Ethical and Racial Disparities in Children’s Mental Health

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Abstract

Despite significant progress in research, practice, and policy over the past few decades, many children and youth continue to experience poor mental health outcomes based on their socioeconomic disadvantage, ethnic or racial minority status, or immigrant status. As a result, many of these children fail to adequately meet developmental tasks, demands, and transitions, such as entry into and successful achievement in school, interpersonal and peer relationships, and civic functioning. Compounding these challenges for minority children and youth is their low levels of mental health service utilization, impediments to accessing care, and care that is not culturally competent or does not conform to evidence-based guidelines.

Introduction

Mental health is at the core of the health and well-being of children and families. Yet up to 50% of the U.S. population will develop a mental health disorder in their lifetime, with most disorders beginning in childhood and adolescence. Racial and ethnic minorities are at particular risk for mental health disorders in adulthood, although interestingly, rates of those disorders are lower in adolescence, relative to the non-Latino white population. However, while some racial and ethnic minority youth experience lower rates of lifetime mental health disorders, their disorders tend to have a more chronic course. Reasons for differences in mental health etiology and outcomes among youth are briefly addressed in this guide. Racial and ethnic minority youth, in addition to their racial and ethnic identity, have other identities pertaining to socioeconomic status, documentation status, sexual orientation, gender identity, and cognitive and physical
ability status. These identities interact with each other and may produce unique challenges for youths. Some complexities they face include addressing multiple forms of discrimination and the disparities resulting from unequal access to and receipt of services as well as from laws and policies limiting their civil and human rights. An awareness of youths’ intersecting identities should serve as the catalyst for action on the part of the practitioner, and such action should begin with an accurate assessment of the availability and accessibility of relevant and effective services for the individual.

The impetus for this practitioner’s guide is the report Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S. (Alegria, Green, McLaughlin, & Loder, 2015), published by the William T. Grant Foundation. A task force, commissioned by the American Psychological Association’s (APA) Committee on Children, Youth, and Families, set out to translate the findings from the report into a usable guide for practitioners. To this end, we summarize the factors described in the report that contribute to, or protect against, the onset and maintenance of mental health disorders for ethnic and racial minority youth. We also describe factors influencing their use of mental health services and provide concrete strategies for addressing the mental health needs of these youths. According to the William T. Grant Foundation report (Alegria et al., 2015), the following are the primary factors that contribute to and perpetuate mental health disparities among ethnic and racial minority youth.

**Socioeconomic Status**

Disadvantages in socioeconomic status (SES) contribute significantly to mental health difficulties among ethnic and racial minority youth. About 39% of African American, 32% of Latino, and 36% of American Indian youth under the age of 18 live in poverty, more than double the rate of non-Latino Whites (14%) and Asians (14%). Lower SES causes mental health disparities because children living in poverty are exposed to more stressors and have fewer buffers to counter that stress. Low SES interacts with poorer quality education and housing, unsafe neighborhoods, and more frequent experiences—or greater perceptions—of discrimination, racism, and oppression. These factors are believed to affect mental health directly by destabilizing social networks and the social structures supporting children, such as neighborhoods, schools, and housing. These unstable social structures may further impair youths’ mental health indirectly by heightening their subjective experiences of stress and undermining their self-worth and self-efficacy. For example, parents of low-SES background may need to work multiple jobs to support their children financially. This may result in those parents having less time to spend engaged in activities with their children, such as reading to them, which can promote socioemotional learning. Children from low-SES backgrounds may thus be more likely to develop mental health problems as a consequence of these conditions and the lack of opportunities in their environment.

**Exposure to Childhood Adversities**

Childhood adversity is an important determinant of mental health disparities in ethnic and racial minority youth. Adverse childhood experiences (ACEs) are stressful or traumatic events that include, but are not limited to, maltreatment, parental incarceration, neighborhood violence, family violence, and parental instability, all of which have immediate and lasting disruptive
effects on youths’ physiological development as well as their physical and mental health. Early and chronic exposure to ACEs is particularly detrimental and has been linked to difficulties in regulating emotion and behavior later in life, which is key to mental health and overall well-being. Ethnic and racial minority youth living in low-income communities are exposed to a greater number of ACEs. Further, although adversities are experienced by all racial and ethnic groups, they can have more impact on racial and ethnic minority youth because such adversities interact with and influence other stressors that children face. For example, ACEs are associated with stressful family relationships and structures, including single parenting, and with early role patterns that perpetuate disparities in mental health, such as teen pregnancy, gang involvement, substance use, and school dropout. To address and, it is hoped, prevent such disparities, school personnel should be trained to identify, as early as possible, children who may be exposed to such adversities. To effectively reach and work with such children and families, the mental health system should maintain a close and viable working relationship with the educational system. Complimentary services provided by the two systems should be holistic and not segmental in nature and should treat the child and family member as intertwined parts of a whole rather than as discrete units.

