Disparities in Behavioral Health Diagnoses:
Considering Racial and Ethnic Youth Groups

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Racial and ethnic disparities in health care occur within broader contexts impacting the youth who present for behavioral health treatment. Clinician bias and clinical uncertainty can influence diagnostic and treatment outcomes. Behavioral health professionals should strive toward effectiveness in the delivery of culturally sensitive interventions to assist in health promotion with youth of color.

The National Academy of Medicine (formerly the Institute of Medicine) published a report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," that highlighted its findings and recommendations on health disparities in the United States [1]. At the request of Congress, the leading committee was charged with assessing the depth of racial and ethnic differences in health care. Assessing this phenomenon, the committee sought to further understand the racial and ethnic disparities gap to assist health care systems and professionals in addressing this issue. Through roundtable discussions, focus groups, and other sources of information, the National Academy of Medicine (NAM) representatives made conclusive findings with specific recommendations.

Although this report targeted health care at large, specific attention was given to behavioral health care systems and professionals who employ their skills to identify and treat behavioral health conditions. Mental health disparities have been well documented, therefore concentrated attention must be given to eliminating barriers that prevent racial and ethnic minority youth groups from reaching full potential through quality treatment.

The following findings from the NAM's report have been highlighted to frame this conversation regarding disparities in diagnoses among racial and ethnic minority youth (aged 10-21) within mental and behavioral health systems: 1) "Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life"; and 2) "Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare" [1].

The field of behavioral health care is primarily composed of psychiatrists, psychologists, counselors, social workers, addiction specialists, psychiatric nurses, psychiatric pharmacists, and those who support them. Each of these groups is tasked with operating within its scope of practice, which includes diagnosing and prescribing treatment protocols that lead to mental wellness. In addition, these professionals are governed by a code of ethics or conduct that encourages consideration for cultural competence.

The United States Surgeon General produced a report, "Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health," outlining directions toward the elimination of mental health disparities [2]. This comprehensive work set in motion considerable research that centered around access to services, treatment, and workforce challenges confronting behavioral health professionals in addressing the needs of underserved racial and ethnic groups. Within its contents emerged the influence that culture and society have on mental health, and the report gives the practitioner guidance toward addressing the needs of underserved racial and ethnic groups. Awareness of mental health disparities among underserved racial and ethnic groups is not lacking. However, it has been challenging to strategically confront and address these issues across behavioral health care systems.

Disparities in Youth Diagnoses

Much of the literature regarding mental health disparities has focused primarily on adults, but there has been recognition of how youth from racial and ethnic groups of color are impacted by these disparities. Youth of color are more likely to be referred to the juvenile justice system while white youth are more likely to be referred to treatment-oriented services [3]. When presenting issues are the same, behavioral health professionals are likely to diagnose youth of color differently than their white counterparts [4]. Existing evidence strongly supports the prevalence of ethnic disparities in the diagnosis of racial and ethnic youth of color with presenting psychological issues [5]. Findings from research

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done by Cummings and coauthors suggest that among adolescents who experienced a major depressive episode, African Americans, Asians, and Hispanics were less likely to receive treatment than their non-Hispanic white counterparts [6]. This study also confirmed that underserved youth were less likely to be treated by a mental health professional or receive medication for depression [6].

African American youth have been found less likely to be diagnosed with attention-deficit/hyperactivity disorder (ADHD) than their non-Hispanic white peers [7]; however, African American youth are more likely to be diagnosed with conduct-related and behavior disorders [8] as opposed to anxiety and substance use disorders. African American male adolescents are more likely to be diagnosed with thought disorders (ie, schizophrenic disorders) but non-Hispanic white adolescents are more likely to be diagnosed with bipolar disorder, alcohol abuse, or major depression [4].

Hispanic youth are more likely to be diagnosed by clinicians with anxiety, adjustment and disruptive disorders, depression, substance use disorders, and psychotic disorders than their non-Hispanic white peers [8, 9]. In comparison to other underserved racial and ethnic groups, Hispanic adolescents have fewer psychiatric diagnoses; however, when receiving emergency care, they were more likely to be diagnosed with psychotic or behavioral disorders than non-Hispanic white adolescents [10].

