SECTION

II Disparities Among Ethnic Groups

3 African Americans

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INTRODUCTION

People of African descent in the United States represent a heterogeneous group of cultures and origins that is becoming increasingly diverse (1). As a group, however, they experience disparities in access to and quality of general healthcare and mental healthcare. Their mental health and experiences in the psychiatric clinical setting are complicated by a multiplicity of historical and contemporary factors that will be addressed in this chapter. Our hope is that this analysis will provide direction for future efforts to improve the mental health status and clinical psychiatric outcomes of people of African heritage.

DEFINITION OF THE POPULATION

In this chapter, the term *African American* will refer to the broad spectrum of individuals of African heritage who reside in the United States, approximately 12% of the population. The majority of these persons were born in the United States and are descendants of slaves with origins primarily in West Africa (2). However, other groups included among African Americans are immigrants and refugees seeking asylum in the United States in recent decades from nations in the Caribbean, Central America, South America, and East, Central, West, and South Africa, and their descendants. The people in these groups represent a wide variety of cultures, languages, and mores. It is important to note that immigration is increasing the diversity of individuals referred to as African Americans (1). In many major cities as many as one third of African Americans are Caribbean immigrants or they are first- or second-generation offspring. Despite their diversity, all individuals of African ancestry must deal with the

specter of racism, which may be a more important contributor to disparities in treatment than such factors as socioeconomic status (1).

DIAGNOSTIC CONSIDERATIONS

According to large-scale national studies using validated structured interviews, African Americans experience the full range of psychiatric disorders (3). For the most part, prevalence rates are similar to or lower than their counterparts in other racial and ethnic groups. However, smaller clinical studies show that African Americans are overrepresented in certain diagnostic groups, including dysthymic disorder, isolated sleep paralysis, and cognitive disorders (2). Moreover, clinicians continue to overdiagnose such disorders as schizophrenia at the expense of mood and anxiety disorders at rates that cannot be accounted for by studies using the more valid structured interviews (4,5). Underrecognition of some mental disorders and excessive misdiagnosis of others may contribute to some of the treatment disparities. In this section, we will examine the African American experience and disparities with regard to the epidemiology and clinical diagnosis of four major disease categories: anxiety disorders, depressive disorder, bipolar disorder, and schizophrenia.

ANXIETY DISORDERS

Some anxiety disorders may show a higher prevalence among African Americans. The Epidemiologic Catchment Area study (ECA), a household survey using structured interviews found higher rates of anxiety disorders among African Americans than other populations (6). In contrast, the National Comorbidity Survey (NCS) replication also used structured interviews and found lower rates of anxiety disorders in racial and ethnic minorities (3). Methodological differences may partially explain the difference. The ECA study was conducted in five cities and oversampled minorities, whereas the NCS was conducted nationally and did not oversample people of color or include persons from institutional settings where people of color are overrepresented. However, prevalence rates based on diagnoses by clinicians invariably find lower rates of anxiety disorders in African Americans (4,7). Misdiagnosis is clearly a factor.

Socioeconomic factors can play a role in the higher prevalence of some anxiety disorders. Posttraumatic stress disorder in particular has been found more often in African Americans, possibly because African Americans are overrepresented in inner cities, which have higher crime rates and poverty, and in combat situations in the military (4,8). Yet, this disorder often is either underdiagnosed or misdiagnosed as other disorders such as schizophrenia. Hence, the evidence is inconclusive at this point about the actual prevalence of anxiety disorders among people of color, and specifically African Americans (7).

What are some of the underlying causes of patient and/or clinical disregard or misinterpretation of anxiety disorder symptoms in African Americans? The lack of use of structured, reliable, and cross-culturally validated assessment instruments could be a factor, although the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) IV is considered to be an important improvement over older diagnostic systems (4). Another potential contributor to underdiagnosis of anxiety disorders is the lack of recognition of subsyndromal symptoms, which may be deemed culturally acceptable responses to environmental stress. The frequent co-occurrence of psychotic symp-

toms and paranoid ideation among African Americans with anxiety disorders is another possible explanation for the misdiagnosis of anxiety subtypes (4). Moreover, African Americans are more likely to seek help in primary care settings, where general medical conditions top the list of differentials (8).

