The Way Ahead

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Introduction

In 2001, US Surgeon General, Dr. David Satcher, commissioned *Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*, which was the first call describing mental health disparities among African Americans, American Indians, Alaska Natives, Asian Americans, Pacific Islanders, and Latino/Hispanic Americans. In the Supplement, we learned "that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity" (US Department of Health and Human Services, 2001, p. 3) than members of the majority culture in the USA. The Surgeon General's report described

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overall barriers to mental health care including stigma, the cost of treatment, and the lack of awareness and/or bias in many clinicians, settings, and systems. The report also clearly delineated the interplay between historical and ongoing racism and discrimination as they influence the mental health of the members of these groups.

One important feature of the report was its highlighting of resilience among African Americans as a strong protective factor. In addition and of great consequence was that the report was one of the first written documents to acknowledge the diversity of the community, noting specifically that African Americans and Black Americans include immigrants from Africa, the Caribbean, and other parts of the world. The Surgeon General's report was also one of the first to delineate clearly the multiple areas in which African Americans faced challenges impacted by or related to mental and behavioral health. Furthermore, most if not all of the areas noted African Americans as a disparities population in comparison to US whites. For example, significant differences were noted in outcomes related to education, income, homelessness, and marital status that impacted epidemiological studies and should be addressed. African Americans have historically been identified as a "high-need population," but have not necessarily received targeted approaches in mental health care that reflect this label. The Surgeon General's report indicated that when African

Americans presented with different symptoms than Whites/European-Americans, there was an increased likelihood of and frequent misdiagnosis of similar symptoms. Overall, we have learned that people of African descent in the USA face many challenges to their mental and behavioral health, but lack a strong body of evidence to support the utility of treatment to address the problems identified.

There is a growing body of evidence regarding the use of specific approaches for the assessment and diagnosis of major mental and behavioral disorders in African Americans and Blacks. Among these, cognitive behavioral therapy (CBT) appears to have the most evidence regarding the assessment and management of anxiety, obsessive–compulsive, trauma, and stress-related disorders. While CBT has garnered a lot of attention in recent years, the approach still significantly underrepresents African Americans in major clinical studies of efficacy and effectiveness. This growing body of research focused on major mental illnesses (like depression, substance abuse, anxiety, and trauma). This raises a number of questions including the import of racism and discrimination as they impact African American mental health, the interplay of physical and mental health problems (e.g., obesity and cardiovascular disease), and the potential impact of "missed" trauma (e.g., lack of assessment and/or misdiagnosis of trauma as ADHD or psychosis). The limited evidence in these areas may lead one to wonder if misdiagnosis and/or lack of data on African Americans and Black Americans' mental health may have contributed to the limited data on outcomes from rigorously assessed clinical interventions and treatments. In other words, is it possible that the lack of African American representation in major research studies or the mislabeling of African American youths' mental illness may contribute to low or poor response rates to tested treatments for major disorders?

On a related note, we elected to examine the sole mental health concern in the World Health Organization's top causes of disability worldwide, depression. As one of the leading causes of disability, depression and its correlates must be understood more clearly in African American youth. As well, binge eating disorders and obesity are prevalent among African American youth with each having unique socialization antecedents. We are pleased to be able to highlight culturally relevant diagnosis and treatments that we believe can make a difference to the mental health needs of African American youth.

While there is an emerging body of literature related to the treatment of mental illness in African American youth, access to care remains a significant problem for this population. The Surgeon General's seminal report accurately highlighted that African Americans were more likely to seek care from primary care providers, emergency rooms and to use alternative therapies (such as pastoral or faith based counseling and social support). Overall, this seminal report was a groundbreaking approach to highlighting the resources and needs of racially diverse US populations regarding mental health. Further, it became a touchstone for disparities research and, in particular, for African American mental health professionals, advocates and researchers. Prior to the report, there was little research focused on demonstrated treatment response and benefit equivalence between African Americans and Whites. Dr. Satcher's report paved the way for mental health professionals to learn more in order to provide the best care for African Americans and for racially diverse persons.

