinic becomes the “dumping ground” for the AMC hub patients “with language needs” beyond the capacity of the hub clinicians. Linguistic capacity among clinicians includes Spanish, Somali, German, French, Portuguese, Italian, Serbo-Croatian,
### Table 1.3  Number of Interviews by Profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total interviews</td>
<td>192</td>
</tr>
<tr>
<td>Psychiatrists, psychologists, and other M.D.s</td>
<td>74</td>
</tr>
<tr>
<td>M.D. psychiatrists, Ph.D. psychologists, other M.D.s, other Ph.D.s</td>
<td></td>
</tr>
<tr>
<td>Other mental health professionals</td>
<td>27</td>
</tr>
<tr>
<td>Social workers, mental health counselors with master’s degree</td>
<td></td>
</tr>
<tr>
<td>Other health-care staff</td>
<td>27</td>
</tr>
<tr>
<td>Nurses, mental health workers, occupational therapists, dieticians</td>
<td></td>
</tr>
<tr>
<td>Patient support staff</td>
<td>47</td>
</tr>
<tr>
<td>Interpreters, chaplains, advocates, mental health associates</td>
<td></td>
</tr>
<tr>
<td>Administrative support staff</td>
<td>11</td>
</tr>
<tr>
<td>Security, housekeeping, dietary, clerical</td>
<td></td>
</tr>
<tr>
<td>Management support staff</td>
<td>6</td>
</tr>
<tr>
<td>Nonmedical administrative and clerical managers</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Authors’ compilation.*

### Table 1.4  Phase 1: Clinician and Staff Interview Demographics (N=192)

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>66%</td>
</tr>
<tr>
<td>Male</td>
<td>34%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean years (SD)</td>
<td>43.16 (12.3)</td>
</tr>
<tr>
<td>Range</td>
<td>21–70</td>
</tr>
<tr>
<td>Origin</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>68%</td>
</tr>
<tr>
<td>Black, African American</td>
<td>12%</td>
</tr>
<tr>
<td>Asian</td>
<td>7%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic, Latino</td>
<td>14%</td>
</tr>
<tr>
<td>Not Hispanic, Latino</td>
<td>86%</td>
</tr>
<tr>
<td>Foreign-born or Puerto Rican–born</td>
<td></td>
</tr>
<tr>
<td>U.S.-born</td>
<td>71%</td>
</tr>
</tbody>
</table>

*Source: Authors’ compilation.*

Afrikaans, Hindi, and Gujarati. Medical interpreters for other languages are also accessible. This language and cultural capacity helps create an environment to which patients are willing to return. We interviewed mental health clinicians and staff from the mental health clinic as well as interpreters serving all medical and mental health units. Sixty-three percent of clinicians and staff interviewed self-identified as white,
14 percent as black, 5 percent as Asian, 18 percent as other, and 27 percent as ethnically Hispanic.

*Academic Medical Center 2 (AMC2)* is a collection of teaching hospitals and academic medical programs. The mergers of hospitals have wrought havoc with previously strong and distinctive cultural identities and ideologies of clinical practice and nursing care (Weinberg 2003). The Latino clinic is an outpatient psychiatric clinic specifically designed to care for Spanish-speaking patients with Spanish-speaking clinicians and support staff; however, because the hospital offers excellent primary care and draws patients from the Greater Boston area, the Latino clinic is not a bounded site, and clinicians from the Latino team also care for patients who do not identify themselves as Latino or Hispanic. The clinic mission was established by its director, a psychiatrist who also trains residents and educates clinicians in culture and psychiatry and cultural competence. Clinicians, staff, and trainees were interviewed, as were patients. Twelve percent of clinicians and staff interviewed self-identified their race as black, 3 percent as Asian, 12 percent as multiracial, and 73 percent as white; 24 percent self-identified their ethnicity as Hispanic/Latino.