SCHIZOPHRENIA

For many years, African Americans have been regarded as having an increased risk of schizophrenia, and they still are at nearly a 10-fold risk of being diagnosed with schizophrenia compared with other populations of color (4,5,9). However, the ECA study found no difference in the prevalence of schizophrenia among African Americans when socioeconomic status was controlled, and the NCS Replication found that African Americans were less likely than European Americans to have nonaffective psychosis, primarily schizophrenia (3,6). Higher rates of schizophrenia in clinical settings have been consistently reported for African Americans compared with other ethnicities in inpatient and outpatient settings, often associated with correspondingly lower rates of affective disorders (9). It has been presumed that affective disorders were being misdiagnosed in favor of schizophrenia. Yet, even with the use of the DSM IV, this pattern of overdiagnosis of schizophrenia in African Americans persists, occurring in a variety of settings, including the Veterans Administration, facilities for juveniles, and public and private facilities (9).

The persistence of this diagnostic disparity is not caused by variance in criteria but rather by failure on the part of the clinician to obtain adequate information and overinterpretation of Schneiderian first-rank symptoms as being exclusively associated with schizophrenia (5). It is not uncommon for African Americans to present with these types of symptoms when experiencing a mood disorder. Additional possible explanations are clinician bias regarding the presence of mood disorders in African Americans and lack of knowledge about idioms of distress among African Americans, such as anger, irritability, and somatic complaints (9). Patient factors include suspiciousness and mistrust, often characterized as "healthy paranoia," and delays in seeking treatment until the crisis point is reached, which may further complicate the diagnostic process (9).

To prevent misdiagnosis, it is necessary to consult family and others in the patient's life so that culturally accepted idioms of distress are not misconstrued. Furthermore, it is essential to consider schizophrenia as a diagnosis of exclusion only after ruling out mood, anxiety, and other disorders from the differential diagnosis.

DEPRESSION

Although schizophrenia has been overdiagnosed among people of African descent, mood disorders, including major depression and bipolar disorder, have been underdiagnosed (5). Depression is a significant problem among African Americans. Williams and colleagues (10) found in the National Survey of American Life (NASL) that rates of depression among African Americans (10.4%) and Afro-Caribbeans (12.9%) were lower than that of white Americans (17.9%). However, rates of subsyndromal depression and dysthymic disorder are higher among people of African descent (11). As a result, higher rates of depression in general are found in African Americans when compared with their Caucasian counterparts.

Both the NCS and NASL found that major depressive disorder in African Americans including those of Caribbean origin is typically overlooked, undiagnosed, untreated, inadequately treated, more severe, and/or associated with greater disability. It is disturbing to note that only 45% of African Americans and 24% of Caribbean Americans with major depression received any treatment (10). Among the underlying reasons for unmet need for depression care among people of African descent is the presentation of depressive symptoms, other then sadness, that still meet the usual depressive criteria. These include the alternate symptoms of irritability, hostility, and somatic symptoms that the clinician may interpret as another psychiatric disorder or even a general medical condition. The problem is further enhanced by the failure of many African Americans to recognize depression when they are suffering from it. This phenomenon is graphically demonstrated in the book "Black Pain" by Terrie Williams (12).

Suicide is an important consequence of depression and is a reminder that depression can be a mortal illness. In the past, suicide was thought to be rare in African Americans. Recent studies, however, have shown that young men of African descent do not differ in rates from their white counterparts in suicide rate (13).

BIPOLAR DISORDER

African Americans are often diagnosed as having schizophrenia or depression when they have bipolar disorder. Although the ECA and NCS studies found little racial difference in prevalence, bipolar disorder was thought to be nonexistent among African Americans until recently (4,5). Misdiagnosis of bipolar disorder when it first presents itself is common in any population. African Americans, however, are much more likely to be underdiagnosed or misdiagnosed at rates of 90% with first presentation (14). A high likelihood of symptom presentations that include irritability, anxiety, or psychosis often lead to the misdiagnosis of schizophrenia. Moreover, many patients often first present with depressive symptoms. Cultural factors that may color the presentation, cultural ignorance, and stereotypical beliefs contribute to the misdiagnosis and missed diagnosis. The preference for service by primary care providers is also a factor because primary care providers often are not familiar with the many ways that bipolar disorder may present and believe it is rare outside of psychiatric settings. Yet, recent studies show that bipolar disorder may make up 10% to 20% of patients in primary care settings (15).

TREATMENT CONSIDERATIONS

The scientific literature is replete with examples of psychiatric treatment disparities experienced by African Americans (1,4). As noted above, the large depression survey amply described the undertreatment of depression and subsequent poorer outcome, even when income was controlled. Other studies have shown that less than a quarter of African Americans receive evidence-based treatment for most mental disorders (16). When African Americans receive psychiatric care, they tend to receive more invasive and potentially detrimental care and they receive less of the more benign forms of treatment. They are more likely to be involuntarily committed, placed in seclusion and restraint, or given higher doses of medication (7). These differences are probably a result of delay in treatment caused by lack of availability, stereotypical beliefs about African

Americans being more hostile, and unwillingness by the provider to be therapeutically engaged. The location and circumstances surrounding psychiatric care for African Americans is also problematic, with high rates of use in emergency rooms, inpatient settings, correctional settings, and primary care settings (2,17). African Americans continue to receive inadequate or no treatment in primary care settings (18).

