Challenges and Obstacles in Treating Mentally Ill Black Patients

December 01, 2006 | Cultural Psychiatry [1]  
By Carl C. Bell, MD [2], Henry W. Dove, MD [3], and Johnny L. Williamson, MD [4]

As the United States becomes more culturally, racially, and ethnically diverse, psychiatry will be faced with the need to treat more diverse populations. This article focuses on challenges and obstacles encountered when treating black patients with mental illness.

As the United States becomes more culturally, racially, and ethnically diverse, psychiatry will be faced with the need to treat more diverse populations. This article focuses on challenges and obstacles encountered when treating black patients with mental illness. The black population in the United States is not a monolithic, homogeneous community. The heterogeneity of the population as a function of the African diaspora is complex and deserving of an understanding that goes beyond the phenotypic identification and assignment of individuals to what we believe to be "black." Language; ethnic culture (eg, Caribbean vs Southern-born); religious practices; socioeconomic status; immigration or refugee status; and the historical participation, or lack thereof, in the unique American experience of race relations defines how persons experience being "black" and express mental illness.

Diversity
The first skill necessary to appropriately treat patients from the black community is to avoid stereotyping members of this diverse group. Such stereotyping is at the root of behaviors that result in the expression of microinsults and microaggression toward members of the African diaspora. For example, psychiatric services staff need to learn not to automatically ask black patients for their "Medicaid cards," but should rather ask, "How does the patient intend to pay for services?"

Conversely, gratuitously attempting to overidentify with the black culture based on stereotypes is equally detrimental, (ie, a white therapist giving a black patient an unsolicited "soul" handshake at their first meeting). Alternatively, the supposition that leads a therapist to prematurely ask about substance abuse before eliciting relevant data to support this possibility may be offensive to a black patient. It is advisable to establish rapport and elicit data that more directly relate to the presenting problem before initiating this and other more sensitive types of inquiry.

Satcher's Culture, Race, and Ethnicity report is an excellent primer that combats stereotyping by emphasizing the importance of recognizing the diversity that exists within black communities. Consideration of the individual patient's social context is important for avoidance of stereotyping and for understanding the context in which the patient's mental illness occurs. Middle-class, working-class, and poor blacks have different patterns of family membership, employment and continuity of employment, number of children, family functions, interaction (egalitarian, patriarchal, matriarchal), income and spending, social and leisure activities, involvement in community affairs, education, attitudes toward work, success, self-reliance, and so on. Despite the myth that all black families are matriarchal, middle-class black families are often egalitarian, and those of Caribbean extraction may be very patriarchal; therefore, making assumptions about black family structure and function is a potential land mine. Factors that affect levels of cultural identity among persons of the African diaspora can be further understood by referring to the underused "Cultural Formulation" section of DSM-IV-TR.

Central to recognizing the diversity within the black community is the development of skills of "cultural sensitivity." It is important to recognize and understand that different cultural, racial, and ethnic groups may require different medication prescribing practices. For example, because blacks have higher blood levels of the medication, they may be more predisposed to tardive dyskinesia given the same dose of a neuroleptic agent than a white counterpart. Simultaneously, while cultural sensitivity is important in the treatment of blacks with mental illness, it is equally important to recognize that there are universal principles of treatment that should apply to all patients. Clinicians must become astute in their ability to draw from both culturally specific and universal principles in their work with black patients.

Perceptions of racism
Another aspect of cultural sensitivity is recognizing that many blacks have been subjected to various
degrees of racism\textsuperscript{14} and have varying levels of recognition of this reality. Misconceptions on the part of blacks may stem from a number of causes.\textsuperscript{5} There may be confusion on the part of blacks as to whether they are being tolerated or accepted by whites. Although some whites truly accept blacks, others may harbor negative stereotypes and only tolerate them. Rejecting the legitimate goodwill of whites is as big a mistake as trusting a white person who harbors racist attitudes. Many blacks have difficulty in recognizing who and consequently pay the price.

A second problem concerns the inability of blacks to distinguish between the supportive efforts of individual whites and the destructive actions of whites as a collective (eg, the long-standing and unaddressed health care disparities between blacks and whites). This confusion occurs when a black person is accepted by a white person and as a result, mistakenly believes that racism no longer exists.

Another problem is knowing when, where, and how to resist oppression (eg, microinsults or microaggression and overt discrimination) versus when, where, and how to accommodate it. There are occasions when racism should be fought bitterly but other times when the fight proves more detrimental than beneficial—for example, when a white psychiatrist stereotypes a black patient by diagnosing a psychotic spectrum disorder when an affective spectrum disorder is more suitable. Because of the power differential, the patient has a difficult choice to make regarding whether to challenge the treating psychiatrist's clinical acumen and authority.\textsuperscript{15} Finally, there may be confusion about whether the locus of control is internal or external. An internal locus of control implies that you attribute your successes to yourself and your failures to your lack of effort. An external locus of control implies that you attribute your failures or successes to something outside of your control. A major problem for blacks is determining when they are in control of their destiny and when there are external factors imposed by racism. If blacks assume an external locus of control (ie, "the man" controls everything blacks do), then blacks will lack motivation to help themselves, and they will lack feelings of self-efficacy. Conversely, if blacks do not recognize the toxic external constraints imposed on them, they could erroneously attribute their failure to their own perceived shortcomings.

The first 3 of these areas of confusion can seriously disrupt the establishment of rapport between the patient and the treatment provider. The American Psychiatric Association's position statement on racism emphasizes the importance of being mindful of the existence and impact of racism and racial discrimination in the lives of patients and their families, in clinical encounters, and in the development of mental health services.\textsuperscript{16} The confusion about locus of control has a tremendous impact on feelings of self-efficacy, making it critically important to discuss these issues with African American patients early in treatment.

**Treatment considerations**

Blacks may harbor fear, distrust, lack of confidence, and anxiety over the prospects of stigmatization—all born of a historical recognition of failures of the health care system to adequately address disparities and exploitation (eg, Tuskegee syphilis experiments).\textsuperscript{17,18} In addition, because exposure to trauma is another common issue for black patients, they should be asked about their experiences with racism and trauma.\textsuperscript{6,19} When treating black patients, it is critical to understand that risk factors are not necessarily predictive factors, since protective factors may intervene. Thus, psychiatrists must actively explore the protective factors surrounding blacks in risky contexts.\textsuperscript{20} In general, protective factors are the strength of social fabric surrounding the patient,\textsuperscript{21,22} the patient's access to state-of-the-art medical technology, the opportunities the patient has had for developing social skills (eg, the capacity for affect regulation), the patient's sense of self-efficacy and self-esteem,\textsuperscript{22} the protective shields in the patient's life (eg, family involvement, church), and the opportunity for the patient to develop a sense of self-efficacy by turning traumatic helplessness into learned helpfulness.\textsuperscript{23}

It is imperative that objective, empiric, evidence-based research guides how best to adapt current practices to mental health issues relevant to the diverse black community. Humanistic interventions geared toward using existing community resources and strengths (including family support, ethnic and spiritual values, education, and belief systems born of tradition) and an understanding of the black experience can be used to construct culturally sensitive and effective mental health services and interventions.\textsuperscript{24}

*Dr Bell is president and CEO of the Community Mental Health Council and clinical professor in the department of psychiatry at the University of Illinois at Chicago. Dr Dove is interim head of psychiatry and associate professor of clinical psychiatry in the department of psychiatry at the University of Illinois in Chicago. Dr Williamson is a staff child psychiatrist at the Community Mental...*
Health Council. They report that they have no conflicts of interest concerning the subject matter of this article.

References:
