SECTION #4

# African American Culture and Community

- Cultural Issues in the Behavioral Health Treatment of African American Children provided by Voices Institute

- *Abstract:* Predictors and Moderators of Agreement Between Clinical and Research Diagnoses for Children and Adolescents
  Authors: A. Jensen-Doss, E.A. Youngstrom, J.K. Youngstrom, N.C. Feeny, and R.L. Findling

- *Abstract:* Attention-Deficit/Hyperactivity Disorder in African American Youth
  Authors: R.K. Bailey, S, Ali, S. Jabeen, H. Akpudo, J.U. Avenido, T. Bailey, J. Lyons, and A.A. Whitehead

- *Abstract:* Overcoming Challenges in the Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder in African Americans
  Authors: R. Bailey and D.L. Owens

- *Abstract:* Diagnostic Patterns in Latino, African American, and European American Psychiatric Patients
  Authors: S. Minsky, W. Vega, T. Miskimen, M. Gara, and J. Escobar

- *Abstract:* Understanding Adolescent Depression in Ethnocultural Context
  Author: H. Choi

- Multiethnic Advocates for Cultural Competence: Cultural Influences and Health Care Series Presentation

## Cultural Issues in the Behavioral Health Treatment of African American Children

**Cultural Issues in the Treatment of Young African American Children Diagnosed with Disruptive Behavioral Disorders**

https://academic.oup.com/jpepsy/article/27/4/339/932319

**Race Matters: Disparities in African American Children with Attention Deficit Hyperactivity Disorder**

https://pdfs.semanticscholar.org/399b/cdab6173e7e7c42365800e622b47366a9efc.pdf

**Racial Disparities in Psychotic Disorder Diagnosis Disorder: A Review of Empirical Evidence Literature**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/

**The Process and Implications of Diagnosing Oppositional Defiant Disorder in African American Males**

http://tpcjournal.nbcc.org/wp-content/uploads/2016/07/Pages147-160-Grimmett.pdf

**Conduct Disorder and Oppositional Defiant Disorder**

https://link.springer.com/chapter/10.1007%2F978-3-319-25501-9_9

**State of Black Boys and Men: Policy and Mental Health Recommendations - American Psychological Association Division 51 Racial and Ethnic Minority Special Interest Group**

http://division51.net/wp-content/uploads/2017/07/StateOfBlackBoysMen.Div51REMSIGReport-2.pdf

**Effective Strategies for Mentoring Black Boys**

https://www.air.org/sites/default/files/downloads/report/Effective%20Strategies%20for%20Mentoring%20African%20American%20Boys.pdf

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Format: Abstract Sort by: Publication Date Per page: 20

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1.
J Consult Clin Psychol. 2014 Dec;82(6):1151-62. doi: 10.1037/a0036657. Epub 2014 Apr 28.

# Predictors and moderators of agreement between clinical and research diagnoses for children and adolescents.

Jensen-Doss A[1], Youngstrom EA[2], Youngstrom JK[2], Feeny NC[3], Findling RL[4].

Author information

## Abstract

**OBJECTIVE:** Diagnoses play an important role in treatment planning and monitoring, but extensive research has shown low agreement between clinician-generated diagnoses and those from structured diagnostic interviews. However, most prior studies of agreement have not used research diagnoses based on gold standard methods, and researchers need to identify characteristics of diagnostically challenging clients. This study examined agreement between youth diagnoses generated through the research-based LEAD (Longitudinal, Expert, and All Data) standard to clinician diagnoses.

**METHOD:** Participants were 391 families seeking outpatient community mental health services for youths ages 6-18 (39.1% female, 88.2% African American). Youths and parents completed research interviews and clinic diagnoses were extracted from clinic records. LEAD diagnoses synthesized results of the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime (KSADS-PL) and the youth's developmental, family, and psychiatric history.