Among children and youth with mental health needs, African Americans are more likely to be found in the juvenile justice system than are white youth with identical presentations (4). Few African American children and youth receive treatment in private hospitals, day treatment, or case management services. Most receive care, if at all, in publicly funded hospitals and residential treatment centers. Those who are in the juvenile justice system are underreferred for mental health services (1).

Socioeconomic (S-E) factors are important. The direct cost of providing service to someone with schizophrenia, for example, exceeds the median family income of African Americans (9); however, even when S-E is controlled, significant disparities remain (1).

Attitudes of the provider clearly contribute to some of the disparity. African Americans are less likely to be offered either evidence-based pharmacotherapy or psychotherapy (16). They are also less likely to get different types of psychotherapy (19). African Americans are less likely than other groups to get evidence-based or optimal treatment in both the primary care and the VA system as well as in public or private mental health settings (18,20). African Americans are less likely to be prescribed newer antipsychotics or antidepressants (7,9). They are less likely to be given electroconvulsive therapy. It is an important treatment modality for depression especially when the depression is intractable, in emergency situations where the risk of suicide is high, or in elderly populations or others who have a low tolerance for antidepressant medication. Electroconvulsive therapy is offered less often to African Americans than to whites even when several factors including S-E are controlled (21).

Attitudes among African Americans can interfere with treatment acceptance. A recent qualitative study queried low-income African Americans who were receiving psychotherapy for the treatment of depression about reasons that African Americans with emotional or psychological problems underuse mental health services. The most frequent response was stigma, followed by dysfunctional coping behavior, shame, and denial (22). A study from the New York State Psychiatric Institute found that although African Americans were more likely than whites to believe that mental health professionals could help people with depression and schizophrenia, they were more likely to believe that treatment was unnecessary (23). In addition, African Americans were more likely to believe that prayer and faith alone was all that was necessary to treat depression.

ETHNOPSYCHOPHARMACOLOGY

Many clinicians are unaware of potential racial/ethnic differences in pharmacological response. For example, many anticipate that people of African descent will respond to medication similar to the way other racial and ethnic groups do because there is considerable genetic similarity across racial and ethnic groups. Unfortunately, many also believe that African Americans require more medication, based on the misconception that African American males are more hostile (4). However, the evidence suggests that African Americans may require, if anything, less medication because of differential pharmacological response.

The importance of ethnic factors in pharmacotherapy gained clinical importance with the medication marketed as BiDil. This agent was tested as a treatment for congestive heart failure and was found to be consistently effective only in African Americans. It subsequently was the first agent receiving FDA approval for a specific racial/ethnic group (17). Racial differences in treatment response and side effect profiles have also been reported with psychotropic agents.

African Americans may require lower doses of antipsychotic and antidepressant medications than do Caucasians. Cytochrome P 450 enzymes metabolize greater than 90% of drugs in clinical use, including antipsychotic and antidepressant medications. Individuals with relatively inactive CYP2D6 alleles (which account for 25% of metabolism of commonly used drugs) tend to have higher plasma levels of antipsychotics and antidepressants (24). Fifty percent of people of African ancestry have reduced functioning or nonfunctioning alleles. This leads to slower metabolism of older antipsychotics or tricyclic antidepressants and higher plasma levels. Chronically higher plasma levels may be associated with an increased risk of side effect intolerance of the medication, which in turn can lead to poorer adherence to treatment and should be compensated for with lower doses in African Americans than in Caucasians to achieve a therapeutic response.

Clinically, African Americans tend to be more likely to discontinue medication (4). African Americans are also more likely to develop tardive dyskinesia when receiving first-generation antipsychotics (25).

In the treatment of schizophrenia and other psychotic disorders, African Americans are less likely to receive newer-generation antipsychotic medications, which are associated with fewer extrapyramidal symptoms, amelioration of negative symptoms of schizophrenia, and a lower risk of tardive dyskinesia. This presents a challenge of choice to the clinician because the newer-generation antipsychotics pose higher risks of type 2 diabetes and significant weight gain, for which African Americans and other populations of color are at greater risk than are Caucasians (7,26). In any case, African Americans are more likely to receive antipsychotic medications when other agents may be as effective and to receive excessively higher doses when ethnopharmacological research would suggest that lower doses are needed.