Smedley, Stith, and Nelson's (2003) edited book, *Unequal Treatment*, was another groundbreaking work that spoke of health differences and health disparities (see Fig. 19.1).

Smedley et al. noted that healthcare disparities existed, but were unacceptable, because of the accompanying worse outcomes for disparities populations. They recommended increased awareness of these disparities by healthcare providers and the general public. Bias, stereotyping, and clinical uncertainty contributed to these disparities, not only of the provider, but also of health systems, patients, and others involved in healthcare systems. Recommendations were made for research, monitoring of data, and education of health professionals and patients. The need for increased diversity among health care professionals as well as cross-cultural education and the provision of culturally competent care was advocated.

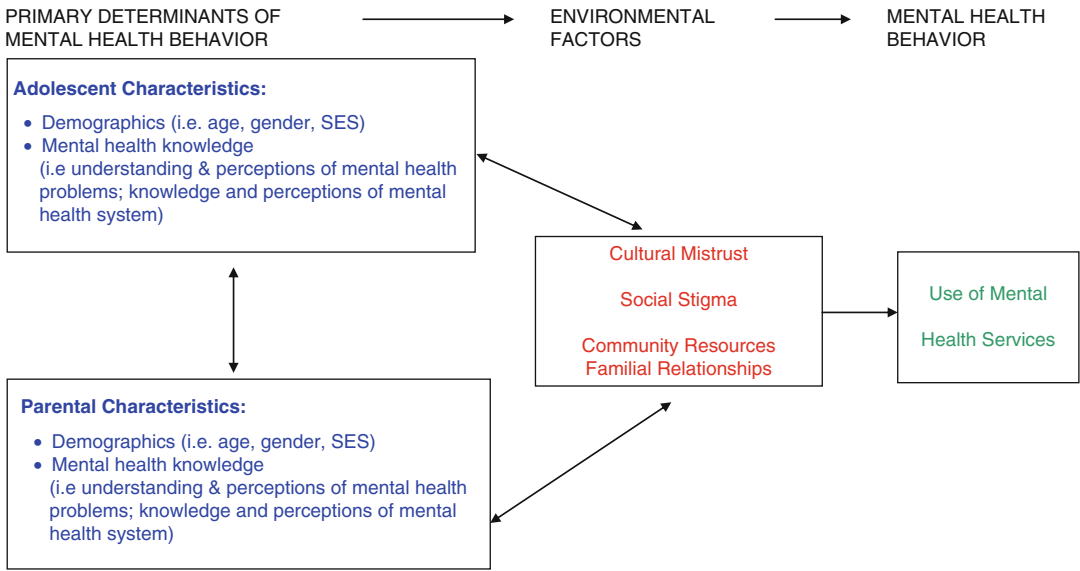**Fig. 19.1** Differences and disparities (adapted from Smedley et al., 2003)
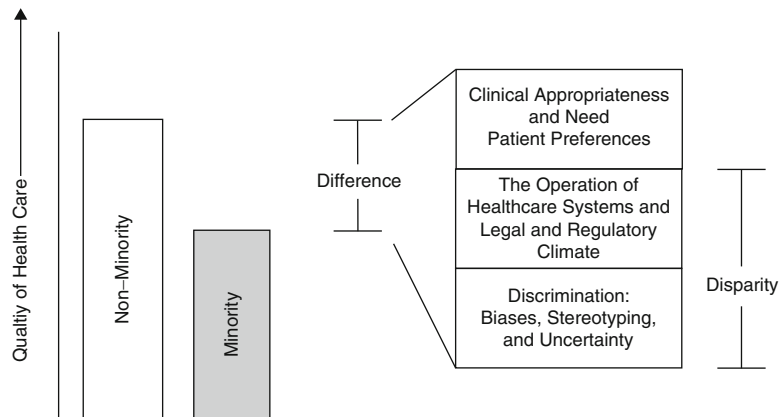
While much of the research and recommendations provided by these two seminal works was groundbreaking, and sorely needed, it focused primarily on the needs of racially diverse adults. Researchers in child and adolescent mental health utilized these frameworks to create a body of literature focused on disparities in youth. For example, the Breland-Noble's (2004) Pathways to Psychiatric Care for Black Youth with Mental Illness expands upon the model presented in *Unequal Treatment* (Fig. 19.2). The Breland-Noble model utilized aspects of the health and mental health disparities literature and combined it with (then) current models of health behavior. Overall, the model is designed to present one mechanism for thinking about how African American youth in particular arrive at psychiatric care noting the interplay among youth, parents, and societal factors in the process of accessing treatment.

