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Management of Depression in Black People: Effects of Cultural Issues

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Abstract

Black people are disproportionately affected by mental illness, including depression. While the prevalence of depression is paradoxically lower among the Black population, the impact of depression on Black people results in greater severity of illness and higher chronicity. The main factors through which Black people experience worse mental health outcomes includes delayed treatment seeking, and poor access to mental health services. Mental illness stigma contributes to the delay in treatment seeking behavior. Stigma refers to negative attitudes, beliefs or behaviors about a particular characteristic of an individual such as their health status. Both patients and mental health professionals experience stigma that impacts health engagement, limits access to effective depression treatments, and compromises positive patient-clinician communication. A commitment to lifelong learning about the role of culture, history, and the psychosocial context of our patients is critical to closing public health gaps in the field of mental health.

Introduction

Conceptualization and Understanding of Depression

Black people comprise 13% of the United States population, yet comprise nearly 20% of those who are living with mental illness[1]. Non-Hispanic Black people have a paradoxically lower prevalence of major depression compared to non-Hispanic white people[2]. Some studies suggest that our measurement scales for depression may not be culturally adapted in a manner that identifies symptoms effectively in certain racial or ethnic groups[3]. Despite the reported lower prevalence of depression, Black people are less likely to use mental health services, more likely to present with more severe and chronic illness[1,4]. These factors lead to worse mental health outcomes and higher disability. Exposure to minority status in the United States increases risk for psychiatric disorders including depression[4]. According to the National Academy of Medicine, Black people and other underserved people of color experience lower healthcare quality across virtually every therapeutic intervention. Black people are less likely to regularly attend outpatient visits for their mental health and are more likely to be hospitalized. The higher level of hospitalization for Black people

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is evidence of the higher likelihood of more severe form of mental illness at time of presentation to our health systems. The delay in treatment engagement leads to greater morbidity and mortality across psychiatric disorders.

Diversity within the Black population (including among African Americans, Afro-Caribbean immigrants, Afro-Latina/o/x immigrants, and African immigrants).

The current scientific literature is limited by approaching race and ethnicity without taking into account within race or within ethnicity differences. We tend to compare health needs across race/ethnicity, leaving out the importance of diversity within racial/ethnic groups. Black people are often perceived in the research literature as a homogeneous group, which has an influence on our clinical approach as mental health professionals. However, there is diversity within the Black population in the United States. This diversity has implications on health needs. Black people have diverse cultures and heritage (for example, Africans, Afro-caribbeans, Afro-Latinas, and African Americans), and differences in psychosocial factors and mental health needs[5]. There are few studies that consider ethnicity and migration in the approach to Black individuals. The Black immigrant population in the United States has increased by 90% in the United States since 2000; 88% of these immigrants whom have arrived from Africa or the Caribbean. PEW research surveys found that 10% of the United States Black population (~4.6 million people) are foreign-born[6]. Black immigrants are often been overlooked in healthcare research, as research studies seldom account for the diversity in nativity and ethnic origin within the Black population. Our approach to diagnosis and treatment of depression needs to take into account the cultural heterogeneity and diversity within the Black population[4,5].

Recognizing the unique mental health needs based on the intersection of race, ethnicity and migrant status for Black individuals.

In order to understand the heterogeneity among Black people, one must consider the intersection of race, ethnicity, and migrant status[4,5]. While we tend to consider differences in gender such as the higher prevalence of depression in women than in men, the literature does not often consider the differences within a minority group such as differences in Black people. Depression prevalence and symptom severity may vary among Black people by ethnicity and gender[4,5].

Understanding depression in the cultural context of the Black community.

Black people have greater stigma towards mental illness, compared to white people[4]. Black people are less likely to seek treatment for depression, compared to their white counterparts. Black people also have greater mistrust of health care systems and health care professionals[7]. The cultural context of Black people influences the ways in which individuals may conceptualize mental illness and the need for treatment. For example, the delay in seeking mental health care and the low access to treatment contributes to worse mental health outcomes[1]. Suicide rates among Black children has been shown to be higher than among white children, a study published in JAMA, showed Black children aged 5 to 11 years had increased rates of suicide, compared to white children[8]. In a study among older adults with depression, 80.5% of white participants felt comfortable seeking services from a mental health professional, compared to only 56.6% of African American participants.

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African American older adults were more likely to experience internalization of stigma (a devalued self-identity) and were more likely to endorse negative attitudes towards mental illness and treatment compared to their white counterparts.

Mental illness stigma, psychopharmacology and views on depression treatment for Black people.

Several studies show the conceptualization of mental illness and its etiology among Black people has an influence on their willingness to engage in help seeking behavior such as the use of psychotherapy and pharmacologic interventions. Black people are less likely to use or be offered Electroconvulsive Therapy (ECT) for depression[9,10]. Black people experience greater level of morbidity and mortality associated with mental illness. Understanding the relationship between cultural context, stigma perspectives and psychopharmacology is critical to improving the mental health outcomes for Black people. ECT has been shown to be an important and at times definitive treatment for severe depression. White people receive ECT at a higher rate than minority populations. The low use of ECT among Black people is a result of several factors including issues with mental illness stigma, perspectives on ECT as a therapeutic intervention, and limited access to mental health services.