African Americans may also have a different response to antidepressants at a receptor level. The STAR*D study, the first large-scale naturalistic study of current antidepressant treatment, presented sequentially, showed that African Americans had poorer responses and longer periods to remission with initial treatment with citalopram and poorer outcomes generally (27). African Americans appear to be less likely to have an allele or type of serotonin receptor that is associated with antidepressive response (28).

African Americans may have less access to some psychotropic medications because of their side effect profile. African Americans have preexisting low leukocyte counts at baseline, also known as benign leucopenia, which is not associated with increased pathology. This is a barrier to prescribing of agents with agranulocytosis as a side effect to otherwise healthy African Americans (7). Such agents include clozapine, which is shown to be more effective than other antipsychotic agents in treating treatment-refractory schizophrenia despite metabolic side effects. Also, carbamazepine is used to treat bipolar disorder, but it has agranulocytosis as a side effect as well.

African Americans are known to show a higher red blood cell–to–plasma ratio of lithium concentration when compared with Asians and Caucasians, and this finding was consistent even when the lithium levels were in therapeutic range (17). This difference is significant because of diminished lithium tolerability in African Americans

and more side effects with high red blood cell/plasma ratios. As a consequence, African Americans with mood disorders are less likely to have lithium treatment prescribed as a single agent or as adjunctive therapy, even though it is effective and relatively inexpensive.

Pharmacokinetic and pharmacogenetic factors may explain why African Americans discontinue psychotropic medication more frequently than other groups (4,29). However, sociocultural factors are also important. Medication adherence is particularly an issue among African Americans, given their mistrust of physicians and psychiatrists, stigma associated with mental illness, and concerns about addictiveness of medication (19). Numerous other factors such as homelessness, substance abuse, support systems, affordability, cultural norms, and medication side effects can affect initiation and maintenance of pharmacologic treatment. To acquire information in these areas, the clinician should get a comprehensive personal and social history and, if given permission, talk to the family to identify potential barriers to successful treatment.

Psychotherapy is effective in the treatment of African Americans and is more acceptable than medication to many, especially in depression treatment (30). Taking into consideration patients' and the therapists' racial identities and worldviews, transference and countertransference are important. The psychotherapeutic relationship is vulnerable to bias and stereotyping which are sometimes unintentional and subconscious; yet, reside at the crux of disparities (31). These factors have considerable impact on care and clinical decision-making (2).

CLINICIAN-PATIENT COMMUNICATION, PATIENT CENTEREDNESS, AND CULTURAL COMPETENCE

Physician communication is a key factor in improving the quality of care and outcomes of patients of African descent. Collins and colleagues (32) found in a national telephone survey that African Americans and other people of color do not fare as well as whites with regard to patient-physician communication. Also, physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with African American patients than with white patients (33). African Americans and other people of color report being treated with disrespect or looked down on in their therapeutic relationships (34).

A recent study of African American and white patients in primary care with depressive symptoms revealed racial disparities in communication between primary care physicians and their patients. The study found that although there were no racial differences in the level of symptoms, physicians made fewer depression-related statements to African American patients than to white patients. Even when depression discussion occurred, physicians determined that fewer African American than white patients were experiencing significant emotional distress. This situation makes evident the need for improvements in communication to help reduce racial disparities in depression care (35).

The false notion that African Americans are more hostile is made worse by dysfunctional communication between patients and providers and by distance on social, economic, and ethnic levels. When patients become suspicious and hostile toward the mental health system, they often choose alternative sources of care or become noncompliant.

Language is an important aspect of cultural identity as well as communication, as spelled out in the DSM-IV-TR Cultural Formulation (DSM IV TR). Among the

broad spectrum of people of African descent in the United States, the primary language spoken is standard English, with some speaking in nonstandard English dialects. Among immigrant and refugee populations of African descent, languages including Haitian, Creole, French, Portuguese, and Spanish are commonly spoken. It is important to provide mental health services in the language that the patient speaks at home by making available bilingual psychiatric clinicians or at least trained translators or interpreters. The National Standards for Culturally and Linguistically Appropriate Services (CLAS), promulgated by the Office of Minority Health, also urge the provision of signage and written materials in the languages spoken by patient populations. Patients who speak English as a second language are more likely to be misdiagnosed as having schizophrenia when they have depression (4). Limited English-proficient individuals may be turned away, may be forced to find their own interpreter (often a family member or friend), may not come back to a second appointment, may not adhere to treatment, or may not receive appropriate and necessary treatment. A growing number of people of African descent are facing this potential barrier to treatment (36).

