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What is This?
Racial/Ethnic Disparities and Culturally Competent Health Care Among Youth and Young Men

Dzung X. Vo, MD, and M. Jane Park, MPH

Racial/ethnic disparities in health and health care are receiving increasing national attention from the fields of public health and medicine. Efforts to reduce disparities should adopt a life-span approach and recognize the role of gender. During adolescence, young people make increasingly independent decisions about health-related behavior and health care, while developing gender identity. Little is known about how cultural context shapes gender identity and gender identity's influence on health-related behavior and health care utilization. The authors review disparities in health status and health care among adolescents, especially young men, by reviewing health care access, clinical services, and issues related to culture, identity, and acculturation. Significant differences in health status by gender exist in adolescence, with young men faring worse on many health markers. This article discusses gaps in research and offers recommendations for improving health care quality and strengthening the research base on gender and disparities during adolescence.

**Keywords:** adolescents; culture; multiculturalism; cultural competency; acculturation; gender; health care disparities; minority health; male health

The United States population is becoming increasingly racially and ethnically diverse. The population of Hispanics and Asian Americans is increasing and that of Whites is decreasing as a percentage of adolescents. These are demographic trends that are expected to continue (see Figure 1). More than 1 in 5 children live in first- or second-generation immigrant families; one fifth of these immigrant children have difficulty speaking English (KIDS COUNT Data Center, 2007). As diversity has increased, disparities in health and health care have received greater national focus. In 2003, the Institute of Medicine (IOM) released a major report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, which documented pervasive racial/ethnic disparities in health care and health outcomes (Smedley, Stith, & Nelson, 2003). The IOM concluded that disparities in health care and outcomes were related both to clinician-level factors (including bias, prejudice, stereotyping) as well as factors in health systems (insurance, access, language and cultural barriers, health care education). *Healthy People 2010*, the nation’s public health agenda, has made reducing disparities among subgroups one of its two overarching goals (U.S. Department of Health and Human Services, 2000). Leading professional organizations, researchers, and advocates have called for policies and programs to address issues regarding race and ethnicity in health care. Professional organizations concerned with children and adolescents, including the American Medical Association (AMA; Elster & Kuznets, 1994; Fleming & Towey, 2001) and the American Academy of Pediatrics (AAP, 1997, 2000; Britton, 2004), have released recommendations and guidelines for improving cultural competence in health services as a strategy to reduce disparities.

In advancing research, programs, and policy to reduce disparities, it is important to adopt a life-span approach that recognizes the role of gender. During
adolescence, young people make increasingly independent decisions about health-related behavior and health care. Developing gender identity is a key task of adolescence. Yet very little research examines how this process varies by cultural context and assesses even less how gender identity shapes health-related behavior and health care utilization. This column reviews disparities in health status and health care access among adolescents, with an emphasis on young men. The column discusses strategies for improving health services for minority youth by reviewing health care access, clinical services, and issues related to culture, identity, and acculturation. There are significant differences in health status by gender during adolescence, with young men faring worse on many traditional adolescent health markers (National Adolescent Health Information Center [NAHIC], 2005). The causes of gender disparities are not well understood. Nonetheless, improving the health of all Americans requires special attention to populations with worse outcomes. This article will also discuss gaps in current knowledge and offer research and policy recommendations.

