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Data from a representative sample of Boston area residents were analyzed to examine differences among ethnic populations in perceived needs and use of services for eight problem areas. The areas studied were: employment problems; financial problems; problems of the aged living alone; alcohol problems; personal; family or marital problems; child behavior or education problems; the need for homemaker services; and the need for a home nurse. The results indicate substantial differences between perceived needs and reported use of services, and both those factors varied by ethnic identification.

We recently examined survey data from the Boston area and identified large discrepancies between the perceived need and the reported use of services (Bradshaw, 1972; Thayer, 1973) in each of eight problem areas (Demone and Cleary, 1983). The areas discussed were employment problems; financial problems; problems of the aged living alone; alcohol problems; personal, family or marital problems; child behavior or education problems; the need for homemaker services; and the need for a home nurse.

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If health and social service professionals are to respond to unmet needs such as these, it is necessary to examine more closely the factors affecting the prevalence of problems, the perception of need, and help-seeking behavior. In this paper we examine the extent to which reported prevalence, perceived need, and actual use of services varies among certain ethnic populations in the Boston area.

Background

The prevalence of many of the problems discussed here varies according to the socioeconomic conditions in the area studied, but a number of researchers have reported systematic variation among ethnic and cultural groups that persist when socioeconomic factors are controlled. For example, there appear to be relatively persistent cultural differences in patterns of alcohol use that are independent of socioeconomic factors (Snyder, 1978; Glassener and Berg, 1980; King, 1961; Chafetz and Demone, 1962; Roberts and Myers, 1967; Room, 1968; Lowenthal, Walt, and Klein, 1975; Schmidt and Papham, 1976). The degree to which symptoms are perceived, labeled and acted upon has been shown to be significantly related to gender, ethnicity, and social class (Zborowski, 1952; Saunders, 1954; Koos, 1954; Zola, 1966; Zborowski, 1969; Angel and Cleary, 1984; Sternbach and Tursky, 1965; Hochschild, 1981; Barnett, Biener, Baruch, 1987; Cleary and Mechanic, 1983; Kessler, Brown, and Broman, 1981; Mechanic, 1972; Koopman, Eisenthal and Stoeckel, 1984; Pennebaker, 1982; Lipton and Marbach, 1984; Cleary, Mechanic, and Greenley, 1982). For example, in a classic study conducted at the Massachusetts General Hospital in Boston, Zola (1966) examined the effect of culture on patients' presentation of symptoms. He examined 29 patients at one of the clinics who had no apparent medical disease. He found that among Italian patients, psychogenic factors were suggested in 11 of the 12 cases. Among the other 17 patients, psychogenic factors were suspected in only four cases.

Zborowski (1952) studied reactions to pain among different ethnic groups in a New York City hospital and concluded that Italians are more oriented towards the actual experience of pain and are primarily concerned with relief from pain, whereas Jews tend to be more concerned with the meaning of the pain and

the potential consequences of their symptoms. He also found the "Old American" patients are more likely to be stoical about pain and Irish Americans have a tendency to deny their conditions.

Croog and Mechanic conducted research that partly replicated, but also extended this earlier work. Croog (1961) analyzed responses to the Cornell Medical Index by 2,000 army inductees and found that Italian and Jewish respondents reported the most symptoms. He found that the pattern of symptom reporting was correlated with education for Italian, but not Jewish, respondents. Mechanic (1963) has also studied the relationship between religion and illness behavior in several studies of university students. In two of his earlier studies (Mechanic, 1963), he found that Jewish students at two different universities reported a higher tendency to use physician services than Protestant or Catholic students. He tested whether the observed differences were due to differences in social class and found that the differences in illness behavior were especially evident among higher class respondents. In a later study of 1,502 randomly selected university students and a group of 274 student applicants for psychological or psychiatric services who were studied prospectively for two years (Greenley and Mechanic, 1976), he found that applicants for psychiatric services were significantly more likely than students in the random sample to be women, Jewish and non-Catholic; to have no religious affiliation or to be nonparticipants in religious activity, to have Eastern European ancestry, or to have been born in the Northeastern United States; to be students in the social sciences, humanities, or fine arts, to be seniors or post-graduate students, and to have fathers with more education and higher status occupations. Applicants for help at the counseling center, on the other hand, were not significantly different from the random sample on religious characteristics. The patterns among students in the random sample reporting use of services were similar. A particularly interesting conclusion from their paper is that most social and cultural factors related more to the decision about where to seek help than on the decision whether to seek help.

