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BRIEF REPORTS

Ethnicity and Mental Health Treatment Utilization by Patients With Personality Disorders

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The authors examined the relationship between ethnicity and treatment utilization by individuals with personality disorders (PDs). Lifetime and prospectively determined rates and amounts of mental health treatments received were compared in over 500 White, African American, and Hispanic participants with PDs in a naturalistic longitudinal study. Minority, especially Hispanic, participants were significantly less likely than White participants to receive a range of outpatient and inpatient psychosocial treatments and psychotropic medications. This pattern was especially pronounced for minority participants with more severe PDs. A positive support alliance factor significantly predicted the amount of individual psychotherapy used by African American and Hispanic but not White participants, underscoring the importance of special attention to the treatment relationship with minority patients. These treatment use differences raise complex questions about treatment assessment and delivery, cultural biases of the current diagnostic system, and possible variation in PD manifestation across racial/ethnic groups. Future studies need to assess specific barriers to adequate and appropriate treatments for minority individuals with PDs.

Keywords: personality disorders, race, ethnicity, treatment utilization

Although the more severe manifestations of personality disorder (PD), such as borderline and antisocial, have been gaining empirical and clinical attention, much about the etiology and treatment of these complex psychopathological constellations remains unknown. Previous studies (Bender et al., 2001, 2006)

found that patients with certain PDs utilize more mental health treatment than do patients with major depression and no PD. While patients with PDs used more inpatient services and medication over time, many discontinued individual psychotherapy after a relatively short period (Bender et al., 2006),

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despite lack of significant functional improvement (Skodol et al., 2005). Another recent study showed that patients with PDs had significantly greater unmet needs, such as risk to self and others and psychological distress, compared with other patients on inpatient services (Hayward, Slade, & Moran, 2006). These results raise questions about the adequacy of the treatment patients with PDs receive and suggest that barriers exist to their proper treatment (Bender et al., 2006).

In 2001, the Surgeon General released a report underscoring the role of race and ethnicity as barriers to receiving adequate and appropriate mental health services (U. S. Department of Health and Human Services, 2001). This assertion has received support from empirical studies documenting significant differences among ethnic groups in use of various mental health treatments. Harris, Edlund, and Larson (2005) found less use of mental health services by most minority groups compared with that by Whites. Similarly, Alegria et al. (2002) observed Hispanics and African Americans¹ were less likely than Whites to receive specialty mental health treatments in particular. Several other studies have shown that Whites receive more services in greater amounts than do African Americans and that African Americans are much less likely to return for treatment after an initial consultation (e.g., Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Sue, 1977). Hu, Snowden, Jerrell, and Nguyen (1991) found greater use of outpatient, but less use of emergency and inpatient, treatment by Hispanics compared with that of Whites, while African Americans used more emergency and less outpatient care.

Examining how minorities view mental health treatment, Cooper-Patrick et al. (1999) showed that African Americans had more positive attitudes than did Whites about receiving treatment. African Americans were less likely to receive specialty mental health services, using primary care providers more often for treatment of mental health issues. Diala et al. (2000) also found that African Americans had more positive attitudes than did Whites about mental health services; nevertheless, after actually utilizing services, African Americans' attitudes became more negative than Whites' attitudes.

Various reasons, such as cultural biases (by both consumers and providers) and higher uninsured rates among minorities, have been cited to explain disparities (Takeuchi, Uehara, & Maramba, 1999). Few studies have considered the role of diagnosis in analyzing treatment utilization among ethnic groups. PDs are of particular concern because prominent disturbances in interpersonal relatedness among PD patients lead to difficulties in establishing and maintaining beneficial treatment relationships (Bender, 2005; Bender et al., 2003). Alarcon and Leetz (1998) have suggested that culture shapes the clinical manifestation of PDs while simultaneously mediating treatment-seeking behaviors that could directly impact outcome. Hence, we might expect minority individuals with PDs to experience greater challenges than do Whites with PDs in negotiating the mental health system. With the exception of Hu et al. (1991), who considered the impact of broad classes of psychopathology and only a global PD category on treatment use by different ethnic groups, no prior studies have examined racial/ethnic patterns of treatment use in a rigorously diagnosed sample of patients with PDs. The purpose of this study was to explore whether the added complexity of PD psychopathology raises particular challenges to treatment-seeking minorities receiving adequate mental health services.