**RESULTS:** Agreement between the LEAD and chart diagnoses was low, not exceeding "poor" agreement for most diagnostic categories (κs = .10-.46, median = .37). Disagreement was largely driven by missed diagnoses, although clinicians also did assign extra diagnoses for some clients. Fewer diagnostic errors occurred when the youth's clinical picture was more clear (e.g., high or low symptom severity, lower comorbidity), when the youth was older, when the family was higher functioning, and when the parent had more depression. However, youth and family characteristics explained very little of the variability in diagnostic errors.

**CONCLUSIONS:** RESULTS support the need to investigate strategies to improve clinician diagnostic accuracy.

PMID: 24773574 PMCID: PMC4278746 DOI: 10.1037/a0036657

[Indexed for MEDLINE] Free PMC Article

Publication type, MeSH terms, Grant support

Curr Psychiatry Rep. 2010 Oct;12(5):396-402. doi: 10.1007/s11920-010-0144-4.

2.

## Attention-deficit/hyperactivity disorder in African American youth.

Bailey RK[1], Ali S, Jabeen S, Akpudo H, Avenido JU, Bailey T, Lyons J, Whitehead AA.

Author information

Abstract

This article examines attention-deficit/hyperactivity disorder (ADHD) in African American youth. Tackling the myths and misinformation surrounding ADHD in the African American community can be one of the most difficult issues in mental illness circles. There is a lot of conflicting information about how African Americans are diagnosed, examined, and treated. This article clarifies some of the misconceptions and offers some comprehensibility to the issue of ADHD in African American youth. The incidence of ADHD is probably similar in African Americans and Caucasians. However, fewer African Americans are diagnosed with and treated for ADHD. That reality flies in the face of some perceptions in many African American communities. Reasons for this disparity have not been fully clarified and are most likely complex and numerous. Some barriers to treatment are driven by the beliefs of patients and their families, while others are the result of limitations in the health care system. Patient-driven obstacles to care include inadequate knowledge of symptoms, treatment, and consequences of untreated ADHD and fear of overdiagnosis and misdiagnosis. System-driven limitations include a lack of culturally competent health care providers, stereotyping or biases, and failure of clinicians to evaluate the child in multiple settings before diagnosis.

PMID: 20697849 DOI: 10.1007/s11920-010-0144-4

[Indexed for MEDLINE]

SpringerLink FULL-TEXT ARTICLE

## Publication type, MeSH terms

J Natl Med Assoc. 2005 Oct;97(10 Suppl):5S-10S.

3.

# Overcoming challenges in the diagnosis and treatment of attention-deficit/hyperactivity disorder in African Americans.

Bailey RK[1], Owens DL.

Author information


## Abstract

The incidence of ADHD appears to be similar in African Americans and white populations. However, fewer African-American than white children are diagnosed and treated for ADHD. Reasons for this disparity have not been fully elucidated; causes are most likely complex. Whereas certain barriers to treatment are driven by patients and their families, others are due to limitations in the healthcare system. Patient-driven obstacles to care include inadequate knowledge regarding the symptoms, treatment and consequences of untreated ADHD and fear of overdiagnosis and misdiagnosis. A survey conducted to explore cultural differences between African-American and white respondents found that African Americans were more likely than whites to be unfamiliar with ADHD. In addition, African Americans felt that they were diagnosed with ADHD more often than whites and that teachers blamed ADHD for learning or behavior problems more often in African Americans. Health system barriers include a lack of culturally competent healthcare providers, stereotyping/biases and failure of the clinician to evaluate the child in multiple settings before diagnosis. Strategies to overcome these challenges include increased dissemination of ADHD information through community events; improved training of clinicians in cultural competence; and open communication among parents, clinicians and school personnel.


PMID: 16350600 PMCID: PMC2640622

[Indexed for MEDLINE] **Free PMC Article**

## MeSH terms

Arch Gen Psychiatry. 2003 Jun;60(6):637-44.

# 4. Diagnostic patterns in Latino, African American, and European American psychiatric patients.

Minsky S[1], Vega W, Miskimen T, Gara M, Escobar J.