**Neighborhood-Level Stressors**

The neighborhood context includes multiple components, such as levels of neighborhood safety, degree of neighborhood social support, extent of neighborhood racial and ethnic segregation, quality and quantity of neighborhood resources (e.g., recreational facilities, availability of healthy foods), and neighborhood norms. Variations in neighborhood context among racial and ethnic minority groups of children can increase inequities in access to formal and informal resources that affect mental health. These resources can include quality of education or the degree of social support. Neighborhood context can also undermine mental health by diminishing an individual’s self-efficacy and overall sense of resiliency. For example, neighborhood violence, regardless of its source or cause, interferes with individuals’ sense of control over their environment and has been associated with increased internalizing and externalizing symptoms as well as with posttraumatic stress disorder and academic difficulties.

A significant amount of racial trauma occurs in low-income communities of color; these experiences range from daily microaggressions to blatant acts of racism that “get under the skin” via stress, daily hassles, and stereotype threat. Implicit bias at the institutional level may increase youths’ negative interactions with schools and police. Although these experiences have gained greater media attention, so too have societal messages denying these experiences and dehumanizing youths of color, particularly African Americans and Latinos. These racial tensions underscore the need for advocacy and community-based social and mental health services.

**Family Structure**

Sixty-seven percent of African American children and 42% of Latino children, particularly Puerto Rican children, live in single-parent households, compared with only 25% of nonLatino Whites. It is important that practitioners identify, understand, and carefully consider contributing causal factors to avoid inadvertently using these differences to support prevailing negative and overgeneralized stereotypes that stigmatize African American and Latino families. Such factors
might include family separation due to immigration or deportation; social, judicial, and economic policies that make it impossible for partners to live together; and housing availability, policies, and restrictions. Regardless of the prevalence of such factors, family structure can contribute to mental health disparities in a number of ways. Deportation of a parent can lead to the placement of children in foster care or to a family’s significant financial instability, increasing children’s stress and compounding the grief of losing their parent(s).

Other ACEs such as maltreatment, family violence, and instability within the home are more likely to occur for children living in single-parent homes and in stepfamilies than for children living with both parents. Children raised in a single-headed household are more likely as adolescents to experience teen pregnancy and single parenthood, which may further contribute to mental health disparities. Particularly among racial and ethnic minority mothers, there is a strong association between being a single parent and risk for depression. It is important to note that maternal depression is related to poor child mental health outcomes.

Practitioners’ Implicit Biases and Limited Cultural Competence

Practitioners’ biases, prejudices, and stereotyping can also play a central role in contributing to disparities in quality of care and outcomes experienced by racial and ethnic minority youth. Many of these biases can be implicit—that is, they occur below conscious awareness. Negative implicit biases are automatic and may manifest as perceptions of minorities as less intelligent, more likely to abuse drugs and alcohol, more violent, and more at risk for treatment noncompliance. These biases about racial and ethnic minorities impact diagnostic decisions. For example, a seminal study found that African American males were disproportionately and incorrectly diagnosed with more severe disorders (e.g., schizophrenia) than White males because of psychiatrists’ biased beliefs that African American males were likely to be violent, suspicious, and dangerous. Disparate care extends beyond diagnostic practices to treatment experiences. Among racial and ethnic minorities, higher rates of mental disorders may be due in part to practitioners’ limited use of guideline concordant, evidence-based psychotherapeutic and pharmacological treatments as well as to their disproportionate use of involuntary commitment procedures.

Although racial and ethnic minorities represent 30% of the population, approximately 90% of practitioners identify as non-Hispanic White. Furthermore, clinical training programs are largely characterized by ethnocentric monoculturalism. Consequently, theories about psychological health and psychopathology, and resultant treatment practices, primarily developed by White male scholars, may have limited generalizability to racial and ethnic minority patients. The lack of diversity in the mental health field means that ubiquitous implicit biases have few opportunities to be challenged and dismantled.

The consequences of unexamined implicit biases are tragic and profound, such as the inappropriate placement of minorities in the criminal and juvenile justice system. This excessive placement in the prison pipeline process is demonstrated by research indicating that untreated attentional and behavioral problems in racial and ethnic minority children are often viewed as signs of conduct disorder, thereby increasing the likelihood of academic disciplinary actions (e.g., suspensions, expulsions). Racial and ethnic minority students are disproportionately
subjected to such actions, which are robustly associated with entry into the juvenile justice system. Given the rapid growth in racial and ethnic minority communities, disparities in the mental health system will worsen without systematic attention. Improved clinical training in cultural competence among practitioners will ensure that all patients receive effective, economical, and safe diagnostic and treatment practices. In spite of the aforementioned personal, family, neighborhood, and societal risks, many racial and ethnic minority youth develop into healthy individuals. Protective factors include the following:

