Current Clinical Psychiatry
*Series Editor:* Jerrold F. Rosenbaum

Morgan M. Medlock
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David R. Williams *Editors*

# Racism and Psychiatry

## Contemporary Issues and Interventions

Humana Press

# Current Clinical Psychiatry

**Series Editor:**

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*To Professor Chester M. Pierce*

*He mentored many of us and taught us much about the inherent dignity of men and women. He helped us avoid defensive, apologetic thinking and urged us to help transform our communities into therapeutic spaces.*

# Foreword

> The most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference.
>
> —W.E.B. Du Bois (1899)

It is a humbling experience to be asked to write the foreword for this book. On the one hand, as the first African American elected to hold the office of president in the 174-year history of the world's oldest psychiatric organization, I am honored to receive the invitation. On the other hand, it seems that we are still fighting the same battle described by Du Bois over a century ago, regarding understanding and incorporating the unique cultural differences encountered at the intersection of race and health care, including psychiatry, into treatment approaches. The need for this book, however, cannot be underestimated, given the current challenges facing both the increasingly diverse population of the USA and the field of psychiatry.

However, Du Bois could not have imagined that over 100 years after he made the above statement, we would still be sorting out this "social problem." And, although he was not a behavioral health professional, in that one statement he provided a critical analysis of a situation about which much has been written in the intervening years: race and racism as social determinants of health and mental health; the impact of both on access, diagnosis, and treatment for diverse racial and ethnic populations; and how these influence training and clinical care. Unfortunately, there remain gaps in our understanding of the cultural and social contexts of individuals from minority groups, which are significant determinants for clinicians and patients as they encounter each other in therapeutic situations. Along with the larger social issues of poverty, discrimination, and racism, these cultural factors often lead to misunderstandings and result in mistrust, bias, and poor outcomes for those who seek mental health services. Additionally, American psychiatry was founded on the principles of European medicine, "emphasizing objective evidence based on scientific inquiry" [1]. This foundation has resulted in gaps in understanding and awareness of the needs of nonwhite populations seeking psychiatric services.

It is a personal privilege to reflect on the work done by those who are part of the history of this issue and participate in the work being done by the next generation of clinicians and scholars in this area. In fact, the title of this book immediately reminded me of a book with a similar title published about 45 years ago—*Racism and Psychiatry,* authored by Drs. Alexander Thomas and Samuel Sillen [2]. They reviewed the impact of historical and contemporary racist thinking on psychiatric diagnostic formulation, addressing the myths and stereotypes of the day. The foreword was written by Dr. Kenneth Clark, best known for his landmark doll test study of "race, color and status on the self-esteem of children." Their work is an early example of a social justice approach to psychiatric training, services, and advocacy, cited in the *Brown v. Board of Education* case when it was heard before the US Supreme Court in 1954.

From the earliest days of psychiatry in America, psychiatrists have struggled with how to deal with racism, which is at the core of relations between blacks and whites in this country. From Samuel Cartwright and *drapetomania* (a "disease" causing blacks to have an uncontrollable urge to run away from their masters) to Benjamin Rush and *negritude* (a rare, congenital "disease," which derived from leprosy and entitled blacks to a double portion of humanity from whites), the field has struggled to understand, within the context of racial and ethnic differences, how to understand and provide treatment to African Americans with mental illness. The 13 founding members of the American Psychiatric Association (which started as the Association of Medical Superintendents of American Institutions for the Insane, then became the American Medico-Psychological Association), at an early organizing meeting, established a "Committee on Asylums for Colored Persons," which may represent the first effort to address the race problem in psychiatry. The history of psychiatry is filled with many stories of the challenges raised—many still unaddressed—as it relates to American psychiatry and African Americans. Over the last 50 years, this history has been chronicled in many different ways. Numerous books, articles (in scientific and lay journals), conferences, and other modes of communication have raised questions regarding racism as a mental illness and the continued racial and ethnic disparities in the clinical arena. Misdiagnosis and research outcomes that result in inadequate and inappropriate treatment for blacks continue to concern many in the African-American community.

In 1970, Sabshin et al. [3] wrote about racism and psychiatry in the *American Journal of Psychiatry*: "We can no longer pretend it does not exist in psychiatry; we must counter our earlier denial with a hyperawareness that we hope will be temporary during a period of transition. Our own openness and effort can encourage other professional groups to also bring the efforts to combat white racism out of the shadows to the center stage of everyday life where this struggle belongs—if racism is to be eradicated." Unfortunately, the estrangement has continued, affecting training, research, and clinical practices, and resulting in a significant disparity in mental health access and treatment.

Understanding the evolution of psychiatry and psychiatric practices in the USA and how it has impacted the health and emotional well-being of African Americans over that same time period is critical to understanding this book's proposed framework for solutions. This millennial-led team has tackled the tough topics, picking up where the 2001 Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* left off [1].

Their approach to discussing and addressing these race-related issues gives hope that perhaps we have reached a point in the relationship between blacks and whites in psychiatry where we can address these issues and move forward in our understanding of how to eliminate disparities and develop strategies for improving the awareness and utilization of psychiatric services by all marginalized groups.

It is significant that the book includes chapters on training and advocacy issues, broadening training to include the incorporation of innovative didactic and experiential examples into the medical education curriculum. The Massachusetts General Hospital (MGH) model is provided as one example of how academic medicine can begin addressing the issues of racism within interpersonal and institutional settings. Its early recognition of the importance of training for faculty and supervisors shows promise for moving beyond earlier efforts in cultural competence training that often did not include these individuals, and therefore left medical students and residents exposed to these concepts and values without solid support within the medical hierarchy. This work is essential to efforts to improve diversity in the psychiatric workforce and promote health equity for marginalized populations.

*Racism and Psychiatry: Contemporary Issues and Interventions* is an excellent contribution to a growing body of work at the intersection of psychiatry, the cultural context, and health equity. Dr. Medlock, her distinguished colleagues, and the contributing authors are to be commended for the excellent job they have done to bring these issues to the forefront in our field. This volume provides an excellent picture of what can happen to create a paradigm shift when a diverse group of highly motivated and social justice–driven individuals tackle long-standing and difficult issues, whether in society or in our profession.

I keep images of other "first" blacks in medicine—Rebecca Lee Crumpler, Rebecca Cole, Susan McKinney Steward, and, of course, Solomon Carter Fuller—with me at all times as reminders of the work done by others and to encourage me to keep moving forward. It is my hope that this volume will be that reminder for other health professionals well into the future.

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# Introduction

Racism is defined as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks [1]." Since the very public shooting of Trayvon Martin in 2012, followed by a never-ending stream of black deaths at the hands of white police, to the President's neutrality over a racist-driven rally in Charlottesville, Virginia, to actions of the Supreme Court and of the Justice Department to eliminate voting protections and reinstate draconian sentencing policies that disproportionately affect men of color—there has been a pressing national conversation about racism and the treatment of black people in the United States, from the period of slavery to modernity. Concurrently, psychiatric trainees and the community psychiatry faculty at Massachusetts General Hospital (MGH) began to address the dearth of formal didactic content exploring the mental health impact of racism on African Americans, a topic that seemed inadequately addressed by standard cultural competency curricula. Shortly thereafter, an anti-racism didactic curriculum was formulated [2], which focused on the levels of racism that intersected, and often disrupted, the mental well-being of African Americans. Entitled "Racism, Justice, and Community Mental Health," this required didactic curriculum engaged psychiatric trainees at all levels with topics ranging from residential segregation and its impact on mental health access and outcomes to personally mediated racism and the clinical encounter. Over 60 trainees participated during the first year, and most of them felt that training that moved beyond cultural competency to directly address racism and its effects on African Americans, specifically, was not only worthwhile, but critical to the practice of psychiatry.

Developing an anti-racism focus in psychiatric training raises additional questions about the role of mental health treatment in the lives of oppressed people. What comprises "treatment" for communities of color, which are marginalized by bias and racism that is structurally embedded in systems of housing, education, and law enforcement? This book is the culmination of our grappling with such questions and desiring to understand and tell a story—though imperfectly—about historical oppression, present-day racism, and potential ways of understanding and intervening in a therapeutic manner when working with individuals and communities whose experiences are inevitably shaped by failures in equity. We also make visible the ways in which the medical profession generally—and organized psychiatry in particular—have reproduced racial inequities in access to care, diagnosis, and treatment. Though we recognize that diverse communities have been impacted by racism, our focus is on the African-American narrative, both to allow for sufficient depth in the discussion and to appreciate the nuanced historical elements of trafficking and enslavement, as well as to understand the communities' subjection to modern versions of anti-black racism. Where possible, we expand the conversation to the experiences of other racial groups in the United States, including Latinx, Native American, and Asian populations.

