

# Introduction to Special Issue: *Journal of Pediatric Psychology* Statement of Purpose—Special Section on Diversity and Health Care Disparities

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Data from the 2000 census reveal that the United States is becoming increasingly diverse at a rapid pace. Between 1990 and 2000, the Latino/Hispanic population increased by >50% (Guzmán, 2001), and the Black and Asian populations both increased at faster rates than the total population (Barnes & Bennett, 2002; McKinnon, 2001). Population projections indicate that between 2000 and 2010, the proportion of individuals considered “White alone (not Hispanic),” will decrease from 69.4% to 65.1%, and by 2050 will be barely a majority, at 50.1% of the total population (US Census Bureau, 2004).

The increasing diversification of the population creates certain responsibilities for the execution of ethical science. Guidelines for federal funding require documentation of efforts toward appropriate representation of racial and ethnic minorities within study design. In our own field, submission guidelines for the *Journal of Pediatric Psychology* indicate that articles must specify the racial/ethnic composition of study samples, and questionnaires, interviews, and procedures that are used with diverse samples must have appropriate normative data. At a minimum, when study samples lack diversity, issues of generalizability and applicability to diverse samples must be addressed within every manuscript. There is also, however, an increasing need for research that specifically assesses the complex relations among race/ethnicity, culture, and health outcomes. The purpose of the *Journal of Pediatric Psychology*'s special section on diversity and health care disparities is to facilitate the presentation of research that addresses (a) the interface between culture and illness management behavior, (b) the mechanisms of underlying health care disparities, and (c) the complex relations among socio-economic status, racial/ethnic background, and disease outcomes.

## Background

Increasing attention to cultural diversity within all the manuscripts published in *JPP* is a critical objective. Even within the past decade, research within our field has fallen short of that goal. In 2002, Clay, Mordhorst, and Lehn did a compelling analysis of the extent to which the studies that served as the basis for certain *JPP* articles on Empirically Supported Treatments (ESTs) actually addressed issues of cultural diversity in any way. In other words, do the benchmark articles from which we draw our conclusions about treatments in pediatric psychology provide information about cultural issues? Do we have any information about whether these treatments are even applicable across a variety of racial and ethnic groups? Results indicated that less than a third of the treatment studies included in the reviews even reported the race/ethnicity of participants, and only a very small fraction of studies (6%) addressed cultural variables as potential moderators of treatment effects (Clay et al., 2002). Interestingly, treatment studies reviewed by Clay and colleagues included interventions for conditions such as asthma, diabetes (McQuaid & Nassau, 1999), and obesity (Jelalian & Saelens, 1999), which are all found to a greater degree among racial and ethnic minorities (Centers for Disease Control, 2004; Ogden et al., 2006).

## Health Care Disparities

Increasing the representativeness of our samples, using culturally appropriate methods of data collection, and interpreting our findings within the broader context of culture are all important objectives. They may, however, not be enough. There is increasing recognition that the interface between culture and processes related to health, such as disease etiology and prevalence, health care access and use, and patient–provider interactions, should

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*Journal of Pediatric Psychology* 33(1) pp. 22–25, 2008

doi:10.1093/jpepsy/jsm093

Advance Access publication September 28, 2007

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in and of themselves be a focus of greater study. In 1999, Congress requested that the Institute of Medicine (IOM) of the National Academy of Sciences investigate the overall extent of racial and ethnic disparities in health care. The result of their careful analysis is detailed in the hallmark IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Institute of Medicine, 2002). This report provides an overview of healthcare quality for diverse racial and ethnic groups, holding constant key demographic factors such as income, insurance status, and access to health care services. Findings were strikingly consistent across disease conditions, and demonstrated that members of racial and ethnic minority groups were less likely to receive important health services for both routine health problems and clinically necessary procedures. Disparities were found across numerous disease areas, including many areas of pediatrics such as asthma, cancer, HIV/AIDS, diabetes, and mental health treatment (Institute of Medicine, 2002).

Since the release of the IOM report, there has been increasing attention called to the need for research in health disparities. Broadly defined, health disparities research addresses differences between demographic groups in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival. Often genetics and environment are implicated in disparities in incidence and prevalence of disease. A larger host of variables is thought to affect disparities in disease management and course, including factors related to the health care system, patient and family level factors, and aspects of the patient-provider interaction (Canino et al., 2006; Institute of Medicine, 2002). In 2000, the National Institutes of Health established the National Center on Minority Health and Health Disparities (NCMHD), an outgrowth of the Office of Research on Minority Health. The mission of the NCMHD is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. Since that time, there has been an explosion of funding opportunities in health care disparities research, with many of the NIH institutes clearly defining strategic plans to address health care disparities within the specific purview of the institutes.

