DOWNLOAD PDF RACIAL DYNAMICS AND MENTAL HEALTH PROBLEMS

Chapter 1 : Depression | NAMI: National Alliance on Mental Illness

For the first time, research reveals how harmful repeated racial discrimination can be on mental and physical health. The study looked at the accumulation of experiences of racial attacks over.

This study compared the health and risk status of adolescents who identify with 1 race with those identifying with more than 1 race. Data are derived from self-reports of race, using the National Longitudinal Study of Adolescent Health Add Health , which provides a large representative national sample of adolescents in grades 7 through Respondents could report more than 1 race. Mixed-race adolescents showed higher risk when compared with single-race adolescents on general health questions, school experience, smoking and drinking, and other risk variables. Adolescents who self-identify as more than 1 race are at higher health and behavior risks. The findings are compatible with interpreting the elevated risk of mixed race as associated with stress. A considerable literature attests to the emotional, health, and behavior risk problems of mixed-race adolescents. The most common explanation for the high-risk status is the struggle with identity formation, leading to lack of self-esteem, social isolation, and problems of family dynamics in mixed-race households. In some studies no differences are found between mixed-race and single-race children. Most studies are based on clinical reports or reports of mixed-race samples without comparison to single-race groups. It is not surprising that such samples lead to the conclusion of emotional and behavior problems, as clinical samples are self-selected for problems. No national data on adolescents have been reported, except from the sample we used. In , the Bureau of the Census introduced a new system of reporting race, providing a list of races and asking respondents to check all that apply. Because an adult in the household filled out the census, children and adolescents had their race reported by a household adult. The National Health Interview Survey NHIS has been using a check-all-that-apply race classification for data collection for 20 years, but data on the health of those reporting mixed race is only recently being reported. These 2 national sources will provide new data on mixed-race adults and children. However, such data are not suitable for examining the racial identity of adolescents, as their race is reported by another person in the household. We test the prevailing view of the literature that mixed-race adolescents are at higher health and behavior risk than single-race individuals because of stress associated with mixed racial identity. An alternative and simpler hypothesis is that mixed-race adolescents are affected by the cultural experience of both races and will have risk status in between their 2 component races. We test the hypothesis that mixed-race adolescents are within the boundary values for the nonrisk individual and family attributes of the 2 single-race groups that constitute their identities. A stratified probability sample of 80 high schools was selected from a list of all high schools. A feeder school was selected by probability proportional to its contribution to the high school for each high school where required, to provide a full range of grades. All students attending on a specific day in each school completed a self-administered op-scan questionnaire a paper and pencil questionnaire with an electronic scoring sheet for answers to be recorded by the respondent under the supervision of a classroom teacher. The questionnaire collected demographic characteristics, health and behavior reports, and race self-identification. Questionnaires were placed in a sealed envelope by the respondent when completed and deposited in a box for project staff pickup. Teachers had no access to the completed questionnaires. About a year later, a probability subsample of school respondents plus those on the school roster but not present at school administration were interviewed at home, using a laptop questionnaire questionnaire recorded in a laptop computer with answers electronically recorded that was administered by an interviewer. Sensitive questions were self-administered using earphones to listen to the questions read from the computer while shown on the screen. The home interview collected a broader range of data than the school questionnaire. A parent or guardian was also interviewed for most respondents. The same race question was asked on the school, home, and parental surveys. Add Health respondents were asked to identify their race answering the following question: You may give more than 1 answer: Add Health used the check-all-that-apply technique, allowing respondents to choose as many races as they wished. Cooney and Radina 11 exploited another Add Health possibility for multiple race classification from this same data source. Cooney and Radina used the