Author information

## Abstract

**BACKGROUND:** The purpose of this study was to examine whether Latino patients presenting for behavioral health treatment showed major systematic differences in presenting symptoms, clinical severity, and psychiatric diagnosis compared with European American and African American patients. Documenting such differences should have important implications for evidence-based clinical practice.

**METHODS:** Data were drawn from a large behavioral health service delivery system in New Jersey, and included administrative data, clinical diagnosis, a clinician-rated global level of functioning, and a self-reported symptoms and functioning scale. The study involved a clinical sample of all new admissions into the system between January 1, 2000, and August 31, 2001. To examine the main effects of ethnicity, in the context of other independent variables, logistic regression was performed for each of 3 dependent binary variables: presence or absence of major depression, a schizophrenia spectrum disorder, and bipolar disorder.

**RESULTS:** Consistent with previous studies, we found that African Americans were diagnosed as having a disorder in the schizophrenic disorders spectrum more frequently than did Latinos and European Americans (odds ratio, 1.80; 95% confidence interval, 1.62-2.00). Latinos were disproportionately diagnosed as having major depression, despite the fact that significantly higher levels of psychotic symptoms were self-reported by Latinos (odds ratio, 1.74; 95% confidence interval, 1.56-1.93).

**CONCLUSIONS:** Latinos in this study were more likely to be clinically diagnosed as having major depression than were other ethnic groups. Further research is needed to determine the reasons for these systematic differences. Possible explanations include (1) self-selection, (2) culturally determined expression of symptoms, (3) difficulties in the accurate application of DSM-IV diagnostic criteria to Latinos, (4) bias related to lack of clinicians' cultural competence, and (5) imprecision inherent in the use of unstructured interviews, possibly combined with clinician bias. Additional research is required to determine the generalizability, accuracy, and applicability of these findings and their possible mechanisms.

PMID: 12796227 DOI: 10.1001/archpsyc.60.6.637

[Indexed for MEDLINE]

UF HSC Libraries Borland In Print

Publication types, MeSH terms, Grant support

ANS Adv Nurs Sci. 2002 Dec;25(2):71-85.

5.

## Understanding adolescent depression in ethnocultural context.

Choi H[1].

Author information

### Abstract

Asian-American adolescents often are regarded as a "model minority" and as being less likely to experience depression than adolescents of other ethnic groups. African-American adolescents are more often diagnosed with schizophrenia than depression. Do these epidemiologic phenomena reflect the real facts, or are these just artifacts shaped by cultural bias or insensitivity prevailing in this society? This article explores the diagnostic bias resulting in misdiagnosis of adolescent depression and reviews the role of culture/ethnicity in mental health and the ethnocultural variations in depression among African-American, Hispanic-American, and Asian-American adolescents. By discussing the issues, this article guides nurses to enhance cultural competence in nursing care.

PMID: 12484642

[Indexed for MEDLINE]

UF HSC Libraries Borland In Print

Publication type, MeSH terms

Am J Orthopsychiatry. 1979 Jan;49(1):53-61. doi: 10.1111/j.1939-0025.1979.tb02585.x.

6.

## Some evidence of race bias in the diagnosis and treatment of the juvenile offender.

Lewis DO[1], Balla DA[1], Shanok SS[1].

Author information

### Abstract

Clinical and epidemiological evidence is presented indicating that many more black delinquent

children and their families fail to receive needed psychiatric and medical services than do white delinquents. Explanations and implications of the reluctance or inability of white mental health professionals to diagnose serious psychopathology in the black delinquent population are explored.

PMID: 758804 DOI: 10.1111/j.1939-0025.1979.tb02585.x

[Indexed for MEDLINE]

## MeSH terms

# Cultural Influences and Health Care Series:
## African American Culture and Community

March 9, 2017

Simone Crawley
Executive Director

# SESSION OBJECTIVES

- Become familiar with health and behavioral health challenges of the African-American community.
- Develop best practices to effectively engage African-American consumers.
- Develop practice-enabling strategies and skills to serve African-American consumers.

