Chapter 2
Identifying Barriers and Access to Mental Health Care for African Americans

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Throughout American history, racial bias, oppression, and various other forms of dehumanization have negatively impacted the lives of African Americans. One area of significance that warrants attention is African American mental health. A genuine understanding of this population's current mental health status requires a contextual grasp of the traumatic and turbulent history they have experienced since initially arriving in this country as slaves in the 1600s. Throughout time periods that included Domestic Slavery (1619–1865), Reconstruction (1865–1877), Jim Crow (1896–1964), and Civil Rights Movement (1955–1968), African Americans have experienced devastating hardships that included extreme forms of racism, and they were most often perceived as less than human (Hammond et al., 2020).

The lingering consequences of this turbulent history remain active today. In a Pew Study exploring race, the majority of surveyed adults believed that the legacy of slavery continued to negatively affect the position of African Americans today. Forty percent of the respondents agreed that not enough racial equality had been made in the country. White respondents were most likely to acknowledge that their race positively impacted their ability to get ahead in life, and over 50% of African American respondents held opposite views and believed their race had negatively impacted them (Pew Research Center, 2019). As further demonstration of slavery's impact on the mental health of African Americans, Gale and associates (2020) conducted a meta-analysis, and the results indicated that a positive relationship existed between internalized racism and negative mental health outcomes. Furthermore, Majors (2020) contended that "mental health provisions and services for people of color have been in crisis for a long time" (p.4) due to racism, discrimination, and

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other forms of inequalities found in organizations, coupled with the lack of cultural competence among White managers and staff in mental health services. It is imperative to understand this history because only then can one appreciate and empathically intervene in a socially just and culturally responsive manner to confront persistent barriers that have contributed to the underutilization of mental health services by African Americans.

Current Status of African Americans

African Americans are the second largest minority group in the United States and currently represent 13.4% of the total US population. Sixteen percent of this population, which is slightly over seven million individuals, reported having experienced a mental illness (U.S. Census Bureau, 2019). In addition, between 2015 and 2018, major depressive episodes (MDEs) increased for all African Americans regardless of age. More specifically, MDEs increased from 9% to 10.3% for African American youth between ages 12 and 17. For young adults between ages 18 and 28, the margin of increase for MDEs was higher, rising from 6.1% to 9.4%. There was also an increase in suicidal thoughts, plans, and attempts for this age group. Finally, for adults between ages of 26 and 49, the gap for MDEs increased from 5.7% to 6.3%. Even with the increase, the rates of MDEs for African Americans are slightly lower than the overall US population (SAMHSA, 2020).

Early History of African American Mental Health

The subject of mental health for African Americans has a historical background impacted by White supremacy, racism, and discrimination. For example, during the 1800s, it was thought that African Americans lacked the capacity to have mental health issues. Dr. John Galt, medical director at the Eastern Lunatic Asylum in Williamsburg Virginia from 1841 to 1862 (Eastern State Hospital, 2020), postulated that African Americans were incapable of becoming mentally ill. He based this conclusion on the fact that African Americans were largely enslaved and not encumbered with tasks deemed stressful, such as land ownership, business management, and engagement in government. Thus, the term *Immunity Hypothesis* was formulated to characterize African Americans since they presumably had no responsibilities that required higher-order thinking, purportedly exempting them from mental distress. The Immunity Hypothesis maintained from the late 1600s through the mid-1800s at which time a contrasting notion of African American mental health was fashioned (Davis, 2018).

This contradictory theorem suggested that African Americans were at greater risk for mental illness than the rest of the population. The Exaggerated Risk Hypothesis was developed at a time coinciding with the eradication of legalized

American enslavement of African Americans. Under this theory, emancipated African Americans were at great risk for mental health problems. Thus, efforts to control and contain this risk were necessary (Davis, 2018).

During this history, some mental illnesses peculiar to African Americans were discovered and advanced. An early American physician, Samuel Cartwright, identified a diagnosis he called drapetomania which was a mental illness that caused enslaved persons to attempt to escape captivity (1851). Suggested treatment for this so-called disorder was removal of both big toes or "whipping the devil out of" the affected individual. Cartwright also described a condition he called dysesthesia aethiopica, which was a mental illness that resulted from or was concurrent with lesions and/or callousness of the skin. Symptomology of this so-called mental illness was lethargy and destructiveness.

Scientific racism facilitated segregation, oppression, and abusive control of African Americans. In effect, the American healthcare system was weaponized against African Americans. Indeed, this history has exacerbated the barriers to mental health care experienced by African Americans historically and currently. This cultural violence has served to force African Americans to engage in self-protective measures that have caused them to often view offers of help through a cynical lens. Those protective measures might be observed as treatment reluctance or refusal. A discussion of a few of those barriers follows.