small, public use subset of Add Health cases and further limited their analysis to adolescents living with both biological parents, 1 of whom had provided a parental interview. Because only slightly more than half of Add Health respondents lived with both biological parents, this analytic strategy resulted in a much reduced sample size, consisting only of adolescents in biologically intact families. If the parent self-identified as 1 race and identified the other parent as another, Cooney and Radina classified the child as mixed race. Parker and Lucas 12 found that parents who reported a spouse of a different race did not necessarily report that their child was of more than 1 race. It should not be assumed that the child reported what parents or coresident adults would have reported for the child, nor that the parents would report themselves as the same race combination if any as the child self-reported. This self-identification assures us that the adolescent racial self-concept is what we are working with. Measurement of Dependent Variables Variables to be correlated with race were derived from both the self-administered school questionnaire and the home laptop interview. They fall into 3 general categories: Risk variables school questionnaire. Self-reported healthâ€”fair or poor vs excellent or good ; wake up feeling tired often or every day in last month; have skin problems such as itching or pimples often or every day last month; have headache often or every day in last month; have aches, pains, or soreness in your muscles or joints every day last month; have trouble falling asleep or staying asleep often or every day in last month; feel depressed or blue often or every day in last month. Risk variables home interview. Guns easily available in the home. Seriously thought about committing suicide during the last 12 months. Ever had sexual intercourse. Skipped school more than 10 times in the last year; repeated a grade; ever received an out-of-school suspension. Nonrisk attributes school and home surveys. Add Health short version of Peabody PVT, 13 percentage in category that are above the overall 75th percentile home interview. Grade point average GPA: Self-reported grades averaged across school subjects , percentage in category with GPA above the 75th percentile for the sample as a whole school questionnaire. Percentage in category who live with 2 parents vs other; school questionnaire. Percentage in category with at least 1 parent with a college degree school questionnaire. School questionnaires with sampling weights were completed by 83 respondents, and home interviews by 18 adolescents. Analysis is computed in Stata Stata Corp, College Station, Tex to adjust for differential probabilities of selection and clustering of the sample. Weighted analyses provide estimates that are representative of the adolescent U. Included in the table are respondents who did not answer the race question. Seventy-eight percent of school respondents omitting race identified themselves as Hispanic.

Chapter 2 : Lesbian, Gay, Bisexual, and Transgender Health | Healthy People

Ethnic-Racial Health Disparities Are Social Justice Issues April is National Minority Health Month: Ensuring the Right to Optimal Health Guns, Media Violence, and Mental Illness.

Lack of interest in activities Hopelessness or guilty thoughts Changes in movement less activity or agitation Physical aches and pains Suicidal thoughts Causes Depression does not have a single cause. It can be triggered by a life crisis, physical illness or something elseâ€”but it can also occur spontaneously. Scientists believe several factors can contribute to depression: When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These changes may lead to depression. Mood disorders, such as depression, tend to run in families. Marital status, relationship changes, financial standing and where a person lives influence whether a person develops depression. Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation. People who have a history of sleep disturbances, medical illness, chronic pain, anxiety and attention-deficit hyperactivity disorder ADHD are more likely to develop depression. Some medical syndromes like hypothyroidism can mimic depressive disorder. Some medications can also cause symptoms of depression. Drug and alcohol abuse. This requires coordinated treatment for both conditions, as alcohol can worsen symptoms. Diagnosis To be diagnosed with depressive disorder, a person must have experienced a depressive episode lasting longer than two weeks. The symptoms of a depressive episode include: Loss of interest or loss of pleasure in all activities Change in appetite or weight Sleep disturbances Feeling agitated or feeling slowed down Fatigue Feelings of low self-worth, guilt or shortcomings Difficulty concentrating or making decisions Suicidal thoughts or intentions Treatments Although depressive disorder can be a devastating illness, it often responds to treatment. The key is to get a specific evaluation and treatment plan. Safety planning is important for individuals who have suicidal thoughts. After an assessment rules out medical and other possible causes, a patient-centered treatment plans can include any or a combination of the following: Medications including antidepressants, mood stabilizers and antipsychotic medications. Exercise can help with prevention and mild-to-moderate symptoms. These include electroconvulsive therapy ECT for depressive disorder with psychosis or repetitive transcranial magnetic stimulation rTMS for severe depression. Light therapy, which uses a light box to expose a person to full spectrum light in an effort to regulate the hormone melatonin. Alternative approaches including acupuncture, meditation, faith and nutrition can be part of a comprehensive treatment plan, but do not have strong scientific backing. Read more on our treatment page.

Chapter 3 : Mental Health and the Current Times: Racial Trauma

"Considering racism as a cause of ill health is an important step in developing the research agenda and response from health services," writes Kwame McKenzie, MD, a psychiatrist at Royal Free and University College Medical School in London.

Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. Am J Public Health. Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. Sexual orientation and mental health. Annu Rev Clin Psychol. The relationship between suicide risk and sexual orientation: Results of a population-based study. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. Centers for Disease Control and Prevention. Sexual orientation and health among U. National Health Interview Survey, [Internet]. National Center for Health Statistics; [cited Apr 12]. Sexual orientation and estimates of adult substance use and mental health: Regular health care use by lesbians: A path analysis of predictive factors. Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Education Development Center, Inc. Compendium of HIV prevention interventions with evidence of effectiveness [Internet]. The effects of unequal access to health insurance for same-sex couples in California. The epidemiology of problem drinking in gay men and lesbians: Sexual orientation and risk of suicide attempts among a representative sample of youth. Arch Pediatr Adolesc Med. A population-based study of sexual orientation identity and gender differences in adult health. Special issues and concerns. Lesbian, gay, and bisexual homeless youth: An eight-city public health perspective. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, â€" Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. CDC; Feb [cited Aug 23]. Overweight and obesity in lesbian and bisexual college women. J Am College Health. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from three US cities. Findings from two needs assessment studies in Philadelphia. National transgender discrimination survey: National Gay and Lesbian Taskforce; Nov. Public policy issues affecting gay, lesbian, bisexual and transgender elders. Tobacco use among sexual minorities in the USA: The health, health-related needs, and lifecourse experiences of transgender Virginians. Virginia Department of Health; Alcohol use and alcohol-related problems among lesbians and gay men. Ann Rev of Nurs Res. Stimulant use and HIV risk behavior: The influence of peer support. Findings and implications for gay and bisexual men.

Chapter 4 : Health and Behavior Risks of Adolescents with Mixed-Race Identity

A considerable literature attests to the emotional, health, and behavior risk problems of mixed-race adolescents. The most common explanation for the high-risk status is the struggle with identity formation, leading to lack of self-esteem, social isolation, and problems of family dynamics in mixed-race households 6 This literature is not entirely consistent.

Science and Engineering Manchester Policy Blogs: All posts You are here: All posts , Ethnicity Posted: We know this from decades of research that has shown that mental health treatment is not the same for people of different ethnic groups in England. To point out a few of these inequalities, Black Caribbean and Black African men are more likely to be sectioned admitted to an inpatient mental health unit involuntarily , or enter treatment via the Criminal Justice System than White men. Pakistani and Bangladeshi women are less likely to be referred for specialist mental health treatment when in need than White women. And overall, most ethnic minority groups report lower satisfaction with their mental health treatment than the White British population. To stress, these data were not collected routinely before and these new statistics were important for highlighting the scale of the problem. But since the DRE programme ended in , there has been no real attempt by the Department of Health to instigate a new race equality initiative for mental health services, and the quality of the statistics, now provided by The Health and Social Care Information Centre HSCIC , has taken a nose-dive too. There are three main problems with these new statistics. First, for most mental health services, HSCIC does not give figures separately for men and women; this is a major flaw because we know that ethnic inequalities for men follow a different pattern than for women. On top of this, none of the figures provided by HSCIC are standardised to the population nor do they adjust the figures for the level of mental illness in the population. This means that we have no idea from looking at the raw data, how this relates to the age structure of the population. Nor do we know if the number of people in each ethnic group using services bears any relation to the number of people that are thought to be suffering from mental illness. This is pretty important because even though some Black ethnic groups have higher levels of mental illness, their levels of incarceration in secure psychiatric units are still higher than would be expected. All in all, this is pretty worrying. Even with these levels of missing data, ethnic inequalities are apparent, so supporters of the HSCIC statistics in their current form may wonder what critics are moaning about. And it looks like the quality of statistics may become worse. HSCIC have recently opened a consultation on changes to the statistics they will provide over the next three years. How long before ethnic group recording is given such little importance that the statistics fail to provide policymakers, researchers and service managers with any usable information on ethnic inequalities? If we are to really tackle racial inequalities within mental health services, reporting accurately on which ethnic groups are using services would be a good place to start. Without this, there is a danger that the true extent of the problem will remain hidden, and racial equality in mental health services will not be achieved.

Chapter 5 : Racial inequality in mental health services: we canâ€™t fix the problem if we donâ€™t have th

A new study looks at the impact that racial discrimination has on mental health. had a higher number of mental health problems than minorities and in the Center on Dynamics of.