More recently, Koopmen, Eisenthal, and Stoeckel (1984) studied 40 Italian-American patients and 44 Anglo-American patients from two ambulatory medical practices. They found that Italian-American patients reported pain significantly more fre-

quently than did Anglo-American patients. Interestingly, however, age and sex were found to mediate the relationship of ethnicity to reported pain. The relationship was only significant among women and among patients over 60 years of age.

There is every reason to believe that these "styles" of symptoms monitoring and response should generalize to other areas of problem appraisal and help seeking. Surprisingly, however, although there has been a great deal written about the need for direct service workers to be sensitive to ethnic differences when providing services (Devore and Schlesinger, 1981), virtually no data exist on the way different ethnic groups report and seek help for a variety of social service needs.

Hypotheses

Our hypotheses, based on the medical help-seeking literature described above, were that:

1. Jewish respondents would be highly likely to acknowledge problems. Furthermore, because past studies suggest that Jews may be more attuned to the consequences of their problems, we expected that they would be the group most likely to seek help for acknowledged problems.
2. Irish-Catholic respondents would tend to deny problems and thus have a low prevalence of reported problems and also have a low incidence of help-seeking.
3. Italian-Catholic respondents would tend to acknowledge problems. However, because of an emphasis on the problem itself rather than the consequences, they will be less likely to seek help for acknowledged problems.
4. The White-Protestant group of respondents was predicted to be likely to acknowledge problems but be stoical and not seek help for their acknowledged problems.

There were a substantial number of black respondents (11.6%) and respondents of other or mixed ethnic backgrounds (26.6%) in the data analyzed, but we had no *a priori* hypotheses about the behavior of these groups.

Study Design and Methods

To test these hypotheses, we analyzed data from a representative sample of residents of the Boston metropolitan area (Rohman, 1975). Although a number of studies have examined

ethnic differences in help-seeking tendencies, this study was unique in that the information collected dealt with a broad range of service providers and collected data from representative samples of the religious and cultural groups studied previously: Blacks, White Protestants, Irish Catholics, Italian Catholics, and Jews (Wechsler, Demone, and Gottlieb, 1978; Wechsler, Gottlieb, and Demone, 1979). Another unique feature of the study is that questions were asked to help distinguish between "felt need" and "expressed need" and "diagnostic needs" and "prescriptive needs." Thus, we were able to distinguish between those who expressed a need for services and those who actually attempted to secure help for their problem.

The 1,043 respondents were residents of the 69 cities and towns constituting the Boston Standard Metropolitan Statistical Area (SMSA) (Rohman, 1975). An area probability sample of all housing units in the SMSA was used. Each block or enumeration district was given a selection probability proportionate to its estimated size in the 1970 census. For the final sample, housing units were drawn from these listings, resulting in a total of 200 blocks, each with an average of 19 housing units, making a total of 3,800 housing units.

The names of all household members were obtained from the selected housing units. Information regarding patterns of residential mobility was also obtained. Finally, one-third of the units were designated for use in the final sample and for more detailed face-to-face interviews with the residents.

Each housing unit in the SMSA had an equal chance of being selected for the sample except that Black households were oversampled. Once a selection was made, substitutions were not permitted. A random selection table was included in the sampling procedure that systematically designated who among the eligible adults (18 years of age or older) would be interviewed. Each interviewer was then randomly assigned to work with a number of households from the sample.

The survey asked about eight service areas: employment problems; financial problems; problems of the aged living alone; alcohol problems; personal, family or marital problems; child behavior or education problems; the need for homemaker services; and the need for a home nurse. Each respondent was asked (a) Was any problem named in the survey experienced in

your household during the preceding year? (b) Was help for the problem sought and (even if not actively sought) received? (c) From whom was the help sought? and (d) Do you know where to call or go to secure help for these problems?

