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# **A CONCEPTUAL MODEL OF BARRIERS TO MENTAL HEALTH SERVICES AMONG AFRICAN AMERICANS**

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## **Introduction**

There is a paucity of empirical research investigating potential causes of racial disparities in mental health status. However, a growing body of literature exists regarding barriers to mental health service utilization among African Americans. This literature suggests that African Americans experience greater difficulty in accessing mental health services than Caucasians (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; McCarthy, 2001). Furthermore, African Americans who do gain access often face barriers to accurate mental health assessment and diagnosis, leading to a lack of effective mental health treatment (Baker & Bell, 1999; McCarthy, 2001; Snowden, 2001; Wang, Berglund, & Kessler, 2001).

The purpose of this paper is to better understand the relationship between barriers to mental health care among African Americans and racial disparities in mental health status and outcomes. First, disparities in prevalence and incidence rates of mental illness and mental disorders for African Americans are identified. Second, racial differences in mental health services utilization and treatment outcomes are examined. Third, barriers to mental health services use are presented in a theoretical framework based on the conceptual model of Swanson and Ward (1995). The paper concludes with suggestions for future research. In this paper, the terms “African American(s)” and “black(s)”, and “Caucasian(s)” and “white(s)” are used interchangeably.

## **Racial Disparities in Prevalence and Incidence Rates**

Racial disparities in prevalence and incidence rates of several mental illnesses and mental disorders, such as schizophrenia, post-traumatic stress disorder (PTSD), phobic disorders, and somatization disorders, have consistently been reported in the literature (Baker & Bell, 1999; Dixon et al., 2001; McAlpine & Mechanic, 2000; McCarthy, 2001; Singleton-Bowie, 1995; Snowden, 2001; Williams, 1995). The lifetime prevalence rate of schizophrenia among African Americans is 2.1%

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compared to 1.4% among Caucasians (Singleton-Bowie, 1995). The current and lifetime rates for phobic disorders among African Americans are 16.2% and 23.4%, respectively, compared to 9.1% and 9.7% among whites (Williams, 1995). The findings of the Epidemiological Catchment Area (ECA) study revealed that 15% of African American respondents reported experiencing somatic symptoms, compared to 9% of Caucasian respondents (U.S. Department of Health and Human Services [USDHHS], 2001).

Additionally, African American sub-populations, such as veterans and the elderly, are unduly burdened by a number of mental illnesses (USDHHS, 2001). For example, the National Vietnam Veterans Readjustment Study found that 21% of black Vietnam veterans suffer PTSD compared to 14% of whites, despite the fact that whites comprised 85% of all U.S. troops in Vietnam (USDHHS, 2001). Among older African Americans, the prevalence and incidence of cognitive impairments, such as dementia and Alzheimer's disease, are much higher than among older Caucasian (USDHHS, 2001).

Furthermore, within high-need populations such as children in the child welfare system and the homeless, who are disproportionately comprised of African Americans, the prevalence of mental illness and psychological disorders is substantially higher than in the general population (USDHHS, 2001; Garland et al., 2001; Koegel, Burnam, & Farr, 1988). An investigation of the prevalence of mental illness among children under the care of the child welfare system shows that approximately 42% of those children meet diagnostic criteria for at least one psychiatric disorder (Garland et al., 2001). Within the homeless population in the U.S., the prevalence of severe mental illness is significantly higher than in the general population (Koegel et al., 1988). It is estimated that African Americans comprise 44% of the homeless population (USDHHS, 2001). Approximately 13% of homeless individuals in the U.S. have been diagnosed with schizophrenia, compared to 1% of the general population, and roughly 30% of homeless individuals have affective disorders, compared to 8% of the general population (Koegel et al., 1988).

### **Racial Disparities in Mental Health Services Utilization**

For African Americans in need of mental health services, the odds of receiving any form of psychological treatment are roughly half those of Caucasians in similar need (USDHHS, 2001; Diala et al., 2000; Snowden, 2001). Not only are racial disparities evident in rates of mental health service utilization, there are also discernible disparities in the types of mental health services sought and received. For example, African Americans are more likely than Caucasians to use emergency or crisis care to obtain mental health services (Cooper et al., 2003; USDHHS, 2001; Hu, Snowden, Jerrell, & Nguyen, 1991; Maynard, Ehreth, Cox, Peterson, & McGann, 1997; Mills, 2000). African Americans are also significantly more likely than

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members of other groups to address mental health issues with primary care physicians rather than with mental health care specialists (USDHHS, 2001; Snowden, 2001). Furthermore, African Americans receive outpatient specialty mental health services at approximately half the rate of Caucasians (Cooper et al., 2003).