Method

Participants

Treatment-seeking or recently treated participants ages 18 to 45 years were recruited from clinical services affiliated with each of four Collaborative Longitudinal Personality Disorders Study (CLPS) sites, or via media advertising. Exclusion criteria were active psychosis; acute substance intoxication or withdrawal; or a history of schizophrenia, schizoaffective, or schizophreniform disorders. Eligible participants who began the assessment signed written informed consent after the Institutional Review Board-approved research procedures had been fully explained. CLPS is a naturalistic, longitudinal study designed to assess PD characteristics and course as well as psychosocial functioning of PD participants and a comparison group with major depression and no PDs.²

The sample³ for this study consisted of 606 participants who provided data on lifetime treatment history at baseline: White (not Hispanic) $n = 434$ (71.6%); African American (not Hispanic) $n = 89$ (14.7%); Hispanic $n = 83$ (13.7%); and 547 participants on whom complete 2-year follow-up data on treatment utilization were obtained: White $n = 399$ (73.0%); African American $n = 79$ (14.4%); Hispanic $n = 69$ (12.6%).

Materials and Procedure

Experienced research clinicians, trained to adequate levels of diagnostic reliability, determined PD diagnoses at baseline by using the Diagnostic Interview for *DSM-IV* Personality Disorders (Zanarini, Frankenburg, SICKEL, & YONG, 1996; Zanarini et al., 2000). Participants were assigned to one of four PD diagnostic groups: schizotypal (STPD), borderline (BPD), avoidant (AVPD), or obsessive-compulsive (OCPD).⁴ Of those who completed both baseline and 2 years of follow-up, distribution by diagnostic group was the following: STPD, 82 (15.0%); BPD, 165 (30.1%); AVPD, 149 (27.2%); and OCPD, 151 (27.6%). A previous CLPS study (Chavira et al., 2003) demonstrated higher rates of BPD among Hispanic participants, compared with African Americans and Whites, and higher rates of STPD for African Americans compared with Whites.

Baseline and follow-along versions of the Longitudinal Interval Follow-Up Evaluation (LIFE; Keller et al., 1987) were used to

¹ We used the broad terms of *White*, *African American*, and *Hispanic* to capture what is admittedly significant heterogeneity within each group.

² For a more detailed description of the rationale for and design of the CLPS, see Gunderson et al. (2000). For the purposes of maximizing sample recruitment, representative disorders of each PD cluster were chosen: STPD, Cluster A; BPD, Cluster B; and AVPD, Cluster C. Although it is grouped with Cluster C, OCPD is significantly distinctive from other disorders to have warranted inclusion.

³ The original sample was recruited between 1996 and 1998 and included 573 participants with PDs, of whom 76% were White. The ethnic representation of the sample was expanded in 2001–2002 by recruiting additional African American or Hispanic participants.

⁴ Diagnostic cell assignment was determined by an a priori algorithm (Gunderson et al., 2000). Diagnostic Interview for *DSM-IV* Personality Disorders diagnoses received support from either the Schedule for Non-adaptive and Adaptive Personality (Clark, 1993) or the Personality Assessment Form (Shea et al., 1987).

assess past treatment utilization and 2 years of prospective follow-up at 6-, 12-, and 24-month follow-up intervals. Lifetime data, both amounts and rates of use, were collected at the baseline interview for the following treatment modalities: individual psychotherapy, group psychotherapy, family therapy, self-help groups, day treatment, halfway house, psychiatric hospitalization, and psychotropic medications. Psychotropic medication categories analyzed included any psychiatric medication and anxiolytic, hypnotic, mood stabilizer, antipsychotic, antidepressant, and anticonvulsant medications. For the 2-year prospective period, rates of use and mean amounts received were calculated for individual therapy, group therapy, family therapy, self-help groups, medication consultations, psychiatric hospitalization, and emergency room visits. Medication variables included any psychiatric medication, anxiolytic, hypnotic, mood stabilizer, antipsychotic, and antidepressant. The life treatment variables have demonstrated good to excellent levels of reliability (Keller et al., 1983; Warshaw, Keller, & Stout, 1994).