*The Private Psychiatric Hospital (PPH)* is unique; it takes all patients and is professionally known as the mental hospital of last resort for Boston area patients for whom beds are unavailable at other institutions. It serves many patients who are poor. Nonetheless, its Joint Commission rating rivals those of the academic medical centers’ hub hospitals. Its patient population is ethnically and racially diverse, and some units are labeled with cultural designations, such as a Hispanic group, but the categorization often does not coincide with patient self-identification. Clinicians and staff interviewed self-identified as 36 percent white, 50 percent black (half of whom were immigrants from Africa), and 14 percent as Asian or Asian Americans.

*The Regional Medical Center* is part of the hub-and-spoke system in which the regional center is a larger satellite. The hospital’s mental health services include inpatient and outpatient clinics with a local reach. Although suburban, it serves poor as well as middle-class patients, including recent immigrants. Clinicians and staff we interviewed practiced in both inpatient and outpatient psychiatric services. Eighty-eight percent of those interviewed self-identified as white, 12 percent as other; 10 percent of those self-identifying as white identified as ethnically Hispanic.

**Interviews with Psychiatric Patients**

In phase two of the study, fifty patients and selected providers from inpatient or outpatient psychiatric clinical settings were interviewed; others also participated in discussions with ethnographers. Patients
were asked about their illness and care, and about how culture mattered in their treatment. Most patients interviewed were highly experienced with psychiatric cultures and openly discussed the benefits, gains, and negative and positive experiences with their various clinics and their clinicians. Interviews ranged between twenty minutes to over an hour and were transcribed and analyzed, also with the aid of Atlas.ti. The patient population, like the provider population, is racially and ethnically diverse, reflecting greater Boston’s current demographics. Thirty percent were born outside the United States, 65 percent self-identified racially as white, 9 percent as black, 26 percent as other; 26 percent of the total self-identified as Hispanic or Latino; ages ranged from eighteen to eighty-four. Thirty percent were covered by private insurance, and 66 percent by Mass Health, Commonwealth Care, or Medicare.

The Book

The chapters draw both on author interviews and observations, and narrative analyses of case studies, as well as from the study’s larger data set and qualitative analyses of multiple interviews. Each chapter explores themes and questions central to the project’s overall investigation and research design, and interprets findings which emerged out of analyses of the empirical data, the interviews and observations, and the ethnographic hanging out.

Cultural Environments of Hyperdiversity

Part I paints a complex portrait of culture and its manifold meanings, roles, and implications in medical as well as psychiatric clinical settings of Greater Boston. In chapter 2, Seth Hannah, a sociologist specializing in social inequality and cultural studies of medicine, sets the stage for our discussion, introducing the book’s motivating concepts of hyperdiversity and cultural environments of hyperdiversity. These terms convey two core meanings. First, hyperdiversity offers a way of describing the increasingly diverse nature of patient populations in contemporary American healthcare settings. Given the heterogeneity within social groups, patient populations cannot be grouped or classified only according to superficial features like phenotype, mother tongue, or nationality. In its second sense, cultural environments of hyperdiversity describes particular social settings in which complex interactions among multiple forms of difference and diversity—for instance, race, ethnicity, culture, gender, sexual orientation, and socioeconomic class—intersect in ways that significantly influence efforts to cultivate clinical rapport and trust. The term hyperdiversity captures those situations in which the link between racial-ethnic identity and culture is weak or broken (shattered) and, as a result, in
which broad, identity-based indicators of cultural difference prove too blunt an instrument for navigating the social heterogeneity within today’s clinical environments.