The theory of pharmacoequity refers to the notion that access to therapeutic interventions for underserved communities including the Black population is a key step towards attaining health equity[11]. Pharmacoequity considers the importance of enhancing medication access, reducing the cost of medication, and reducing the overall burden of access to prescriptions. Even when there is access to medications, perspectives on the etiology of depression can significantly influence the actual use of medication or modalities like ECT. For Black people, and for most individuals, patient's family and culture has an influence on decision making in mental healthcare. In addition to patient's family, cultural context, the history experience with the physician-patient interactions influence future interactions.

The role of medical mistrust, religiosity, and bias/microaggressions/racial discrimination in mental health care seeking behavior.

Medical mistrust refers to the belief that an individual or system is working against one's best interest or wellbeing[12,13]. For Black people, mistrust of health systems stems from historical and ongoing social and economic injustice and inequities. The term *microaggression* was created by Chester Pierce, and it refers to everyday racial offenses, that may be subtle, but produce deleterious effects for racial minorities[14]. In addition racial discrimination experiences influence mental healthcare seeking behavior.

In a comprehensive systematic review on implicit bias in healthcare, evidence of pro-white and anti-Black bias among a variety of healthcare professionals across multiple levels of training and disciplines was found[15]. There were disparities in treatment recommendations, impairments in expectations of therapeutic bonds, and deficiencies in empathy[15]. In addition, providers with higher implicit bias demonstrated worse patient-provider communication[15]. Additionally, on the part of the patient, perceived lifetime discrimination was associated with attenuated endothelial recovery from acute mental stress[16], thereby, increasing risk for depression and other chronic illnesses. Moreover,

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several studies have also shown that stress from racism and discrimination (also known as weathering) have potential long-term detrimental biological effects, such as altering the efficacy of the immune response[17]. Another consequence of stigma and other healthcare disparities is the increased frequency of misdiagnosis of Black people, which results in inaccurate treatment recommendations[18]. The risk of misdiagnosis and adverse health outcomes due to race or ethnicity impact the effectiveness of treatment recommendations and the experience of healthcare systems in minorities.

Religious perspectives on mental health

Religious organizations serve as a central and trusted space in many Black communities[19]. Religious beliefs have an influence on the conceptualization of mental illness[19,20], including perspectives on depression illness, management, and treatment. It is essential for clinicians and mental health systems to create safe spaces within our health care models for Black adults with religious conceptualizations of depression. Trust of mental health systems may be enhanced when Black people who have religious beliefs feel comfortable sharing their beliefs with their therapist or psychiatrist without fear of judgment[19–21]. Clinicians should avoid an approach that dichotomizes the role of psychiatric interventions and religious support. Some Black adults report feeling the need to suspend their religious beliefs as a prerequisite to engage in mainstream psychiatric interventions[20]. Rather than an approach that dichotomizes the role of psychiatric interventions and religious support, studies have shown that religious support can improve overall health status[22]. Creating nonjudgmental and safe spaces for Black people with religious conceptualization of depression may lead to improved clinician-patient communication and enhanced trust of clinicians and mental health systems[20].

Culturally informed management of depression in the Black community.

We tend to focus on cultural competency, rather than cultural humility. However, the notion of mastery of culture (or the attainment of competency) is inherently fallible and may perpetuate stigma (stereotypes and labeling) through confirmation bias (such as every Black patient one encounters needs help with housing or every Black patient is socioeconomically disadvantaged). Cultural humility is focused on lifelong learning, listening, and self-evaluation in our approach to our patients, particularly patients who come from different backgrounds than our own[23].

Several studies have shown that white people with positive emotions were more able to accurately recognize Black faces; people who experience positive emotion were better able to see others as part of a common “ingroup”[24]. Positive emotion has contributed to empathy and the capacity to be more inconclusive in interpersonal encounters. Busy emergency rooms and outpatient clinics (associated with physician burnout) raise stress and adversely impact the quality of communication with patients; hence, building structures that teach skills in mindfulness and that involve Balint groups can mitigate the impact of these non-optimal conditions.

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There is a need for cultural adaptation of measurement scales for depression in order to better identify depressive symptoms early on, enhance diagnostic accuracy, and reduce delays in treatment seeking[3].

Conclusion

There are ongoing mental health disparities for Black people that lead to higher morbidity and mortality from mental illness compared to white people[1,4]. In order to address mental health disparities, improve clinician-patient interactions, and close public health gaps, we need to consider the cultural and social context as well as the diversity of Black people[5]. Black people report higher stigma and lower trust of health systems compared to white people. The noted higher severity and higher chronicity due to mental illness, including delayed treatment seeking and elevated rates of inpatient hospitalization leads to worse mental health outcomes[1,4]. Black people are less likely to receive or be offered definitive treatments for depression such as ECT[9].

Clinicians and mental health systems would benefit from considering the role of religious and cultural beliefs that may influence the conceptualization of depression and other mental illnesses for Black people[5,19]. There are historical and contemporary injustices that contribute to current mental health disparities. There are also longstanding disparities related to access to mental health treatment due to financial limitations; however, individual experiences of Black people within mental health systems can be improved by enhancing cultural competency and cultural humility[23]. As clinicians, a commitment to lifelong learning about diverse cultural perspectives, and a robust understanding of the psychosocial context of our patients is critical to improving both individual and community mental health experiences for Black adults.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Disclosures

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