Misdiagnosis of African-Americans with Psychiatric Issues – Part I

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Purpose: This article highlights issues of misdiagnosis in an African-American, adult clinical population by doing point prevalence, record review study within a comprehensive community mental health center.

Method: Psychiatric evaluations of 330 patients were reviewed and clinically identifiable variables of: a) childhood Intellectual Disability (ID), special education, Attention Deficit Hyperactive Disorder (ADHD), or Autism/Pervasive Developmental Disorder (PDD); b) head injury causing Organic Brain Syndrome (OBS) or Temporal Lobe Epilepsy (TLE); c) a history of chronic substance abuse prior to the development of psychiatric symptoms; or d) childhood trauma causing Anxiety, Depression, and Panic Disorders were tabulated.

Results: Two hundred and twenty patients, who were free of the four variables, had a single psychiatric diagnosis and 18 had multiple co-morbid diagnoses. More than 25% (92/330) of the patients had the four variables in their histories. Four of the 92 patients had more than one variable in their history. Of the remaining 88 cases, 42 had psychiatric issues beginning in childhood (28 had history of ID, 4 had history of learning disabilities, 3 had history of ADHD, 7 had histories of Autism/PDD); 9 had histories of OBS or TLE; 20 had histories of substance abuse; and 18 had histories of extensive childhood trauma).

Conclusions: Careful attention to common issues in African-Americans can inform the psychiatric diagnostic process pointing to prevention or treatment considerations that would benefit the African-American community at large.

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DYNAMICS OF MISDIAGNOSIS OF AFRICAN-AMERICANS

The history of psychiatry informs us, although psychiatry has made some progress in making objective scientific diagnoses of some heretofore-psychiatric disorders (e.g. delirium from pellagra and general paralysis of the insane[1]), and has been able to provide efficacious and effective treatment and prevention strategies for some heretofore-psychiatric disorders,[2,3] objective tests for many psychiatric disorders do not yet exist. In addition, psychiatry has an unfortunate habit of "…surrendering authority over diseases of known somatic origin marked by disturbed behavior…"[1, p 125], leaving psychiatry in a "…somewhat odd position of retaining jurisdiction over all the mental diseases of unknown etiology."[1 p. 126]

Accordingly, psychiatry cannot be considered an exact science. Although the search for a somatic etiology for the more devastating psychiatric disorders, Schizophrenic and Mood Disorders, seems to be getting closer, it has still eluded science, forcing the major psychiatric diagnoses to be made on history, signs, and symptoms of the disorder. Fortunately, clinical practice suggests that most medical disorders, including those in psychiatry, can be made by obtaining a careful and detailed history.[4] However, because there is no objective test for the diagnosis of psychiatric disorders, the diagnostic process is fraught with potential to be misapplied to various populations, especially African-American populations who rarely get "state of the art" diagnosis and treatment.

ISSUES OF MISDIAGNOSIS OF AFFECTIVE DISORDERS IN AFRICAN-AMERICANS

In an early 1980's point prevalence[5] study of an African-American psychiatric clinic on Chicago's Southside, Bell and Mehta[6, 7] highlighted the problem misdiagnosis of African-Americans with Manic-Depressive Illness (currently called Bipolar Disorder). This study revealed that African-American's with Bipolar Disorder were frequently diagnosed as having Schizophrenia despite having classic histories, signs, and symptoms of a Mood Disorder – one of the current exclusion criteria necessary to make a diagnosis of Schizophrenia.[8] More recently, Chien and Bell have reviewed the literature on how the diagnosis of schizophrenia is affected by race[9] and, note that Schizophrenia has been diagnosed clinically at higher rates in African Americans than in Caucasians in contrast to epidemiological surveys that show equal prevalence of schizophrenia among different racial groups. Chien and Bell[9] also provide theories to explain the increased clinical diagnosis of Schizophrenia among African-Americans such as African-American's "primitive mentality," psychodynamic theories suggesting African-Americans were more likely to have Psychotic Disorders rather than Affective Disorders, the empirical findings that African-Americans may have more first-rank psychotic symptoms, e.g. hallucinations and delusions, or that broad social factors (e.g. being overrepresented in lower socioeconomic classes and having less access to health care) may influence different diagnostic rates among ethnic groups. Bell and Mehta[7] suggest, because African-Americans are often treated by public mental health systems that are not as sophisticated nor as well-resourced as private mental health

systems, African-Americans are given short shrift when it comes to careful and thorough diagnostic assessments.