Religious and ethnic information was summarized by the coders and respondents were classified as being either Black (not of Spanish origin); White Protestant (including Quaker, Unitarian, Christian Scientist, Christian); Irish Catholic; Jewish; Spanish; mixed or other Catholic; and other. At the time of the study, the survey firm used had not developed a procedure for oversampling Hispanic households, and so there were only 13 such respondents in the sample. For the analyses reported below, respondents classified as Spanish, mixed or other Catholic, and other were combined into a single category.

Results

The sociodemographic characterisitics of the ethnic groups studied are presented in Table 1.

As the data in Table 1 indicate, the ethnic groups studied vary substantially in respect to a number of important characteristics. The Black respondents had lower incomes, were least likely to own their residence and were most likely to be separated or divorced, but least likely to be widowed. They were also younger, on average, and tended to come from larger households. The Italian Catholic respondents were more likely to own their residences, more likely to be male, married, and relatively unlikely to be widowed. They also tended to come from larger households. The Irish Catholics in the sample tended to be older and female, were the respondents most likely to be widowed, and had an average income lower than all the groups except Blacks. Certain characteristics are related to both the prevalence of problems and the propensity to seek help for problems. Thus, when we present results from our analyses, it is useful to keep these sociodemographic differences in mind.

Prevalence of Problems

The prevalence of each of the eight problems was measured by asking respondents whether they or any household member experienced the problem in the past year. These data for each ethnic group are presented in Table 2.

Table 1

Sociodemographic Characteristics of Respondents

	Black (n = 119)	White Protest. (n = 263)	Irish Catholic (n = 151)	Italian Catholic (n = 147)	Jewish (n = 77)	Mixed and Other (n = 276)
% Owner Occupied Homes	22	59	50	64	42	49
% Male	42	43	38	52	47	43
% Married	41	58	48	66	45	57
% Separated or divorced	24	9	9	8	9	12
% Widowed	6	10	19	7	14	11
Average # of people in household	3.3	2.6	2.7	3.2	2.4	2.9
Average # of children	1.0	.6	.7	.9	.6	.8
Average age	37	46	47	44	42	43
Average on income scale*	6.6	9.4	8.3	8.8	8.8	8.7

*Family income was coded as an ordinal variable ranging from 0 to 18, where 0 represented less than $1,000 and 18 represented a reported income of more than $50,000.

In a study such as the one reported here, it is impossible to know how much answers to an interviewer reflect true prevalence and how much they reflect a tendency to mention problems. However there are several interesting patterns in the data presented in Table 2. As noted above, Blacks are the most economically disadvantaged ethnic group in our study. Thus, they report the most financial problems and have the second highest rates of employment problems. This may partly explain the fact that they also have the highest rate of personal problems needing counselling. They also have the highest rates of problems with alcohol, and need for a home nurse, problems not necessarily associated with economic conditions.

The Jewish respondents in our sample also were relatively likely to report problems. For example, they reported the highest frequency of homemaker needs, employment problems, child

Table 2

Percent of Respondents in Different Ethnic Groups who Reported Problems in the Preceeding Year (number with problem in parenthesis)

Problem Area	Black (n = 119)	White Protest. (n = 263)	Irish Catholic (n = 151)	Italian Catholic (n = 147)	Jewish (n = 77)	Mixed and Other (n = 276)
Homemaker	6.7	5.3	8.6	2.7	10.4	6.6
	(8)	(14)	(13)	(4)	(8)	(18)
Finances	41.2	8.0	13.9	8.9	7.8	15.0
	(49)	(21)	(21)	(13)	(6)	(41)
Employment	32.8	17.2	13.9	19.9	33.8	21.9
	(39)	(45)	(21)	(29)	(26)	(60)
Child Behavior	24.5	28.8	9.8	23.2	31.6	19.1
Education	(12)	(19)	(4)	(13)	(6)	(18)
Counseling	29.7	15.2	11.9	14.5	27.3	16.9
	(35)	(40)	(18)	(21)	(21)	(46)
Aging	13.4	17.1	10.7	7.5	20.8	8.0
Relative	(16)	(45)	(16)	(11)	(16)	(22)
Alcohol	16.1	12.9	13.2	11.6	12.5	13.1
	(19)	(34)	(20)	(17)	(9)	(36)
Home Nurse	7.6	4.6	6.6	2.7	2.8	2.5
	(9)	(12)	(10)	(4)	(2)	(7)