Data Analysis

Forward stepwise logistic regression was used to assess differences among the three ethnic groups in lifetime rates of treatment at baseline and 2-year follow-up rates (participants could receive treatments at any time during this 2-year period). General linear models (analyses of variance) were run to assess differences in amounts of treatment among the three ethnic groups. Because the treatment amount variables were significantly skewed, the variables were transformed prior to entry into the model by taking the log of (1 + treatment amount). Since there were extreme outliers, the variables were winsorized by replacing extreme values with the

90th percentile value (Marascuilo & McSweeney, 1977). The tables report means that are winsorized, nontransformed, and adjusted for covariates in the model. Separate analyses were done to assess lifetime treatment rates at baseline and for the 2 years prospectively. Both general linear models and logistic regression analyses controlled for number of lifetime Axis I disorders, age, gender, and socioeconomic status. PD group by ethnicity interaction effects were also tested. Analyses were conducted with SAS Version 8.2 (SAS Institute, 1999); only participants who had complete data for all variables, including covariates, were retained in the analyses.

Results

Psychosocial Treatment Use

Table 1 compares the proportions of each ethnic group having received various treatments. At baseline, both African American (odds ratio [OR] = 0.22; 95% confidence interval [CI] = 0.07, 0.70) and Hispanic (OR = 0.47; 95% CI = 0.09, 0.96) participants with PDs were less likely to report receiving psychosocial treatment of any type in their lifetimes than were White participants with PDs. Specifically, African Americans were less likely to report a history of individual psychotherapy (OR = 0.29; CI = 0.14, 0.61) and family therapy (OR = 0.48; CI = 0.27, 0.85). Hispanics were less likely than Whites to report individual psychotherapy (OR = 0.33; CI = 0.15, 0.70), family therapy (OR = 0.41; CI = 0.23, 0.75), self-help (OR = 0.19; CI = 0.09, 0.40), day treatment (OR = 0.23; CI = 0.10, 0.51), and psychiatric hospitalization (OR = 0.41; CI = 0.23, 0.76). Hispanics were less likely than African Americans to report lifetime self-help (OR =

Table 1
Comparisons of Proportions of Ethnic Groups Receiving Types of Psychosocial Treatment: Lifetime Retrospective at Intake and 2-Year Prospective

Treatment	White (n = 396)		African American (n = 78)		Hispanic (n = 74)		Wald chi square	df	p
	n	%	n	%	n	%			
Lifetime									
Any psychosocial	389	98.23 _a	71	91.03 _b	69	93.24 _b	7.77	2	.0206
Individual	375	94.70 _a	63	80.77 _b	61	82.43 _b	13.65	2	.0011
Group	156	39.39	31	39.74	34	45.95	ns	2	ns
Family	150	37.88 _a	18	23.08 _b	17	22.97 _b	13.09	2	.0014
Self-help	150	37.88 _a	24	30.77 _a	9	12.16 _b	18.45	2	<.0001
Day treatment	105	26.52 _a	17	21.79 _a	8	10.81 _b	13.67	2	.0011
Halfway house	60	15.15	15	19.23	8	10.81	ns	2	ns
Hospital	193	46.74 _a	33	42.31 _{ab}	29	39.19 _b	9.46	2	.0088
Prospective									
Individual	300	81.30 _a	49	70.00 _b	46	74.19 _{ab}	6.91	2	.0316
Group	87	23.58 _a	14	20.00 _a	30	48.39 _b	16.35	2	.0003
Family	41	11.11	4	5.71	10	16.13	ns	2	ns
Self-help	73	19.78 _a	13	18.57 _a	5	8.06 _b	8.31	2	.0157
Medication	256	69.38	42	60.00	44	70.97	ns	2	ns
Emergency room	59	15.99	7	10.00	11	17.74	ns	2	ns
Hospital	86	23.31 _a	15	21.43 _a	6	9.68 _b	10.95	2	.0042

Note. Proportions that share the same subscript are not significantly different.

0.24; CI = 0.10, 0.51) and day treatment (OR = 0.32; CI = 0.13, 0.84). There were no significant differences in reported group therapy or halfway house treatment between the ethnic groups.

The 2-year prospective data showed that African Americans continued to report less likelihood than did Whites of receiving any individual psychotherapy (OR = 0.51; CI = 0.29, 0.92), but Hispanics did not. Hispanics remained less likely to receive self-help treatment (OR = 0.24; CI = 0.09, 0.63) and psychiatric hospitalization (OR = 0.22; CI = 0.09, 0.54) than Whites receive. In addition, Hispanic participants were less likely to receive self-help (OR = 0.30; CI = 0.10, 0.93) or hospitalization than were African American participants (OR = 0.27; CI = 0.09, 0.79). During this follow-up period, however, Hispanic participants were more likely to receive group treatment than were either Whites (OR = 2.94; CI = 1.75, 5.56) or African Americans (OR = 3.85; CI = 1.72, 8.33).

