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Treatment Barriers for Low-Income, Urban African Americans With Undiagnosed Posttraumatic Stress Disorder

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Abstract

African Americans in low-income, urban communities are at high risk for exposure to traumatic events as well as for symptoms of posttraumatic stress disorder (PTSD). Approximately 22% of 220 participants recruited from urban hospital medical clinics met survey criteria for PTSD. Among the common traumas were having relatives/friends murdered (47%), being attacked with weapons (64% of men), and being sexually attacked (36% of women). Although desiring mental health services, only 13.3% of those with PTSD had prior trauma-focused treatment. Barriers to treatment included limited transportation and finances, family disapproval, and unfamiliarity with accessing treatment, among others. These data highlight the need for an awareness of the high prevalence of trauma and PTSD in this population.

A growing number of studies (e.g., Alim, Charney, & Mellman, 2006; Liebschutz et al., 2007) indicate that low income African Americans living in urban environments are at high risk for both exposure to traumatic events and for symptoms of posttraumatic stress disorder (PTSD). A recent study of 617 African American primary-care patients found a 65% rate of life-time trauma exposure and a 33% rate of PTSD (Alim, Graves et al., 2006). Notably, PTSD appears to be often underdiagnosed and untreated in these as well as in other populations (Magruder et al., 2005).

The current literature does not clarify to what extent these high levels of trauma exposure and PTSD symptoms stem from factors related to poverty, urban environment, race/ethnicity or their interaction. Furthermore, it has been suggested that low-income African Americans are less likely to receive mental health services and are more prone to seek mental health care via emergency services or primary care (Gary, 2005; Snowden, 2003; Snowden & Pingitore, 2002). Hines-Martin, Malone, Kim, and Brown-Piper, (2003) propose three types of barriers to help-seeking behavior and to mental health access among low-income African Americans: individual (e.g., stigma, competing responsibilities, knowledge deficits), institutional (e.g., bureaucratic red tape), and cultural (e.g., family opposition).

This study aims to (a) examine the frequency of trauma exposure and PTSD symptoms in a sample of low-income- African Americans seeking treatment in primary care clinics of an urban, public hospital; (b) examine reported needs for mental health counseling services in this population, and how these needs relate to PTSD symptoms; and (c) examine the perceived individual, institutional, and cultural barriers to receiving services and mental health care, and the relationship of these barriers to PTSD symptoms.

METHOD

Participants and Procedure

Two-hundred twenty participants, a sample of convenience, were approached while waiting for appointments in nonpsychiatric hospital clinics within a major southeastern hospital that serves a primarily (>90%) African American indigent population. Approximately 1 out of 5 waiting patients were approached during each recruitment effort until the desired sample size was achieved. Descriptive analyses of self-reported racial/ethnic and demographic data are in Table 1. Eligibility requirements included ability to give informed consent. All questions were asked verbally via face-to-face interviews that lasted approximately 60 minutes. Safety and wellbeing were assessed during and following the interview, and at-risk participants were accompanied to Psychiatric Emergency Services. Participants were paid \$15.00 for participation and procedures were approved by the Institutional Review Board.

Measures

The Traumatic Events Inventory (TEI) is a 14-item screening instrument for lifetime history of traumatic events (see Table 2 for assessed traumas; Schwartz et al., 2006).

The Modified PTSD Symptom Scale (MPSS) is a 17-item self-report scale that mirrors the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV*; American Psychiatric Association, 1994) criteria for PTSD. The MPSS demonstrates good psychometric properties in similar populations (Falsetti, Resnick, Resick, & Kilpatrick, 1993). These individual MPSS frequency items were summed to obtain a total, continuous PTSD score. We also scored each item as present/absent with items endorsed at ≥ 1 counted present. The *DSM-IV* PTSD diagnostic criteria were applied, allowing us to create a categorical variable that coded participants as PTSD present or absent.

Receipt of mental health services and the receipt of PTSD-focused treatment were collected via yes/no self-report questions that asked if patients had ever sought care for a list of psychiatric diagnoses, including PTSD.

The Medical and Social Needs Questionnaire is a 23-item self-report measure developed for this study, assessing the self-perceived importance of a range of social and medical services (e.g., housing, job placement services, parenting training). We examined participants' responses to four items: "Right now, how important to you is ... (a) individual counseling, (b) family counseling, (c) drug or alcohol treatment, and (d) mental health care." Items were rated on 5-point Likert-type scale (0 = *not important*, 4 = *extremely important*).