problems, and problems with an older relative. They also had the second highest rate of reported personal problems. These results are especially interesting because the Jewish respondents had incomes comparable to those of respondents in other ethnic groups, were least likely to report a problem with finances, and came from relatively small households (Table 1). Thus, although it is not possible to distinguish true need from reported need, these data are consistent with the hypothesis that something about Jewish culture reinforces the acknowledgement of problems.

The areas asked about in our study that are most subjective and thus most likely to be influenced by cultural effects on over or under reporting are child behavior problems and counselling needs for personal problems. It is interesting to note that in both these areas, Jewish respondents had high reported rates and Irish Catholic respondents had the lowest reported rates, as hy-

pothesized. The Irish also reported relatively few employment problems and had the second lowest rate of problems with an older relative. Counter to our hypothesis, however, Italian-Catholics had relatively low rates of problem reporting. They had the lowest rates of problems requiring homemaker services, problems with an aging relative, alcohol problems, and problems requiring a home nurse. They also reported the second lowest rate of personal problems. They had intermediate rates on financial employment, and child problems. Although not consistent with our hypothesis and the literature, it should be remembered that the Italian-Catholics in our sample were relatively well off financially, and were the more likely to be married.

Though the alcohol problem rates are generally consistent with the literature, (Blacks, Irish Catholics, and White Protestants reporting the higher rates and Jews and Italians lower) the range is narrower than customarily reported. One possibility is that different cultural groups are converging in their use of alcohol. An analysis of 3,584 male adolescents in the mid 1960s secured in the same metropolitan area found the customary ethnic variation (Demone, 1966). Assimilation, in so far as alcohol problems was concerned, had not as yet taken place in the mid 1960s. The striking finding of the present data is the relatively modest cultural differences except for the high Black alcohol problem rates.

Help-Seeking

In Table 3 we present the proportion of respondents in each ethnic group who sought help for their reported problems. Although the numbers on which these calculations are based are small, certain trends are noteworthy. First, consistent with our hypothesis, Jewish respondents were relatively likely to seek formal help for problems. For employment they were the group most likely to seek help, and for problems with older relatives they were the group second most likely to seek help. Interestingly, however, they were less likely than all groups except for Blacks to seek help for personal problems. Thus, the two groups with the highest rates of reported personal problems were the least likely to seek help. Overall, the other reported rates of help seeking are not consistent within ethnic groups. For example,

we predicted that the Protestant group would have average rates of problem identification, but low rates of help seeking. In fact, their problem reporting was slightly below average, but their help seeking was not as predicted. They were the group most likely to seek help for homemaker services and alcohol related problems (comparable to Italian Catholics). The rates for other help seeking were consistently in the middle. Similarly, although we predicted that Irish Catholics would not be as likely as other groups to seek help for their problems, they were the group most likely to seek help for personal problems. The rates for Italian Catholics were generally as predicted, but somewhat inconsistent. They were most likely to seek assistance for problems with children and finances. They were more or as likely as any other group to seek help for alcohol problems. For employment problems and aging relatives, however, they were relatively unlikely to seek help. This may be an example of a situation in which the Italian extended family helps deal with certain problems.

Discussion

A major limitation of these data and data from similar surveys is that they contain no independent assessment of the presence or severity of problems. For example, our question about job problems was: ". . . have you . . . needed help finding a job or deciding what kind of job would be best for you . . .?" The reported problems in one group may reflect unemployment and the reported problems in another may reflect mostly searching for a more fulfilling job. Furthermore, variations in problem reporting and help seeking are probably problem-area specific. Thus, for example, whereas financial concerns may be most salient for Black respondents (Table 1), concerns about child behavior and education issues may be more important for other groups.

