
LABELING VS. EARLY IDENTIFICATION: THE DILEMMA OF MENTAL HEALTH SERVICE UNDER-UTILIZATION AMONG LOW-INCOME AFRICAN AMERICAN CHILDREN

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The past decade has brought increased attention to the diagnosis and assessment of mental health problems for children. Researchers have made great strides in understanding children's brain development (NIMH, 2001; Shore, 1997), poverty's deleterious influences on child development (e.g., Conger et al., 1992; Duncan, Brooks-Gunn & Klebanov, 1994; McLeod & Shanahan, 1993; Offord et al., 1992), and treatments for mental illness (e.g., Burns, Hoagwood & Mrazek, 1999; USDHHS, 2001). The use of medications and treatment modalities to intervene and improve children's lives has increased dramatically and there seems no immediate end to the search for a "cure" for negative behaviors and symptoms that parents and society as a whole would like to extinguish. This increase in knowledge of mental health problems also has stimulated greater interest in early preventive services in order to decrease the onset of mental disorders and serious emotional disturbances among children. The rationale and impetus for this area of interest appears sound – if we can identify children who exhibit symptoms of behavioral and emotional problems early on, we have a greater chance of reducing these symptoms.

However, despite the strides that have been made in the area of children's mental health, many issues remain unresolved, particularly those that concern African American children and families. While treatments, interventions, and service have been developed and tested empirically for some conditions, many are not completely effective or have not been studied for their effectiveness among African Americans (NIMH, 2000). Several problems with existing services have been noted including availability, accessibility, acceptability, and accountability. Mental health services are not easily accessible, particularly for those individuals who do not possess adequate health insurance or who have a low income (USDHHS, 2001; Richardson, 2001). Even when health insurance is available, there may be a lack of African American mental health providers in the community whom parents would feel comfortable taking their children to see. Parents may not be aware of the resources available in their communities or find negotiating a complex service delivery system difficult. Also parents and professionals may be concerned that current assessments

used to identify children with mental health problems are culturally biased or do not recognize the potential influence of cultural factors in their assessment. Or perhaps, parents are not willing to have their children labeled with having a mental health problem that will follow their child throughout their educational years – relegating their children to special education classes, being stigmatized by their teachers, family members, and friends as a “bad seed,” or starting their child on the road to fulfilling society’s stereotypes that their child will end up with serious problems, in prison, or not live to reach adulthood. Finally, many ethnic minority parents do not trust that mental health professionals and social service agencies serve their families’ best interests.

In this paper, we explore some of these concerns through a review of the literature on mental health service utilization for African American children, and in particular, address the benefits and challenges of instituting programs for early identification of mental health problems in children. We will discuss the prevalence of mental health problems in African American children, service utilization, barriers to service use, and discuss the dilemma of early identification and treatment for mental health problems.

Mental Health and African American Children

Few epidemiological studies of children’s mental health have been conducted. Of those that exist, comparisons between African American and white children have produced mixed results. For example, results of the Great Smoky Mountains Study of Youth have found that African American children have higher rates of functional enuresis (Costello et al., 1996), but similar rates for all other disorders examined, and of co-morbidity. Other studies suggest higher rates among African American children for obsessive-compulsive disorder (Valleni-Basile et al., 1996) and conduct disorder (Costello et al., 1988). However, Seigel and colleagues (1998) reported no differences in mental health problems between African American and white children.

Among adult samples, patterns of mixed results are also observed. Two major epidemiological studies of mental disorders, the Epidemiologic Catchment Area Study (ECA) and the National Co-morbidity Survey (NCS), provide evidence that rates of mental illness among African American adults are similar to white adults, except that African Americans may be less likely to be depressed than whites and more likely to suffer from phobia than whites (Zhang & Snowden, 1999). The ECA found higher levels of any lifetime or current disorder among African Americans in comparison to whites; however, these differences were eliminated once demographic characteristics such as income were accounted for (Robins & Regier, 1991; Regier et al., 1993). In general, ethnic differences in rates of disorders have been confounded by income factors (Vega & Rumbaut, 1991). More recently, Kessler and colleagues (1994)

found that African Americans had lower lifetime prevalence of mental disorders than whites and were less likely to suffer from a co-morbid substance abuse disorder.