# Important Disclaimers

## Culture

*Shared beliefs, values, customs, languages, abilities and traditions that influence behavior. Culture is a paradox, while many aspects remain the same, it is also dynamic, constantly changing.*

- Viewing culture generically can allow for stereotyping and failure to identify the needs of the individual receiving care.
- Never assume all those who identify with a particular culture behave the same.
- There are underlying similarities in experiences and nuances that members of cultures share.
- We are all members of multiple cultures
  - Socioeconomic status, gender, geography, age, etc.

# Setting the Scene

## Historical Trauma

*Cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.*

## Trauma specific to the African American community

- Trans-Atlantic Slave Trade
- Institutional racism- *state sponsored discriminatory practices in housing, education, socioeconomic status, etc.*
  - Jim Crow laws
- Daily microaggressions- *events involving discrimination, racism, and daily hassles that are targeted at individuals from diverse racial and ethnic groups.*
  - *"You speak so well."*
  - *"What are you?"*
  - *"Can I touch your hair?"*

# Making the Connection

# Setting the Scene

## Social Determinants of Health

*Conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.*

## Conditions disproportionately impacting African Americans

- Socio-economic status (SES): education, employment, housing, transportation
- Physical environments/neighborhoods/zip codes
- Access to/availability/affordability/utilization/quality of services
- Individual/institutional discrimination/prejudice: by race, ethnicity, sexual orientation, gender identity or expression, or socio-economic status
- Social or environmental stressors/support
- Belonging to a racial/ethnic, or traditionally unrepresented, under-represented, or invisible group

# 2017 Health Value Dashboard™

March 2017

# Healthcare system

## Equity profile

| Metric | Disparity Ratio | Group with worst outcomes | Group with best outcomes | Estimated impact if disparity eliminated |
|---|---|---|---|---|
| **Preventive services** | | | | |
| **Prenatal care.** Percent of women who completed a pregnancy in the last 12 months and did not receive prenatal care in the first trimester (2014) | | | | |
| By education level | 1.56 | Not finished high school 49.7% | High school graduate 31.9% | — |
| By race/ethnicity | 1.77 | Black 40.7% | White 23% | — |
| **Hospital utilization** | | | | |
| **Diabetes with long-term complications.** Admissions for Medicare beneficiaries with a principal diagnosis of diabetes with long-term complications per 100,000 beneficiaries, ages 18 years and older (2014) | | | | |
| By race/ethnicity | 4.02 | Black 716 | Asian 178 | — |
| **Heart failure readmissions for Medicare beneficiaries.** Rate of Medicare beneficiaries discharged from the hospital with a principal diagnosis of heart failure who were readmitted for any cause within 30 days after the index admission date, per 100 index cases (2014) | | | | |
| By race/ethnicity | 1.02 | Hispanic 20.1 | Asian 19.7 | — |
| **Timeliness, effectiveness and quality of care** | | | | |
| **Mortality amenable to healthcare.** Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care (2012-2013) | | | | |
| By race/ethnicity | 2.78 | Black 164 | Hispanic 59 | 1,414 deaths |

# Public health and prevention

## Equity profile

| Metric | Disparity Ratio | Group with worst outcomes | Group with best outcomes | Estimated impact if disparity eliminated |
|---|---|---|---|---|
| **Health promotion and prevention** | | | | |
| **Low birth weight.** Percent of live births where the infant weighed less than 2,500 grams (2014) | | | | |
| By education level | 1.38 | Not finished high school 11.1% | High school graduate 8% | — |
| By race/ethnicity | 1.83 | Black 13.4% | White 7.3% | — |
| **Teen birth rate.** Rate per 1,000 births to females 15-19 years of age (2015) | | | | |
| By race/ethnicity | 2.13 | Black 40.8 | White 19.2 | — |