In spite of these limitations, these data are extremely rich in the information they provide about the diversity in Boston among the particular ethnic and cultural groups studied with respect to their propensity to report problems and seek help for those problems. It is important to emphasize that these findings may not generalize to other cities and may not persist over time. The

Table 3

Proportion of Respondents with Problems who Reported Seeking Help by Ethnic Group (number of respondents in parentheses)

Problem Area	Black (n = 119)	White Protest. (n = 263)	Irish Catholic (n = 151)	Italian Catholic (n = 147)	Jewish (n = 77)	Mixed and Other (n = 276)
Homemaker	—[a]	42.9 (14)	23.1 (13)	—	—	27.8 (18)
Finances	36.7 (49)	40.0 (20)	33.3 (21)	46.2 (13)	—	43.9 (41)
Employment	65.8 (38)	62.2 (45)	66.7 (21)	58.6 (29)	75.0 (24)	59.3 (59)
Child Behavior Education	91.7 (12)	88.9 (18)	—	100.0 (13)	—	77.8 (18)
Counseling	70.3 (118)	84.8 (263)	88.1 (151)	85.5 (145)	72.7 (77)	83.1 (272)
Aging Relative	53.3 (15)	40.0 (45)	31.3 (16)	27.3 (11)	50.0 (16)	23.8 (21)
Alcohol	27.8 (18)	37.5 (32)	35.3 (17)	37.5 (16)	— —	30.3 (33)
Home Nurse	—	50.0 (12)	—	—	—	—

[a] Cells with less than 10 respondents not reported.

character of social problems and the way in which ethnicity shapes the perception and response to those problems are extremely variable from region to region and change over time. Furthermore, we do not have a good theoretical understanding of the cultural patterns reported here and in the literature. We suspect such behavior may change as cultural groups become increasingly assimilated in different areas.

Certain inconsistencies in our data emphasize the complexity of the factors related to help seeking. A person or significant others must be aware of a problem, define it as a problem needing professional help, be aware of sources of help, decide to seek help, and actually take action before a client actually appears at a helping agency. Thus, differences in prevalence, acknowledgement of problems, and action-taking all contribute to variations in the proportion of different ethnic groups seen by a

provider of social services. Furthermore, these patterns may differ depending on the problem area studied.

The basic findings reported here are not meant to imply or reinforce any stereotypes about certain cultural or ethnic groups. They do serve to emphasize, however, the need for social agencies to be sensitive to cultural and ethnic heterogeneity in the areas they serve. In almost any setting where there are significant racial, cultural, ethnic, and religious variations, there likely will be large variations in the probability that people will seek help for different types of problems. If providers are not sensitive to such variations, they may not be able to provide services to the populations most in need. For example, in the Boston area a group providing alcohol services might judge its success in addressing alcohol related problems by counting the number of clients it serves. In all likelihood, depending on the location of the agency, a large proportion of the clientele would be Irish Catholic. However, the data presented here suggest that Blacks have the highest rates of perceived alcohol related problems, and the lowest propensity to seek help for those problems. Thus, it might be that to address alcohol problems most effectively, the agency might have to be more active in reaching out to the Black community to increase awareness of their services and to match the services provided to the needs of the community. In general, these data emphasize the need for health and human service providers to be sensitive to the needs of different ethnic groups, be aware of the ways cultural background may influence problem reporting, and the importance of understanding how different help seeking patterns filter the people who actually seek help. These caveats similarly apply to the interpretation of data collected in needs assessment surveys. Unless we are sensitive to these issues, it is extremely easy to incorrectly interpret low reported rates of problems as low need when, in fact, they may reflect, at least in part, unreported need.

At the national level, it is important that ethnic, cultural, and religious differences be taken into account when developing service programs. A dramatic example of a failure in this respect is the inability of the federal government to develop a comprehensive program for the prevention and care of AIDS that recognizes and addresses the heterogeneity of the populations served. The risk factors for infection vary dramatically among

subsets of the population and the ways in which persons perceive and respond to information about AIDS will clearly be a function of sociodemographic, regional, cultural, and ethnic factors (Cleary, Rogers, Singer et al., 1986). These factors are not likely to be static, but developing at least a description, and hopefully an understanding of such variations is critical to the development of rational and effective social policy.

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