Medication Use

Table 2 compares the proportions of each ethnic group using various classes of psychotropic medications. At baseline, African Americans (OR = 0.35; CI = 0.02, 0.71) and Hispanics (OR = 0.37; CI = 0.16, 0.83) were less likely than Whites to report having ever received psychotropic medication. This finding held for anxiolytic, mood stabilizing, and antidepressant medications, all of which both African Americans and Hispanics reported only about one-third to one-half as often as did White participants. There were no differences by ethnic group for lifetime hypnotic, antipsychotic, or anticonvulsant medications.

Lifetime psychotropic medication use analyses also yielded two PD diagnostic group by ethnicity interactions: for any psychotropic medications, $\chi^2(6) = 13.18, p = .0402$; and for antidepressants,

$\chi^2(6) = 14.12, p = .0283$. White participants with BPD were greater than six times more likely than Hispanic participants with BPD (OR = 6.61; 95% CI = 2.22, 19.68) and seven times more likely than African American participants with BPD (OR = 7.45; 95% CI = 2.25, 24.70) to receive any psychotropic medication. Similarly, White BPD participants were seven times more likely to receive any lifetime antidepressants compared with Hispanic BPD participants (OR = 7.02; 95% CI = 2.94, 16.74) and African American participants with BPD (OR = 7.14; 95% CI = 2.65, 19.20).

The prospective data show that African Americans remained less likely than Whites to receive any psychotropic medications over the follow-up period (OR = 0.47; CI = 0.26, 0.87), but no difference was found for Hispanics, generally speaking. However, anxiolytic, antidepressant, mood stabilizer, and anticonvulsant medications were used less by Hispanics than Whites, and African American participants were less likely than White participants to use anxiolytics and antidepressants.

Amounts of Treatment Received

Table 3 presents the amounts of psychosocial treatments utilized in the lifetime and over the first 2 study years by the three ethnic groups. Both African Americans and Hispanics received significantly less individual psychotherapy than did Whites prior to study intake. African Americans and Hispanics received less family therapy over their lifetime prior to baseline, and Hispanics used less self-help groups than did African Americans and Whites and had significantly fewer weeks of psychiatric hospitalization than had Whites. There were no differences among the three groups on group therapy, day treatment, and halfway house use. There was a PD diagnostic group by ethnicity interaction for lifetime weeks of

Table 2
Comparisons of Proportions of Ethnic Groups Receiving Types of Psychotropic Medications: Lifetime Retrospective at Intake and 2-Year Prospective

Medication	White (n = 396)		African American (n = 78)		Hispanic (n = 73)		Wald chi square	df	p
	n	%	n	%	n	%			
Lifetime									
Any psychotropic	338	85.35 _a	51	65.38 _b	51	69.86 _b	19.61	2	<.0001
Anxiolytic	176	44.44 _a	17	21.79 _b	15	20.55 _b	25.45	2	<.0001
Antidepressant	313	79.04 _a	41	52.56 _b	41	56.16 _b	26.56	2	<.0001
Hypnotic	22	5.56	4	5.13	4	5.48	ns	2	ns
Mood stabilizer	112	28.28 _a	11	14.10 _b	12	16.44 _b	15.21	2	.0005
Antipsychotic	83	20.96	17	21.79	12	16.44	ns	2	ns
Anticonvulsant	71	17.93	10	12.82	10	13.70	ns	2	ns
Prospective									
Any psychotropic	298	80.76 _a	49	70.00 _b	45	72.58 _{ab}	7.57	2	.0227
Anxiolytic	103	27.91 _a	9	12.86 _b	10	16.13 _b	12.49	2	.0019
Antidepressant	249	67.48 _a	31	44.29 _b	36	58.06 _b	14.01	2	.0009
Hypnotic	16	4.34	4	5.71	4	6.45	ns	2	ns
Mood stabilizer	81	21.95 _a	11	15.71 _{ab}	8	12.90 _b	7.67	2	.0216
Antipsychotic	73	19.78	7	10.00	11	17.74	ns	2	ns
Anticonvulsant	71	19.24 _a	10	14.29 _{ab}	8	12.90 _b	7.86	2	.0196

Note. Proportions that share the same subscript are not significantly different.