Racism

According to Mental Health America (n.d.), racism is a serious mental health issue because it causes trauma that is directly associated with mental illness. There are also different types of racism that must be taken into consideration when discussing mental health. For example, systemic racism consists of three parts that include history, culture, and institution and policy. Institutional racism is based on unfair treatment and inequitable policies specially based on race created and enforced by institutions. Internalized racism happens when White supremacy causes African Americans to believe that they are inferior as a result of their race. Reverse racism occurs when White people deny privileges they are afforded as a result of their race and furthermore claim that striving to improve the lives of minority groups is racism against them. Racial colorblindness is a form of aversive racism. Finally, racial trauma is a form of stress created by repeated exposure to racism through daily events or isolated incidences (Lawrence & Keleher, 2004). Medical racism has been reflected in the mental health profession as evidenced by the Gara et al. (2019) study whereby clinicians who treated African American clients focused on psychotic symptoms rather than symptoms of major depression compared to other minority groups. The actions contributed to African American clients, particularly males, being diagnosed with schizophrenia at a much higher rate. This study recommended that screening be required for major depression when assessing African American clients for schizophrenia to help eliminate inaccurate diagnosing. Treatment for

mood disorders differs from schizophrenia, and the outcome for these conditions is often more positive than for schizophrenia. As a result, African American clients do not receive optimal care, and the treatment they receive is more at risk for making their conditions worse (Gara et al., 2019).

Stigma

Goffman (1961) wrote that once an individual received mental health treatment, their social standing would forever be changed, and fear of this change could be identified as a mental health stigma. Even as African American people are more likely to report presenting concerns that are indicative of a mental health need, they are less likely to seek help (Cook et al., 2017). For example, the Matthews et al. study (2006) indicated that African Americans believed that mental health stigma was a serious and consequential problem within their community. They were also likely to feel shame about seeking treatment for their mental health concern and have concerns about how others might react toward them. In another qualitative study exploring mental health care for African Americans (Alang, 2019), African American participants perceived counseling stigma as a form of double discrimination because their Blackness and mental illness were devalued. There are references to this stigma as a problem in the human services literature (Gary, 2005; Tyler & Slater, 2018), but seldom have the foundations of this construct been questioned. Pescosolido (2013) notes that one of the issues with research in this area has been related to failure to consider trends of prejudice and discrimination that co-mingle with stigma. In addition, false and misleading information about mental illness passed down from generations of African American families must be factored into consideration (Matthews et al., 2006). It must also be factored into consideration of how mental health was racialized for African Americans. Thus, notions of stigma in the African American community must be examined through the lens of the above mentioned history of oppression.

Insurance Access and Socioeconomic Status

According to Artiga et al. (2020), based on American Community Survey data, slightly over 11% of the African American population were uninsured. Also, from 2010 to 2018, African Americans were 1.5 times more likely to be uninsured than Whites, which is directly related to alarming and disproportionately lower levels of wealth within the African American community. For example, in an economic report conducted by the US Joint Economic Committee (2020), when compared to Whites, African Americans experience far worse economic conditions by earning only 59 cents to every dollar that Whites earn. In addition, African Americans are also twice as likely to live in poverty and less likely to own their homes (42%

compared to 73% of White families). Furthermore, the median wealth for African American Families is $17,000 compared to $171,000 for White families. Finally, even when education is factored into consideration, the wealth difference between African American and White households still increases (U.S. Congress Joint Economic Committee, 2020).

These are significant factors that are related to both help-seeking and mental health outcomes. Although mental health seeking is a barrier, it must be considered within the greater context of an individual's pursuit of satisfying their daily needs. Any investigation that lacks an appreciation of the challenges of individuals living in low wealth may fail to consider the notion that mental hygiene may be a lower priority compared to meeting other more basic needs for food and shelter. This priority will persist until such time when those mental health concerns overwhelm other needs. In short, the cost of attending to mental health must be considered in the larger context of other perhaps more pressing basic needs.

Cultural Mistrust

One of the most significant factors that have deterred African Americans from seeking mental health treatment is cultural mistrust. Terrell et al. (2009) define cultural mistrust as "the belief acquired by African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted" (p. 299). In a study of 163 African American mothers' attitudes toward mental health utilization, Murry et al. (2011) found that while they were overwhelmingly positive about help-seeking, about a third of the 163 mothers reported that they fear White providers would not understand the challenges of their families. This lack of trust seems merited when we consider the findings recorded by the American Psychiatry Association which found that African Americans who presented for treatment were (a) less likely to receive evidence-based medicines, (b) less likely to receive appropriate psychotherapy, and (c) more likely to be misdiagnosed with more serious diagnoses than are warranted by their presenting issues (American Psychiatric Association, 2017).

Implications

Counselor implications for best practices, research, and policy development are important to make access to mental health care for African Americans practically relevant. Mental health professionals must include race, gender, class, and other diversity considerations in their applied practice to create the change necessary to affirm African Americans. Subscribing to racial colorblindness and other approaches that ignore or minimize the unique differences that African American clients bring to counseling perpetuates racism, discrimination, and oppression. Counseling

models with culturally specific, culturally sensitive, and culturally responsive interventions and techniques are preferred. Such models affirm African American personality, behavior manifestations, culture, norms, and values rather than pathologize them.