We understand racism as a three-tiered construct that operates on institutional, interpersonal, and internal levels [3]. Institutional racism creates 'differential access to the goods, services, and opportunities of society', by the social construct of "race." An example of institutional racism is the reduced access to medical care and over-representation in the penal system for African Americans. Interpersonal racism is the driving force behind race-based assumptions about the abilities, motives, and intentions of others. It can lead to feelings of suspicion toward or lack of respect for the other, as well as contribute to blatant acts of discrimination, such as police brutality and hate crimes. Internal racism refers to the negative psychological impact of racism upon the members of a stigmatized race. This can manifest as self-devaluation, resignation, and hopelessness.

With this framework in mind, we have organized the book into three sections. The first section lays the historical foundation for anti-black institutional racism in America, beginning with the institution of slavery. Chapter 1 explains how racism intersected with organized medicine and psychiatry, providing a critique of how physicians and health professional organizations have both contributed to and challenged racist ideologies in society. Chapter 2 builds upon this discussion by examining the impact of historical racism-mediated traumas on the internal functioning of African Americans. The chapter is balanced by a discussion of strategies for building capacity and coping among individuals with a lived experience in dealing with racism and discrimination.

The second section of the book moves from a discussion of the historical legacy of slavery to contemporary issues—including residential segregation, homelessness, and mass incarceration—and how these issues affect mental health and access to treatment for mental health problems. Chapter 3 helps readers decipher the complex literature on racial/ethnic segregation and its impact on mental health and access to services. The protective effects of living within ethnic communities are explored, along with the negative consequences that result from a concentration of social factors (e.g., poverty) that target a "race" of individuals. The latter consequences are a direct result of institutional racism. Chapter 4 continues with a discussion of housing by exploring homelessness and its disproportionate impact on African Americans. The chapter offers significant depth and perspective on how this problem developed, but also suggests multiple approaches to achieving housing equity—a critical factor for achieving health overall—through practice, policy, and research.

Chapter 5 turns the discussion to what is colloquially known as "The New Jim Crow" [4]—a system of targeted policing and incarceration of racial minorities. A plethora of issues related to the criminal justice system are explored, including the shift from hospital-based to jail- and prison-based mental health treatment since the 1960s, as well as the punitive approach taken to addressing substance use disorders in minority communities versus medical approaches to addressing those same issues in white communities. Consistent with the focus of the entire book, the chapter does not end with naming problems, but ends with exploring solutions. Here, the authors explore strategies for changing the criminal justice system's treatment of individuals with mental health disorders, from the initial point of crisis to community re-entry. Solutions that can change the conversation and trajectory—from one of punishment and discrimination to one of treatment and rehabilitation—are the focus.

Chapters 6 and 7 explore interpersonal racism within the clinical encounter. Chapter 6 begins by recounting the tragic narratives of the police shootings of Jordan Edwards, Philando Castile, Tamir Rice, and Trayvon Martin, among other narratives of the mistreatment of unarmed black Americans by officers and civilians. This background is used to support the chapter's central conclusion, i.e., that the black body represents a *phobogenic object* [5] in white American society. The dynamics uncovered when an individual whose body is the source of *object fear* [6] presents for therapy are explored through the case discussions of two black men. The chapter also explores racism-related material that may arise in treatment, through a case discussion of a white client who seeks help from a black therapist. Chapter 7 continues the discussion of interpersonal dynamics in treatment by offering a comprehensive review of the causes and manifestations of bias in the diagnosis and treatment of African Americans and other racial minorities. This review guides clinicians with recommendations for achieving equity in their prescribing and psychotherapy practice.

The final section of the book provides strategies for the clinical engagement of individuals who are coping with and overcoming the systemic, interpersonal, and internal effects of racism. Chapter 8 discusses the role of the black church [7] in the lives of African Americans, the most religiously involved racial group in the United States. The Christian church presents the gospel of Jesus Christ, which bestows freedom and a transformed identity. The church is also a critical channel of hope and resilience for African Americans through its worship, counseling, and support functions. The chapter challenges clinicians to consider interventions that boldly address the spiritual concerns of clients along with their clinical presentations. Integrating spirituality into treatment is one strategy for addressing cultural mistrust, and Chapter 9 advances the discussion by considering a range of interventions that can strengthen the rapport and alliance between providers and clients with experiences of racism and discrimination.

Chapters 10, 11, and 12 consider the structural changes that must take place within Psychiatry if the field is to move toward equity. Chapter 10 acknowledges the glaring need for more providers of color and suggests strategies for recruiting and retaining individuals from minority backgrounds. Chapter 11 considers the profound gaps that exist within medical education, where issues of racism and privilege are rarely named or are inadequately addressed through cultural competency curricula. The need to move beyond these conversations in training to develop and implement anti-racism and structural competency curricula is acknowledged and explored through the discussion of specific examples and approaches. Chapter 12 considers the role of the mental health provider as an advocate for racial/ethnic minorities. Policy and political approaches, along with clinical and research interventions for achieving behavioral health equity are explored.

The final chapter returns to the interpersonal and internal lenses for understanding racism-related experiences. It is a clinical toolkit that contains a medley of approaches that we hope will foster creativity and broaden the discussions around race and identity in psychotherapy.

We humbly submit this book to readers as an effort to highlight contemporary conversations about racism in a formal psychiatric text. In completing this work, we were guided by the ideas of many who have devoted their careers to bringing concerns about racism and its consequences to the forefront of academic psychiatry. We hope that readers will be inspired not only to join the long list of individuals who take an interest in dismantling racism but also to take the actions necessary to move us forward. We hope that this text will be useful in developing anti-racism curricula across the country. As conversations bloom, we look forward to seeing change.

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# Part I

# Historical Context

# Origins of Racism in American Medicine and Psychiatry

# 1

Kimberly Gordon-Achebe, Danielle R. Hairston,
Shadé Miller, Rupinder Legha, and Steven Starks

## Introduction

Modern-day commentary on the history of racial oppression in America often highlights the social and political atmosphere of slavery from its inception in 1619. Much has been written on the evolution of these injustices—the Civil War, the Black Codes, the Reconstruction period, the Jim Crow laws, and White Nationalism—and the resistance movements that have countered them (e.g., the Abolitionist, Civil Rights, Liberation, and #BlackLivesMatter movements) [1–3]. Overarching themes of racism frame certain spheres in society. Critiques of the criminal justice, housing, education, financial, and health care systems typically review inherent disparities that persist for black Americans [4–9].

In most cases, analyses of disparities in health care and medical practice skirt the origin and historical impact of attitudes and policies within organized medicine.

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Medicine, at its core, is a noble and ethical helping profession, so difficulty arises with self-condemnation.

However, several practices within organized medicine and psychiatry have perpetuated inadequate care for black patients. They include limitations on the influence of black physicians and stymying of the research needed to enhance black Americans' health; promotion of unscientific, unethical, and unjust medical research and clinical practices; and support for policies that have further marginalized blacks. The prevailing sociopolitical and economic realities of blacks have created racialized mental health disparities. The consequences of these practices have been service disengagement, pervasive mistrust in medical care and research, and nonideal pathways to care (e.g., school-to-prison pathways, involuntary psychiatric hospitalizations, and care in child welfare and correctional settings) [10–12].

## American Colonization and Slavery

The impacts of racism and racial stratification on the mental health of blacks in the USA extend as far back as the 1600s. From the beginning, enslaved blacks were aware that their only options were to "submit or die" [13]. Each day consisted of an assault on their autonomy. To survive, the enslaved had to submit. They were punished for being defiant, mature, or independent. They could not express themselves. "[The slave] must, in fact, learn to treat himself as chattel, his body and person as valuable only as the owner placed value on them. He must learn to fear and exalt the owner and to hate himself" [13].