**Racial/Ethnic Disparities in Health Status and Access to Services: The Scope of the Problem**

**Disparities in Health Status**

A substantial body of research has demonstrated that socioeconomic status (SES) has a critical role in shaping health status for people of all ages, including youth, with poor people faring worse on almost every measure of health status (Braveman & Egerter, 2008). Research indicates that SES and race/ethnicity both contribute to disparities in health status (Braveman & Egerter, 2008). National data identify both gender and racial/ethnic disparities on many measures of health status and related behaviors among adolescents and young adults. Minority youth fare worse on measures of general parent-rated health, health-limiting conditions (Wen, 2007), and rates of asthma (McDaniel, Paxson, & Waldfogel, 2006). An analysis of nationally representative data reported that minority adolescents and young adults in general reported worse health status on a range of health outcomes.
and behaviors, including diet, physical activity, obesity, substance use, sexually transmitted diseases, and mental health symptoms (Harris, Gordon-Larsen, Chantala, & Udry, 2006), with Native Americans and Black youth most frequently faring worse. Adolescent men have more than twice the mortality rate of women and substantially higher rates for the three leading causes of adolescent death: motor vehicle crashes, homicide, and suicide (see Figure 2). Among adolescent males, there remain disparities among racial/ethnic groups. As demonstrated in Figure 3, Black adolescents have higher homicide rates, whereas Native American and White adolescents have higher suicide rates. Figures 4 and 5 demonstrate differences in reported risk behaviors in adolescents by gender and, among men by race/ethnicity, from the Youth Risk Behavior Surveillance System (YRBSS). YRBSS data are rarely reported for Asian American Pacific Islander (AAPI) youth. An analysis of YRBSS data from the 1990s reported that relative to other youth, similar gender differences exist among AAPIs and, among AAPI men, there were relatively low rates of substance use, weapon carrying, and riding with a drinking driver. Although less likely to be sexually experienced, AAPI men who have had sex are no more likely to use a condom than other young men; AAPI men also report rates of suicide attempts and ideation similar to other young men (Grunbaum, Lowry, Kann, & Pateman, 2000).

The health status of Latinos in the United States deserves special mention. Adolescent and young adult Latino men have a higher mortality rate compared with Whites (Hayes-Bautista et al., 2002). Although this might be expected, given the generally lower SES profile of Latinos, this disparity stands in contrast to most Latino–White differences in health status. Latinos appear to have better health outcomes on key measures in other periods of the life span, including infant mortality, life expectancy, and age-adjusted mortality (Abraido-Lanza, Chao, & Florez, 2005; Hayes-Bautista et al., 2002), a pattern referred to as the Latino mortality or epidemiologic paradox.

Disparities in Health Care Utilization and Access

The IOM report presented data on disparities in health care and access, focusing primarily on adults (Smedley et al., 2003). Relatively less is known about these disparities in youth and, in particular, for young men. Elster, Jarosik, VanGeest, and Fleming (2003) reviewed the literature on racial/ethnic disparities in health care in adolescents and reported preliminary evidence suggesting disparities in primary care and mental health services for minority youth (Elster et al., 2003). Most studies reviewed reported that Black and Latino youth received fewer primary care services, and several studies also indicated that Black and Latino youth received fewer mental health services. In addition, the review reported preliminary data suggesting that minority youth receive more reproductive health services than White youth.

Other analyses using nationally representative surveys support the findings of Elster et al. (2003). Using data from 2000 to 2002, researchers reported that minority children and teenagers received less well-child care than Whites and that Asian and Pacific Islander children received significantly less preventive care than Whites, despite similar insurance rates (Selden, 2006). An analysis of 2003-2004 data revealed multiple racial/ethnic disparities in medical and oral health care, insurance coverage, and health care access of children (Flores & Tomany-Korman, 2008), with all five minority groups studied (Asian/Pacific Islanders, Latinos, Native Americans, African Americans, Multiracial) reported to be medically underserved. African American children overall experienced the greatest number of disparities measured. No significant gender differences were reported in these studies. Data from 2005 revealed multiple race and gender disparities in health care, reporting that Hispanic adolescents and young adults had the lowest rate of medical care, that young men received less dental...
Figure 3. Mortality rates, overall and by cause; young men, ages 15 to 19, by race/ethnicity, 2005. NH, non-Hispanic; A/PI, Asian/Pacific Islander; AI/AN, American Indian/Alaskan Native.

Figure 4. Selected measures of risky behavior by gender, high school students, 2005. *Past year; ** past month; ***did not use a condom during last sexual intercourse, among those who had sex in the past 3 months.
care, and that Black young adults had the highest rate of unmet dental care needs (NAHIC, 2008). It is important to note that these studies do not examine the preventive services relevant to adolescents, such as anticipatory guidance in sensitive areas such as sexuality, substance abuse, and mental health.