Over time, the literature has developed in the use of terms for our population of interest. For example, we are aware that many refer to descendants of Black Africans forcibly transported to the USA as either Black (a racial descriptor) or African American (a descriptor of ethnicity used as a synonym for race). We have generally used the term African American, although most extant literature does not differentiate between African Americans, African-Caribbeans, Afro-British, Continental Africans, or any other combination. In 2013, as we began thinking about this effort, our goal for this volume was to review the current literature on pediatric mental health disparities including the many advances made since the two

noteworthy works on disparities and culture in health and mental health. In 2015, as we concluded our work, we realized that although we know more, we have many of the same questions and concerns. We still see conflicting literature, we find that there remains a lack of epidemiological evidence to which we can refer [with the exception of the National Survey of American Life (see Chap. 1)], and we still find an overrepresentation of African American youth at one end of the socioeconomic spectrum, leaving us with very little information on socioeconomically diverse African American youth.

Recognizing that misdiagnosis is a fact, we are excited by what we have learned from this volume that can help us identify strategies to prevent misdiagnosis. For instance, collaboration with culturally competent and experienced providers, community engagement, and self-awareness as researchers and clinicians are all tools indicated in this book as helpful in reducing diagnostic bias. In addition, this book describes tools at our disposal, like the DSM-5 Cultural Formulation, the Cultural Formulation Interview, and Therapeutic Assessment, to guide our process of evaluation. We are pleased to acknowledge the import of these tools and to report evidence of their effectiveness.

Our book also highlights the import of addressing sociocultural factors influencing health behaviors. Specifically, we illuminate some of the root causes of mental health stigma among African Americans and Blacks and suggest additional non-socioeconomic barriers to mental health care.

PRIMARY DETERMINANTS OF ⟶ ENVIRONMENTAL ⟶ MENTAL HEALTH
MENTAL HEALTH BEHAVIOR   FACTORS   BEHAVIOR

Adolescent Characteristics:
- Demographics (i.e. age, gender, SES)
- Mental health knowledge
  (i.e understanding & perceptions of mental health
  problems; knowledge and perceptions of mental
  health system)

Cultural Mistrust

Social Stigma

Community Resources
Familial Relationships

Use of Mental

Health Services

Parental Characteristics:
- Demographics (i.e. age, gender, SES)
- Mental health knowledge
  (i.e understanding & perceptions of mental health
  problems; knowledge and perceptions of mental
  health system)

Fig. 19.2 Pathways to psychiatric clinical care for Black adolescents with mental illness (adapted from Breland-Noble, 2004)

While we have gained increased knowledge from our authors regarding contributing factors to stigma and poor treatment initiation, engagement, and adherence, more remains to be done regarding how to help clinicians identify and address mental health stigma in patients. The book's contributors have identified the ways in which mental health literacy and stigma are intertwined and in many instances have offered innovative approaches to addressing and reducing both. For example, there is some discussion of the potential of partnering with primary care providers and settings as well as innovative partnerships with community-based organizations to increase African American uptake of psychiatric care.