To date, only a limited number of articles published in *JPP* have specifically addressed issues of health care disparity or cultural diversity as areas of scientific inquiry. In 2002, *JPP* published a special issue on Ethnic Minority and Low Income Children and Families (Edited by Diane Willis), which provided a refreshing range of

articles on topics such as use of complementary and alternative medications for asthma in a Hispanic community (Bearison, Minian, & Granowetter, 2002), assessment of the interface between culture and treatment in African-American children with disruptive behavior disorders (McNeil, Capage, & Bennett, 2002) and predictors of risky sexual behavior in minority females (Bachanas et al., 2002). The special issue was a milestone in *JPP*'s journey toward an increasing emphasis on culture, yet much remains to be done to stimulate research in this key area.

### **Incorporating Multiple Levels of Influence**

Research that moves beyond documenting demographic differences to providing explanatory models of cultural differences should be our goal. Given that socioeconomic status and race/ethnicity are frequently confounded within research design, careful attention to the differential effects of these factors is also critical. As an example, Hanson and Chen (2007) recently reported results from an evaluation of the pathways among socioeconomic status (SES), race, and body mass index (BMI) in a sample of adolescents. Although lower SES and African-American race were both significantly associated with higher BMI, the mediational pathways differed such that sedentary behaviors mediated the association between SES and BMI, and physical activity mediated the association between race and BMI (Hanson & Chen, 2007). Koinis Mitchell and colleagues (2007) propose the use of a multidimensional cumulative risk index to conceptualize the variety of factors (beyond poverty or race/ethnicity alone) that may contribute to asthma morbidity in urban children. These research efforts provide useful models of strategies that can be used to disentangle the complex effects of poverty, race/ethnicity, and culture on health and health behaviors.

### **Reciprocal Influences**

Although research assessing an array of predictive factors relating to disparities in health outcomes is sorely needed, a social ecological framework (Brown, 2002; Kazak, 1989), suggests that we not overlook the reciprocal influences between children, families, and larger contexts. Such a model proposes that just as culture may influence family and child variables, such as illness management behavior, these behaviors may have reciprocal influences on the larger system of culture. As an example, a substantial

body of research has demonstrated that African-American and Latino parents have significant concerns about the use of asthma medications, such as fear of addiction (Mansour, Lanphear, & Dewitt, 2000) and preference for use of natural remedies (Bearison et al., 2002). Recent research in the genetics of asthma has shown that there may be considerable racial and ethnic variability in how individuals respond to asthma medications (Burchard et al., 2004; Tsai et al., 2006), which raises the possibility that some cultural beliefs about medications may actually be derived from varied experiences with medication efficacy. Ongoing consideration of the reciprocal influences between individual, family, and cultural systems will be necessary to advance our understanding of children's health in context.

### Patient/Provider Interactions

Research that addresses issues of cultural diversity and disparity also points to factors that may move us out of our own "comfort zone" as the objective, impartial scientist or empathic health care provider. The IOM report acknowledges that although multiple sources may contribute to disparities in health care, there is evidence that bias or stereotyping on the part of the health care providers themselves may also be a key factor in contributing to differences in care. Certain conditions such as time constraints, incomplete information, and pressure to make rapid clinical decisions may predispose health care providers to use "cognitive shortcuts" that may set the stage for reliance on unconscious stereotypes and biases (Institute of Medicine, 2002). A recent study by Pottick and colleagues (Pottick, Kirk, Hsieh, & Tian, 2007) illustrates this concept among mental health professionals. Researchers asked social workers, psychologists, and psychiatrists to review standard vignettes about a student in an urban school. In each vignette, enough information was provided to substantiate the diagnosis of conduct disorder, however, the name and race/ethnicity of the student was manipulated to be Carl (black), Carl (white), or Carlos (Hispanic). Clinicians of all races tended to label white children with mental illness more frequently than children of color with the same symptoms, suggesting that negative behaviors may be seen as more normative for minority children (Pottick et al., 2007). Although we may be most comfortable in assessing patient, family, and cultural contributions to health care disparities, aspects of the health care provider/patient interaction may also provide

a unique window to understanding differences in health outcomes between racial/ethnic groups.

### Conclusion

Research on diversity and health care disparities is a "growing edge" for the *Journal of Pediatric Psychology*. Establishment of the Special Section on Diversity and Health Care Disparities is meant to stimulate scientific inquiry in exciting new directions, through the development of empirically supported treatments for diverse populations, the identification of cultural variables that may serve as protective factors, and the advancement of models that integrate culture and socioeconomic context as related, but distinct variables in the health care process. The establishment of a special section on Diversity and Health Care Disparities is intended to stimulate interest and increase the proportion of manuscripts that address these critical topics within *JPP*. Given this is a new research area for *JPP*, research employing qualitative methods and novel methods of data collection are encouraged for submission. Review articles, commentaries, and manuscripts proposing new theoretical perspectives are welcomed. By broadening our research base in cultural diversity and health care disparities, we will be insuring that our science reflects the increasingly diverse demographics of the United States, and is relevant for the families that we serve in a wide variety of health care settings.

*Conflict of interest:* None declared.

*Received August 24, 2007; revisions received August 24, 2007; accepted September 1, 2007*

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