The enslaved could not adopt a healthy sense of self-esteem or invest in themselves. The institution of slavery rendered blacks powerless and scarred mentally. This loss of autonomy resulted in the inability to express feelings. Because of racial terrorism, slaves learned to suppress their anger. Suppression of anger became a survival strategy and frequently saved them from a quick and horrendous death [14]. Presently, these effects are seen clinically and broadly in society. In treatment settings, patients may suppress or deny anger and emotions. As Brown notes, these denials become normative: "false affability, passivity, resignation, and ultimately withdrawal or inward self-destruction" [14].

## Defining Blackness: Illness and Inferiority

Benjamin Rush, MD, a signer of the Declaration of Independence and often heralded as the "Father of American Psychiatry," defined "negritude" as a mild form of leprosy that could be cured only by becoming white [15]. Despite the observation by Rush (a cofounder of America's first antislavery society in America) that Africans appeared to become insane after entering slavery in the West Indies, his medical terminology was used to justify the inhumane treatment of enslaved blacks [16, 17].

Although Rush was against slavery, the disorder he defined was used to potentiate the cruel treatment of slaves [15–17].

Throughout US history, psychiatry has been used to validate slavery. The 1840 US Census claimed that enslaved blacks were free of mental illness: "The black man becomes prey to mental disturbances when he is set free" [12, 15, 17]. To support this claim, psychiatric professionals manufactured data suggesting that insanity rates increased in relation to a black person's proximity to the north. The further north they lived, the more insane they were likely to become [18]. These proslavery findings were challenged by Dr. James McCune Smith, the first black physician to earn a formal medical degree at the University of Glasgow in Europe. Smith wrote, "Freedom has not made us mad. It has strengthened our minds by throwing us upon our own resources" [19].

Samuel A. Cartwright, MD, a prominent Louisiana physician and a leader in the proslavery movement, coined the mental health disorder "drapetomania." Its symptoms (seen only among the enslaved) included the uncontrollable urge to escape, disobedience, talking back, and refusing to work [18]. Cartwright identified whipping as its therapy. He encouraged overseers and slave owners to keep the enslaved submissive and to treat them like children with "care, kindness, attention, and humanity, to prevent and cure them from running away" [15, 20]. He also diagnosed slaves with *dysaethesia aethiopica*, or rascality [15]. Cartwright chastised Northern physicians who "ignorantly attributed the symptoms to the debasing influence of slavery on the mind" [15, 20]. Theories of ethnogenetic vulnerability and inferiority, such as Cartwright's, were readily accepted and perpetuated white supremacy and racism in American culture [18, 21].

Dr. Cartwright was not alone in his oppressive psychiatric theories. James Woods Babcock, a psychiatrist and former superintendent of the South Carolina State Lunatic Asylum, used proslavery arguments to explain that Africans were "incapable of coping with civilized life" [12, 22, 23]. In his 1895 article "The Colored Insane," he attributed the "rapid increase of insanity in the negro" and the constant accumulation of black lunatics to emancipation [12]. In 1895, Dr. T.O. Powell, the superintendent of the Georgia Lunatic Asylum, reported that considering increasing rates of insanity after emancipation, the hygienic and structured conditions during slavery served as protective factors against consumption, a form of insanity [15, 24].

## Scientific Racism

Scientific racial theories were developed in the eighteenth and nineteenth centuries in the USA and Europe. They emerged when imperialism and colonialism were prominent in European culture. In Benedict Augustin Morel's Theory of Degeneration, social conflict, aggression, insanity, and criminality were signs of regression to a racially primitive stage of development, which had physical and mental manifestations [12]. This tendency was said to lie dormant in white people. To Morel, *démence précoce* (schizophrenia) epitomized degeneration.

The scientists and evolutionists Jean-Baptiste Lamarck and Charles Darwin propagated the concept of degeneration by involving race thinking to explain "progress" [12]. In 1965, Sir Aubrey Lewis, the chair of London's Institute of Psychiatry, posited that non-Europeans were mentally degenerate because they lacked Western culture [12]. Aubrey Lewis became the foremost psychiatrist of the twentieth century in the UK. He transformed psychiatry in Great Britain and produced a generation of academic psychiatrists, and he was directly responsible for both shaping the Maudsley Hospital from its early beginnings and bringing about the existence of the Institute of Psychiatry as part of the University of London [12].

According to Lewis, blackness was equivalent to criminality and madness [12]. Cesare Lombroso, an Italian psychiatrist and the founder of the field of "criminal anthropology" in the 1890s, produced tables of photographs identifying physical features that characterized criminality and insanity. He believed that white races represented the triumph of the human species [12, 25]. He theorized that signs of criminality and madness that remained were primitive features of blackness. In *The White Man and the Coloured Man*, Lombroso wrote that only white people have reached the most perfect "symmetry of bodily form" and "freedom of thought" [25]. Carl Jung explained that many American negative traits were due to "living together with lower races, especially with Negroes" [26]. Stanley Hall, a psychologist, called Africans, Chinese, and Indians "adolescent races" [26]. An increase in insanity and other degeneracy that threatened the biological well-being of white American people was blamed on immigration [12, 27].

The concept of degeneration propagated crude theories of hereditable traits of criminality, feeblemindedness, and sexual deviance. American psychiatrists and physicians embraced theories to protect societal views and perpetuate racism. The aforementioned theorists pathologized cultural and racial differences—a pattern that persists. These physicians and scientists failed to analyze the impact of terror, familial disruption, isolation, and extreme poverty on health and perceived insanity among blacks. Exposing scientific racism is essential to protecting blacks from further psychiatric abuses and facilitating resolution of social, political, and economic problems [28, 29].

## Twentieth-Century White Supremacy

### The Eugenics Movement

A decade after the Civil War, the US Congress passed the Civil Rights Act of 1875, prohibiting discrimination in public places and, paradoxically, providing the foundation for the Jim Crow laws, which ensured separate and inferior treatment for blacks. The eugenics movement of the early 1900s bolstered whites' fears of integration and broadened concern about inheriting undesirable traits from blacks and other minorities. Across the country, social reformers, legislators, physicians, and medical superintendents joined forces to pass sterilization laws that eliminated what they perceived as negative traits (e.g., pauperism, mental disability, dwarfism, promiscuity, and criminality) [30]. The legal ramifications of these efforts included immigration restrictions, interracial marriage bans, and forced sterilization. Unsurprisingly, these negative traits appeared concentrated in poor, uneducated, and minority populations [31].

Policies instituted between 1907 and 1940 resulted in 18,552 mentally ill persons being surgically sterilized [31]. Sterilization efforts initially focused on the disabled and later the poor. Sterilization advocates viewed reproductive surgery as a necessary public health intervention that protected society from deleterious genes and the social and economic cost of managing "degenerate stock" [30–32]. Certain laws stated that inmates of any state institution could be sterilized if the institution's board found the patient to be idiotic, insane, feebleminded, epileptic, or an imbecile. Sterilization programs found legal support in the Supreme Court case *Buck v. Bell* (1927), which set a legal precedent for sterilization of inmates of public institutions [32]. Thirty states adopted eugenic sterilization laws, which accounted for the forced sterilization of approximately 60,000 Americans. The extent of sterilization and its practices on minority populations, particularly black Americans, needs further research and investigation [33].

Eugenics influenced the passage of the Immigration Act of 1924, which limited the number of southern and eastern Europeans who could enter the country and prohibited immigrants from Asia; these policies remained in effect until the 1960s. In all of its parts, the most basic purpose of the 1924 Immigration Act was to preserve the ideal of U.S. homogeneity. Congress revised the Act in 1952. The 1930s marked a shift in forced sterilization, amplified by the atrocities of the Holocaust, committed against people of Jewish descent. Despite waning scientific and public support and the history of the human rights abuses of Nazi Germany, state-sponsored sterilizations in the United States continued long after the war. Sadly, its practice in the USA did not end until the 1970s [30, 31, 33, 34].

Understanding the role of American psychiatry in eugenics is complex. Hitler admittedly followed the laws of several American states, which allowed for prevention of reproduction of the "unfit," with the consequence that psychiatrists played a key role in the Jewish Holocaust [28, 35]. The *Journal of the American Medical Association* supported eugenics in its call for more robust science to explain mental disorders [31].

