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Mental Healthcare Disparities Disparities Affect Treatment of Black Adolescents

Dr. Alfiee M Breland-Noble, PhD

PREMIER and Duke Clinical Research Institute Fellow in the Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC

Research in the area of health disparities has increased in recent years. Various sources cite widespread differences between whites and people of color in a variety of healthcare treatment areas including cardiovascular disease, cancer, maternal and child health and mental health.¹ In 2001, US Surgeon General David Satcher commissioned a report supplement to illuminate racial mental health disparities, provide empirical support to document the differences, and offer strategies for use in reducing the disparities.² In accordance with a number of the suggestions from the Surgeon General's report, the purpose of this article is to present a paradigm that may assist in addressing health disparities in child and adolescent psychiatric research and clinical care.

Regarding blacks and psychiatric clinical care in particular, the following discussion is presented to elucidate sociocultural (ie, nonfinancial) barriers to treatment, the unique aspects of shame and stigma that blacks associate with treatment, and black cultural mistrust of the mental health system. The focus of clinical care in this article is adolescent depression, and the Breland-Noble Model of Pathways to Psychiatric Clinical Care³ serves as the backdrop for this discussion.

Please note that in this article, the term "blacks" is being used to refer to people of various ethnic groups within the category of black (non-Hispanic), including African Americans, emigrant Caribbean Blacks, and emigrant Continental Africans in the United States.

DOCUMENTING DISPARITIES

The Unequal Treatment report released in 2002¹ provides empirical evidence of the widespread disparities faced by people of color in interactions with the health service system in general and mental health system in particular. As an example, the report provides evidence describing the infrequency with which blacks are treated with beneficial psychotropic medications and the frequency with which they are involuntarily hospitalized compared with white counterparts.¹ The evidence also suggests that, even when controlling for socioeconomic status, severity of illness, and insurance status, the differences persist.^{4,5}

Although most of the research in mental health disparities focuses on adults, children and adolescents face similar obstacles to receiving high-quality psychiatric clinical care. For example, various reports document the higher likelihood of black youth with psychiatric disorders being referred to the juvenile justice system for castigatory services, while white youth are referred for treatment-oriented, ameliorative types of services.^{6–8} Replications of such diagnosis and treatment bias are also available in the literature and suggest that, given the same symptoms, mental health professionals will diagnosis black and white patients differently.^{9,10}

Historical Barriers

Years of oppression have influenced the degree to which blacks place trust in the health system. This has been perpetuated in large part by the most widely recognized and infamous example of moral and ethical misconduct committed against blacks — the Tuskegee Experiment. The negative effects of this experiment still resonate widely with many blacks, while relatively few whites are aware of its existence.^{11–12}

It appears these types of discriminatory practices against blacks contribute greatly to the cultural mistrust exhibited toward the mental health profession. Cultural mistrust is a phenomenon that has been documented by a number of black scholars. It is defined as a healthy paranoia exhibited by people of African descent toward institutions, systems, and individuals that have exhibited harm in the past and the potential for future harm.

Cultural mistrust manifests itself in a number of ways, including blacks' beliefs that healthcare professionals cannot and will not accurately diagnose their health problems, which necessitates vigilance toward more proactive and aggressive interactions with health professionals to secure adequate care.^{11,13} Further, such beliefs contribute to the documented patterns of lower clinical care use by blacks, including children and adolescents.^{14–17}

Perceptual Barriers

Blacks exhibit differences from whites regarding perceptions of mental health concerns in a number of areas. Foremost among these are stigmatization and illness thresholds. In particular, black and white Americans hold very different views regarding perceptions of the degree of stigma associated with psychiatric illnesses. They also hold different views regarding perceptions of type, severity, and prognosis of the same presenting problems.

Mental illness stigma is associated with all racial and ethnic groups in the United States^{18,19} and, therefore, is not unique to blacks. The differences lie in the degree of stigma that people of different races associate with psychiatric illness. For example, black parents report that a primary reason for their lack of willingness to subject a child to psychological assessment through the child's school is associated with the great potential for punitive intervention in the family by social service agencies.^{20,21}

As it relates to self-perception and identification of psychiatric problems, black parents report less alarm for children with internalizing problems (of which depression is a type) than do clinicians.²² Conversely, black parents appear to exhibit more alarm for those types of behaviors most likely to generate external problems for the adolescent and family (ie, educational and financial) than for those problems internal to the child. This type of differentiation is well documented by scholars and is well described by the term "John Henryism," or the strategy of employing active coping to overcome adversity and problems.^{23–25} In other words, unless the psychiatric problem causes visible and identifiable harm or stress to the adolescent and family, the problem is handled by diverting attention to more visible and manageable problems.

The information included to this point provides an adequate backdrop for a presentation of the Breland-Noble Model³ and a discussion of its utility in addressing health disparities in the area of adolescent depression.

DEPRESSION, BLACK ADOLESCENTS, AND CLINICAL CARE

Depression in the adolescent population is an important mental health issue. The Surgeon General's Report² identified a limited research-base for children of color and detailed the

great risks associated with depressive disorders for black youth. Other research supports these findings and suggests depression in youth is associated with increased risk of suicidal behaviors.²⁶ The suicide rate for blacks between ages 10 and 19 increased from 2.1 to 4.5 per 100,000 (114%) between 1980 and 1995.²⁷ This adds validity to the importance of prevention and intervention.