The Barriers to Need Questionnaire is a 16-item self-report measure developed for this study to assess unmet health care and social services needs in low socioeconomic status (SES) and/or African American populations. The items are rated on a 4-point Likert-type scale (0 = *none* to 3 = *very much*). It is divided into three rationally derived subscales: (a) individual barriers (eight items: $\alpha = .67$, $M = 17.17$, $SD = 4.48$; e.g., daily crises and lack of transportation, child-and-family care, finances, good physical health, and flexible work schedule); (b) institutional barriers (five items: $\alpha = .60$, $M = 11.57$, $SD = 4.76$; e.g., unprofessional staff conduct, bureaucratic red tape, ineligibility for services, and unfamiliarity with accessing

services); and (3) cultural barriers (three items: $\alpha = .65$, $M = 7.05$, $SD = 2.19$; e.g., familial, community, and religious disapproval of mental health service).

RESULTS

Exposure to Traumatic Events and Level of PTSD Symptoms

Table 2 presents TEI data and indicates high levels of trauma exposure in this sample. Using the PTSD categorical variable, 22% of participants had current PTSD. Of these 45 participants meeting criteria for PTSD, 95% were at one time consumers of mental health services, having prior diagnoses and treatment for depression, ($n = 23$), schizophrenia ($n = 10$), anxiety disorder ($n = 7$), and bipolar disorder ($n = 3$). Yet, per self-report, only 13.3% of these PTSD patients had received prior PTSD-focused treatment.

Perceived Importance of Mental Health Services and PTSD

The sample rated the following services as at least somewhat important to their lives: mental health care—31%, individual counseling—27%, family counseling—21%, and substance abuse treatment—13%. Based on a composite score of number of mental health services reported as needed, 43.9% of participants endorsed the importance of at least one type of mental health service. The importance of mental health services correlated positively to the continuous MPSS score, $r(184) = .18$, $p < .01$. Using categorical variables, those with PTSD were significantly more likely to report mental health care, PTSD = 46.7%, without PTSD = 20.8%, $\chi^2(1, N = 183) = 5.14$, $p < .05$; and individual counseling, PTSD = 41%, without PTSD = 24.7%, $\chi^2(1, N = 185) = 4.01$, $p < .05$, as important.

Posttraumatic Stress Disorder and Barriers to Health Care Access

The above data suggest that there is a need for mental health services and that participants with PTSD are not receiving such treatment. Thus, we looked at barriers to services within this population. We compared participants with and without PTSD across the three barrier subscales using the need for mental health/counseling composite scores as a covariate. We found a significant difference for individual barriers, $F(1, 180) = 4.76$, $p < .05$, and institutional barriers, $F(1, 182) = 4.28$, $p < .05$. The average number of individual barriers for PTSD subjects was 8.31 ($SD = 3.94$) compared to 6.52 ($SD = 4.44$) for those without PTSD. The average number of institutional barriers for PTSD subjects was 4.78 ($SD = 3.35$) compared to those without PTSD, 3.19 ($SD = 4.29$). In the sample as a whole, the most likely to be endorsed barriers to accessing mental health services included limited finances and transportation (the majority of participants lived below poverty level), family disapproval, negative therapy experiences of others, community disapproval, and ineligibility for services.

We conducted exploratory analyses correlating total MPSS with each of the individual items on the individual and the institutional barriers scales. The significant items from the individual subscale were physical health preventing use of services, $pr(181) = .26$, $p < .001$; high levels of daily crisis/no time available, $r(181) = .30$, $p < .001$. The significant items from the institutional subscale were too much hassle, $pr(181) = .20$, $p < .01$; unaware of steps to obtain services, $r(181) = .17$, $p < .01$; and service eligibility issues, $pr(181) = .24$, $p < .001$.

DISCUSSION

Our participants reported a higher rate of PTSD (22%) than in the general U.S. population, which is estimated to range from 9 to 12% (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Participants with PTSD endorsed desire for mental health services, but were unlikely to have received PTSD-focused treatment. Notably, those meeting survey criterion for PTSD were more likely than those without PTSD

to rate mental health care and individual counseling as important. Our overall sample data confirm prior research investigating barriers to mental health access for low-income African Americans (Gary, 2005; Hines-Martin, et al., 2003; Snowden, 2001).

We found higher levels of individual and institutional barriers to be associated with increased PTSD symptoms. This suggests that in an environment in which a number of barriers to mental health services exist, PTSD patients may be even more likely to face difficulties. Thus, barriers may have led to inadequate treatment resulting in more severe PTSD symptoms as compared to those who reported fewer barriers. Importantly, the reverse could also be true, that people who have increased barriers to treatment may be more likely to develop PTSD.