The important correlated concept of cultural competence entails engagement of patients as partners in problem solving and decision-making, holistic consideration of social and cultural context, and the consequences of patients' experiences with illnesses. Social and cultural barriers between healthcare providers and patients may affect the quality of healthcare. Some African Americans harbor distrust of healthcare providers and institutions on the basis of historical or ongoing experiences of discrimination (4). Providers may harbor overt or subconscious biases about people of color that influence their interactions and decision-making (2,4).

Spirituality plays an important role in African American life, promoting mental health and prevention and serving as a key source of support (1). Collins and colleagues (32) report that 12% of African Americans use alternative care for religious or cultural reasons compared with 4% of whites. Many African Americans rely solely on spiritual support in lieu of professional treatment.

The religious diversity among people of African descent in the United States is considerable. Although Christianity, and its various denominations including Catholicism and Protestant denominations, is the predominant religion, African Americans belong to a wide range of faiths including Islam, Judaism, Buddhism, Yoruba, and other belief systems. Religion has been recognized as a source of strength for African-descendent populations, contributing to mental health promotion and resilience. However, religious beliefs and fervent expression, especially among fundamentalist Christian worshippers, have been misconstrued as signs of psychopathology. Many fundamentalists believe that mental health treatment may be inconsistent with their faith. This underscores the importance of psychiatrists and other mental health professionals in understanding the normative manifestations of the religious beliefs and practices of the African American subpopulations they serve.

Patient centeredness is an approach to the patient as a unique individual with his or her own story; one that requires the physician to understand the patient as well as the disease. It involves exploring the illness experience, understanding the whole person, finding common ground regarding management, incorporating prevention and health promotion, and being realistic about personal limitations. The physician tries to enter the patient's world and to see the illness through the patient's eyes (9).

Part of understanding the whole person involves understanding the family role. Family involvement can influence outcomes in people with schizophrenia, and African Americans are no exception. African Americans tend to be supportive in their

family involvement with a loved one with schizophrenia. Yet, they also are more likely to believe that the mentally ill individual may be dangerous (9). Nevertheless, behavior that may be toxic in other cultures, such as high emotionality, intrusiveness, and critical comments, does not predict poor outcomes in African Americans (9). These findings underscore the importance of culture in determining how the family interacts with a member who is severely mentally ill.

PREVENTIVE CONSIDERATIONS

Taking a public health approach to mental health and psychiatric illness, one should consider primary prevention. Much of recent psychiatric research has focused on identifying the genetic basis of mental disorders (9). Identifying risk genes for mental disorders does not preclude extragenetic factors. For example, Caspi and associates (37) showed that a serotonin receptor allele was indeed a risk gene for depression. However, it was associated with depression only in individuals with a history of childhood abuse. Thus, genetic factors probably interact with environmental stressors such as physical abuse, substance abuse, or other physical or social insults to cause a mental disorder. Identifying and addressing these stress factors may prevent the development of some disorders.

Primary prevention involves taking proactive steps to prevent illness, such as intervening with support after loss, trauma, or disaster to protect against depression or anxiety disorders in vulnerable people or providing prophylactic treatment for depression or schizophrenia in African Americans with a strong family history. Such actions are infrequently attempted. Nevertheless, despite a strong focus on the genetics of mental illness, factors such as substance abuse, family rearing, and stress seem to interact with risk genes to determine if a mental disorder is expressed or has a poor outcome.

"Risk factors are not predictive factors due to protective factors" is an important concept, particularly in mental health. It dictates that mental health professionals invest resources in protective factors, such as social support and social fabric, which can serve as a buffer against inevitable stressors and negative environmental conditions that many African Americans encounter. Such investment can foster resilience in populations that might otherwise fall prey to significant challenges to mental health or outright expression of psychiatric illness in the face of overwhelming stressors or negative life events.

CONCLUSION

Dove and colleagues (38) provide a series of corrective measures for mental health disparities, including:

- Decreasing the discriminatory attitudes associated with psychiatric illness through education
- Improving communications and providing training in social skills for people with mental illness
- Increasing access and availability of psychiatric care in communities with significant levels of unmet need
- Increasing the number of providers serving African American populations
- Increasing educational efforts to enhance adherence to treatment

The mental health system and its providers must become more patient-centered and receptive to the needs of African Americans and their families. A system based on compassion may explain the superior outcomes seen in third-world countries and recovery-based provider systems.

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