BLACK PSYCHIATRIC PATIENTS' REACTIONS TO THE CULTURAL MISTRUST INVENTORY

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This pilot study examined African-American psychiatric patients' reactions to the Cultural Mistrust Inventory, a measure of blacks' mistrust of white society. Twenty-two black psychiatric patients were screened for the Culturally-Sensitive Diagnostic Interview Research Project. All patients were debriefed after the screening interview including queries about their reactions to the experience, whether they would be willing to participate in the next interview, and their reasons for participating or not. Patients' responses were recorded verbatim and were categorized in terms of their valence (positive, neutral, or negative) and affectivity (yes or no) by independent raters. Agreement between raters in terms of the valence of patients' reactions was very good, but it was poor to fair in terms of affectivity ratings. The majority of these black patients' responses were positive and nonaffective. Administration of the Cultural Mistrust Inventory to black psychiatric patients does not cause negative emotional reactions. (*J Natl Med Assoc.* 1998;90:776-778.)

Key words: psychiatric patients ◆ cultural mistrust ◆ African Americans

The need for greater sensitivity to cultural issues in the diagnosis and treatment of psychiatric disorders in diverse ethnic and racial groups has inspired culturally relevant research projects. One such project is the Culturally-Sensitive Diagnostic Interview Research Project.[1] This project examines the role of cultural beliefs related to paranoia in the differential diagnosis of schizophrenia and depression among African Americans. Cultural differences in paranoid symptom expression by black Americans occur because of historical and contemporary experiences with racism.[1-5] Diagnosis and treatment of psychiatric disorders in African-American patients require sensitivity to issues of racism.[1,6,7] To date, no empirical research has attempted to differentiate paranoia linked to cultural mistrust from pathological delusions. Research of this nature is essential to efforts to sensitize mental health professionals to the cultural experiences of African Americans.

Terrell and Terrell[8] developed the Cultural Mistrust Inventory (CMI) to assess blacks' mistrust of white society. Cultural Mistrust Inventory scores predicted premature termination of treatment in a sample of African Americans seeking counseling services.[9] However, this measure has never been used to study persons with serious mental illness. Consequently, the National Institute of Mental Health Review Committee recommended that my research protocol include a pilot study in which a debriefing session was used to ensure that patients did not have any adverse reaction to being administered the CMI. Our institutional review board went a step further and required the research protocol to include an assessment of patients' reactions to the administration of the CMI to avoid any "violent" reaction by these black patients.

On the one hand, it could be argued that such requirements stem from racial stereotypes,[7] and on the

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other hand, two high-profile cases of mass murder in New York City legitimize these concerns. The first case involved a black gunman on the Long Island Railroad who killed several people because, according to his notes, he was treated unfairly by white society.[10] The other case involved an armed black man who burned down a clothing store in Harlem during a protest against the white store owner subleasing to a black store owner, killing himself and several employees.[11] Thus, it is plausible that discussions of racial injustice could elicit hostile reactions from some black persons, especially vulnerable populations such as psychiatric patients. Given these competing views, this study was undertaken to determine black psychiatric patients' reactions to the CMI.

MATERIALS AND METHODS

Participants and Procedures

Twenty-two black psychiatric patients were screened for the pilot study of the Culturally-Sensitive Diagnostic Interview Research Project by a black licensed psychologist with 11 years of clinical experience.[1] This pilot study sample consisted of 13 men and 9 women. Participants ranged in age from 24 to 58 years (mean=42.37 and SD=8.58). Reviews of patients' charts revealed that the predominant diagnosis was schizophrenia (68%), followed by diagnosis unspecified (18%), and affective disorder (14%).

Patients were recruited by letters, flyers, and presentations explaining the study. Participants were first given a brief mental status examination to determine their capacity to give informed consent, and then they gave written informed consent before continuing the screening interview.

After each interview, the debriefing statement was read to patients and three questions were asked:

- What are your reactions to being asked these questions and the other scales?
- Will you participate in the next interview?
- What is your reason for deciding to participate or not participate?

Responses to the second question were fixed and open-ended for the other questions. Responses were recorded verbatim. Patients reviewed the recorded responses and signed the debriefing form, if they believed the recordings to be accurate.

Statistical Analysis

The verbatim responses to the first and third questions were transferred to rating forms. Two licensed clinical psychologists with >5 years of experience rated the valence (positive, neutral, or negative) and affectivity (yes or no) of these responses. Mental health professionals were used because manifestations of delusional thinking or thought disorders in the content of patients' verbal responses presumably would not distract them. Interrater agreement on valence and affective ratings was calculated using the kappa statistic. Intrarater agreement between valence and affective ratings was determined from the phi coefficient.

RESULTS

Interrater agreement in terms of the valence of patients' reactions to the CMI was good (κ=.71; P<.0001). The distribution of agreement on valence ratings was 57% positive, 24% neutral, 5% negative, and 14% disagreement. Interrater agreement for ratings of affectivity was poor (κ=.36; P=NS). The distribution of agreement on affectivity ratings was 52% no, 19% yes, and 29% disagreement. The association between valence and affective ratings was stronger for the first rater (ϕ=.50; P<.10) than the second rater (ϕ=·35; P>.10). Most participants said yes (86%) or maybe (9%) to the next interview. Interrater agreement on ratings of the valence of reasons for participation was also very good (κ=.73; P<.0001). The distribution of agreement was 55% positive, 15% neutral, 15% negative, and 15% disagreement. Agreement between ratings of affectivity of reasons was fair (κ=.50; P<.01). The distribution of agreement was 75% no, 10% yes, and 15% disagreement. Again, the correlation between ratings of valence and affectivity was stronger for the first rater (κ=.50; P<.10) than the second rater (κ=.32; P>.10).

DISCUSSION

These results suggest that black psychiatric patients' reactions to an interview with the CMI are likely to be positive most of the time. More than half of the patients had positive thoughts about the experience based on independent evaluations of their responses. Independent ratings of the affectivity of the reactions indicated that more than half of the responses was nonaffective. Recommendations have been made to address African-American experiences with racism and their perceptions of how they are treated in American society as a means of enhancing the cultural sensitivity of mental health services.[1,6,7] The current findings provide support for

these recommendations.

There was more disagreement between raters in terms of the affectivity of these patients' reactions. One rater tended to perceive greater correlation between affectivity and valence. This may explain partly the lower interrater agreement on the affectivity of patients' reactions. It may be that judgments of affectivity are more susceptible to subjective impressions. This should be explored in future research. Replications of this study also should use a larger sample of patients and several interviewers.

CONCLUSION

Administration of the CMI to black psychiatric patients does not seem to cause negative emotional reactions. On the contrary, such discussions may facilitate mental health services to African-American patients. Reluctance on the part of clinicians to address issues of racism may be due to racial stereotypes.[7] Thus, dialogue about black patients' cultural experiences also may benefit service providers by challenging these stereotypes. The cultural competence of mental health professionals would be enhanced by replacing stereotypic beliefs with culturally relevant knowledge about the black experience in America.

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