The three subsequent chapters explore three strategies employed within American health care settings in response to these cultural environments of hyperdiversity: interpreter services, chaplain services, and clinician-patient matching. In chapter 3, Sarah Willen, an anthropologist of immigration and medical anthropology, explores the apparent dilemma that an increased commitment by health-care institutions to provide interpreter services, often supported by state mandates and institutional funding, does not necessarily resolve the clinical challenges associated with language barriers, often because clinicians have limited familiarity or experience discomfort with their institutions’ prevailing models of clinical interpretation. Chapter 3 characterizes the largely unchoreographed dance among patient, interpreter, and clinician, the often ambiguous role of interpreters, and their frustrations with clinicians who just don’t get it. In chapter 4, Lisa Stevenson, a cultural anthropologist specializing in medical anthropology, explores how chaplaincy comes to be seen as a cultural service in major medical centers, noting that “to know how culture counts we need to know what counts as culture.” Stevenson explains how the potential divisiveness of religious difference has largely been reworked into a cultural difference both palatable and comprehensible to hospital bureaucracies. Despite the challenging translational work that leaves many chaplains “praying along”—at times uncomfortably—with people who do not share their faith, their services are nonetheless consistently identified by other hospital staff as an institutional attempt to provide culturally sensitive care. A third strategy, which Willen considers in chapter 5, addresses the technique of matching patients with providers who share their cultural or racial-ethnic backgrounds. Although clinician-patient matching was touted in the 1990s, especially in mental health, the clinicians we interviewed are generally unconvinced of its singular value for either improving clinician-patient rapport or remediating disparities in mental health outcomes.

Clinical Cultures, Clinical Realities

Part II takes us into the dizzying worlds of psychiatry and mental health practice in Greater Boston. Drawing on interviews with psychiatrists, other mental health clinicians and support staff, and patients, as well as on author experiences as psychiatrists, these chapters feature a unique mix of insider and outsider perspectives on contemporary clinical realities in cultural environments of hyperdiversity. Chapter 6, by Sarah S. Willen, Seth Hannah, Ken Vickery, and Mary-Jo DelVecchio Good, with psychiatrist-researcher Marina Yaroshenko, traces the personal journey
of Dr. Z. through emigration from the former Soviet Union to a professional journey through multiple American training residencies, each stressing different therapeutic models from psychodynamic to biological modalities of diagnosis and therapeutics. In chapter 7, Sadeq Rahimi, a scholar of cultural psychiatry, Seth Hannah, and Mary-Jo DelVecchio Good illustrate how the practice of modern psychiatry is not a closed culture but is instead shaped by a number of external factors in the social, political, and institutional environment. Using the notion of cultural traffic, they find that global flows of knowledge—the growing cosmopolitan and biomedical nature of modern psychiatry—and global flows of people—increasing hyperdiversity among patient populations and practicing psychiatrists—combine to shape local forms of clinical practice.

Cultural and interpersonal dynamics and how they influence the perspectives and experiences of patients are addressed in chapters 8 and 9. In chapter 8, Elizabeth Carpenter-Song, a psychological anthropologist who specializes in the lived experiences of patients in psychiatric treatment, as well as those of their families, engages with American psychiatry as a moral enterprise, attending to the on-the-ground realities of clinicians and patients, and asks what one is to make of happy patients. Carpenter-Song argues that we have much to learn from patients’ positive experiences, and that recognition—the “who are you” question—is crucial to positive therapeutic relationships in mental health care, regardless of patient ethnicity and diversity or patient-provider matching. In chapter 9, Joseph Calabrese, anthropologist and psychotherapist, explores the flip side of this question, the negative as well as positive experiences in two psychiatric in-patient services, one in Boston and one in the Midwest. Calabrese also finds that recognition of the patient as a person and the quality of clinician interaction is of ultimate importance, and that a single dismissive interaction can lead patients to distrust an entire institution or even an entire professional discipline. He also notes that patients spoke about experiencing discrimination from physicians other than psychiatrists—not on the basis of race or gender but instead of the stigma of mental illness.