The lack of differences in rates of mental disorders has long been a paradox for researchers who have tied high levels of stress to mental health problems (Dohrenwend and Dohrenwend, 1969; Karno et al., 1987; Kessler et al., 1995; Robins & Regier, 1991). Because of the disproportionate rates of poverty, the legacy of slavery, and contemporary experiences of overt and covert discrimination, researchers have hypothesized that African Americans would have elevated rates of mental health problems, rather than lower or similar rates.

Although the existing data on African Americans reveal comparable levels of mental disorders, other indicators of mental health should be discussed. For example, it should be noted that African Americans may have higher rates of somatization, an idiom of distress where troubled individuals report symptoms of physical illness that cannot be explained in medical terms (USDHHS, 2001). Robins and Regier (1991) found higher levels of somatic symptoms for African Americans (15%) than whites (9%) using ECA data. There is also recognition of culture-bound syndromes, such as isolated sleep paralysis, characterized by an inability to move while either waking up or falling asleep (Bell, Dixie-Bell & Thompson, 1986; American Psychiatric Association, 1994), and “falling out,” characterized by a sudden collapse sometimes preceded by dizziness (USDHHS, 2001; American Psychiatric Association, 1994).

Further indicators of need can be found in data related to social system services. African Americans are overrepresented in some high-need populations, including the homeless population (Jencks, 1994), the juvenile justice system (Bureau of Justice Statistics, 1999), and the foster care and child welfare systems (USDHHS, 1999). For example, according to a 1999 report, 56% of the 110,000 children waiting to be adopted and 44% of the children in the public foster care system are African American. These high-need populations are often overrepresented by individuals who meet criteria for mental disorders and are at high risk for mental health problems. These groups also are often excluded from epidemiological survey research.

Mental Health Service Utilization

While the overrepresentation of African American children in high-need populations may signal to some that mental health problems are underestimated, the number of youth in these high-need groups that might have benefited from preventive or appropriate intervention services, and thus avoided entry into these groups, is discussed less often. Therefore, we should consider how representation in high-need populations might differ if disparities did not exist in rates of mental health service use. Research has demonstrated consistently that African American children are less likely

to receive treatment for mental health problems. Cunningham and Freiman (1996) found that African American children were less likely than white children to have made a mental health outpatient visit. Other studies have found that African American and other minority children were less likely to receive mental health care provided by specialists, physicians, and nurses, or in psychiatric inpatient care and schools (Costello et al., 1997; Cuffe, Waller, Cuccaro, Pumariega & Garrison, 1995; Zahner & Daskalakis, 1997). However, African Americans are overrepresented in residential treatment centers, public mental health services, and the child welfare system, which are funded typically by public sources and serve children once problems have become severe (Bui & Takeuchi, 1992; Halfon et al., 1992; McCabe et al., 1999).

Studies of African American adults also reveal lower rates of mental health care utilization; however, mental health related complaints in the general medical sector have been found to be greater for African Americans compared to whites (Snowden, 2001). The greater use of the general medical sector may be due to the manifestation of somatic symptoms as well as delayed treatment due to a lack of available and appropriate primary and secondary preventive services. Additionally, African Americans are overrepresented in their use of psychiatric emergency care compared to whites, Asians, and Latinos (Hu, Snowden, Jerrell & Nyugen, 1991; Snowden, 2000). The over-utilization of emergency care may signify a possible link between a pattern of crisis-oriented treatment and significant barriers to service utilization that lead to delayed care.

On the other hand, African American families have been found to exhibit a number of coping strategies that may buffer the deleterious effect of poverty, discrimination, and stress. Neighbors and Jackson (1996) present several studies that demonstrate strategies of coping with stress, including facing up to the problem and doing something about it (Broman, 1996), minimizing perceptions of threat (Johnson & Crowley, 1996), and religious orientation and prayer (Broman, 1996; Taylor & Chatters, 1991). Mutual commitment and a helping tradition are also recognized as sources of coping in African American communities, especially among family, friends, neighborhood, and religious and voluntary associations (Neighbors, 1997; Snowden, 2001). Identity and pride also are suggested as buffering factors for the effects of discrimination in physical health outcomes among African Americans (Williams, Spencer & Jackson, 1998). However, Snowden (2001) notes that while effective coping strategies are recognized for many, these support sources are not necessarily used when problems are framed in psychological, mental health, or psychiatric terms. Studies suggest that indirect assistance in the form of general encouragement, companionship, and social and spiritual advice may be preferred (Taylor & Chatters, 1991) or waiting for problems to remit without formal intervention (Cooper-Patrick, Powe, Jenkes, Gonzales, Levine & Ford, 1997).