# Social and economic environment

## Equity profile

| Metric | Disparity Ratio | Group with worst outcomes | Group with best outcomes | Estimated impact if disparity eliminated |
|---|---|---|---|---|
| **Education** | | | | |
| **Fourth-grade reading.** Percent of 4th graders who were not proficient in reading by a national assessment (NAEP)(2015) | | | | |
| By income | 1.6 | Eligible for free/reduced lunch 77% | Not eligible for free/reduced lunch 48% | — |
| By race/ethnicity | 2.0 | Black 84% | Asian 42% | — |
| By disability status | 1.6 | With a disability 91% | Without a disability 57% | — |
| **High school graduation.** Percent of incoming 9th graders who did not graduate in 4 years from a public high school with a regular degree (2015) | | | | |
| By race/ethnicity | 2.88 | Black 40.3% | Asian 14% | — |
| **Employment and poverty** | | | | |
| **Child poverty.** Percent of persons under age 18 who live in households at or below the poverty threshold (2015) | | | | |
| By disability status | 1.79 | With a disability 36.5% | Without a disability 20.5% | 20,931 Ohio children |
| By race/ethnicity | 4.21 | Black 45.9% | Asian 10.9% | 134,142 Ohio children |
| **Adult poverty.** Percent of persons age 18+ who live in households at or below the poverty threshold (2015) | | | | |
| By disability status | 1.98 | With a disability 22% | Without a disability 11.1% | 154,148 Ohio adults |
| By education level | 2.05 | Not finished high school 27.3% | High school graduate 13.3% | — |
| By race/ethnicity | 2.55 | Black 25.7% | White 10.1% | 161,022 Ohio adults |
| **Unemployment.** Annual average unemployment rate, ages 16 and older (2015) | | | | |
| By disability status | 2.45 | With a disability 13% | Without a disability 5.3% | — |
| By education level | 2.6 | Not finished high school 17.4% | High school graduate 6.7% | — |
| By race/ethnicity | 2.81 | Black 13% | White 4.6% | — |
| By income | 8.79 | Less than$20K 32.6% | More than $80K 3.7% | — |
| **Trauma, toxic stress and violence** | | | | |
| **Adverse childhood experiences.** Percent of children who have experienced two or more adverse experiences (2011/2012) | | | | |
| By race/ethnicity | 1.57 | Black 35.4% | White 22.6% | 49,043 Ohio children |
| By disability status (special needs) | 1.59 | With a special need 36.1% | Without a special need 22.7% | — |
| By education level | 1.66 | Not finished high school 54.9% | High school graduate 33% | — |

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# Improving Your Approach

## Cultural Competence

*"Cultural Competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services." (Ohio Statewide Endorsed Definition, 2010)*