During the age of Progressivism (from the 1890s to the 1930s), American and Canadian psychiatrists made attempts to modernize their profession to attract medical trainees. Urbanization and the mixing of races stirred the conversations and anxieties of America [30, 31]. Since eugenics provided a theory for the inheritance of criminality, violence, sexual promiscuity, substance use, and intellectual inferiority, it resonated with psychiatrists who worked in state institutions for the "mentally handicapped."

Abraham Myerson, an American psychiatrist and neurologist, was arguably one of the most vocal opponents of eugenics of his time, yet he accepted aspects of the sterilization of the mentally disabled. He also advocated for more selective sterilization and spoke against Nazi eugenic law. While he acknowledged that there could be a heredity factor involved in mental illness, he also recognized that the social environment played a major role. He cautioned against the expectation that sterilization programs would reduce the incidence of mental illness and radically affect the level of intelligence in society [33, 36].

Dowbiggin argues that despite the historical accounts of racially motivated eugenics, psychiatrists of that time were largely drawn to this movement for professional rather than ideological reasons. He urges readers to consider the historical environment in which these psychiatrists worked and lived, and to not condemn them for paths not taken [31]. Braslow corroborated this conclusion by studying therapeutic practices of the twentieth century at a California state psychiatric hospital. His research demonstrated that psychiatrists rarely relied on eugenic rationales for decisions to sterilize hospital patients and more often "remade sterilization into a therapeutic procedure aimed at solving what they believed to be their patients' individual needs" [37, 38]. Without excusing this behavior, he acknowledges the existence of competing rationales for the perpetuation of such practices. Psychiatrists were largely motivated by relieving the suffering of their patients. Second, they were preoccupied with public policy and the need to legitimize their profession at a time of asylum medicine for patients with chronic and intractable diseases.

By examining the history of a professional community and its adoption of a discourse and practice, one sees how a biomedical theory can translate into a narrow and detrimental policy. It is important to acknowledge these missteps in history to ensure that future policies consider a holistic approach, which includes careful examination of racial identity, culture, and diversity.

## Medical Experimentation on Persons of Color

During the time of slavery, African Americans were often sold to physicians and used as experimental subjects. The basic premise that perpetuated systemic racist experiments was that African Americans were inferior to whites [39]. The heat stroke experiment performed by Dr. Thomas Hamilton [10] and the vesiculovaginal fistula repair experiments conducted by Dr. J. Marion Sims [40] are among the many examples of how slaves were exploited to study medical conditions. Among the most atrocious and renowned medical experiments perpetrated against the black community was the Tuskegee syphilis experiment conducted by the US Public Health Service. This 40-year experiment studied the natural progression of syphilis in 400 African-American males, under the premise of treating them for "bad blood" [41]. Participants were deceived into participation and offered no opportunity for informed consent. They were manipulated into continuing their participation with the promise of free annual physicals and coverage of their burial expenses. Most remarkable were the extraordinary lengths to which researchers went to withhold treatment. Despite evidence to the contrary, the Tuskegee experiment was deemed necessary, since notions of racial differences in the sexuality of blacks and their susceptibility to sexually transmitted infections were widely accepted in the medical community. Representatives from the Centers for Disease Control on two separate occasions in the 1960s determined that it was necessary for the study to continue. The prevailing idea was that medical care could not alter the evolutionary projection for blacks [41]. It took a public outcry, sparked by an article written in the *New York Times*, to bring about the Tuskegee experiment's end [42].

Experiments such as Tuskegee have perpetuated mistrust among black Americans and deterred them from participating in medical research. During the 1980s and 1990s, research aimed at understanding blacks' underrepresentation in clinical research found that their exclusion was due to mistrust, as well as the pervading thought that white males were more generalizable to the population [36]. Later studies of minority participation found that mistrust was an underlying theme even when participants were unaware of the Tuskegee experiments [43].

The effect of underrepresentation of African Americans in medical research has had a profound impact on racial health disparities. Their involvement in research is crucial for understanding disease prevalence and effective treatment. Drug metabolism serves as one example. Ethnic variations in the metabolism of drugs are not uncommon. Without sufficient data, accurate dosing in subgroups cannot be determined [39]. Efforts to eliminate racial disparities in research remain largely ineffective. Research designed to eliminate racial disparities often focuses solely on mistrust and fails to acknowledge other linkages to racism [44].

## Racial Oppression in Medical Education and Organized Medicine

### The Flexner Report and Its Impact on African-American Health

In 1908, the American Medical Association Council on Medical Education and the Carnegie Foundation for the Advancement of Teaching collaborated to improve health care. The foundation invited Abraham Flexner, a professional educator (and nonphysician), to survey the quality of medical schools. Flexner's approach included an ideal in line with the German model of medical education—one that had been in place at Johns Hopkins—which primarily focused on scientific and laboratory medicine. Some observed that it overlooked patient-centered ideals, the role of health and healing, and a consideration of social issues, particularly those affecting vulnerable populations [45–48]. After the Civil War, southern medical schools refused admission to black students. In response, missionary groups established medical schools, as did black physicians, who developed independent schools.

In the late nineteenth century, as many as 12 black medical schools existed. There were nine black medical colleges at the time of Flexner's survey and only seven when he wrote his report in 1910; they included Flint in New Orleans, Leonard in Raleigh, and the Knoxville, Memphis, and Louisville schools. Given the lack of resources and standards, they were under scrutiny for reform [49] (Table 1.1).

When Flexner's report was released in 1910, he recommended closure of all but two of the seven black medical colleges (Howard University Medical Department and Meharry Medical Department of Central Tennessee College). He offered no mechanism for population-based needs assessment to develop a workforce to serve the nearly 10 million black Americans living at that time (despite his knowledge of

**Table 1.1** Defunct black medical schools in the USA

1. Lincoln University, 1870–1874, Oxford, PA
2. Straight University Medical Department, 1873–1874, New Orleans, LA
3. Leonard Medical School, Shaw University, 1882–1918, Raleigh, NC
4. New Orleans University Medical College (Flint Medical College), 1889–1911, New Orleans, LA
5. Louisville National Medical College, 1888–1912, Louisville, KY
6. Hannibal Medical College, 1889–1896, Memphis, TN
7. Knoxville College Medical Department, 1895–1900, Knoxville, TN
8. Knoxville Medical College, 1900–1910, Knoxville, TN
9. State University Medical Department, 1899–1903, Louisville, KY
10. Chattanooga National Medical College, 1899–1904, Chattanooga, TN
11. University of West Tennessee College of Physician and Surgeons, 1900–1923, Jackson, TN; 1900–1903. 1907, Memphis, TN; 1907–1923
12. Medico-Chirurgical and Theological College of Christ's Institution, 1900–1908?, Baltimore, MD

Source: [49]

this gap). His report reinforced segregated and unequal medical education and perpetuated unequal treatment along racial lines.

Baker et al. emphasized that "Flexner could have recommended several strategies: integrating African Americans into white medical schools (as he recommended for the coeducation of women physicians), creating segregated branches at high-quality white schools, providing resources to improve poor-performing African-American schools, or increasing the enrollment at existing high-quality African-American schools" [46]. The lack of philanthropic support crippled, and led to the demise of, the other independent and religiously affiliated black medical colleges (located predominantly in southern states) and placed significant limits on the educational prospects in medicine for blacks over the next several decades.

Today, one might consider the ramifications for the future of American health care if three fourths of all medical schools closed within the next decade. Community engagement would wane. Research and innovation would stagnate. Patients would suffer, and many might die without an adequate medical workforce.

The Flexner Report's impact at the inception of the twentieth century was deleterious for the black community, which had minimal access to care in a "separate but equal" nation. Historically, aspiring doctors studied and trained in their home states, where they had connections and support. Nationwide, either black students were denied entry into white institutions or several obstacles were in place to limit their opportunities.

For black patients, few viable options for care were available, and it was often substandard. It would be more than 50 years before passage of the Civil Rights Act of 1964 and the Social Security Amendments, which began to rectify segregation in education and health care. The American Medical Association (AMA) and Carnegie Foundation's initial aim in 1908 to improve health had the opposite effect for the black community. The health care system failed to nurture the trust of blacks and was the impetus for racial disparities in medical care.