ISSUES OF AFRICAN-AMERICAN CHILDREN WITH ORGANIC BRAIN ISSUES

In 1979, Bell[10] did a point prevalence study in a Chicago Board of Education Pupil Service Center studying the diagnoses of 274 African-American children referred for a complete diagnostic assessment. This study found that of the children being assessed 8% (5 females and 17 males) had a clear history of Organic Brain Syndrome (OBS) and per psychological testing were trainable mentally handicapped (TMH). Frequently, these children presented due to poor frustration tolerance leading to poor "affect regulation,[11]" which often ended in violent or hostile behavior. As not all children who have OBS and are TMH are explosive, these children were classified as seriously, emotionally, disturbed; and they showed disturbances in memory, judgment, intellect, orientation, and stability of affect. In addition, these children showed marked global visual, auditory, and tactile agnosias; expressive speaking, receptive listening and seeing, and expressive writing aphasias; writing aphasias; ideomotor and constructional apraxias; spatial orientation difficulties, and poor right/left body discrimination. Finally, these children tended to be highly excitable, hyperactive, and distractible with poor attention spans. The second category this empirical study identified were children who were "educable mentally handicapped" (EMH) and who had poor frustration tolerance leading to poor impulse and/or affect control (explosive) usually resulting in hostility or violence but who were not as severely impaired as the OBS/TMH group. These children's disturbances in memory, judgment, intellect, orientation and stability of affect were not as severe as in the OBS/TMH group, and, while they also showed global difficulty with the agnosias, aphasias, apraxias, spatial orientation and right - left body discrimination, these problems were not as severe as the OBS/TMH group. However, these children tended to be excitable, hyperactive, distractible, and explosive, thus they could be said to have externalizing problems[12] EMH children with neurotic features were the third category, which consisted of 4% of the population being, studied (2 females, and 9 males). These children had neurologic findings similar to the "explosive" EMH children however; these children tended to be sad because they knew they were slow and wanted to be like everyone else, thus they could be said to have internalizing problems.[12]

ISSUES OF HEAD INJURY IN AFRICAN-AMERICANS

In 1985, the Community Mental Health Council research team published an article on the prevalence of coma in black subjects.[13] This article found that nearly half (45.4%) of the randomly selected control, precare (i.e. anxious), and aftercare (i.e. psychotic) patients had experienced a coma at least once during their lives. Subsequent to this empirical study, this research organization published two reviews on Coma and the etiology of violence.[14, 15] This team also reported on a case history of a patient with a serious head injury and subsequent coma that later developed into a patient history of intermittent, non-schizophrenic, psychotic symptoms that was misdiagnosed as schizophrenia.[16] This patient had a clear history of being in an auto accident that killed three of the four passengers in the car and resulted in the patient being comatose for 10 days.[16]

Unfortunately, despite the empirical evidence these studies provided, the issue of head injury and coma in African-Americans did not gain any traction until football players began to show signs of violence, dementia, and psychosis after traumatic brain injuries.[17–19]

ISSUES OF CHRONIC SUBSTANCE ABUSE IN AFRICAN-AMERICANS

In 1985/1986, the CMHC research group began to notice a phenomenon of patients who were diagnosed as Schizophrenic, but who were extremely interpersonal and who also had extensive work histories.[20] While these patients reported hallucinations, insomnia, and paranoid ideation, they lacked evidence of the second necessary criteria for a diagnosis of Schizophrenia, i.e. psychosocial deterioration. Furthermore, these patients did not develop their psychotic symptoms until they were mid- or late life adults after an extensive history of chronic substance abuse.

THE POINT PREVALENCE STUDY

The purpose of this article is to highlight issues of diagnosis in an African-American adult clinical population by doing a point prevalence,[5] record review study of one psychiatrist's caseload in a comprehensive community mental health center (CMHC). Due to the loss of psychiatric work force in a Chicago CMHC, the lead author had to step in to ensure appropriate patient care continued for the patients being served. As the Nation's first Black Psychiatrist – Solomon Carter Fuller – learned, sometimes the least sought after jobs in medicine are actually the frontier for new discoveries.[21] As the patients were new to the first author, and there were difficulties reading the writing of the previous psychiatrists, new psychiatric evaluations were undertaken and computerized. Because of our understanding of prevalence patterns of childhood developmental issues resulting in psychiatric treatment;[10] the prevalence of head injury;[13–15] the misdiagnosis of various OBSs;[16] the misdiagnosis of Bipolar Disorder and Substance Abuse Disorders;[6, 7] and Stress-Related Disorders in childhood[22–26] in African-Americans these areas were carefully explored. In part II, the authors