Positive Home and School Environments

In the home, adults, including, but not limited to, parents, grandparents, and other extended family, foster resilience in children when they provide appropriate warmth, monitoring, support, and encouragement. The quality and character of school life (i.e., school climate) includes multiple domains, such as safety, supportive relationships, stimulating teaching and learning spaces, and the external environment, and are associated with outcomes that extend beyond the school environment, such as reduced aggression and violence. To develop and sustain positive school climates, many schools are adopting strengths-based programs, ethnic and racial socialization workshops, and anti-bullying programs; proactively sponsoring Gay–Straight Alliances on campuses; actively engaging in trauma-focused curricula (e.g., trauma sensitive schools–community partnerships); and providing staff professional development. Moreover, schools are increasingly investing in family engagement programs that form and strengthen trust and a shared commitment to the child’s well-being. Also, school-based mental health screenings can be used for evaluation of, and intervention with, youth to promote healthy school involvement and timely referral for mental health services.

Stable Parental Mental Health

Even in the presence of parental mental health challenges, stability in the home environment allows for the formation of emotional connections among family members through consistent and structured family routines. Children facing a parent’s depression, for example, benefit from having access to other healthy adult role models who can consistently meet their needs, serve as trusted confidants, and build their sense of coping and efficacy. While positive parent–child interactions exist in single-parent households, the involvement of fathers during childhood has been shown to protect against adolescent psychological distress in non-intact families. Emerging interventions that aim to improve and support co-parenting when a parent experiences mental illness are critical to children’s well-being.

High Levels of Social Support and Religious and Community Involvement

Supportive relations in the community, including peer interactions, have been associated with high youth efficacy, and in turn, with positive mental health and academic and vocational outcomes in high-risk environments. In addition, religious and community involvement of youths and their parents has been associated with stronger social networks and access to resources, as well as with civic engagement.

Positive Racial and Ethnic Identity
A positive view of their racial and ethnic identity can be protective factors when children confront racism and discrimination. Positive racial and ethnic identity is associated with positive global self-esteem, which has direct implications for mental health. Racial and ethnic minority parents can support their children’s positive identity by teaching them about race and ethnicity, a process also called racial and ethnic socialization. This type of socialization involves both the instillation of racial and ethnic pride and the preparation for confronting discrimination. When parents involve children in understanding and appreciating their heritage and offer a space for children to seek support, problem solve, and express their emotions about social injustices, they promote the child’s development of positive self-esteem, efficacy, and coping.

Practitioners should use these protective factors to inform their approach to treatment in order to promote resilience in racial and ethnic minority youths. Even youths who have experienced ACEs can achieve favorable mental health outcomes when protective factors help to provide a buffer against perceived stressors. Protective factors may involve characteristics of the youths themselves (e.g., self-value, resiliency, and self-efficacy across settings; ability to self-regulate emotions and behavior) or their environment (e.g., support of friends and family, community safety). In adopting a strengths-based approach, practitioners identify the presence or absence of protective resiliency factors and then use this information to locate supportive resources for the child. For example, if a child’s parent is diagnosed with a medical illness that limits the parent’s ability to support the child, a practitioner could then look to other positive adult role models in the child’s extended family, school, community, or religious group to provide the necessary assistance and support. To this end, mental health and social services should maintain updated lists of persons and community groups that are capable of serving diverse, nontraditional, and non-English-speaking families. Racial and ethnic minority youth demonstrate low rates of mental health service use in both community and school settings. Moreover, when they enter treatment, they often face barriers that make it difficult for them to remain in treatment and to improve.

Less than 40% of youths with mental health needs receive mental health services, and racial and ethnic minority youths are more likely to have unmet mental health needs compared with their non-Latino white counterparts. Disparities in service use are multiply determined and include individual, practical, attitudinal, and systemic factors coming together to influence the likelihood that youths with mental health needs receive services. For example, practical barriers like lack of insurance coverage, difficulties with transportation, or availability of services on weekends or evenings disproportionately impact minority families. Attitudes and beliefs about mental health services, including concerns about stigma, differences in identification of mental health needs, and differences in explanations for children’s difficulties, are also more likely to result in fewer racial and ethnic minority youths using mental health services. Furthermore, systemic factors, such as a lack of linguistically appropriate services in the community or lack of availability of culturally competent or ethnically matched practitioners, may create additional access barriers for minority families.

While minority youths have higher rates of unmet needs overall, research also suggests that individual factors, such as the types of problems youths have, also contribute to patterns of service use. For example, racial and ethnic minority youths with externalizing problems have a high probability of being connected with mental health services, whereas those with internalizing problems have higher rates of unmet needs relative to their non-Latino White counterparts.
Beyond initial access to services, racial and ethnic minority youths are less likely to receive quality care and more likely to experience ongoing factors that impact engagement in and retention of services. Thus, disparities in service use can result from a range of factors affecting referral, access, and/or engagement.

