

Disparities in Mental Health Treatment in U.S. Racial and Ethnic Minority Groups: Implications for Psychiatrists

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Disparities in health status and treatment outcome among members of U.S. racial and ethnic minority groups are well documented. Recent reports from the Institute of Medicine (1,2), the U.S. Department of Health and Human Services (3), the Surgeon General (4), and the President's New Freedom Commission on Mental Health (5) all urge immediate action to overcome these disparities. This paper describes some implications of these findings for the practice of psychiatry.

The importance and scope of the problem

Disparities exist in both access to and quality of mental health care for racial and ethnic minority groups in the United States. Examples of these disparities include the underutilization of psychiatric services by persons from ethnic minority groups, problems in treatment engagement and retention of persons from minority groups, the overdiagnosis of schizophrenia among African Americans and depression among Latinos, the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans and lower dosages among Latinos), and very high rates of substance use disorders

and completed suicide among Native Americans (6–11).

In other areas of medicine the disparities are no less alarming. Life expectancy is lower and infant mortality rates are higher among African Americans, and diabetes is endemic among African Americans, Latinos, and Native Americans (12). Thus the discourse on disparities is not an academic exercise but rather a matter of life and death. We believe that it is our collective responsibility as a profession to address these disparities—it is our responsibility to our patients, to our communities, and to the pursuit of social justice.

Clinical proficiencies and disparities: the intersections

Treatment engagement and cultural mistrust

In addition to access barriers, such as inadequate insurance coverage, other factors affect minority patients' utilization of mental health services. Inadequate detection of psychiatric conditions by primary care physicians and underreferral of these patients to psychiatric care constitute fundamental deficits. Even for those who gain access to treatment, early dropout (often after just the first session) and high rates of missed appointments for psychiatric treatment are a persistent problem. Thus effective communication with the patient, especially in first interactions, is essential to engage patients in treatment.

It is important to note that several aspects of the initial encounter with clinical care environments are "scanned"

by persons from racial and ethnic minority groups, as they are by members of other vulnerable groups, such as women and homosexual, bisexual, and transgender individuals. This scan involves a personal evaluation of the individual's comfort level with the treatment provider. The comfort level experienced by the patient determines how safe he or she feels to disclose personal information. From the scan, important cues emerge from sources such as the reading material in the waiting room, the demeanor and diversity of the support staff, the receptivity to accompanying family members, and the verbal and non-verbal communication of the psychiatrist. Does the psychiatrist reveal, by questions asked or not asked or cues followed or not followed, that he or she has biases that may interfere with understanding the patient's frame of reference? Does the psychiatrist seem aware of, and responsive to, the normative mistrust by some minority patients of the psychiatric establishment related to the profession's historic Eurocentrism, andryarchy, and heterosexism? Does the psychiatrist display flexibility in understanding personal narratives rooted in differing value systems, coping strategies, and experiences with discrimination?

Assessment and stereotypification

Effective assessment begins with presuppositions of what is normative behavior. Common assessment tools, such as *DSM* checklists, IQ tests, and personality inventories, have long

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been known to be culturally biased in their criteria (13). For example, African Americans often score higher on measures of mistrust and paranoia, which, if not considered in context, can result in a misdiagnosis of a psychotic disorder. However, if seen through the context of the history of oppression of these individuals, mistrust can be understood as warranted and normative. Similarly well documented is the overdiagnosis of schizophrenia among African Americans who report putative symptoms of psychosis, the same symptoms that, if reported by European Americans, are more likely to result in a diagnosis of a mood disorder (14).

Recent reports identify other subtle, but nonetheless consequential, ways in which our biases and stereotypes affect assessments of patients from ethnic minority groups and therefore have an impact on treatment and outcome (2). Of note, the psychiatric framework for evaluating behavior is rooted in European-American historical tradition. Value systems, frames of reference, behaviors, and symptom presentations that do not fit that tradition are more likely to be seen as dysfunctional or deviant or merely as a cultural idiosyncrasy. Even our therapeutic language contains hues of this bias: the value placed on individualism, competitiveness, and time-efficiency; the measures of success; and assumptions about appropriate family structure and gender role obligations.

Language barriers and effective communication

Among patients for whom English is a second language, qualified interpreters to translate content are not always used in clinical practice. Far less often is cultural context translated, which may be done more effectively by a trusted bilingual family member or friend of the patient in addition to a professional interpreter (15–17).