When it comes to Asian and Pacific Islander youth, Asian youth have less chance of being diagnosed with ADHD but are more likely to receive diagnoses of disruptive behavioral disorders, substance use disorders, and psychotic disorders [9]. These youth are also less likely to be diagnosed by clinicians with depression but more likely to be diagnosed with anxiety or adjustment disorders [7].

Lastly, Native American (American Indian) youth are less likely to be diagnosed with anxiety disorders but more likely to be diagnosed with ADHD and substance use disorders than non-Hispanic white youth [11]. Unfortunately, most studies of Native American youth comparing them with other underserved racial and ethnic youth groups lack a representative sample that allows for generalization. More research and study are needed to better understand the needs of Native Americans and better assist clinicians in diagnosing and addressing mental health conditions within this population.

Studies that have highlighted these disparities in rates of diagnosis must examine factors that contribute to this issue. Treatment settings, clinicians' experiences, and diagnostic training are among the factors that may contribute to such discrepancies in diagnoses among underserved racial and ethnic youth. Clinicians treating these populations could have differing interpretations and meanings assigned to presenting issues. Misdiagnoses have been strongly associated with clinician impressions, their assessments, and the instruments used in the diagnostic procedures [12]. For many youth, diagnosis can be further complicated by the role of caregivers (ie, parents, teachers), who are often involved in reporting symptoms to clinicians that inform their assessments [5], especially when there is conflict in symptom reports.

While these studies are alarming and concerning, they further suggest the importance of training behavioral health professionals to be effective in diagnostic and assessment skills. These clinicians must be aware of general cultural traits, adolescent culture, and challenges in society that impact underserved racial and ethnic youth. When underserved youth of color walk through the doors of mental health facilities, they bring their experiences, including microaggressions and racism toward their identity group at large.

Diagnostic Disparities

Accurate diagnoses are considered the foundation of health care treatment. If health care providers misdiagnose presenting issues or misconstrue a cluster of symptoms, it can lead to a negative prognosis and devastating outcomes. Research has emphasized disparities in diagnoses [8, 9] and cultural factors relevant to diagnosing have also been discussed in the literature [13, 5]. Cultural perspectives on diagnosing have been given by medical associations, pharmaceutical industries, and other professional organizations [14]. While this has had some attention, there has been little movement toward ensuring a common approach to diagnosing [13].

Behavioral health and psychiatric diagnosing encompasses observing symptoms and behaviors through the youth's personal history or experience while taking into consideration any biological factors [13]. Psychiatry, which offers the medical aspect of behavioral health, unlike other aspects of medicine does not rely on blood tests or laboratory tests but on guidance from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Psychiatrists' approach to diagnosing has evolved since the first edition of the (DSM).

Even as the DSM evolved through a logical approach across many countries, cultural factors were still omitted [13]. Upon arrival of the DSM IV, acceptance of a cultural perspective was adopted through cultural formulation and acknowledgment of culture-bound syndromes, but this was only included as an appendix in the back of the manual. Cultural formulation occurs when the clinician assesses and takes into consideration an individual's cultural background and how it influences symptom presentation or any behavioral dysfunction [15]. In this process, the clinician must recognize how differences impact the therapeutic relationship and how these factors impact presenting issues to ensure they objectively appraise information gathered [15].

Behavioral health care providers must be able to use cultural information in the context of cultural formulation guidance in ways that lead to more accurate diagnoses. During the clinical interview, behavioral health professionals must

integrate knowledge and awareness of cultural experiences relevant to underserved racial and ethnic youth groups and integrate these factors into the clinical interview. Sensitivity to the youth's background would ensure the interviewer considers the youth's story [16] and its cultural influence on presenting symptoms.