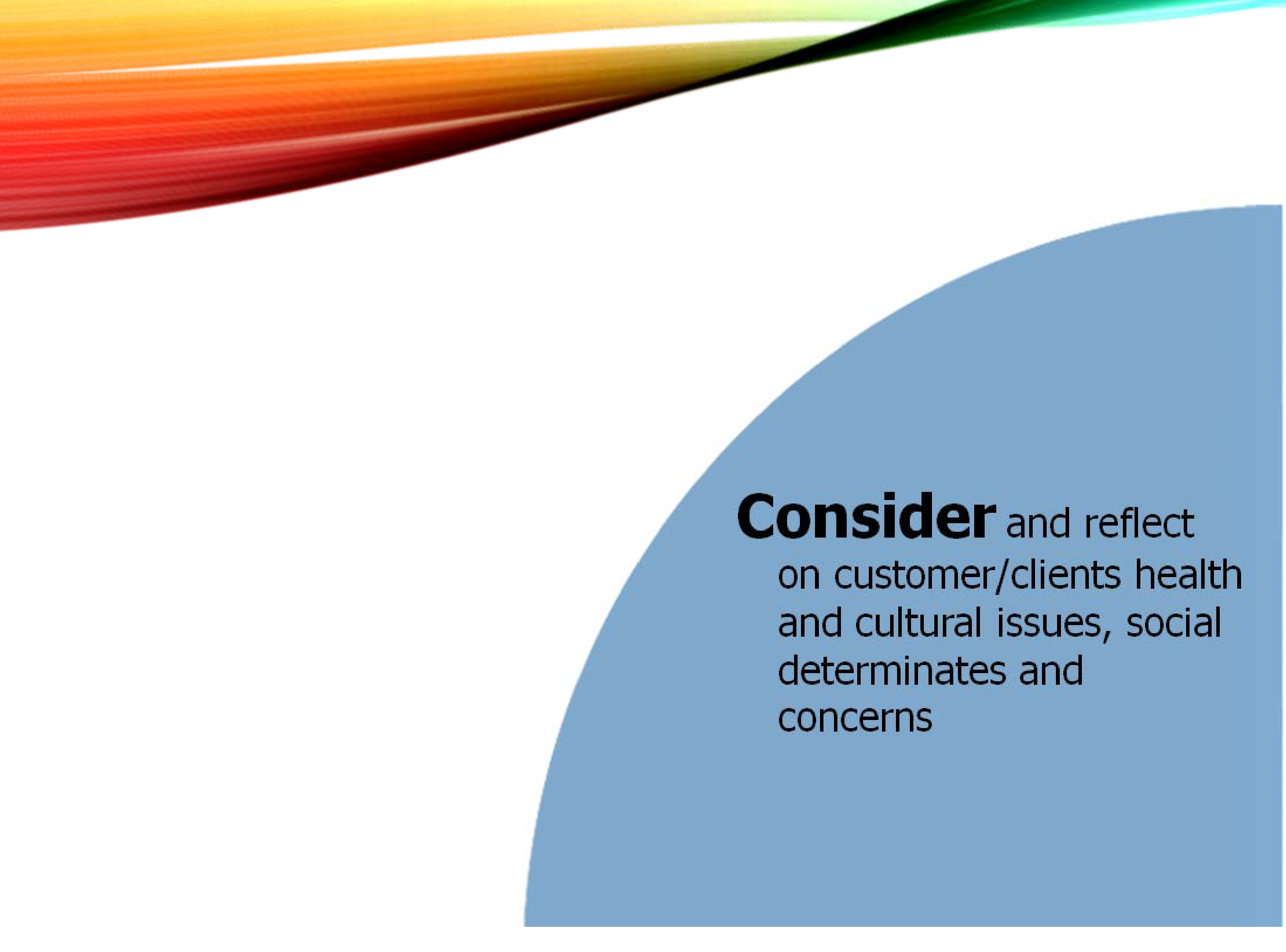
## Cultural Safety

*Spiritually, socially and emotionally safe environment where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.*