## The American Medical Association and Racial Segregation

In 1870, three black physicians from the newly formed and integrated National Medical Society (NMS) of the District of Columbia sought recognition as delegates to the AMA at its annual meeting held in Washington, DC. This society had been formed in response to racial exclusion from the local and all-white medical society, the Medical Society of the District of Columbia (MSDC). The MSDC challenged the integrated group's seating and place as a delegate society of the AMA. Through a series of procedural disputes, the AMA Committee on Ethics ultimately excluded NMS members, pointedly noting that its decision had not been based on race or color [45]. One of the NMS physicians re-presented his credentials in 1872, yet again was denied seating. This second rejection was attributed to his institution's (Howard University's) violation of the association's code of ethics: their department allowed women to serve. To avoid controversy in subsequent years, the AMA granted local societies full autonomy in determining membership standards within their organizations [45]. This tolerance of racial discrimination significantly impacted black physicians, most of whom resided in southern states. Exclusion from medical societies created a barrier to licensing, board certification, hospital privileges, and training and educational opportunities. These barriers prompted counteraction and the formation of the National Medical Association (NMA) in 1895. The AMA later described its supposed condemnation of racial discrimination yet refused to sanction member societies until its 1968 constitution and bylaws amendment gave its judicial council the authority to expel constituent societies for racial discrimination in membership.

In the AMA's *American Medical Directory* (established in 1906), a directory of all physicians in the USA, black physicians were listed as "colored." This designation placed financial limitations on them and added impediments to acquiring insurance and loans. The NMA vigorously protested; however, the label was removed only in 1939 because of negative publicity. The NMA continued to press the AMA on matters related to integration, segregated hospitals, and "separate but equal" social policies. The two organizations often took opposing positions on national legislative policies, with the AMA consistently being placed on the wrong side of history [45, 46].

In 2005, the AMA Institute for Ethics convened a panel to review the historical roots of the racial divide in American medicine. In 2008, that panel delivered its report, which led to an apology to the NMA. The panelists uncovered practices and policies that had ignored racial segregation, discrimination, and exclusion since the AMA's foundation [47]. The culmination of these actions (and inactions) limited access, resources, and medical education and training opportunities for black physicians, and contributed to health disparities for blacks.

In his written apology in 2008, AMA President Dr. Ronald Davis, as cited by Baker, noted: "These dishonorable acts of omission and commission reflected the social mores and racial segregation that existed during those times throughout much of the United States. But that context does not excuse them. The medical profession, which is based on boundless respect for human life, had an obligation to lead society away from disrespect of so many lives. The AMA failed to do so and has apologized for that failure" [47].

## Responses to Civil Rights Within Organized Psychiatry

The omission, exclusion, and discrimination faced within the AMA extended to the experience of black psychiatrists in their professional associations. Illustrative of this point is the content of two books published by the American Psychiatric Association (APA). *One Hundred Years of American Psychiatry* [50] offered scant details on black American culture and life, and little on the contribution of black Americans to psychiatry. This 649-page volume, published in commemoration of the association's 100th year, included less than three paragraphs on black Americans. It briefly recounted the separate and segregated psychiatric institutions that provided treatment to blacks; though they were unnamed, the text described the Central Lunatic Asylum for Colored Insane and the Eastern State Hospital. The text gave an impression of the treatment of black soldiers after World War I. The author offered what today might be viewed as a racially biased review of the symptom presentation of these veterans [50]. Lastly, Dr. Solomon Carter Fuller, America's first black psychiatrist and neuropathologist, was listed only in a footnote for his contribution to the psychiatric literature.

*The History and Influence of the American Psychiatric Association* [51] presented 416 pages of landmark achievements in the Association's history. Again, black culture and the accomplishments of black psychiatrists were scarcely mentioned. The book briefly summarized the impact of the Thirteenth Amendment, dedicated two paragraphs to the Civil Rights movement, and dedicated little to illustrations of equal rights and nondiscrimination national policies [51].

More telling was what the book excluded. There was no mention of the APA's stance or actions on matters of racial equality and racial justice. This publication minimally outlined policy development within the APA. It reviewed the formation of the APA Council on National Affairs in 1963, which was the association's attempt to examine its positions on national legislation and policies including civil and equal rights. Barton wrote, "In the troubled years of the 1960s issues surrounding civil rights, powerlessness, and discrimination intruded into the APA.…At the Miami meeting in 1969 President Waggoner (1969–1970) gave black minority members a voice in the policy making by designating Observer-Consultants to APA components" [51]. The tone of Barton's language—the use of the words "intruded" and "gave"—displayed subtle bias and may have reflected the dismissive stance of the APA in those times.

Dr. Jeanne Spurlock, in her book *Black Psychiatrists and American Psychiatry*, sought to clarify the omissions of the aforementioned texts and offered a historical perspective on the actions of black psychiatrists. She described the opposition of the APA president-elect in 1948 to the desegregation of Veterans Administration hospitals. She noted that in the 1950s the APA withdrew its involvement in school desegregation—a topic of importance to black psychiatrists [52]. The Black Psychiatrists of America (BPA) was formed at the annual meeting of the APA in 1969 in response to the association's failure to adequately highlight the impact of racism on the mental health of black Americans. The BPA made specific demands of the APA, the National Institute of Mental Health (NIMH), and the American Board of Psychiatry and Neurology (ABPN), which centered on inclusion of black psychiatrists in leadership roles and focused on issues facing black Americans. The APA Board of Trustees responded to the BPA with the formation of the Ad Hoc Committee of Black Psychiatrists (later developed into a full committee and caucus subsequently). The selection of black nominees as candidates for vice president and other elected offices stemmed from the committee's work, as did the hiring of black psychiatrists as members of staff in the newly formed Minority Group Program (in 1972); in 1974, it expanded in scope as the Office of Minority Affairs (later the Office of Minority/National Affairs and currently the APA Division of Diversity and Health Equity).

The efforts of black psychiatrists were not specific to the APA. They were fully aware of the effects of racism in America and acted to promote solutions. Brown and Okura discussed the well-studied and documented national impact of racism and noted that the National Advisory Commission on Civil Disorders (i.e., the Kerner Commission, tasked by President Lyndon Johnson to examine the *more than 150 volatile and deadly race riots* of 1967) identified racism as "the primary cause of violence in the nation." In addition, the Joint Commission on Mental Health of Children, Inc., (developed by federal law in the late 1960s to formally examine the mental health needs of children) found racism to be the primary health problem in America at that time [53]. Brown and Okura revealed that the APA Caucus of Black Psychiatrists scrutinized the actions of the NIMH, "faulting it, along with other federal agencies, for failing to include more Blacks in decision-making roles and failing to accelerate equal employment opportunities" [53]. Pressed by the caucus and spurred by the Community Mental Health Centers Act of 1963 to improve mental health care service delivery to minorities, those with special needs, and the disenfranchised, the NIMH Center for Minority Group Mental Health Program was developed in the fall of 1970. This center stimulated research, increased training opportunities, and sought to define, measure, and combat racism in all forms.

The 1960s and 1970s were hallmarked by increased urgency from black psychiatrists to respond to social issues. Structural changes within the APA and NIMH occurred in response to the actions of black psychiatrists, who were an integral part of the Civil Rights movement. In the illustrations above, black psychiatrists acted autonomously in ways that were opposed to their *professional* identities, as defined by the APA and NIMH, and disconnected from organized psychiatry.

## Racial Oppression in Modern-Day Practice

Both perceived and overt racism have deleterious effects on the physical and mental health of African Americans. African-American men have one of the lowest life expectancies in the population, which is the result of disparities in homicide, cardiovascular disorders, hypertension, diabetes, and substance use [54]. Civil rights activist Dr. Martin Luther King, Jr., recognized the influence of psychological research in public policy development and its responsibility to inform policy makers regarding the impacts of such laws and legislation on communities of color. He encouraged social scientists to continue examining discrimination and prejudice, and urged them to focus their research agendas on understanding the plight of African Americans [55].

In the late 1960s, shortly after the Civil Rights movement, the American Psychological Association called for a new psychology to critically re-examine and re-evaluate past scholarly work and create new work to adequately examine and conceptualize the culture of blacks, sparking research on racial identity. It was believed that within the body of psychological literature, there was an absence of a meaningful conception of black culture. This forced the interpretation of most of psychology's data on blacks into two seemingly dichotomous categories: one of biological incapacity (genetic inferiority) and one of social deviance and pathology (environmental deprivation). It was suggested that future work should produce a revolution of new perspectives that would replace the old racist rhetoric embedded in the social science literature [56, 57].