In our own clinical work, we have seen firsthand the impact of poor mental health literacy and mistrust of mental health care providers. This mistrust stems from multiple factors including unconscious bias on the part of providers, stigma, and cultural mistrust. We have seen clear evidence of misdiagnosis and have worked with our trainees to encourage thoughtfulness and direct verbalization in order to help to improve diagnosis and outcomes. Directly, but empathetically identifying and addressing these often-awkward topics can help clinicians, parents of mentally ill youth, and ultimately the youth themselves.

As we look at the sometimes untoward effects of medications and misdiagnosis, we are left wondering if misdiagnosis of African Americans may have contributed to untoward effects of the medications matched to the illnesses (mis)diagnosed. For example, the field currently lacks a robust literature on childhood onset schizophrenia or early onset schizophrenia among African Americans. So, how adequately are we addressing psychotic illness in this population of youth? Furthermore, what additional relationships will we find in the area of adverse drug reactions as we learn more about the pharmacogenomics related to mental illness and its treatment? Is it possible that the use of higher than necessary doses of first generation antipsychotics led to increased stigma and refusal to seek treatment—resulting in more severe symptoms and a longer duration of untreated psychosis? It is possible that lack of information on childhood and/or early onset schizophrenia, may have led to poor matching of medications to the illness, resulting in poor outcomes and increased medical mistrust. All of this may have also inadvertently contributed to the overutilization of more restrictive levels of care (due to poorly matched medications for specific illnesses) and higher doses of medication, with more adverse effects. Our understanding about pharmacogenomics and

its impact on the metabolism and effect of medication is still in its early stages. However, we are confident that focused, culturally relevant, and personalized mental health care makes a difference and the more we know, the better our implementation and treatment will be for African American and racially diverse youth.

As researchers and clinicians we see similar trends in psychotherapy. Specifically, we continue to note gaps in the research literature regarding what is most effective for African American youth with psychiatric illness. Though we have emerging evidence in the areas of motivational interviewing, cognitive behavioral approaches, and mindfulness-based treatments (particularly for those with chronic stress), African American youth are significantly under-represented among those included in randomized controlled trials of these interventions. Furthermore, when African American youth and families are included in RCTs, samples are more often homogeneic and not representative of the ethnic and socioeconomic diversity existent within the population.

In African American youth, the underdiagnosis of Autism Spectrum Disorders (ASD) continues, negatively impacting access to education and healthcare interventions. The overrepresentation of African American youth in special education (Heller, Holtzman, & Messick, 1982; Osher, Woodruff, & Sims, 2002) is a related disparity with additive and lifelong negative impact affecting youth across the life course. An additional disparity in the behavioral health arena is the overdiagnosis of African American youth with disruptive behavior problems even when their symptoms mirror those for which majority culture youth receive mood disorder diagnoses. All of these factors reflect the ideas contained in the Surgeon General's report on culture and mental health as well as the ideas espoused in the *Unequal Treatment* book. Fortunately, our contributors offer much food for thought to help us better assess, engage, and treat African American youth across the ethnic and sociocultural spectrum using culturally relevant tools.

Regarding mechanisms for reducing access to care disparities, our contributors make a number of strong suggestions that warrant consideration.

For example, they suggest that service provision through community-based settings may decrease barriers to care and effectively neutralize stigma. In addition, culturally adapted treatments that account for the unique cultural context of African Americans and Blacks may be of import. They also suggest that innovative approaches to engaging African American youth and families via psychoeducation and outreach might be necessary for increasing the appeal of psychiatric care. Overall, each of the approaches might have great potential for enhancing social support, decreasing behaviors detrimental to good mental health, promoting emotional and behavioral well-being, and for promoting a heightened appreciation of cultural attributes.

While we may be years away from producing large scale clinical trials of mental health interventions to help us understand their utility for African American youth, we are pleased that we have provided an overview of the current state of the literature and articulated the many and varied needs for reducing and eventually eradicating the disparities facing African American youth and families in the area of mental health.

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