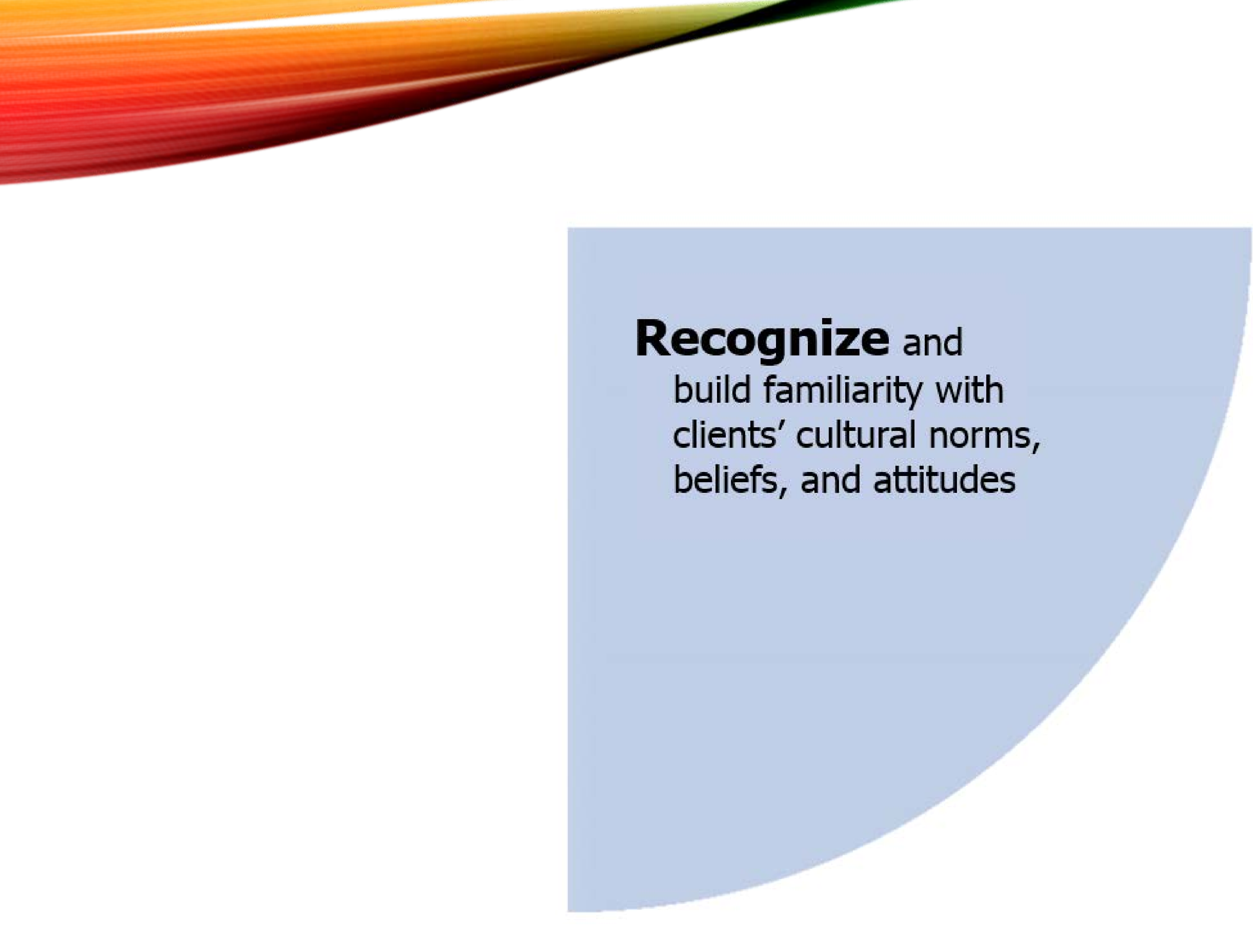
## Examining Your Implicit Bias

*The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Understanding your own culture is also critical to reaching greater understanding.*