Medication use and communication about medication

Effective use of medications with patients from racial and ethnic minority groups requires knowledge about the differences in metabolism of medications that are based on enzyme poly-

morphisms in different ethnic groups and knowledge about issues related to medication adherence. Our scientific knowledge in the area of psychopharmacology for racial and ethnic minority groups is just now expanding through federally sponsored research. Psychiatrists must make a conscious effort to stay abreast of new developments in this area (10). Adherence to medications by patients from ethnic minority groups can be influenced by general mistrust of physicians and the psychiatric profession given abuses of the past or more specific concerns, such as stigma about mental illness, past adverse experiences with medications, or the patient's fears of becoming dependent on medications.

Psychotherapy, race, and racial identity

The need for psychiatrists to understand their own cultural biases as they bear on the therapeutic relationship is as essential as having undergone personal analysis is to the practicing psychoanalyst. Similarly, psychiatrists should use self-reflection and surveillance of evoked feelings about race during the session in the same way that the analyst uses transference and countertransference.

In addition, psychiatrists should not succumb to the fallacy of believing that all members of a given racial or ethnic group are homogeneous; rather, they should understand that there are within-group differences—that is, that there is texture and complexity within racial and ethnic groups that lead to very different identities and worldviews among members of the same group. These within-group variations of identity and worldview, or “racial identities,” have important treatment implications. The interactions between the racial identity of the patient and the racial identity of the therapist may influence treatment alliance and outcome more than race-matching of the patient and therapist (18). A patient of any race who, because of personally experienced or witnessed racism, has a racial identity characterized by a keen understanding of the implications of race might drop out of treatment if he or she believes that the therapist (of any race) has a racial identity characterized by

obliviousness to the implications of skin color on life experiences and therefore cannot enter into the patient's frame of reference.

Conversely, consider a patient from a minority group whose racial identity is characterized by the minimization of the significance of race—someone who has believed all of his or her life that people are treated in accordance with their behavior, not on the basis of the color of their skin. This patient comes to treatment after experiencing for the first time overt racial discrimination, such as being singled out and ill treated as a criminal suspect just because of the color of his or her skin. If the therapist (of any race) shares the same racial identity as this patient, the therapist and the patient may collude to deny the significance of race and misattribute the patient's experience to factors other than discrimination. Such a therapist would not be able to facilitate healthy racial identity growth for this patient. It would take a therapist of any race but with a racial identity characterized by an understanding of the implications of race to comprehend that this patient's worldview has been shaken by having experienced first-hand that race does matter. A therapist with that understanding would be able to facilitate healthy racial identity growth for this patient above and beyond the treatment of his or her posttraumatic symptoms.

Recommendations

Professional and regulatory bodies with responsibility for the accreditation of facilities and providers should set clear and consistent policies to redress these disparities. Determined efforts at change may create resistance from within the profession. Resistance may be triggered by efforts to create new service arrangements and to implement new standards in the licensing and certification of providers, the accreditation of educational institutions, and the development of research guidelines at federal agencies and academic medical centers. The American Psychiatric Association (APA) must be prepared to respond adequately to these challenges.

The Office of Minority Health of the U.S. Department of Health and

Human Services has created two documents, *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care* and *Setting the Agenda for Research on Cultural Competence In Health Care* (19,20), that have articulated a starting point to address disparities, but much more is needed. APA has formed a work group to address issues raised in the Surgeon General's report (4). Although APA's work group affords visibility and legitimacy to the issue and the work group has translated the broad recommendations of the report into operational objectives, there are limitations. It remains unclear how the APA initiative can induce individual psychiatrists to increase their skills, what incentives or accountability mechanisms can be devised to change the systems of care in which psychiatrists practice, how coordination of the emerging research base for translation of new knowledge into practice on a routine basis can be improved, and how the problem of access barriers can be surmounted, including stigma associated with mental illness, inadequate referral from primary care, and limited insurance coverage. These are difficult issues that in practice are easily relegated to the back burner. Thoughtful, sustained, and targeted guidance from APA is needed.

Training in medical school and residencies is now expected to cover health disparities. We urge medical schools and residency programs to provide required didactic and experiential coursework in appropriate health care for individuals from minority groups and to integrate these topics throughout the entire curriculum. Similarly, we believe it is important both to train more minority psychiatrists and to expand the skills and knowledge of all psychiatrists in the area of minority mental health (21).

We urge the American Board of

Medical Specialties to require training in minority mental health before conferring Board certification or recertification. We urge providers to follow CLAS standards in their organizations, and we call on practitioners to obtain regular continuing education in minority mental health issues and to seek consultation as needed.

There is an urgent need to expand our knowledge base about effective treatments for individuals from ethnic minority groups. We therefore encourage an energetic research agenda for minority mental health—that is, one that utilizes culturally informed assessments for participants in all research studies and that promotes the systematic transfer of information to practitioners and behavioral health care organizations. ♦

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