When considering the service use of children and adolescents, it is also important to note that they rarely refer themselves for services. Thus, adult gatekeepers of mental health services (e.g., caregivers, teachers, and service providers) are largely responsible for identifying need and facilitating referrals and access to services. Barriers and facilitators to service use likely occur at this adult-gatekeeper level. In this manner, practitioners represent an important gatekeeper with the ability to identify mental health needs and support families in accessing and engaging with needed services.

As described previously, there are many factors that impact—both directly and indirectly—the emergence of disparities in mental health need and service use among racial and ethnic minority youth. It is clear that achieving better mental health for these youths involves more than the youths themselves (e.g., their home environment, neighborhood, and cultural background). Although factors contributing to these disparities may occur long before a practitioner has contact with the family, practitioners can play an important role in addressing and eliminating these disparities once families come into contact with mental health services. By recognizing factors reviewed previously and understanding their potential impact on referral, identification of need, diagnosis, and engagement in and retention of services, practitioners can be better equipped to deliver services in a way that mitigates the negative effects of mental health disparities. Below are some recommended ways to acknowledge these factors within the clinical encounter to maximize the likelihood that practitioners understand the needs and contexts of families that present for services and to support those engaged with services.

**Culturally Grounded Clinical Practice**

Practitioners who practice cultural humility in the clinical encounter are better able to connect with and serve their racial and ethnic minority clients. Cultural humility involves reflecting on what one knows about a particular group and what one does not know about the unique values, experiences, meanings, and goals of the individual in the therapy room, regardless of their group membership (Falicov, 2014). Culturally humble practitioners also reflect on how personal life experiences may bias their familiarity with and acceptance of their clients’ lived experiences, and they learn from their clients by adopting an “other-oriented” approach to therapy. Humility can allow practitioners to approach their work with a client with healthy curiosity, rather than with overly confident and potentially erroneous assumptions about the client (Sue & Sue, 2002). Striving to be culturally humble, rather than competent, facilitates lifelong learning.

Cultural humility is more than learning from clients. It involves intentional and honest self-reflection about what practitioners bring to the clinical encounter in terms of lived experiences and cultural influences. Some of these influences include age and generational status, developmental or other disability, religion and spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and
gender. To initiate this process, practitioners can begin by writing down all of the cultural influences, past and present, that explain their own identity. Next, they should examine which ones were the most and least salient. They should then ask what makes these influences vary in salience. Is it lack of experience with an influence, such as being an able-bodied practitioner and not knowing any individuals with disabilities? Or is it bias, such as their holding egalitarian values but having grown up in a household prejudiced about race? Or is it both?

Practitioners should also examine how their diverse cultural backgrounds shape their worldview—that is, their own beliefs, decisions, and interactions. Practitioners may do this through self-reflection or in consultation with a trusted clinical supervisor. By recognizing which influences grant them privilege in society, they can become more aware of their blind spots as a result of that privilege and relative to their clients who differ from them. Even practitioners who share many influences with their clients need to consider the personal experiences that have shaped both their worldview and that of their clients, acknowledging what they know and what they do not know. Every person is different, and regardless of who is in the room, every encounter is a cultural encounter.

Culturally responsive services can result in greater client engagement, healthier therapeutic relationships, and better treatment retention and outcomes for racial and ethnic minority youth. For instance, therapeutic interventions that are adapted to reflect the client’s cultural metaphors, contexts, assumptions, and language have demonstrated their effectiveness with Puerto Rican teenagers (Roselló & Bernal, 1999). Meta-analytic approaches have not only confirmed the effectiveness of a cultural adaptation approach but also highlighted the reason for its efficacy related to nonadapted treatments (Smith, Domenech Rodriguez, & Bernal, 2011). Those treatments that address a client’s own cultural views of his or her illness were found to produce the most positive outcomes (Benish, Quintana, & Wampold, 2011). Thus, practicing cultural humility can be beneficial for the practitioner, the client, and their shared therapeutic alliance.

The APA (2003) has encouraged increased implementation of multicultural guidelines in clinical practice and psychology graduate training. Generally, these guidelines recommend that practitioners recognize the importance of multicultural sensitivity and understanding within their work as well as the biases they may hold that impact their ability to do this. Also, practitioners are encouraged to use culturally appropriate skills within clinical practice and to promote culturally informed policy development at the organizational level. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) also developed a Treatment Improvement Protocol (TIP) series as an easy reference guide for practitioners. TIP 59 is dedicated to improving cultural sensitivity among practitioners and helping them reflect upon their practice.

References