Barriers to Service Utilization

Accessibility and availability of mental health services are considered major barriers to service utilization. Lack of health insurance is an accessibility barrier, as nearly a quarter of African Americans are uninsured (Brown, Ojeda, Wyn & Levan, 2000). However, insurance alone does not account for the disparate utilization rates. Padgett and colleagues (1995) found that even when African Americans possessed insurance with more generous mental health coverage, higher levels of service use were not observed compared to whites. The lack of available services is also an important barrier. Mental health services are not readily available in rural areas where higher proportions of African Americans live in the South (Holzer, Goldsmith & Ciarlo, 1998). In urban areas, service providers may not accept Medicaid or serve only high-need individuals who display severe problems, thus rendering service unavailable to urban African Americans who are represented disproportionately in poor communities (USDHHS, 2001).

Attitudinal barriers to service utilization are just as important, though discussed less often. Richardson (2001) uses social cognitive theory to understand how positive outcome expectations encourage the decision to engage in mental health service use. She reports that African American parents disproportionately had negative ideas and attitudes about the mental health profession and were twice as concerned about disapproval from family members, others knowing, and embarrassed about seeking services. Parents may feel as though they are at fault or will be made to feel that they are at fault for their child's behaviors, and therefore not want others to know. Additionally, African American parents were twice as likely as white parents to expect providers to lack knowledge of treatment methods, twice as likely to find providers untrustworthy and disrespectful, and more likely to have difficulty obtaining transportation. African American parents were three times more likely to expect providers to give poor care, and not know what mental health professionals do and how interventions could help.

Stigmatization is another major barrier that is only beginning to be addressed nationally. The Surgeon General's Report on Mental Health suggests that stigma associated with mental disorders have persisted throughout history and are manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance (USDHHS, 1999). Discrimination in housing and employment against people with mental disorders has been reported, particularly for severe disorders (Penn & Martin, 1998). African Americans with mental health concerns may find themselves in "double jeopardy," where discrimination based on race is further compounded by discrimination based on mental illness. The roots of stigma can be traced to the separation of mental health from the mainstream of health, lack of understanding of mental illness, public attitudes related to fear of violence, and selective and stereotyping media

coverage (USDHHS, 1999).

Among children, stigma is manifested by labeling. According to Link and Phelan (1999), a label is a definition that identifies a particular type of person, and when deviant, a label designates a violation of a social norm. With regard to mental illness, deviation from norms dictating appropriate emotions in given situations are labeled and may carry a stigma. Mental illness is associated with a number of negative attributions, including dangerousness, unpredictability, weakness, worthlessness, distrustfulness, incompetence, or generalized attributions of being bad or dirty (Link & Phelan, 1999). These labels can lead to expectations of rejection, lower self-esteem, and hinder the development of social networks. Link and colleagues (1987; 1989) suggest that expectations of rejection can lead to strained interactions and withdrawal from social contacts in order to minimize rejection. The power of labels is also manifested in stereotypes that are reinforced by personal doubts of one's own competence and self-worth (Link & Phelan; Crocker & Major, 1989). Link and Phelan (1999) cite Steele and Aronson's work on stereotyped threat (1995), showing that African American college students perform worse on standardized tests when they were told that the test measured their intellectual ability. Having to combat stereotypes and labels based on race and mental health status may be difficult, particularly if we consider the lack of available resources in education and mental health services in impoverished communities.

While very young children with mental health problems may not necessarily be aware of the stereotypes and labels attributed to them, it is almost certain that their families are sensitive to the costs of identification. This may affect their attitudes towards help seeking. Over time, however, children, too, may come to understand these labels, which may consequently affect their ability to function.