Existing models such as the Adlerian theory, person-centered therapy, and cognitive behavioral therapy are the foundation of mental health professions, but they hinge upon Eurocentric values. This is not to say that they are not useful to African American clients but how culturally sensitive can the inferiority complex be without considering the impact of White privilege, systemic oppression, and prolonged racism on an African American client's psyche?

Ward et al. (2013) showed that African Americans are becoming more open to seek mental health services. Therefore, more Afri-centric and Afro-centric models need to be developed, and existing models need to be used in research to emphasize the practical application of the findings.

It is imperative that top-tiered counseling journals and flagship conferences become willing to accept such culturally specific manuscripts and conference proposals even though the profession's readership and audience are still currently predominantly White. Increasing culturally relevant journal articles and conference breakout sessions would radically diversify the counseling profession, give educators scholarly literature to diversity counseling curriculum, and equip mental health professionals with culturally specific and culturally responsive tools and interventions to effect change among African American clients and families. Such moves by the profession are acts of advocacy and demonstration of the commitment to diversity and inclusion.

Now more than ever, considering the current sociopolitical climate, mental health professionals must advocate for African Americans. Counselors striving for cultural competence are able to offer honest and thoughtful discourse to combat negative stereotypes perpetuated against African Americans. Moreover, culturally competent mental health professionals and scholars are able to see African Americans as a heterogeneous group and offer research findings and services that emphasize the diversity of African Americans and their experiences. Mental health professionals targeting various oppressions (i.e., racial, gender, economic, etc.) are crucial to the advancement of African Americans.

Public policy has been simply defined as the government's response to an issue or problem. Mental health professionals must be knowledgeable about how public policy affects African Americans. They must be attentive to current and proposed policies, if none other, then definitely those related to mental health. As aforementioned, history shows that people with mental illness, particularly African Americans, have not been protected. Public policy done wrong exacerbates stigma associated with mental illness and widen barriers to mental healthcare access. Contrarily, when it is done well, it can lead to the destigmatization of mental illness among African Americans by utilizing prevention approaches, increasing mental health literacy and providing early detection and intervention, offering integrative care to address existing health disparities, and operating with a recovery mindset. Mental health

professionals who engage in public policy advocacy can request that cultural information and contemporary racial realities be included in public policy.

Culturally Responsive Interventions

Counselors' inattention to culture and other contextual considerations has led to the overdiagnosis, underdiagnosis, and misdiagnosis (Ancis, 2004) of African American clients. Therefore, it is imperative that counselors consider culture, cultural norms and values, and cultural stressors in assessing, diagnosing, and treatment planning of African American clients. Such culturally responsive interventions positively impact the therapeutic alliance, treatment outcomes, and client satisfaction (Ancis, 2004). Although the authors include a few interventions that incorporate and address cultural considerations into the counseling process, we agree with Ancis (2004) whereby we believe that "culturally-responsive approaches are thus not limited to a specific procedure…but encompass the entire interrelationship between clinician and client(s)" (p. 14).

A most rudimentary approach to honoring the uniqueness of African Americans is to correctly pronounce their names. Shortening the names of African American clients, nicknaming them, or simply refusing to learn or call them by their names is unethical, oppressive, and a misuse of the presumed power counselors have. Simply ask the client how to pronounce their name, and then practice saying it until it is pronounced correctly. Working toward correctly pronouncing a client's name is indicative of the work counselors are willing to do with them and instills trust.

Day-Vines et al. (2007) proposed broaching, a culturally relevant technique used to examine the impact of race and culture upon clients' presenting problems. Counselors who broach race and culture appear more credible, and clients report higher satisfaction, disclose more, and are more likely to return for follow-up appointments (Day-Vines et al., 2007, 2013; Jones & Welfare, 2017). Just as counselors broach expectations about the counseling relationship by going over their professional disclosure statements, they could easily incorporate contextual factors by speaking about their cultural backgrounds and asking clients to speak about theirs. Chang et al. (2004) offered the following to address race and culture in counseling: Tell me about your racial heritage, what does it mean to be a person of color, what do you think about my race, at what point did you become aware of my race? We recommend that counselors find questions they feel comfortable answering and asking to ascertain how race and culture impact the client's presenting problem and the therapeutic relationship.

Incorporating discussion about racism, privilege, and oppression into counseling is another culturally responsive intervention that can promote wellness about African American clients. When African Americans experience racial microaggressions, many of them think they are imagining what they have seen, heard, or been experiencing. When they are overlooked for occupational positions or promotions due to racial, cultural, or appearance bias, it is important that they have a counselor

who can help them have the courage to address the possibility of discrimination and to advocate for justice. Counselors who use a colorblind approach would blame the client or put the responsibility of change onto the client when it is a systemic structure that needs to be challenged and changed.

Considering the racial injustices African Americans have endured in the United States, counselors can no longer subscribe to colorblind treatment approaches where race and culture are ignored, denied, or minimized. Practicing interventions like broaching, pronouncing names correctly, and addressing racism, privilege, and oppression in counseling are just a few ways to improve mental wellness among African American clients.

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