Nearly 50 years later, there has been a proliferation of literature advancing the conceptualization of black racial identity. This is not to say that the literature has achieved the goal targeted by scholars of that time. The practices of mental health providers and the structural policies of institutions meant to engage racial and ethnic minorities in mental health treatment are influenced by implicit biases in the conceptualization of the cultural/racial identity of blacks [58]. These biases influence evidence-based practices and lower the standard of care for blacks [58, 59]. The treatment and culture of blacks examined under a dominant white cultural lens further perpetuate bygone ideologies and interpretations about identity, behaviors, coping strategies, and psychological distress [56].

## The Impact of Reductive Language

The term “race” can be defined only in the context of social constructs and does not reflect subspecies of the human population [60–62]. Use of race as a classification tool by some scientists is rooted in racism, whereby the classification is used to perpetuate inequalities. Researchers such as Fullilove [60] have supported the elimination of race as a classification variable in public health research, while others have argued that scientists should take a closer look at how the construct of race has contributed to health disparities. They have argued that eliminating race as an identifier is discriminatory and has led to worse outcomes. Some scientists have proposed using ethnicity as a variable to understand health disparities in various social groups. This stems from the consensus that the USA is a postracial society and that the concept of race has been modified over the past centuries [44, 60]. Considering the current sociopolitical climate and debates on race and racism in the USA, it is evident that the USA is certainly not a postracial society.

The Public Health Critical Race (PHCR) praxis counters prior arguments and proposes that the only way to eliminate disparities among ethnic minorities is to address racism and its effects on health [44]. They argue that current research focuses on race as a demographic variable without fully acknowledging the role of racism in contemporary society. By incorporating racism as a variable, researchers can better examine its role in health disparities. Only by direct confrontation of race and racism can the elimination of health disparities be achieved [44, 63–65].

## The Current Stance in Psychiatric Practice and Research

Despite DNA evidence confirming that all humans are biologically one race, there continue to be social presumptions of race, which perpetuate discrimination and contribute to health disparities among black Americans [44]. Blacks have been, and continue to be, overrepresented in public mental health institutes and are more likely to be involuntarily committed [66]. Some historical explanations for the overrepresentation are that blacks are genetically prone to mental illness; blacks are more vulnerable because of low socioeconomic status; blacks are vulnerable because of social isolation and a weak family structure; and that blacks may be less likely to offer themselves to treatment and present only when they are in crisis [66]. However, what is often overlooked is how institutional biases influence this overrepresentation. The criteria for commitment are often interpreted loosely and allow for provider bias to affect the outcome. Research has shown that commitment criteria serve as a poor predictor for future behavior, dangerous behavior, and cultural factors [66]. Furthermore, those who are involuntarily committed are rated as more hostile and suspicious than those who are admitted under voluntary status [66].

Current research also indicates that there is overdiagnosis of schizophrenia in black communities when demographical factors are controlled for [58]. This represents an influence of bias on the current method of diagnosing blacks. Explanations for inequities have blamed stereotyping and diagnostic biases, biased diagnostic instruments, and cultural distance between the client and the clinician [58]. Additionally, blacks are more likely to be diagnosed with intellectual disability or borderline intellectual functioning. Often, they are assigned these diagnoses through use of culturally insensitive intelligence quotient evaluations or assessments based solely on informal interpersonal interactions [57, 58].

These stigmatized views of blacks act as a barrier hindering them from seek mental health services. Black youth report stigma, mistrust, and ineffective treatment as common reasons not to seek help for mental health problems [67]. Ineffective treatment is regarded as targeting symptoms with pharmacotherapy and cognitive behavioral therapy without addressing the overall mental condition from a culturally appropriate standpoint [67].

Instead of the traditional Eurocentric model, it has been proposed that an Afrocentric approach be used in the therapeutic process when treating blacks. The Afrocentric perspective is grounded in recognition of the culture, history, and unique experiences of blacks and how those experiences affect the person [67]. Studies have shown that when black youth are guided by an Afrocentric worldview, they manage stressors more effectively and report fewer depressive symptoms [68]. However, there remains a sparsity of systematic analyses of culturally sensitive services for African Americans [68].

**Conclusion**

The status of American medicine and psychiatry, and its effects on people of color, particularly blacks, can be better understood by investigation of how the legacy of racism has shaped policies and practices throughout medical history

[69, 70]. During American colonization and slavery, being black was likened to primitiveness, where it was promulgated that blacks were unable to control their basic impulses and drives such as anger, sexuality, and criminality because of hereditary defects [15–17, 20, 25]. Prominent psychiatrists developed terminology that pathologized basic human desires, such as freedom, when fulfillment of those desires was sought by blacks and contradicted the will of those in power [20]. Statistics were also skewed to promote slavery by propagating the idea that emancipation seemed to increase rates of insanity among blacks. The oppression of blacks by the medical institution continued with the use of black people as experimental subjects. Experiments such as Tuskegee illustrated several faults within society's perception of blacks. First, it sexualized black people and took the stance that blacks were unable to control their impulses and therefore were more likely to die from a curable sexually transmitted infection. Second, it disregarded the right to informed consent prior to research participation [41, 43].

In the realm of medical education, the Flexner Report serves as a prime example of how blacks were hindered from academic advancement when many black medical schools were closed, having been labeled as substandard instead of being provided with the resources to improve or being integrated with white medical schools [45–49]. In addition, psychiatry educators and researchers promoted false science, despite strong evidence refuting their claims. Generations of unchecked biases, prejudices, and racism invited physician educators, scientists, practitioners, and policy makers to infiltrate the medical profession with racist propaganda, which clearly contradicted their own science and bodies of work.

Yet, in the medical profession's darkest hour, there were psychiatrists who advocated against discrimination and called for scientifically based reasoning within treatment sectors. Dr. Benjamin Rush, a prominent physician and the "Father of American Psychiatry," advocated for treatment of what he called "*negromania*, which is a form of madness, a want of perception, or an undue perception of truth, duty, or interest, that affected 'white' people in all parts of the country, but in 1783, the disorder was prevalent only in the South. Negromaniacs in their collective illness and misery failed to perceive that Negro slavery violated the laws of nature and God and that the interest, health, and happiness of white Southerners lay in their own free honest labor" [16, 17]. Interestingly, over two centuries later, racism has yet to be classified as a psychiatric disorder. Many argue that this omission gives legitimacy to extremists who promote hate throughout this country. Dr. Alvin Poussaint is among the many prominent black psychiatrists who have urged the American Psychiatric Association to include extreme racism as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [65].

The events reviewed in this chapter are not simply historical remnants of American history. They serve as a foundation for many of the current health disparities among African Americans. Racist ideologies have been used incessantly throughout history and have fostered implicit bias in providers while perpetuating racial health disparities for blacks, such as improper treatment and diagnosis, and unconventional pathways for seeking treatment (e.g., child welfare, juvenile services, school-to-prison pipelines, involuntary commitment, and mass incarceration) [29, 57, 64].

Despite clear, solid, and documented research outlining the impact of adverse experiences such as poverty, trauma, racism, and discrimination on the development of psychiatric symptoms, it has only been in the past two decades that medicine and psychiatry have embraced racism as an impediment to public health. To address the current disparities in African-American health, and specifically mental health, it is important to acknowledge the racial biases against African Americans at the individual and structural levels. Recently, the idea of a need for cultural sensitivity has been introduced into medical training programs across the country. The next step is to reconcile cultural sensitivity principles with antiracism and antioppression frameworks in clinical practice while addressing racial and ethnic behavioral health disparities and their elimination [64, 71].

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# 2

# The Legacy of Slavery in Thoughts, Emotions, and Behaviors: Using Cognitive Behavioral Therapy to Frame the Impact of Slavery on African Americans

Sannisha K. Dale and Kimberly J. Merren

## Introduction

The system of slavery lasted for approximately 250 years in the USA and inflicted an exponential number of traumas and abuses on the minds and bodies of African Americans. While slavery was abolished with the Thirteenth Amendment, racism and oppression have continued through systems strongly rooted in the history of slavery, such as law enforcement [1], education [2, 3], housing [4], the workforce [5], and medicine [6, 7]. The historical traumas that occurred during slavery and postslavery (e.g., lynching), as well as race-related traumas and microaggressions that African Americans continue to experience today, may have lasting consequences for the mental health of African Americans [8–10]. African Americans live with the legacy of traumas from slavery and beyond in their thoughts, emotions, and behaviors [11, 12].