The book’s final chapters offer a sobering window into the real-life, day-to-day culture of psychiatry by revealing how challenges posed by cultural environments of hyperdiversity are often eclipsed by growing administrative, bureaucratic, and economic demands and constraints. Here, we as researchers and authors ask, “Does economy trump culture?” In chapter 10, cultural psychiatrist Antonio Bullon collaborates with Good and Carpenter-Song to analyze how paperwork and documentation—cultures of practice driven by the technological mode so salient today in medicine—have become increasingly regarded by clinicians as burdens imposed by outside forces intruding on clinic time and therapeutic work with patients. This burden is especially true for psychiatrists treating disadvantaged and minority patients, who are most likely to require not just
care for mental health and medical problems, but also assistance in meeting social needs. The technical rationality driving documentation practices emerges in even starker relief in chapter 11, by Hannah and Good, in collaboration with the psychiatrist and anthropologist Lawrence T. Park. The authors highlight the anxiety and frustrations that psychiatrists, mental health clinicians, clinic directors, and patients experience when confronted with a maze of insurance and financial regulations both public and private. Clinicians in our study speak about their frustrations especially when their patients get stuck because of financial constraints.

This last chapter foregrounds one of the book’s central insights. Although hyperdiversity poses substantial challenges to psychiatry and the entire medical commons, we find that individuals and institutions readily rise to redress problems of disparities and to enhance culturally competent or sensitive and quality care for Greater Boston’s mosaic of patient populations. The authors find, however, that economic complexity complicates these efforts, at times posing far greater challenges to providing equitable mental health care for minorities and disadvantaged patients than any due to cultural difference.

Notes

1. Many institutions of academic medicine, community health clinics, and nonprofit medical centers and charity and religious hospitals, and even for-profit hospitals seeking Medicaid and Medicare and other public funding, required attention to cultural distinctions, in particular the requirement that patients had a right to interpreter services. This can also be seen as a marketing issue to reach out to the widest possible patient population.


3. These questions resonate with the foundation’s program in culture contact and more specifically in immigration and ethnicity. The many publications on immigration and culture contact from the RSF series and research programs are relevant here (see, for example, Waters 1999; Kasinitz et al. 2008; Bluestone and Stevenson 2000; Shweder, Minow, and Markus 2004; Hochschild 1995; Hochschild and Powell 2008; Suárez-Orozco and Páez 2003; Bean and Stevens 2003).

4. These were part of the OEO projects of President Johnson’s Great Society movement.


6. Susan Saulny’s New York Times article, “Multiracial Nation, Many Ways to Tally” (2011) is an example of hyperdiversity. Uncertainty about an individual’s culture, race, and ethnicity is common among many young Americans...
who check all or other. Ms. M., who is part Irish, Peruvian, Chinese, Cherokee and Shawnee, is categorized differently depending on who is counting. Her father calls her Hispanic, she and her mother prefer to use other, and her best friend uses mixed race; in the census she can use four races, with the U.S. Department of Education she would be Hispanic, and with the National Center for Health Statistics she would be Asian.

7. UC Davis had a cultural consultation clinic of which we (Mary-Jo and Byron Good) were a part.


9. The DSM III Case Book (Spitzer et al. 1981) included eighty-seven cases that were 75 percent white professionals, wealthy business people, or members of the middle class; 15 percent prisoners or unemployed or elderly; and 11 percent working class; one case suggested a Hispanic ethnic identity (Good 1993). In the DSM IV, 20 percent of male adults were marked by a race or ethnicity, while 13 percent of women were (Spitzer 1994; Cermele, Daniels, and Anderson 2001).

10. This is a paraphrase of a comment by Michael Jackson on understanding the human condition and learning how to live with others as an anthropologist. William James Hall, Harvard University, April 15, 2011.

11. A cultural change in psychiatry from roman numerals to Arabic and digital formats allows for possible changes without changing the identifying numeral—that is, 5.0, 5.1 and so on.