Financial barriers, especially inadequate insurance, contribute to disparities in health care access. About 12% of adolescents had no health insurance coverage according to a study using data from the 2002 National Health Interview Study (Newacheck, Park, Brindis, Biehl, & Irwin, 2004). This study also reported significant racial/ethnic disparities in insurance coverage: Blacks were about 1.4 times more likely than Whites to be uninsured, and Hispanics were more than 3 times more likely than Whites to be uninsured. This disparity retained its significance among Hispanics after adjusting for SES and other factors but not among Blacks. Older age (15-18 years compared with 10-14 years) was also significantly predictive of being uninsured, but gender was not. The disparity among Hispanics worsens in young adulthood, with only one half of Hispanics aged 18 to 24 years reporting health insurance coverage according to 2006 data (NAHIC, 2008). Expansion of public health insurance programs, particularly the State Children’s Health Insurance Program (SCHIP), has been associated with increased insurance coverage rates for adolescents as well as decreased racial/ethnic disparities in insurance coverage (Newacheck et al., 2004; Shone, Dick, Klein, Zwanziger, & Szilagyi, 2005). Despite the increase in insurance coverage from public programs such as SCHIP, large numbers of eligible adolescents remained uninsured (Morreale & English, 2003; Newacheck, Hung, Park, Brindis, & Irwin, 2003).

Patients with limited English proficiency face significant barriers to health care (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007; Kuo, O’Connor, Flores, & Minkovitz, 2007). The IOM, AMA, and AAP call for the use of professional interpreter services in clinical encounters with language discrepancy between patients and clinicians (Britton, 2004; Fleming & Towey, 2001; Flores, 2006; Smedley et al., 2003). A small, but growing literature, focusing almost exclusively on adults, consistently indicates
that not using interpreters or using ad hoc interpreters, such as untrained staff, friends, or family members, adversely affects quality of care and health outcomes in patients with limited English proficiency (Flores, 2005; Karliner et al., 2007). Conversely, the use of professional interpreters is associated with better patient–clinician communication, higher satisfaction with care, increased health care utilization, and improved clinical outcomes (Flores, 2005; Karliner et al., 2007). The use of children or adolescents as ad hoc interpreters brings special risks because they may not be fully proficient in both languages, are more likely to make errors of clinical consequence, and may avoid or intentionally mistranslate sensitive issues (Flores, 2005; Flores et al., 2003; Vo, Pate, Zhao, Siu, & Ginsburg, 2007). Studies examining health care among adolescents with limited English proficiency could not be located.

**Improving Quality of Care**

**Perceived Racism and Race-Concordance**

The IOM report concluded that “some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care” (IOM, 2002, p. 1). Evidence to date relies on studies that examine perceived health care quality and perceived racism among adults and rarely addresses the role of gender. Racial/ethnic minority patients, relative to White patients, tend to give more negative ratings on quality of their health care, communication with their clinicians, impressions of their clinicians, and overall satisfaction with care (Doescher, Saver, Franks, & Fiscella, 2000; Haviland, Morales, Reise, & Hays, 2003; Murray-Garcia, Selby, Schmittiel, Grumbach, & Quesenberry, 2000). Minority patients report perceptions and concerns about racial bias and prejudice in their clinicians and in the health care system as a whole (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Vo et al., 2007). A study of African American adults reported that perceived racism and mistrust of Whites had a significant negative impact on trust in their clinician and satisfaction in their health care (Benkert, Peters, Clark, & Kevess-Foster, 2006). This study reported no significant differences in perceived racism or cultural mistrust by gender. A study using audiotape and questionnaire data in adults’ physician–patient interactions reported that physicians had more verbally dominant and less patient-centered communication with African American patients compared with Whites (Johnson, Roter, Powe, & Cooper, 2004). In general, little is known about the role of gender and masculinity on quality of care or perceptions of racism in health care settings.