Posttraumatic stress disorder (PTSD) and complex trauma [13] are mental health diagnostic concepts that help with framing the ways in which slavery and racism continue to impact the thoughts, feelings, and behaviors of many African Americans. However, African Americans continue to utilize strategies to cope with racism and oppression, and to survive and thrive despite their experiences [14]. Strategies such as social support, spirituality, advocacy, and recognizing and reclaiming their collective and internal strengths may help with minimizing

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the effects of racism [15]. Building on and utilizing the voices and experiences of African Americans, current research efforts are aimed at adapting evidence-based psychological approaches such as cognitive behavioral therapy (CBT) to develop psychological treatments to address symptoms of trauma and enhance strategies for coping with racism and oppression [16, 17]. This chapter reviews (1) PTSD and complex trauma; (2) traumas that have occurred during and after slavery; (3) the impact of slavery on thoughts, feelings, and behaviors; (4) strategies for coping; and (5) a promising and culturally adapted psychological treatment.

## Posttraumatic Stress Disorder and Complex Trauma

Posttraumatic stress disorder and complex trauma are diagnostic conceptualizations describing a range of symptoms that individuals may struggle with following exposure to traumatic experiences. Traumatic experiences include, but are not limited to, having one's life/safety threatened, physical and sexual assault, witnessing life-threatening injury or assault, and receiving news of the serious injury or death of a loved one. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [13], some individuals may experience an acute stress response following exposure to a traumatic event, which includes intrusion and re-experiencing (e.g., intrusive thoughts or memories, nightmares, physical or psychological reactions to reminders), avoidance (e.g., avoiding people, places, or things that are reminders of the trauma; avoiding thoughts and feelings about the trauma), negative alterations in cognition (e.g., negative thoughts about oneself, others, and the world; distorted self-blame) or mood (e.g., strong negative emotions such as shame and sadness; emotional numbing; feeling disconnected from others), and increased arousal symptoms (e.g., hypervigilance, being easily startled, sleep disturbance, irritability, anger). To be diagnosed with PTSD, the individual must experience these symptoms for at least 1 month, and the symptoms must significantly interfere with the individual's ability to function (e.g., in terms of work, school, relationships) and/or cause significant distress.

Although the DSM and other diagnostic manuals have not yet adopted complex trauma as a diagnostic category, this construct offers additional insight into the sequelae of traumatic experiences, especially traumas that occur over an extended period [13, 18]. Examples of prolonged traumas include slavery, intimate partner violence, sexual trafficking, childhood abuse/neglect, kidnapping, incarceration in concentration camps, and war imprisonment. During these prolonged periods, survivors are likely to experience multiple traumatic events, including emotional, physical, and sexual abuse. In addition to the PTSD symptoms previously noted, complex trauma may result in a prolonged sense of terror and learned helplessness, and may have a significantly negative impact on an individual's feelings of self-worth, self-efficacy, self-esteem, and overall sense of identity [13, 18].

## Revisiting the Traumas of Slavery and Beyond

Being enslaved is a massive trauma. During slavery, African Americans were subjected to compounding traumas, including the sale of their children and family members, the rape of women and children, brutal beatings, being witnesses to the murder of other slaves as a means of instilling intimidation, and starvation. Statistics on the number of traumas that African Americans were subjected to during slavery are lacking; however, biographical narratives shed light on the extent of the atrocities. For example, Mollie Kinsey, an African-American woman who lived during slavery, described how young girls were sold and how her young sister was raped repeatedly:

> Dey had slaves in pens, brung in droves and put in dem pens jes' lak dey wus cows. Dey sold dem by auctionin' off to the highest bidder. I wus only a chile and nevah went 'round much. Dey put girls on the block and auctioned dem off. 'What will you give fer dis nigger wench?' Lot of the girls wus being sold by their master who wus their father, taken rat out uv the yards with their white chilluns and sold lak herds uv cattle [19].
>
> My sister was given away when she wus a girl. She tole me and ma that they'd make her go out and lay on a table and two or three white men would have in'ercourse with her befo' they'd let her git up. She wus jes' a small girl hone. She died when she wus still in her young days, still a girl. Oh! You is blessed to live in this day and don't know the tortures the slaves went through. Honey, slavery wus bad, but I wus so young I missed all the evil but chile I know'd 'bout it [19], pp. 200–201.

Although the literature mostly discussed the raping of women and girls, African-American men were also sexually victimized during slavery [20]. They were forced to have sex with enslaved women to "breed" enslaved offspring and, occasionally, forced intercourse occurred while the slave master watched [20, 21]. In addition, slave masters often abruptly dismantled marriages. As one man described:

> I have known him to make four men leave their wives, for nothing, and would not let them come and see them any more on the peril of being shot down like dogs; he then made the women marry other men against their will [22].

Unfortunately, no slave was exempt from the trauma and cruelty of slavery. Wesley Burrell, an African-American man who lived through slavery, described how pregnant women were beaten and how slaves were prohibited from singing or praying—coping strategies that might have been somewhat soothing:

> De people was mighty cruel on us in slavery time. Some would take us an' stake us to four stakes an' whip us until de blood run down; sometimes dey hit five-hundred or more licks. Some of de women, when pregnant would be beaten with dere stomach down in a hole an' dey was tied to a stake. Dey was not allowed to sing or pray; if caught doing so we would git a whippen. We was not allowed to go from one place to another without consent of de boss. De pat-roller would whip dem if dey should be caught without a pass from de boss. Many days when snow was knee deep an' my old marster had his boots an' over coat on, I would have to go with him an be bare foot an' with nothing on my head [19], p. 193.

Post emancipation, African Americans were subjected to lynching (i.e., being tortured and murdered at the hands of white mobs). It is estimated that approximately 3500 African Americans were lynched between 1882 and 1968 [23]. Ida B. Wells [24] described the public torture and murder of Henry Smith (in 1893 in Texas), an African-American man who was falsely accused of murdering a 4-year-old white child:

> [He] was placed upon a carnival float in mockery of a king upon his throne, and, followed by an immense crowd, was escorted through the city so that all might see the most inhuman monster known in current history. The line of March was up Main Street to the square, around the square down Clarksville street to Church Street, thence to the open prairies about 300 yards from the Texas and Pacific depot. Here Smith was placed upon a scaffold, six feet square and ten feet high, securely bound, within the view of all beholders. Here the victim was tortured for fifty minutes by red-hot iron brands thrust against his quivering body. Commencing at his feet the brands were placed against him inch by inch until they were thrust against the face. Then, being apparently dead, kerosene was poured upon him, cottonseed hulls placed beneath him and set on fire [24].

African-American girls, boys, women, and men who experienced and witnessed atrocities such as rape and beating most likely experienced symptoms of PTSD and complex trauma; however, the psychological impact of these traumas did not end with the events themselves. Stories of these traumas have been passed down through generations to the present and continue to have a negative psychological impact [25]. It is also important to note that while slavery may have been abolished in 1865 by the Thirteenth Amendment, the vestiges of slavery are still present and continue to oppress and traumatize African Americans via racism in the justice system (police brutality and homicide), incarceration, housing, education, health care, and the workforce [1–6, 26]. In essence, African Americans have never had a historical moment free of trauma, when they could regroup and heal [27, 28]. Instead, they live daily with overt acts of racism, subtle racial microaggressions, stories of African Americans being murdered by white supremacists [8, 29], and seeing videos of black bodies being brutalized and executed by members of law enforcement [30].

## Ongoing Legacy of Slavery in Thoughts, Emotions, and Behaviors

Cognitive behavioral therapy (CBT) is an evidence-based psychotherapy approach that has been shown to be effective in decreasing psychological distress and symptoms across numerous diagnoses, such as PTSD. One of the core tenets of CBT is framing experiences within the three components of thoughts, feelings, and behaviors. Understanding the impact of slavery in terms of thoughts, feelings, and behaviors can be helpful in informing the use of CBT approaches in culturally adapted interventions for African Americans who may continue to deal with the effects of slavery and ongoing oppression.