# Tools for Navigating Interactions

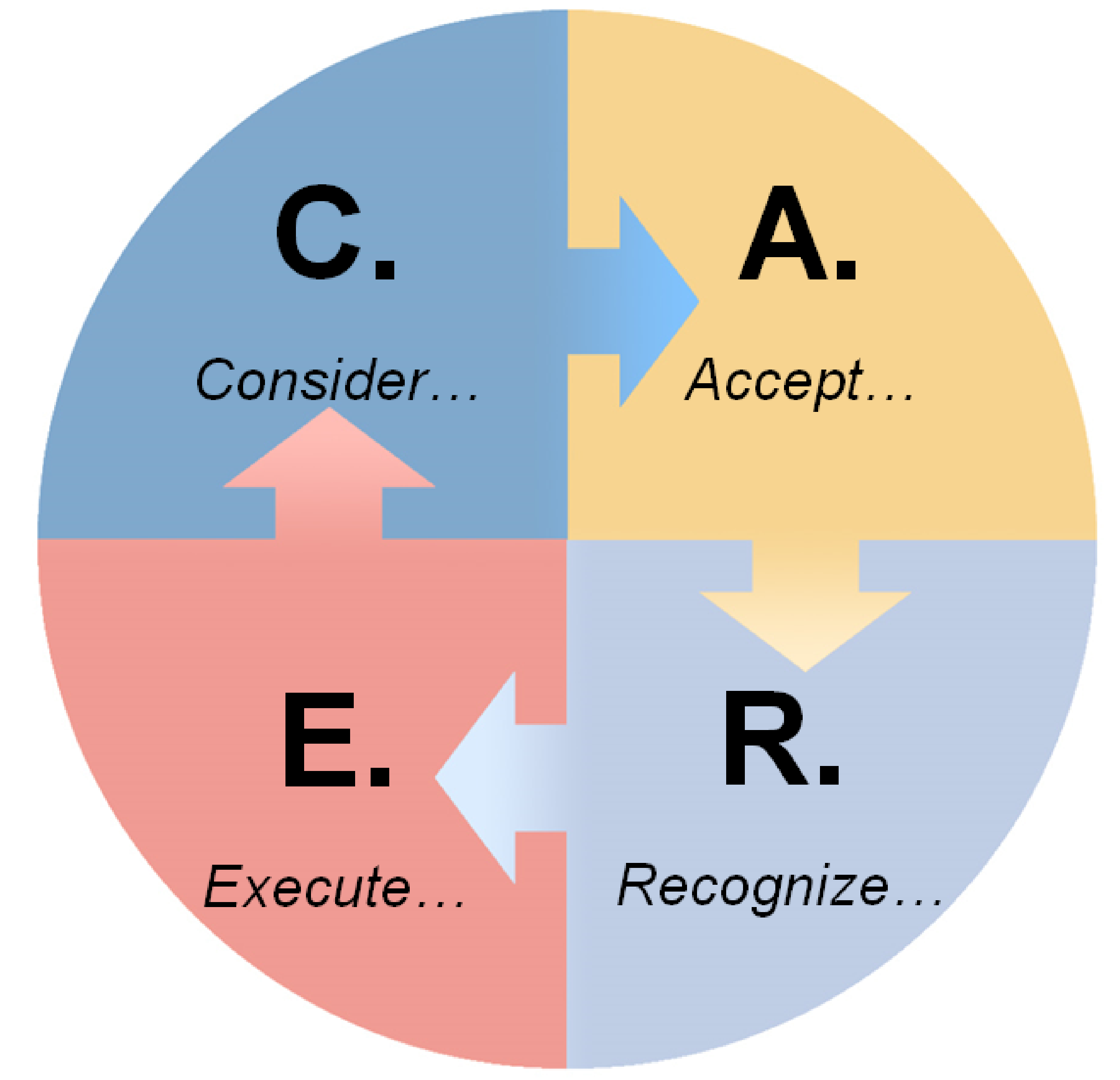

Consider and reflect on customer/clients health and cultural issues, social determinates and concerns

**Accept** and understand that customers'/clients' cultural differences, practices, and perspectives will impact their health care experience.




Multiethnic Advocates for Cultural Competence

**Execute** a proactive, culturally sensitive health care intervention that supports customers'/clients' recovery and respects their cultural values without compromising the quality of their health care and medical treatment


C.
Consider…
A.
Accept…
R.
Recognize…
E.
Execute…

# References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- Michaels. (2010). *Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice.* Center for Excellence in Children's Mental Health.
- Williams, R. (1999). *Cultural Safety – What Does it Mean for our Work Practice?* Australian and New Zealand Journal of Public Health.

# Resources

- The Kirwan Institute for the Study of Race and Ethnicity
  http://kirwaninstitute.osu.edu/researchandstrategicinitiatives/#implicitbias

  33 W. 11th Avenue, Columbus, Ohio 43201

  Telephone: 614.247.1633

- Implicit Bias Self Assessment: Take an Implicit Association Test!

  https://implicit.harvard.edu/implicit/

# CONTACT US!


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