The AAP and the Association of American Medical Colleges have advocated for more diversity in the health care workforce as a strategy to reduce racial/ethnic disparities (AAP, 2000; Cohen, Gabriel, & Terrell, 2002). A small body of research has examined the role of race-concordance (patients and providers being matched on race/ethnicity) on patient perceptions of health care. Data from a 1994 nationally representative survey of adults reported that Black and Hispanic patients were more likely to give higher ratings to a race-concordant physician than a White physician (Saha, Komaromy, Koepsell, & Bindman, 1999). These data also reported that White, African American, Latino, and Asian American patients were more likely to use needed health services and less likely to delay services when their physician was race-concordant (LaVeist, Nuru-Jeter, & Jones, 2003). Smaller studies suggest that race-concordant visits are associated with a more participatory physician–patient communication style (Cooper-Patrick et al., 1999) and longer visits, characterized by more positive patient affect (Cooper et al., 2003). A nationally representative survey in 2001 reported that minorities had lower satisfaction with and less use of health services than Whites, but indicated that race-concordance did not explain the racial differences in quality of interactions (Saha, Arbelaez, & Cooper, 2003). A survey of about 700 primary care physicians in California reported that Black and Hispanic physicians disproportionately serve communities with concentrated minority populations and care for poor patients (Komaromy et al., 1996). Overall, the evidence to date strongly supports efforts to increase health care workforce diversity as a strategy for reducing disparities.

The literature on perceptions of race-concordance in youth is sparse, although a study in Asian American youth reported that race-concordance was desired by some youth but not ranked highly in importance (Vo et al., 2007). The literature has largely not reported findings on gender differences in patient perceptions on perceived racism and race-concordance in the health care setting.
Ethnic Identity and Health

Ethnic identity has been conceptualized as a commitment and sense of belonging to the group and involvement in ethnic social and cultural practices (Phinney, 1990). Acculturation is a related concept, which has been defined as “the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (Berry, 2005, p. 698). Acculturative stress refers to the psychological stress associated with the acculturation process (Berry, 2005). Acculturation among minority youth is thought to be complex and multidimensional instead of linear, and there are significant controversies within the literature on how to define and conceptualize acculturation (Abe-Kim, Okazaki, & Goto, 2001). Approaches to exploring identity and acculturation in research and clinical practice include inquiring about place of birth and generational status, language preference, and preferences regarding food, social networks, and entertainment (Fleming & Towey, 2001; Unger et al., 2002).

Ethnic identity and acculturation has been reported to have significant effects on the mental and physical health and behaviors of youth. Increased ethnic identity and acculturation has been linked to higher self-esteem in some studies (Phinney, Cantu, & Kurtz, 1997; Rhee, Chang, & Rhee, 2003). Other investigators have reported that less acculturated youth are at higher risk, with psychosocial risk factors including bullying, social isolation, poor confidence, not feeling safe, and suicidality (Lau, Jernewall, Zane, & Myers, 2002; Yu, Huang, Schwalberg, Overpeck, & Kogan, 2002, 2003). On the other hand, more acculturated youth have been reported to be at increased risk for a variety of health risk behaviors—a pattern referred to as the healthy immigrant effect (Flores & Brotanek, 2005). The relationship between acculturation and psychosocial risks may be mediated by the “acculturation gap,” or discrepancy in parent–child acculturation, according to a small body of literature. Immigrant youth tend to adopt the values of the host countries more quickly than their parents do, resulting in discrepancies in values between the youth and their families (Chung, 2001; Phinney, Ong, & Madden, 2000). Emerging research supports strategies to reduce youth violence and substance abuse that include supporting positive ethnic identity development, enhancing bicultural self-efficacy (the ability to function effectively in multiple cultural contexts), and improving family communication by addressing intergenerational cultural conflicts (Le & Stockdale, 2008; Soriano, Rivera, Williams, Daley, & Reznik, 2004; Szapocznik, Prado, Burlew, Williams, & Santisteban, 2007).

Providing Culturally Competent Care

Numerous clinical guidelines, including the recently released Bright Futures, advocate for routine screening of psychosocial risk factors, including sexual health, health risk behaviors, and mental health, in adolescents and young adults (Hagan, Shaw, & Duncan, 2008). The AAP, in a policy statement, defined culturally competent health care as “the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of all cultural distinctions leading to optimal health outcomes” (Britton, 2004, p. 1677). The AMA advises clinicians to assess ethnic identity and acculturation of minority and immigrant youth in clinical practice (Fleming & Towey, 2001). It has issued a workbook on culturally effective care for adolescents that calls for clinicians to pay particular attention to cultural aspects of health care, such as distrust of government and medical systems, language barriers, cultural influences on worldviews, health beliefs, and health practices, and identity formation and acculturation among immigrant youth (Fleming & Towey, 2001). Similarly, leaders in the mental health field advocate for multicultural competencies in counseling, which includes counselors being aware of their own cultural assumptions and values, understanding the worldviews of culturally different clients, and developing appropriate ways of working with culturally diverse clients (Sze, Arredondo, & McDavis, 1992). Other characteristics of culturally competent clinicians include self-critique and humility (Tervalon & Murray-Garcia, 1998).