Among the questionnaire items assessing individual barriers, the experience of daily crisis, lack of time, and difficulty obtaining services were all related to level of PTSD symptoms. This is consistent with qualitative research indicating that many low-income African Americans have competing obligations (e.g., insufficient finances, extremely stressful lives) that may minimize the priority of help-seeking (Hines-Martin et al., 2003). It is also possible that this association occurs because PTSD is a disorder marked by avoidance, which could be exacerbated by the nature of the trauma. Such avoidance may also include avoidance of care.

Among the institutional barrier items, unfamiliarity with clinical services and ineligibility were related to more PTSD symptoms. It is not unusual for low-income African Americans, who may be marginalized and some of whom may not be well-educated, to feel intimidated by institutional procedures. Thus, our results are consistent with data suggesting that institutional barriers can diminish seeking or complying with treatment (Atdjian & Vega, 2005; Copeland, 2005). The increased level of institutional barriers may also reflect provider's lack of awareness in identifying PTSD and a lack of PTSD-focused services.

Fears of family and community disapproval were highly endorsed cultural barriers in subjects with PTSD. Others have found that subjects often deny mental illness to maintain the positive regard of others and to avoid personal embarrassment (Cooper-Patrick, Brown, & Palenchar, 1995; Gary, 2005). Likewise, families may become stigmatized when a relative needs psychiatric care (Gary, 2005). Familial and community disapproval of treatment seeking is often rooted in the African American view of faith and the church community as essential for coping with life's problems, even mental health difficulties (Snowden, 2001; Taylor & Chatters, 1986).

Study limitations included the novel, and yet untested Barriers to Need Questionnaire, use of a proxy for PTSD diagnosis instead of a formal *DSM* diagnostic interview, and no examination of gender effects. As a descriptive study, we cannot say if the rates of trauma and barriers to treatment were primarily a function of racial, ethnic, cultural, financial, or combined SES status. Reliance on self-report for all variables and self-selection may have introduced biases related to recall or information errors, specifically with regards to self-report of previous treatment. The study population, which is overall highly traumatized, can be seen as both a limitation and strength of the study.

In summary, our data suggest the need for awareness of the high prevalence of trauma and PTSD in this population. The data also suggest that PTSD is undertreated in primary care settings and that this may be related to barriers in receiving mental health services. Future research may determine if these same barriers are faced by similarly disadvantaged populations and the degree to which other potentially causal mechanisms such as poor health education, contributed to these barriers. In the meantime, awareness of these barriers might help clinicians begin to work with their patients on solutions to overcome them.

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Table 1

Descriptive Statistics of Sample's Demographic Data Based on Self-Report

Gender	130 Women (59.3%), ages range 18 to 79 ($M = 36.7, SD = 15.26$) 90 Men (40.7%), ages ranging from 18 to 78 ($M = 41.32, SD = 15.91$)
Race/ethnicity	97.3% African Americans 2.7% Caucasian, Hispanic, Biracial, and other
Education	37.6% < 12th grade education 38.4% High school diplomas/general equivalency diploma 24% > 12 th grade education
Employment	64.7% Unemployed with 26.6% receiving disability 35.3% Employed with 5.1% receiving disability
Monthly income	36% < \$500 28% \$500–999 26% \$1,000–1,999 10% > \$2,000
Psychiatric history	27.6% Depression 8.6% Schizophrenia 8.2% Anxiety 2.7% Bipolar disorder 4.1% Posttraumatic stress disorder 28.5% Past substance abuse and 6.8% current substance abuse 19.9% Voluntarily and 6.4% involuntarily hospitalized in past

Table 2Percentages of Self-Reported Lifetime Rates of Exposure to Traumatic Events ($N = 220$)

Event	
Natural disaster	18.5
Serious accident or injury	35.7
Sudden life-threatening illness	23.9
Military combat or service	2.3
Murdered family member or friend	46.8
Suicide of close friend or family member	14.9
Attacked with gun, knife, or weapon	42.5
Attacked without weapon	28.6
Witnessed violence between parents or caregivers ^a	39.7
Beaten as a child	12.2
Sexual contact before age 13	21.7
Sexual contact after 13 with physical force	15.5
Pressure/threat for sexual contact w/o physical force	9.5
Unspecified traumatic events	16.3

^aTotal $n = 68$ for this question as it was added later in data collection.