12. By the mid-twentieth century, as massive mental hospitals and asylums began to be regarded as inhumane and deinstitutionalization became the norm, the community health movement began to flourish. Although many mentally ill patients had legitimate reasons to fear and distrust the asylum psychiatry of the mid-twentieth century and the stigmata taint of hospitalization, with the establishment of community mental health services and a sea change in medication options, the treatment for mental illness was less onerous.

13. Joe Gone’s October 2011 conference at the University of Michigan has culture counts as its theme. The conference, titled Reconciling Cultural Competence & Evidence-Based Practice in Mental Health Services, featured contributions by leading experts in the field of culture and psychiatry (psychiatrists, anthropologists, and health services researchers). Culture and psychiatry go together, and the meaning of each has been dynamic and fluid. For many years, the National Institute of Mental Health actively supported basic research and training programs, including those for anthropologists in culture and psychiatry. Harvard’s training program in Culture and Mental Health Services Research (MH 18006), directed for twenty-four years by Byron Good, Arthur Kleinman, and Mary-Jo Good, supported the postdoctoral fellows who contributed to the project described in this book.

The classic literature in anthropology, culture, and psychiatry is far too vast to be fully referenced here. Several notable publications include Mezzich et al.’s Culture & Psychiatric Diagnosis: A DSM-IV Perspective (1996), anthropologically important studies, including Kleinman and Good’s Culture and
Depression (1986), Kleinman’s Rethinking Psychiatry (1991), and Luhrmann’s Of Two Minds (2000). Ethnographic classics include Estroff’s Making It Crazy (1981), Rhodes’s Emptying Beds (1995), and the sociological classic Asylums by Goffman (1961). More recent ethnographic work appears in collections such as Jenkins and Barrett’s Schizophrenia, Culture, and Subjectivity (2004), Hinton and Good’s Culture and Panic Disorder (2009), and Jenkins’s The Pharmaceutical Self (2011). Culture, Medicine and Psychiatry, a journal of cross-cultural and comparative research (founded by Arthur Kleinman in 1977), was edited by Byron and Mary-Jo Good from 1986 through 2004, with Anne Becker, Peter Guarnaccia, and Roberto Lewis-Fernandez through 2006, and currently by Atwood Gaines since 2007. It has been a central academic journal in this field.

Despite this interest in culture, psychiatry has also had significant blind spots and disparities and inequalities in treatment by race, especially black and white, are documented in IOM’s Unequal Treatment, in Good et al.’s Unequal Treatment (2003), and in Jonathan Metzl’s The Protest Psychosis (2009).

14. A tension between universalism and cultural particularism is a different form of dualism, yet recalls Tanya Luhrmann’s cultural analysis of psychiatry’s duality between bioscience and biologically grounded psychiatric practice and psychodynamic therapeutics and practice, in her ethnography, Of Two Minds (2000).

15. See 2003 special issue of Culture, Medicine and Psychiatry (CMP), The Politics of Science: Culture, Race, Ethnicity and the Supplement to the Surgeon General’s Report on Mental Health, edited by Doris Chang, Mary-Jo Good, and Byron Good; authors of essays in CMP tell the story of their contributions to the Surgeon General’s supplement, Mental Health: Culture, Race and Ethnicity (Chang, Good, and Good 2003; Lopez 2003; Manson 2003; Miranda, Nakamura, and Bernal 2003; Richardson, Flaherty, and Bell 2003; Satcher 2003; Snowden 2003; Sue and Chu 2003; Takeuchi and Gage 2003).

16. There is some debate over which drugs are best, but African American men were less likely to be prescribed the most recent innovative psychopharmaceuticals (Good et al. 2003).


19. Suffolk County is comprised of the city of Boston and its surrounding communities, and is a good proxy for Greater Boston.

20. Between 2000 and 2006, the number of residents in the city of Boston from Haiti increased 6 percent, from Jamaica 13 percent, and from various African countries 52 percent.

21. Ownership shifted from community to academic medical centers for some Community Health Clinics; clinics were also absorbed into the Partners and CareGroup complexes.

References