Parents of children with mental health problems may also be wary of the negative consequences levied by school and social service personnel if their child is identified. Many parents may be aware of the disproportionate representation of African Americans in serious emotionally disturbed (SED) classrooms as well as special education classrooms, an additional label that may follow them throughout their schooling. Studies examining this phenomenon have reported higher rates of African American children in special education and SED classrooms nationally (Civil Rights Project at Harvard University, 2002; Osher, Woodruff & Sims, 2002; Serwatka, Deering & Grant, 1995). Causes for the disproportionate representation of racial minority students in special education and SED classrooms include cultural differences that may lead to predisposition to a diagnosis (e.g., motor precocity as an indicator of hyperactivity, affinity for intense and varied stimuli that may cause students to perform less well in monotonous and unstimulating classrooms), a lack of uniform identification procedures, bias in the assessment instruments used in diagnosis, poverty, and insti-

tutional racial discrimination (Boykin, 1983; Serwatka et al., 1995). These factors may contribute to low-income, African American parents' lack of confidence in schools and the social service system and negatively influence help seeking behavior. This is illustrated in a study by Keller and McDade (2000), which found that low-income parents were less likely to believe in or seek out help than families with higher incomes. The least likely sources of help were child protective services, school personnel, clergy, social services, and counseling agencies.

Recommendations for Future Research and Practice

How do we deal with this dilemma of early identification and treatment for mental health problems and the risk of labeling and stigmatizing children so early in their lives? First, we utilize interventions that employ primary prevention techniques. For example, we must provide basic services to all children and families that address self-concept, positive aspects of ethnic identity, education, and family assets and needs. Low-income ethnic minority children should not be excluded from supportive resources, and these resources should be available readily to families who are currently under-served.

One program that exists nationally is Project Head Start, a pre-school program administered by the federal government that provides academic, developmental, health, and mental health services for low-income and special needs children. Head Start is particularly adept at providing comprehensive educational programs that are developmentally appropriate; however, resources committed to mental health services are uneven from agency to agency. Similar programs with more funding and resources, such as the Early Training Project, the Carolina Abecedarian Project, and the Perry Preschool Project have demonstrated long-term positive effects in achievement tests, lower incidence of special education, and higher grade retention (Currie, 2000). Increased funding for mental health services within early education programs and a well-funded universal preschool program could lead to high-quality prevention and intervention programs for emotional and behavioral problems that are accessible to under-served families.

Second, we must continue to develop tools for assessment and diagnosis that are culturally unbiased, accurate, and easy to use. At minimum, assessment instruments should include norms from ethnically diverse samples. Further, we must understand the types of behaviors that concern low-income, African American families and how mental health problems are conceptualized in particular communities so that interventions can be developed around these concerns. Assessment instruments must be easy to use so busy school personnel and service providers can obtain feedback readily on children's behaviors and emotions. In addition, assessment tools should be validated clinically by culturally competent diagnosticians to avoid misdiag-

noses and ensure accuracy.

Third, we must consider not using the phrases *mental health and mental disorders*, to reduce stigma and labeling. Phrases like *child development, support, and well being* focus on positive aspects of functioning. These terms could be used to promote school activities and be incorporated in everyday educational curriculum. School-wide family events could be used to provide parent education for psychological issues and increase family involvement in addressing problems. Educational curricula can address children's ability to identify and express feelings as well as focus on the consequences of different behaviors. These efforts must be developmentally and culturally appropriate and with appropriate methods for home reinforcement as needed.

Programs that bring parents together and provide a safe space for them to share their experiences with parenting can be a source of social support and informal psycho-education. Further, parent support groups may provide important respite from childcare. For example, a community program in Detroit provides children with educational child care services while parents meet together with a family resources worker to share their experiences with raising their children. Advertising the program as a parent respite with high-quality children's programming rather than mental health or parenting classes appear more attractive to families looking for assistance and support.

Finally, we must continue to address institutional and societal attitudes and practices that oppress low-income, minority families. We must support anti-poverty strategies, such as Head Start, Early Head Start, expanding the Earned Income Tax Credit (EITC), economic safety net programs like TANF, universal child health care, Medicaid, and nutrition programs like Food Stamps and WIC. Within our institutions, we must support education and higher educational opportunities for low-income ethnic minority communities. We must consider expanding programs for gifted children in these communities, rather than supporting the proliferation of unwarranted special education tracking. We must staff our schools with individuals who can provide culturally competent mental health services and provide on-going staff training and development in this area. We must be critically conscious of our biases and assumptions about ethnicity and income. And, finally, we must support efforts toward the elimination of racial disparities in services and supportive resources to ensure equal access and accurate identification and intervention for African American children.

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