Disparities in rates of psychiatric hospitalization between African Americans and Caucasians are evident as well. For example, African American men are almost three times more likely than Caucasian men and African American women are 2.5 times more likely than Caucasian women to be hospitalized for psychiatric reasons (USDHHS, 2001). Moreover, severely mentally ill African American men and women are more likely to be rehospitalized for psychiatric reasons than their Caucasian counterparts (USDHHS, 2001; Mills, 2000; Snowden, 2001). African Americans are also less likely than Caucasians to receive guideline-concordant treatment, have higher rates of attrition from mental health treatment programs (Cooper et al., 2003; USDHHS, 2001; Snowden, 2001; Wang et al., 2001), and are more likely to end treatment after only one session (50% vs. 30%, respectively) (Beaman, 1994).

### **Barriers to Service Utilization and Effective Mental Health Care**

As described in the Introduction, there is a growing body of literature related to barriers to mental health service utilization among African Americans. The work of Swanson and Ward (1995) provides a conceptual framework in which different types of barriers may be placed. This framework includes four categories of barriers. *Sociocultural barriers* include “racial and ethnic discrimination and cultural beliefs,” such as fear or mistrust of the mental health care system and cultural beliefs regarding mental health and mental illness. *Systemic barriers* result from inherent aspects of the mental health care delivery system, such as the perceptions of mental health service providers toward African Americans, and culturally inappropriate screening measures, diagnostic procedures, and treatment programs. *Economic barriers* are obstacles to mental health services resulting from economic status, such as lack of health insurance or mental health care coverage. *Individual barriers* are perceptions of vulnerability to disease and denial of disease (Swanson & Ward, 1995). All of these barriers may have a significant impact on mental health services utilization and the quality of mental health care received by African Americans.

#### **Sociocultural Barriers**

Fear and mistrust of the mental health care system and mental health treatment may be considerable sociocultural barriers to mental health service utilization among African Americans. Historically, many African Americans have been devalued and mistreated by the U.S. health care system (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003; Harris, Gorelick, Samuels, & Bempong, 1996; Swanson & Ward, 1995).

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Consequently, many African Americans have come to fear and mistrust the health care system, as well as health care providers (Gamble, 1997; LaViest, Nickerson, & Bowie, 2000; Roberson, 1994; Smith, 1999; Swanson & Ward, 1995). In addition, African Americans appear to be equally apprehensive of the mental health care system and mental health treatment. A recent report published by the Surgeon General stated that the “proportion of African Americans who feared mental health treatment was 2.5 times higher than the proportion of whites” (USDHHS, 2001, p.63). Another sociocultural barrier to mental health services utilization may be the perceived stigma associated with mental illness. Compared to Caucasians, African Americans are more likely not to seek mental health treatment due to stigma (USDHHS, 2001). According to McCarthy (2001), stigma associated with mental illness has resulted from a common cultural attitude among African Americans that discourages those in need of mental health services from seeking treatment. Consequently, many African Americans who are experiencing mental health problems may be embarrassed or ashamed to seek treatment or openly discuss their problems with friends and relatives, much less with mental health care professionals (Snowden, 2001).

Clients’ spiritual belief systems can play a crucial role in the psychotherapeutic process (Carone & Barone, 2001). For many African Americans, spirituality is a fundamental component of their belief system (Constantine, Lewis, Conner, & Sanchez, 2000; Cooper et al., 2003; USDHHS, 2001; Frame & Williams, 1996; Mattis, 2002; Snowden, 2001). However, many therapists seem reluctant to address spiritual issues with their clients (Frame & Williams, 1996). When spiritual issues arise, therapists may find themselves ill equipped and/or unprepared to address such matters (Frame & Williams, 1996). African American clients may perceive a therapist’s reluctance or inability to address spiritual issues as an intolerance of his or her belief system or as a failure to recognize the significance of these issues in his or her life (Frame & Williams, 1996). Consequently, such clients may become dissatisfied and discontinue treatment. Spirituality is a desired component of the treatment process for many African Americans in need of mental health services (Snowden, 2001; USDHHS, 2001). Therefore, a therapist’s neglect of spirituality may present a major barrier to positive treatment outcomes among members of this racial group.