Table 3
Comparisons by Ethnic Group of Amounts of Mental Health Treatment Received: Lifetime Retrospective at Intake and 2-Year Prospective

Treatment	F value	p	White (n = 396)		African American (n = 78)		Hispanic (n = 74)		Differences
			M	SE	M	SE	M	SE	
Lifetime									
Individual (mo.)	16.48	<0.0001	44.3	2.5	24.9	5.5	32.2	6.3	AH < W
Group (mo.)	1.23	0.2942	6.5	1.1	4.7	2.4	9.9	2.8	ns
Family (mo.)	6.41	0.0018	2.8	0.3	0.9	0.8	1.3	0.9	AH < W
Self-help (mo.)	7.42	0.0007	11.8	1.5	11.6	3.2	2.8	3.7	H < AW
Day treatment (wks.)	0.87	0.4208	7.6	1.7	4.6	3.6	5.8	4.2	ns
Halfway house (wks.)	1.73	0.1790	6.0	1.2	8.6	2.6	2.2	3.0	ns
Psychiatric hospital (wks.)	7.07	0.0009	8.6	1.2	4.2	2.6	1.6	2.9	H < W
Prospective									
Individual (sessions)	3.49	0.0314	44.7	2.4	29.3	5.5	37.7	6.5	A < W
Group (sessions)	6.71	0.0013	6.5	0.8	4.2	1.9	14.1	2.2	WA < H
Family (sessions)	1.14	0.3220	0.8	0.2	0.7	0.4	0.7	0.4	ns
Self-help (sessions)	2.12	0.1208	4.9	0.6	5.1	1.4	1.9	1.7	ns
Medication (sessions)	3.86	0.0218	12.3	1.2	5.7	2.6	9.2	3.1	A < W
Hospital (weeks)	3.61	0.0279	2.3	0.2	1.9	0.6	0.6	0.7	H < W
Emergency rm. (visits)	2.26	0.1049	0.3	0.03	0.24	0.1	0.14	0.1	ns

Note. A = African American; H = Hispanic; W = White.

psychiatric hospitalization, $F(6, 532) = 2.84$, $p = .01$: White participants with BPD had more weeks of psychiatric hospitalization than did Hispanic and African American participants with BPD.

The 2-year prospective data showed that African Americans had fewer individual therapy and medication sessions than had Whites. Hispanics received more family therapy than did African Americans and Whites but had fewer weeks of psychiatric hospitalization than did White participants. A PD diagnostic group by ethnicity interaction for number of medication sessions over 2 years, $F(6, 486) = 2.53$, $p = .0202$, indicated that White BPD participants attended more medication sessions than did the Hispanic and African American BPD participants.

Post Hoc Alliance Analyses

Given that African Americans and Hispanics received less individual psychotherapy than did Whites, we elected to determine if aspects of the therapeutic alliance differentially predicted amount of individual therapy.⁵ Significant results emerged for the ethnicity by positive support interaction for African Americans and Hispanics. That is, although African Americans and Hispanics received less individual treatment than did Whites, the number of individual sessions increased for the two minority groups as the positive alliance score increased, but not for Whites.

Discussion

In previous studies (Bender et al., 2001, 2006), we found that CLPS participants with PDs had more extensive histories of psychiatric outpatient, inpatient, and psychopharmacologic treatment than did participants with major depressive disorder and no PD.

Our current investigation considered the African American and Hispanic participants in our studies, finding treatment use by participants with PDs unequal across race and ethnicity, even after controlling for socioeconomic status. Overall, African American and Hispanic participants with PDs received a significantly narrower range of psychiatric treatments than did White participants, despite the fact that the more severe PDs were proportionately higher in the minorities (STPD in African Americans and BPD in Hispanics; Chavira et al., 2003).