The following section summarizes the literature for specific racial/ethnic groups related to ethnic identity and acculturation among adolescents and, where possible, gender identity. There is relatively little in the literature on delivering culturally competent health care in adolescence that addressed both gender and culture and how the needs of young men may differ from that of women. Clinicians can better serve minority youth by affirming diversity and positive ethnic identity development, both in the characteristics of the health care site as well as in individual clinical interactions. Clinicians should be alert to possible acculturative conflicts within families and assist in mediating such conflicts or referring to a culturally
competent mental health provider. In their role as advocates and community leaders, clinicians can advocate for youth development programs that integrate what is known about fostering positive ethnic identity and bicultural self-efficacy.

It is worth noting, however, that each racial/ethnic group is a heterogeneous category with significant diversity within each group regarding cultural norms, psychosocial histories, language, and nation of origin. Clinicians should avoid focusing on particular facts or presumed cultural attributes about specific racial/ethnic groups so as to avoid inadvertently exacerbating stereotypes and disparities. Instead, the essence of cultural competence is an individualized and patient-based approach that incorporates skills and attitudes that may be applicable with diverse populations (Carrillo, Green, & Betancourt, 1999). For example, AAPI youth are sometimes perceived as a “model minority” and, as a consequence, may not be screened adequately for health risk behaviors (Kao, 2006; Vo et al., 2007).

Although the YRBSS data cited earlier do indicate relatively low levels of risky behavior in many areas, these data also indicate that AAPI youth have similar risk in others. Furthermore, research indicates that AAPI youth display significant heterogeneity in risk behaviors by ethnic subgroup, geographic origin, and migration/refugee history (Chen, Unger, Cruz, & Johnson, 1999; Grunbaum et al., 2000; Mayeda, Hishinuma, Nishimura, Garcia-Santiago, & Mark, 2006; Spencer & Le, 2006). In general, clinicians should screen AAPI youth for health risk behaviors just as they would for any other group.

**Specific Cultural Issues**

**African Americans.** Black youth, and young Black men in particular, are disproportionately affected by violence and homicide, school failure, unemployment, and poverty (Blash & Unger, 1995; Park, Paul Mulye, Adams, Brindis, & Irwin, 2006). Some studies have reported that Black male youths who have stronger ethnic identity are less likely to engage in violence (Soriano et al., 2004). Other research has reported that a positive ethnic identity is a protective factor for improved mental health and decreased drug use among African American youth (Szapocznik et al., 2007). These findings suggest that resiliency and positive development can be encouraged in Black male youth by fostering positive self-esteem and ethnic identity and improving parent support, community involvement, and appreciation of African American heritage (Blash & Unger, 1995). Although African American youth may not be immigrants, they may still experience acculturative stress, which includes threats to racial identity and to culturally specific values and lifestyles. A study examining acculturative stress in African American college students reported that acculturative stress was distinct from general life stress and was significantly related to symptoms of depression and anxiety (Joiner & Walker, 2002). The study indicated that students at a historically Black college reported less acculturative stress than students at a large state university, suggesting that an environment supportive of positive ethnic identity development may be protective against acculturative stress for Black youth.

Theory on gender identity development in Black men has proposed that Black men may experience psychological strain trying to live up to traditional male role norms, exacerbated by racism and discrimination as well as gender role conflict resulting from competing (European versus African) traditions of masculinity (Wade, 1996).

One study testing Black racial identity and Black male gender identity theory with a Black adult male sample reported that men with an internally defined Black identity (Blacks as the reference group, with an openness to the strengths of White culture as well) were less likely to report gender role conflict, possibly because these men may likewise have an internally defined masculinity and an openness to traditionally “feminine” gender role traits (Wade, 1996). Overall, the literature to date on identity development and acculturative stress in young Black men suggests that clinicians and policy makers should support interventions that foster positive Black identity development, acknowledge the potential for stress from racism and acculturation, and affirm African American culture and history, both at the individual as well as the community level.

**Latinos.** The Latino mortality paradox may be partially mediated through acculturation. Data from the 1991 National Health Interview Study reported that after adjusting for SES, higher acculturation in Latinos was generally associated with unhealthy behaviors, including high alcohol intake, current smoking, and high body mass index (Abraido-Lanza et al., 2005). Acculturation in Latino youth specifically has been linked to health risk behaviors including poor nutritional and behavioral habits (Unger et al., 2004), smoking initiation (Unger et al., 2000), delinquency (Samaniego & Gonzales, 1999; Vega, Gil, Warheit, Zimmerman, & Apospori, 1993), and binge drinking.
The links between acculturation and certain risk behaviors appear to be mediated through parental monitoring and family conflict (Dinh, Roosa, Tein, & Lopez, 2002; Samaniego & Gonzales, 1999; Smokowski & Bacallao, 2006). Acculturation in Latino youth also appears to be related in a complex fashion to sexual risk behavior (Guilamo-Ramos, Jaccard, Pena, & Goldberg, 2005; Unger & Molina, 2000).

Intergenerational acculturation gaps are significant in Latino youth and families. A study of Latino high school students in California reported that parent–child acculturation discrepancy was associated with lower family cohesion, which was in turn associated with higher levels of substance use (Unger, Ritt-Olson, Soto, & Baezconde-Garbanati, 2007). Another study reported that parent–child discrepancy in cultural identity factors was associated with more drug use in Latina adolescents and college students (Felix-Ortiz, Fernandez, & Newcomb, 1998). Acculturative stress also appears to play a major role in psychosocial risk and has been linked to depression and suicidality in Latino adolescents and college students (Crockett et al., 2007; Hovey & King, 1996). This body of literature suggests that clinicians should assess acculturation in Latino youth and acculturative gaps in Latino families while performing risk assessments and interventions with Latino youth.

Clinicians should be aware and incorporate understanding of normative cultural values when working with Latinos (Flores, 2000). For example, to express respeto (respect), a provider would show appropriate deferential behavior to a patient or their family members based on their age and social status. A respect for the value of familiarismo (loyalty to the extended family) would acknowledge and provide an opportunity for the extended family to be involved in support and medical decision making. When working with Mexican American men, research has suggested the utility of supporting the value of machismo, or manliness, which could encourage health-seeking behavior as a way of fulfilling cultural and familial obligations to be good fathers, husbands, and community members (Sobralske, 2006). When providing culturally appropriate guidance with Latino parents in talking to their teenage children about sexual health, clinicians can reflect understanding of familiarismo and simpatia (smooth family functioning and face-saving) by helping parents have open relationships with their teens, stay calm, and be honest about mistakes and limitations (Guilamo-Ramos & Bouris, 2008). In addition, Latino parents should be actively encouraged to talk to their sons, and not just their daughters, about sexual health (Guilamo-Ramos & Bouris, 2008).

Asian Americans and Pacific Islanders. Normative cultural values from many countries in Asia emphasize collectivism and individual sacrifice for the family, respect for elders and filial piety, collectivism, saving face and preventing shame to the family, and delayed sexual activity until marriage (Lee, Choe, Kim, & Ngo, 2000; Le & Kato, 2006; Vo et al., 2007). Cultural taboos may make it difficult for parents to talk about sexual health with their teenagers (Kao, 2006). There is a growing body of evidence that suggests that increasing acculturation among AAPI youth is associated with a variety of health risk behaviors, including obesity-promoting behaviors (Unger et al., 2004), smoking (Chen et al., 1999; Unger et al., 2000), delinquency (Le & Stockdale, 2005; Wong, 1999), alcohol use (Hahm, Lahiff, & Guterman, 2003), and sexual behaviors (Hahm, Lahiff, & Barreto, 2006; Tosh & Simmons, 2007). An acculturation gap between parent and child has been associated with parenting difficulties and family conflict in Asian American families (Buki, Ma, Strom, & Strom, 2003; Lee et al., 2000), which in turn has been reported to mediate the effect of the acculturation gap on depressive symptoms in Asian American adolescents (Ying & Han, 2007). Acculturation gaps have also been reported to be predictive of youth violence (Le & Stockdale, 2008) and have also been hypothesized to play a role in the initiation of substance use in AAPI youth (Bhattacharya, 1998). In general, clinicians serving AAPI youth should assess acculturation, be alert to the possibility of acculturation gaps contributing to family conflicts, and understand how these cultural dynamics can affect the mental health and risk behaviors of these youth.