Abstract Clinicians and researchers have pointed to the need for culturally sensitive mental health interventions. Yet it has not been determined if the inclusion of cultural elements affects the way mental health clients experience services. This study examined clients who had received mental health treatment from outpatient mental health clinics to investigate whether culturally related elements involving race and ethnicity were important to clients and whether they were related to client satisfaction and perceived treatment outcomes. Ethnic minority clients generally felt that issues regarding race and ethnicity were more important than did White clients. When these elements were considered important but were not included in their care, clients were less satisfied with treatment. Consistent with the notion of cultural responsiveness, these findings provide empirical evidence that culturally relevant aspects of the mental health service experience are salient to ethnic minority clients and can affect how they respond to services. Similarly, the Institute of Medicine IOM, reported that African American and Hispanic patients were more likely to report dissatisfaction with their relationships with providers and to perceive poorer quality of care. Using a clinical sample of Asian American and White mental health outpatients, Zane, Enomoto, and Chun found that Asian Americans reported lower service satisfaction, less confidence in their provider, and greater levels of symptomatology that were attributed to a lack of culturally responsive therapy. Moreover, the American Psychological Association APA, Committee on Accreditation, recognized the importance of integrating discussions of race and ethnicity into the field of psychology by highlighting these issues in clinical training programs. Client Experiences in Treatment Mental health researchers have long recommended the use of a consumer perspective on care provider cultural competency Pope-Davis et al. Therefore, the assessment of client satisfaction is a necessary and critical element in the evaluation of mental health services DiPalo, This definition also includes the perceived adequacy of treatment and the surrounding milieu i. Given the continual emphasis on patient-centered care, it is important to understand what mental health clients expect regarding culturally responsive care. Although we do acknowledge the importance of distinguishing between race and ethnicity, for the purposes of this article and its scope, issues of race and ethnicity are discussed collectively and inclusively, similar to other studies e. Racial Match Racial match, or concordance, has been described as one element of culturally responsive care and a potential factor in reducing mental health disparities for ethnic minorities. In a counseling situation, therapist ethnicity may be one of the most important features to which clients first attend. Ward conducted a qualitative investigation of counseling processes and perceptions of counseling specific to African American clients within a community mental health agency. During the first counseling session, clients reported assessing the race and ethnicity of the counselor above everything else Ward, Only after an assessment of racial match did clients assess other counselor variables e. Some studies have shown racial match to be associated with increased utilization, favorable treatment outcomes i. A more recent meta-analysis of 10 studies found no significant difference between racially matched dyads versus unmatched dyads with regard to staying in treatment and overall functioning for African American and White clients Shin et al. Ward found that racial match might be more important for individuals with a stronger Black identity. Addressing Race and Ethnicity in Treatment Although a host of research studies has centered on the topic of racial differences e. Other research has found that counselors who directly addressed racial issues in the first two sessions of a session counseling experience reported creating an environment conductive to building a strong therapeutic relationship with their clients Fuertes et al. Therefore, it is important to consider how these types of experiences might affect the therapeutic process. Although they found that race was salient to a majority of their participants, they were unable to assess the relative importance of the various factors described by clients as salient e. We examined if specific elements associated with purportedly culturally sensitive or culturally competent mental health care were important to ethnic minority and White clients and whether or not their inclusion in treatment was actually related to the way clients experienced their treatment.

At the time of data collection, the university served a population of over 28, students, about half of whom were ethnic minorities. The majority of the clients Staff at these centers were comprised of clinicians, counselors, mental health workers, psychiatrists, and support staff. The study was comprised of 75 In terms of ethnicity, there were 57 The sample had slightly more Whites The majority of the clients were single Demographic differences by type of participant were analyzed. Significant differences emerged for marital status, education level, and employment. Private clients were more likely to be single or never married Procedure Clients from the private sector were either currently receiving or had at some point received mental health services for their problems. These clients received course credit for their participation. Community-based clients who were waiting to see their care provider in the clinic were asked by a research staff member to participate in the study. Eligibility for the study was based on consent and sufficient mental capacity to complete all the measures. An Asian American research staff member thoroughly reviewed the consent form and procedures of the study with each client before he or she could participate. Participants completed the questionnaires individually while either waiting to see their provider or after meeting with their provider. The majority of clients spent approximately 20â€”30 minutes completing the measures. Respondents could also choose to enter a monetary raffle. This study received institutional review board approval. The CATS assesses how clients perceive and respond to specific service elements that address cultural issues Leff et al. These elements are reflected in the format of the survey, so that each element contains questions regarding its importance and inclusion in treatment. Demographic questions also were included in this measure. It is part of a broader mental health report card that also includes indicators obtained from medical records or administrative databases. The MHSIP consumer survey is a item self-report instrument designed to be completed by the client without assistance. The items are rated on a 5-point Likert-type scale ranging from 1 strongly disagree to 5 strongly agree. Clients can also indicate that an item is not applicable to them. Cronbach alphas for the present sample were as follows: First, to test for ethnic differences in importance ratings of the three cultural elements, a multivariate analysis of variance MANOVA was conducted. If a significant overall ethnicity effect was found, t tests were performed. Second, bivariate analyses were conducted to assess the linear relationships among the key study variables. Given the somewhat small sample size of this study, we had these first two analyses inform which cultural elements should be entered as predictors in subsequent regression analyses. Third, importance and inclusion scores were standardized, and then discrepancy scores were calculated reflecting the difference between the importance of an element and the extent to which it was included in service. Larger discrepancy scores indicated that clients tended to value the element, but it was not included in care. A series of two-step hierarchical regression analyses were run to determine the relative contribution made by demographic and cultural factors on client satisfaction and perceived outcomes. In the first step, age, gender, and type of participant were entered as predictors. In the second step, cultural elements were added to the model. Regression analyses were run for each of type of client service evaluation: Crosstabs and t tests were employed for categorical and continuous variables, respectively. The ethnic minority and White sample differed significantly by age, nativity status, and employment status. Ethnic minorities were also more likely to be unemployed No significant differences emerged on the four outcome variables.