In addition to acknowledging African American clients’ spiritual belief systems, it is equally important that therapists be familiar with their African American clients’ linguistic systems. Psychotherapy is considered by many to be a “talking cure” (Beaman, 1994). As such, the efficacy of psychotherapy is contingent upon successful communication between therapists and their clients, which requires that therapists understand their clients’ language and dialect. It is well established that many African Americans speak with a unique dialect, interchangeably referred to as Black or African American English (Washington, 1998). Although African American English is a “systematic, rule-governed linguistic system” (Washington, 1998), it may be

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perceived as a sign of cognitive deficits or inferior intelligence by those unfamiliar with the dialect (Beaman, 1994). Therapists' inability or unwillingness to recognize African American English as a distinct language, one that implies cultural differences rather than cognitive deficits, may create significant barriers to effective mental health care and positive treatment outcomes. Within therapeutic relationships, this erroneous assumption on the part of therapists may be detrimental to therapeutic processes and may lead to misdiagnosis and inappropriate treatment (Beaman, 1994).

### **Systemic Barriers**

Systemic barriers to effective mental health treatment for African American may be inherent to mental health care delivery systems. Two systemic barriers may be included in this category. The first, clinical bias, occurs when clinicians' perceptions of African American clients are influenced by prejudices and/or stereotypes, or when African American clients are judged against the cultural norms of Caucasians (USDHHS, 2001). Clinical bias may result in inappropriate or differential treatment and diagnosis of African American clients (McCarthy, 2001). For example, accurate diagnosis most frequently occurs when diagnosticians are blinded to the racial identity of patients (Neighbors, 1997). This finding suggests that clinical judgment is influenced by the race of the client. Additionally, despite known differences in symptom expression between African Americans and Caucasians, it is reported that diagnosticians frequently lack the cultural competence required to recognize such differences (Neighbors, 1997).

The second systemic barrier is the use of culturally inappropriate measurement instruments in mental health settings, which affects the accuracy of assessment and diagnosis processes and the efficacy of treatment. Each racial and ethnic group has its own set of cultural characteristics consisting of values, norms, attitudes, and expectancies (Ferketich, Phillips, & Varran, 1993; Marin & Perez-Stable, 1995). Given these differences, it may be unrealistic to assume that concepts can be measured in the same way for all groups of people. Among African Americans, symptoms of psychological distress may be expressed differently than among Caucasians (Neighbors, 1997). For this reason, many assessment measures may be invalid when administered to African American clients. Furthermore, some argue that the use of culturally inappropriate diagnostic instruments has resulted in the overdiagnosis of psychotic disorders and the underdiagnosis of affective disorders (Dixon et al., 2001; Neighbors, 1997).

### **Economic Barriers**

Barriers to mental health service utilization often result from socioeconomic status. For example, individuals with limited financial means may be unable to purchase medical insurance and/or mental health care coverage. Lack of insurance coverage

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generally impedes access to health care (Swanson & Ward, 1995). More specifically, a study conducted by Wang et al. (2001) found that among those with a perceived need for mental health care, having medical insurance coverage strongly predicted whether mental health services were received. The study additionally revealed a strong relationship between lack of mental health care coverage and receipt of non-guideline-concordant care; this relationship was found independent of whether mental health services were sought from a general practitioner or a specialty mental health care provider.

Uninsured individuals tend to rely on public health care services for mental health treatment, where they may experience difficulties in obtaining specialty mental health care (McAlpine & Mechanic, 2000; Snowden, 2001). Approximately 25% of all African Americans are without health insurance coverage of any kind, compared to 11% of Caucasians (McCarthy, 2001). However, even among uninsured individuals, racial disparities in mental health service utilization persist. For example, compared to uninsured Caucasians receiving public mental health services, African Americans are still less likely to receive specialty mental health care (Maynard et al., 1997).