A study exploring the perspectives of Asian American youth on health care reported that Asian American youth largely wish to be treated like all other youth and most highly value universal characteristics such as cleanliness, respect, and privacy (Vo et al., 2007). However, many of these youth wanted clinicians to be knowledgeable about Asian cultural values and traditional medicine and wanted clinicians to help them communicate with their parents about difficult issues. Acculturation appeared to have complex effects on Asian American youths’ views regarding certain issues, including the use of interpreter services and patient–clinician confidentiality.
A small qualitative study of gender identity development among recently immigrated Vietnamese American high school students reported that these youths’ culture and gender identity formation was complex and dynamic (Stritikus & Nguyen, 2007). The youth constructed their own gender identities, which fit with their particular social contexts, strategically adopting elements of Vietnamese and mainstream American cultural norms in a process described as “selective acculturation,” which was different across genders. Many of the boys in this study maintained that they could selectively adopt American cultural attributes and yet maintain their core Vietnamese identity, but they tended to disapprove of girls adopting American culture because this was seen as a rejection of their Vietnamese heritage. This emerging area of research suggests that clinicians should be sensitive to potentially complex and dynamic interactions between ethnic and gender identity development among AAPI youth.

Native Americans. There is relatively less literature on culturally competent health care with Native American youth, and much of it focuses on mental health and suicidality—issues that affect this population disproportionately (see Figure 3). Research with relatively small samples of Native American youth has reported culturally specific variables associated with suicidal ideation, including perceived discrimination and lower identification with traditional ethnic culture (Yoder, Whitbeck, Hoyt, & LaFromboise, 2006). Researchers examining correlates of suicidality across tribes have reported tribe-specific heterogeneity of suicidal ideation (Novins, Beals, Roberts, & Manson, 1999). Overall, the research supports clinical and youth development strategies that foster positive ethnic identity among Native American youth, although specific risk-identification and prevention strategies are likely to be tribe specific.

Conclusions

Racial/ethnic disparities in health status and health care are pervasive. Major leadership organizations in public health and medicine have called for the elimination of these disparities. Significant gender disparities are also reported, with adolescent and young adult men having significantly worse mortality and health risk behaviors, although little is known about the causes of gender disparities or how racial/ethnic and gender disparities interact. Efforts to improve cultural competence in health care can focus on reducing systemic barriers to health care access and improving cultural competence in clinical services provided. Further efforts should be made to reduce disparities in health insurance coverage. Culturally competent services should include adequate professional interpreter services. Efforts should also be made to increase the racial/ethnic and linguistic diversity of the health care workforce and to improve cultural competence training of health care providers (Britton, 2004; Weissman et al., 2005). Clinicians serving immigrant youth should assess acculturation and potential intergenerational acculturation gaps. Efforts to reduce risk behaviors in racial/ethnic minority youth should foster healthy ethnic identity development and bicultural self-efficacy and address acculturative stress and intergenerational family acculturation gaps and conflicts.

Although much is known about racial/ethnic disparities and cultural competence in youth, there remain many unanswered questions. The bulk of the research on racial/ethnic disparities in health is on adults, not on children and adolescents. There are many methodological and conceptual controversies in the study of ethnic identity and acculturation. Research on broad racial/ethnic categories such as African American, Latino, and Asian American/Pacific Islander ignores significant within-group heterogeneity and may marginalize salient issues of particular subgroups. More research needs to be done from the perspective of the youth themselves. Finally, more research is needed on how race and gender interact. Little is known about how cultural factors interact with male gender identity development in young men of color and how these factors combined may influence risk behaviors and, ultimately, health outcomes.

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