Except for group psychotherapy, Hispanics were significantly less likely than Whites to receive most types of mental health treatments during the retrospective lifetime period, with less likelihood of individual therapy, self-help groups, and psychiatric inpatient units during the prospective period. African Americans reported less individual and family psychotherapy retrospectively than did Whites as well as significantly less individual treatment in the follow-up period. Hispanics were less likely than African Americans to receive lifetime self-help and day treatment as well as self-help and inpatient treatment during the 2-year prospective

⁵ Alliance data were collected prospectively over 2 years on the LIFE. The alliance section of the LIFE interview comprises 13 items asking the extent to which a treater interacted with or affected the interviewee in specific ways (e.g., "seem to care about you or show a sense of concern," "make you feel understood," or "appear to be angry or annoyed"). Regression analyses were conducted to assess the presence of interactions between ethnicity and three alliance dimensions derived from the 13 items (negative alliance, positive technique, and positive support). Significant results were positive support by African American interaction, $F(1, 306) = 6.42$, $p = .0118$; and positive support by Hispanic interaction, $F(1, 306) = 8.41$, $p = .0103$.

period. Both African Americans and Hispanics were less likely to have received psychotropic medications, assessed both retrospectively and prospectively.

There were also significant differences in the amounts of various treatments utilized by minorities compared with that utilized by Whites. Hispanics received less individual, family, self-help, and inpatient hospital services retrospectively and less inpatient admissions during the follow-up period. That African Americans received the least amount of individual therapy, both lifetime and prospectively, is consistent with observations by Cooper-Patrick et al. (1999) that this group is more likely to seek treatment in primary care settings. At the same time, our alliance analyses indicated that positive support is more crucial for minority patients in individual psychotherapy, corroborating prior studies (e.g., Diala et al., 2000; Reis & Brown, 1999) showing minorities at higher risk for premature dropout. Clearly minorities' culturally shaped attitudes about relationships, such as the importance of *confianza* (trust and intimacy) to Hispanics, are likely to influence treatment relationships as well (Anez et al., 2005). Thus, our finding that the experience of positive support predicts the amount of individual psychotherapy received by African Americans and Hispanics is consistent with a growing consensus that race, ethnicity, and culture are crucial considerations in establishing and maintaining a facilitative treatment alliance with minority patients (e.g., Anez et al., 2005; Comas-Diaz, 2006; Reis & Brown, 1999; Takebayashi, 2005).

The lower proportions of African Americans and Hispanics using various psychotropic medications may reflect disparate attitudes among groups regarding these medications. Other possible explanations include ethnic differences in medication metabolism, which could affect clinical effectiveness and exacerbate side effects (Alarcon, 2005). Mental health providers may also carry biases about the nature of psychopathology in minorities that affect pharmacotherapy prescribing. For example, Opler, Ramirez, Dominguez, Fox, and Johnson (2004) observed that clinicians assumed that unacculturated Hispanics were too influenced by suggestion and so did not inform these patients about possible medication side effects. Uninformed, these patients experienced side effects as *nerviosismo*, or an increase of symptoms due to life stressors. When this situation was recognized and the clinicians addressed side effects directly, compliance and treatment alliance improved.

Treatment use differences between minorities and Whites were amplified at the more severe end of PD pathology. Minority patients with BPD (with higher proportions among Hispanics) were less likely to have used psychotropic medications over their lifetimes, particularly antidepressants; were less likely to have attended medication consultations during the follow-up period; and received less psychiatric inpatient treatment. Inasmuch as individuals with BPD often have higher levels of comorbid Axis I disorders than do those with other PDs (Zanarini et al., 1998), these medication and inpatient disparities raise additional questions about the interactions of minorities with BPD with the mental health system.

On the other hand, some of the variance between groups may reflect biases within the assessment process. As Chavira et al. (2003) have noted, the current diagnostic system is predicated on Euro-Western norms that may not be adequately sensitive to cultural variation. Further, there may be differences across racial/

ethnic groups in the ways that psychopathology is manifested. Several examples of work designed to address this question in Hispanics have yielded mixed results across PD diagnoses. Grilo, Anez, and McGlashan (2003) tested a Spanish language version of the Diagnostic Interview for *DSM-IV* Personality Disorders (Zanarini, Frankenburg, Sickel, & Yong, 1996; Zanarini et al., 2000) and found particular problems with reliability and criterion sets for all Cluster A diagnoses, implying that certain traits may be viewed as odd or paranoid when the assessor does not adequately understand the cultural context. At the same time, Grilo and colleagues (2003) reported that reliability data for the Cluster B and Cluster C PDs were generally comparable with those reported for primarily White samples. More recently, a study of diagnostic efficiency of *DSM-IV* BPD criteria in monolingual Hispanic patients (Grilo, Becker, Anez, & McGlashan, 2004) revealed considerable similarity to those reported previously for our CLPS group (Grilo et al., 2001). Although further research on cultural differences and potential biases across ethnic groups in studies of PDs is sorely needed, such convergences across studies do support certain aspects of the construct validity of PDs across ethnic groups (Grilo et al., 2004).