In addition to medical and mental health care coverage, the geographic region in which an individual resides may serve as an economic barrier to mental health service utilization (USDHHS, 2001; McCarthy, 2001). Socioeconomic status is correlated with location of residence. Persons of low socioeconomic status are often forced to live in poor, inner-city communities in which few mental health care providers are located (McCarthy, 2001). Mental health providers are equally absent in poor rural communities (McCarthy, 2001). Thus, members of poor innercity and rural communities in need of mental health services are faced with the additional burden of costs associated with lengthy travel to and from mental health care locations, such as transportation expenses and extended time off from work.

Economic barriers to mental health service utilization are not unique to African Americans. However, as previously noted, one in four African Americans is without health insurance coverage of any kind (McCarthy, 2001). Furthermore, 22% of all African Americans live below the national poverty line (USDHHS, 2001). Thus, for many African Americans lack of medical insurance and mental health care coverage, as well as location of residence, present considerable economic barriers to mental health service utilization.

### **Individual Barriers**

Individual barriers refer to individual perceptions of mental health and mental illness (Swanson & Ward, 1995). These perceptions may determine the manner in which individuals interpret symptoms of mental illness. For example, a person who thinks of mental health and mental illness in dichotomous terms (“normal” vs. “crazy”)

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may not recognize their symptoms as being mental health related (Hines-Martin et al., 2003). Furthermore, when individuals in need of mental health services acknowledge their mental health problems, they may not know how to go about accessing services (Hines-Martin et al., 2003). A study conducted by Hines-Martin et al. (2003), designed to investigate barriers to first-time use of mental health services among African Americans, revealed that many participants perceived mental health and mental illness to be dichotomous states. The study further revealed that most participants experienced difficulties in obtaining initial mental health treatment because they were unfamiliar with the process of accessing mental health services (Hines-Martin et al., 2003).

Additional individual barriers to mental health service utilization include the need to maintain a “strong” personal and public self-image and the need to maintain a sense of “control” over life (Hines-Martin et al., 2003). In the study conducted by Hines-Martin et al. (2003), many participants associated mental health problems with poor self-efficacy. Other participants reported that despite experiencing psychological distress, they viewed their problems as far less severe than those of others in their immediate surroundings. Subsequently, participants did not feel “entitled” to disclose problems to others or to seek assistance.

### **Summary and Conclusion**

African Americans in need of mental health services face many barriers in receiving effective mental health treatment. These barriers may be placed into the conceptual framework developed by Swanson and Ward (1995), which includes sociocultural barriers, systemic barriers, economic barriers, and individual barriers. Racial disparities in mental health status and rates of mental health services utilization have been well documented (Baker & Bell, 1999; Beaman, 1994; Cooper et al., 2003; Dixon et al., 2001; USDHHS, 2001; McAlpine & Mechanic, 2000; Neighbors, 1997; McCarthy, 2001; Mills, 2000; Singleton-Bowie, 1995; Snowden, 2001; Wang et al., 2001; Williams, 1995). However, little is known regarding underlying factors that may contribute to many of these disparities. Additional research is needed to better understand the impact of barriers to mental health services among African Americans on racial disparities in prevalence and incidence rates of mental illness and rates of mental health services utilization. For example, it is unclear whether higher rates of mental health treatment attrition are related to lack of health insurance coverage, dissatisfaction with treatment programs due to clinical bias and/or culturally inappropriate care, or other factors. Future research is needed regarding the determinants of treatment attrition among African Americans clients.

Higher rates of emergency mental health services utilization among African Americans have been found to persist regardless of whether public or private mental health care services are used (Maynard et al., 1997). Therefore, racial disparities in

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types of mental health services sought and received do not appear to be related to insurance status. Further research could explore potential causes of specialty mental health treatment underutilization among African Americans. Additional research is also needed to establish the existence and prevalence of clinical bias within the mental health care delivery system and its impact on mental health treatment outcomes among African Americans.

Finally, accurate statistical summaries of prevalence and incidence rates of mental illness are contingent upon accurate clinical assessment and diagnoses. For this reason, clinical studies are needed to examine the extent to which standardized measures commonly used for assessment and diagnostic purposes are culturally appropriate for use with African American clients. This is an important point because the use of culturally inappropriate measures by clinicians may lead to inaccurate diagnoses or treatment recommendations for African American adults.

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