The Surgeon General's report is echoed by recent epidemiological studies that provide varied prevalence estimates of depressive disorders for black versus white adolescents and support the need for more focused attention on depressive disorders among black youth.^{17,28} It is possible that black adolescents' disproportionate exposure to distressful life events including racism, stereotyping, living in poverty, violence, and involvement in social service programs such as foster care exacerbate reported mental health trends.²⁹

In general, the body of research devoted to psychiatric clinical care of US children and adolescents is growing and suggests that blacks are much less likely to enter traditional forms of mental health treatment than their white counterparts, even when presenting problems are similar.¹⁵ Such rates may reflect the use of nonmedical therapists (eg, religious leaders, native healers), as well as culturally based resilience, rather than reliance on traditional psychiatric systems.³⁰

BRELAND-NOBLE MODEL

The Breland-Noble Model of Pathways to Psychiatric Clinical Care (Figure, see page 537) is a conceptual model of mental health behaviors for depressed black adolescents that reflects the varied relationships that contribute to the identification of and help-seeking behaviors for depressed black adolescents. It is based on Andersen's³¹ Health Service Use Model and includes three domains. The model posits that certain characteristics of the youth and their families (ie, primary determinants of mental health behavior) interact in leading to the recognition of psychiatric problems (ie, environmental factors) and determining next steps in addressing those problems (ie, mental health behavior). Specifically, parental and adolescent individual characteristics, such as socioeconomic status, and their mental health knowledge, including the understanding and perceptions of mental health problems, are affected by environmental factors including cultural mistrust, social stigma, community resources for use in managing psychiatric illness, and qualitative aspects of the familial relationship, all of which work together to influence clinical care use.

It is hypothesized that black adolescents and their families do not use a systematic method for identifying the disorder; that black adolescents and their parents consult different entities for help, and that blacks perceive mental health clinical care as a majority culture phenomenon for people with severe psychopathology, thereby making these services irrelevant for them. The model is one that might be used by "brokers" of clinical care for adolescents and families. For example, psychiatrists, psychologists and other mental health service providers might be encouraged to educate referred youth and families about the benefits of those treatments empirically validated for black adolescents.

CLINICAL DIRECTIONS

To address the problems posited in the model, I have designed a culturally responsive intervention. The components of this intervention include: culturally relevant psychoeducational training to increase depressive disorder recognition; understand the role of indigenous treatment methods currently employed by families; increase willingness to seek appropriate clinical care; and increase efforts in self-advocacy for culturally relevant, empirically supported treatments.

The intervention is designed within a familial context as a culturally relevant means of addressing black culture and is designed for use with a representative sample of black adolescents and families to address unmet need.

Using the techniques of motivational interviewing,³² the intervention includes a four-session module as the primary means of increasing the participation of black adolescents and their families in psychiatric clinical care for depressed adolescents ages 11 to 17. Motivational interviewing was selected because, for patients traditionally reluctant to seek psychiatric care, clinician advice-giving is not always welcome and can be detrimental to the clinician–patient relationship. However, by accounting for the reluctance and ambivalence, a brief motivational interviewing approach might be an ideal framework in which to engage patients in considering health-promoting behaviors (including using clinical care) that they may not have considered previously.

The sessions include an initial, semiscripted telephone or in-person screening procedure used to determine inclusion or exclusion information and provide any requested information to the interested party. This is followed by a telephone intervention that includes a review of a brief assessment of a motivational interviewing measure, reflective listening, and eliciting self-motivational statements. Two treatment sessions follow, including an individual adolescent portion, a parent portion, and a joint parent–child portion.

The foci of the sessions are to elicit any feelings of ambivalence and concern regarding psychiatric clinical care from both parents and adolescents, discuss the cultural factors associated with clinical care for the families, and identify techniques for use in addressing ambivalence or concerns about clinical care for the adolescent. It is believed that by directly discussing parent and adolescent feelings and concerns before the initiation of treatment, the families and therapist or investigator can share ownership of the process of engagement and allay familial concerns that might hinder clinical care participation.

CLINICAL IMPLICATIONS

The findings on adolescent depression and perceptions of clinical care and research among blacks raise a number of concerns, including the effects of a limited evidence base for treating depression in these youth and perceptions of clinical research and care by blacks for youth with psychiatric illness. Therefore, it seems important for investigators to gain a general understanding of blacks' perceptions of clinical research and care for youth and then begin to address these factors in the context of an important mental health issue — namely, adolescent depression.

The model and an as-yet untested intervention are presented here to provide clinicians with alternatives to traditional methods of providing care for depressed black adolescents in the context of the family. It is hoped that, by reading about specific techniques, clinicians will gain some practical knowledge of how to encourage and support black participation in evidence-based, culturally relevant clinical care.

EDUCATIONAL OBJECTIVES

1. Discuss contemporary and historical factors affecting racial, health disparities in psychiatric clinical care.
2. Evaluate black cultural mistrust of the mental healthcare system.
3. Identify institutional and clinician-level approaches for increasing clinical care use by blacks for adolescent depression.

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Figure 1.