The current study has several limitations. Treatment data were obtained from study participants without corroborating sources. However, although patients may vary in the accuracy of their reporting, our approach has been the standard method used in prior studies (e.g., Kessler et al., 1999; Olfson & Pincus, 1994). Although this is the largest prospective study of treatment utilization by patients with PDs, our sample of minorities (African American $n = 79$; Hispanic American $n = 69$)—while relatively large—may have kept us from identifying additional “smaller-effect” differences. In addition, our sample comprised individuals who were treatment-seeking, currently in treatment, or who had had some prior treatment. Therefore, the results may not generalize to individuals with PDs who are reluctant to seek treatment and may actually understate the discrepancies between minorities and Whites. Also, although the four groups studied represent the PD spectrum and the co-occurrence of other PDs was assessed, the impact of PDs other than that of the targeted four was not considered. Further, because this is a naturalistic study, our data cannot address whether those who entered the mental health system received appropriate and effective treatments. Even if Whites received more treatment, we cannot conclude that it was optimal treatment for PDs.

Our results raise important questions about specific factors that may affect use. For example, are the African American participants in our study receiving less of certain treatments because of negative prior experiences with the system, as Diala et al. (2000) have suggested? We are currently addressing this shortfall of information by collecting data on barriers to treatment of PDs, such as a belief that treatment does not work, stigma attached to psychological problems, ignorance about how to access services, and so on.

Further inquiry should target the heterogeneity within ethnic groups. It has been suggested that different subgroups within ethnicities have different experiences affecting the development of psychopathology and attitudes toward treatment. For African Americans, remnants of historical institutional discrimination in the United States may appear in attitudes toward treaters and service agencies. Within Hispanic ethnicity are numerous groups

with different migratory and cultural histories. One study showed considerable heterogeneity among Hispanic subgroups in the use of mental health treatments (Harris, Edlund, & Larson, 2005), a diversity we acknowledge among our Hispanic participants. Furthermore, our study did not consider level of acculturation, which has also been observed to influence both emotional well-being and service utilization (Mezzich, Ruiz, & Munoz, 1999). Lastly, we did not assess whether the treatments administered in community-based clinics were more culturally sensitive than those received from other providers.

The nexus of PD, race/ethnicity, and mental health service use remains complex and requires further empirical inquiry. Individuals with PDs are often burdened by interpersonal difficulties and other problems of living that complicate seeking and receiving proper mental health treatments. If we are to improve the prospects of all individuals with PDs, we must seriously consider not only the barriers of psychopathology, but the potential barriers of race and ethnicity as well.

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Call for Nominations

The Publications and Communications (P&C) Board of the American Psychological Association has opened nominations for the editorships of **Psychological Assessment**, **Journal of Family Psychology**, **Journal of Experimental Psychology: Animal Behavior Processes**, and **Journal of Personality and Social Psychology: Personality Processes and Individual Differences (PPID)**, for the years 2010-2015. Milton E. Strauss, PhD, Anne E. Kazak, PhD, Nicholas Mackintosh, PhD, and Charles S. Carver, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2009 to prepare for issues published in 2010. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

Search chairs have been appointed as follows:

- **Psychological Assessment**, William C. Howell, PhD, and J Gilbert Benedict, PhD
- **Journal of Family Psychology**, Lillian Comas-Diaz, PhD, and Robert G. Frank, PhD
- **Journal of Experimental Psychology: Animal Behavior Processes**, Peter A. Ornstein, PhD, and Linda Porrino, PhD
- **Journal of Personality and Social Psychology: PPID**, David C. Funder, PhD, and Leah L. Light, PhD

Candidates should be nominated by accessing APA's EditorQuest site on the Web. Using your Web browser, go to <http://editorquest.apa.org>. On the Home menu on the left, find "Guests." Next, click on the link "Submit a Nomination," enter your nominee's information, and click "Submit."

Prepared statements of one page or less in support of a nominee can also be submitted by e-mail to Emnet Tesfaye, P&C Board Search Liaison, at etesfaye@apa.org.

Deadline for accepting nominations is **January 10, 2008**, when reviews will begin.