Chapter 6 : Repeated experiences of racism most damaging to mental health

We've talked before about racial dynamics in the planning and organizing stages as well as in dialogues and calendrierdelascience.com round off the posts, we'll give you examples of racial dynamics to watch out for when working on action.

Racial discrimination and health effects: Current research and new areas of study By Farah Qureshi As the deaths of Michael Brown, Eric Garner, Tamir Rice and Freddie Gray have captured headlines and sparked protests across the United States over the past year, there has been a renewed discussion about how structural issues of racial inequity influence various domains of life, including law enforcement , economic opportunity , educational achievement and indicators of health. Despite heightened public awareness, non-white Americans continue to have overwhelmingly different views about the prevalence and impacts of racial and ethnic discrimination. Studies have consistently found that experiencing discrimination is associated with poorer health outcomes overall, but findings on the specific factors have been mixed. Much depends on the health problem in question as well as different approaches to studying these issues, highlighting the need to further understand existing controversies in the field. Williams of the Harvard T. Chan School of Public Health examine what current research has shown; inconsistencies in methodologies that may influence observed results, and future directions for study in areas that have been historically neglected. Key points highlighted in the review include: Experiences of discrimination are a form of stress that can have serious implications for mental and physical health, ranging from depression, anxiety and post-traumatic stress disorder to all-cause mortality and hypertension. Controversies in the field are focused primarily on how experiences of discrimination are recorded and measured in scientific studies. Concerns around how discrimination is defined broadly compared to specifically racially motivated , perception bias the fact that certain types of people may be more or less likely to perceive experiences as discriminatory , and the intersection of different forms of discrimination, all present challenges to public health studies. Perception bias can present in two forms: Minimization can exist when the cost of reporting discrimination is high, if experiences are unclear and nuanced, or it can simply be the result of denial. Vigilance, on the other hand, can be the product of prior personal or cultural experiences, and has been related to improved feelings of self worth. Overall, it is not clear which forms of perception bias are more common in the population; however, the authors note that it is important to interpret study findings cautiously, and also to consider the extent to which studies have addressed anger-related personality characteristics found to be associated with both discrimination and poor health. To address the question of whether racially discriminatory experiences are unique compared to unfair treatment broadly, researchers typically employ a two-stage approach to asking about discrimination: An understudied area remains the impact of chronic discrimination. Emerging areas of research include: Promising approaches that have been associated with improved outcomes include: As research documenting the adverse effects of discrimination on health continues to grow, these efforts will become critically important as a means of improving health in societies shaped by racism and other forms of discrimination. African-American, Hispanic, Latino, civil rights, discrimination, racism Last updated: July 8, We welcome feedback. Please contact us here.

Chapter 7 : 4 ways to address issues with racial dynamics in the action phase | Everyday Democracy

Mental health and substance abuse has clearly become pop culture trends at the moment as any and everyone is now talking about these issues. For clinicians, it is our duty to support underserved populations, especially when the trends have faded.

Chapter 8 : Racism, Sexual Assault Issues May Challenge Collegians' Mental Health

Race and racism both play a significant role in black people's vulnerability to mental health distress and our reluctance

to seek treatment, Kevin Washington, Ph.D., president of the Association.

Chapter 9 : Racism Is Harmful to Your Mental Health | HealthyPlace

As the deaths of Michael Brown, Eric Garner, Tamir Rice and Freddie Gray have captured headlines and sparked protests across the United States over the past year, there has been a renewed discussion about how structural issues of racial inequity influence various domains of life, including law enforcement, economic opportunity, educational achievement and indicators of health.