Historical Influences

Youth of color are subjected to the history of racism in mental health and other historical barriers that have, intentionally and unintentionally, led to disparities in diagnosis and treatment. Regardless of the origin of disparities, behavioral health professionals must be aware that they exist and informed of strategies to address mental illness for youth of color. Medical research and mental health care have foundations of racist behavior that still permeate throughout the health care system.

Samuel Cartwright, MD, can be identified as responsible for playing a role in misdiagnosis among underserved racial and ethnic groups. In the 19th century, Cartwright coined the term "drapetomania" to ascribe mental illness to African slaves who sought to escape and not conform to the institution of slavery [17]. His work was accepted and published in medical journals and was embedded into the culture of that day, laying the foundation for other publications to follow.

Cultural and racial differences in mental health care have been misunderstood over the years and have been positively correlated with overdiagnosis of mental disorders and likely contributed to misdiagnoses as well [17]. Misdiagnoses of mental health problems among underserved racial and ethnic youth groups lead to improper care and treatment [5]. Research has suggested some differences in diagnoses among underserved youth groups centered around interview format (structured versus unstructured), culture and language, and interpretation of symptoms [18]. When clinicians are familiar with these factors and take them into consideration, they can more accurately confirm diagnoses and ultimately initiate accurate treatment plans that will lead to positive outcomes among underserved racial and ethnic youth groups. This effort can be more unvaryingly applied through shifting of cultural competency knowledge into culturally proficient methods.

Cultural Competence and Proficiency

Cultural competency, "a set of behaviors, attitudes, and policies that come together to work effectively in cross-cultural situations," has been emphasized across many professional sectors of our society, especially in health care [19]. While the term receives much attention and focus, behavioral health professional organizations have been limited in assisting their membership toward obtaining proficiency of skills. Cultural competency has been expanded to include attaining the knowledge, skills, and attitudes to provide effective care for diverse populations and suggests providers utilize culturally competent knowledge and skills that are compatible with those served [20]. These definitions alone are inclusive and describe what cultural competency should be, but fail to describe methods or practices to ensure professionals become proficient in applying this knowledge to the lives of those served, commingled with their training in addressing mental health conditions.

How professional groups are trained in cultural competency can determine their consideration for racial and ethnic differences when a person of color presents for treatment. Therefore, competence and proficiencies related to the cultural experiences of underrepresented groups are paramount to successful treatment engagement and success. Behavioral health professionals must be sensitive to the intersections of race, ethnicity, and treatment issues with consideration for how these factors align with their professional training. It is important to note the difference between cultural competency and cultural proficiency. Academic training should include preparing professionals for encounters with those who are culturally different from themselves. Academic programs often highlight the need to recognize differences and accept these differences without allowing personal bias and preconceived notions to impact service delivery (competence). Students and professionals should be made aware of how these differences affect presenting issues; however, we must also know how to effectively intervene with sensitivity and employ treatment protocols that lend to successful outcomes of treatment (proficiency). Learning how to employ skills or knowledge in consideration of one's personal attitudes will begin to reduce the disproportionality of diagnoses among youth of color.

Conclusion

North Carolina's public behavioral health professionals are challenged to treat very complex issues of persons who present for treatment for mental health, substance use, and/or developmental disabilities. This complexity is often layered with social, economic, educational, physical health, and family issues in a transforming mental health system. These factors further complicate progression toward wellness. Behavioral health professionals typically only see a glimpse of how these complexities are interrelated and influence presenting symptoms for treatment. Considering this, behavioral health professionals at large have done a great job addressing and preventing debilitating issues and, in many instances, death.

As our society becomes more global and evidence-based, it will be important for institutions of higher education and professional schools to ensure their students are prepared to address the needs of underserved racial and ethnic youth, and that effective methods of treatment are consistently employed through cultural proficiency and skill. This begins with awareness and commitment to accessing all available resources while living up to our ethical codes and responsibilities as professionals. Underserved racial and ethnic youth are due the best available services. It has been the intent of

this review to renew our commitment and service to those youth of color who have traditionally been underserved and retool our skills toward improving their outcomes toward wellness. NCMJ

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