## Thoughts

Negative thoughts stemming from the traumas that occurred during slavery (directly experienced or indirectly experienced through generational stories) may include negative thoughts about oneself, others, the world, and the future [8, 13, 18, 31, 32]. Negative thoughts about oneself may include "I am a weak person; I cannot rely on myself; I cannot stop bad things from happening to me, and there is something wrong with me as a person" [33]. Further, individuals may struggle with low self-worth, low self-efficacy, low self-esteem, and a poor sense of self, especially in terms of their strengths and abilities—psychological issues that are often correlated with historical experiences [34–39].

Communities are often viewed as a close extension of the self and, because of historical trauma, African Americans may have similarly negative thoughts about members of their community: weak, unreliable, not empowered to stop bad things, and damaged [33]. Individuals may also have negative thoughts about those outside their community [1, 30, 32, 40], such as "I cannot trust anyone; others will treat me unfairly; I am not valued by others [41, 42], and others will hurt and possibly kill me." The world, in general, may be viewed as a dangerous place, and the future may be seen as bleak, hopeless, and/or nonexistent (e.g., "All I have is today") [41–43]. These negative thoughts are not "distortions" and need to be understood within the context of the historical trauma of slavery and ongoing trauma and oppression.

## Feelings

Negative thoughts stemming from the traumas of slavery [19, 21–23, 31, 44] may be accompanied by negative emotions and physiological symptoms seen with PTSD and complex trauma. These emotions may include sadness, anger, irritability, shame, terror, helplessness, and numbness [13, 18]. In addition, African Americans may experience physiological responses such as being easily startled, heart palpitations, hypervigilance, and sleep disturbance [13]. Unfortunately, African Americans are often not given the space or freedom to experience these emotions. Instead, their emotional expressions are often "policed" (e.g., such expressions are commented on, and they are told how to feel and express their emotions), minimized (e.g., they are told they are being sensitive), and/or dismissed [28, 45, 46].

## Behaviors

A core behavioral response to trauma is avoidance, and African Americans may engage in avoidance of people, places, or things that are reminders of the traumas of slavery or present-day racism [47, 48]. In addition, individuals may avoid and attempt to mentally suppress their own thoughts and feelings about slavery and ongoing oppression [28]. However, given that African Americans account for 13% of the US population, it is nearly impossible to avoid others who may serve as reminders of slavery or perpetuate modern racism. Nonetheless, some African Americans may select environments (e.g., neighborhoods, schools, colleges, work environments) with a visible presence of African Americans [49]. While temporarily putting thoughts of slavery out of one's mind may be helpful to regulate emotions [13], in the long term it prevents processing of slavery-related traumas [18]. Beyond avoidance, because of feelings of sadness, individuals may withdraw from activities or social support systems and neglect their own self-care [45, 46, 50, 51]. Another behavioral response may include expressing one's anger [52]. However, responses to anger expressed by African Americans may be dangerous and lethal, given that African Americans are incorrectly stereotyped as threatening, and their emotions and bodies are seen as things to silence, control, and subdue [53].

Put in motion by the traumas of slavery and maintained by ongoing oppression, the negative thoughts, feelings, and behaviors experienced by Africans Americans can result in a high level of distress and significantly disrupt their ability to function and thrive at home, work, school, and in relationships [6, 36, 38, 45, 51, 54–56]. Further, as seen with complex trauma, slavery and ongoing oppression may severely impact an African American's sense of self-esteem, self-worth, and self-efficacy—and, consequentially, their self-care (e.g., engaging in enjoyable and health-promoting behaviors) (Fig. 2.1).

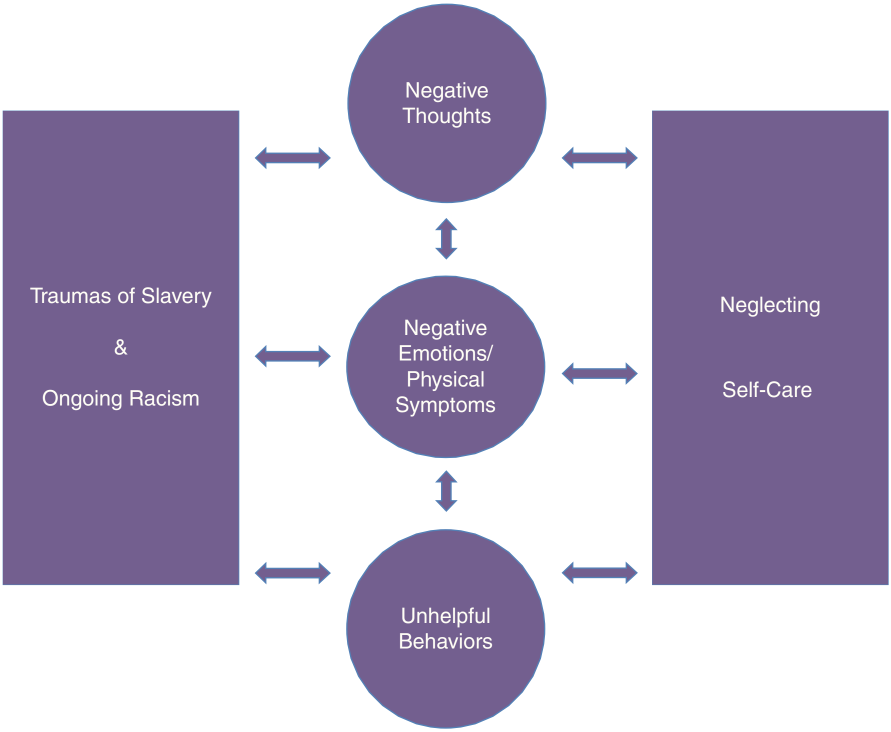

**Fig. 2.1** Negative impact of slavery on thoughts, emotions, and behaviors

## Clinical Diagnoses and Implications

Clusters of symptoms, thoughts, and behaviors that an African American may struggle with may be conceptualized as PTSD, depression, anxiety, and other mental health disorders. The current literature has highlighted the association between present-day discrimination and PTSD, anxiety, and depressive symptoms [57–59]. Pieterse and colleagues [57] noted associations between racism and psychological distress, anxiety, and depression. The conceptualization of symptoms experienced by African Americans (in the context of historical trauma and oppression) as psychiatric diagnoses does pathologize “natural responses” and may move the focus away from the oppressors and structural forces, and onto the individual. Nonetheless, psychiatric conceptualizations may also guide providers to seek out appropriate tools and interventions to help individuals cope and strive. A pitfall that psychiatric or psychological providers should be mindful of is attempting to treat (via medication and/or therapy) the symptoms that an individual may report without (1) seeking to understand how racism and oppression might cause those symptoms; (2) providing a safe space for the relationship between racism and psychiatric symptoms to be explored; and (3) empowering the client with strategies (e.g., legal advocacy) and supports to help them challenge the system of racism. In addition, efforts to aid the individual should be matched with efforts by professionals in psychology and psychiatry to work against systematic oppression within clinical practices, within academic and medical institutions, and beyond.

## Mechanisms of Surviving, Coping, and Healing in the Face of Racism and Oppression

Despite the vestiges of negative thoughts, emotions, and behaviors from slavery and ongoing oppression, African Americans continue to utilize strategies for coping and healing. Coping strategies of seeking social support, having an awareness of racism as systemic, utilizing assertiveness, ignoring the perpetrator, and exercising caution are commonly employed to cope with the impact of racism [16]. Gaylord-Harden and Cunningham [56] found that among African-American adolescent boys and girls, racism-related experiences predicted the use of culturally relevant coping strategies: emotional debriefing (e.g., creative self-expression via poetry, songs, raps, and stories) [60], spiritually-centered coping (e.g., asking God for strength, praying) [51, 61], and communalistic coping (e.g., leaning on members of one’s community, such as family) [62]. Black men and women have also coped with racism by utilizing general problem-focused coping methods such as developing a strategy (planning), focusing on what they can do (active coping), seeking support from others about what to do (instrumental support) [63], and prioritizing the problem and putting other tasks aside (suppression of competing activities) [52, 64, 65]. For instance, West and colleagues [65] found that among black women, the use of problem-focused coping buffered the effects of racial discrimination.

Strategies for coping with racism may also be instilled through parenting. Anticipating the discriminatory experiences that their children will face, African-American parents communicate messages to their children on how to cope with racial discrimination (e.g., by using spirituality, avoiding self-blame, and advocating for one's rights) [62]. In addition to the messages that parents communicate to children, family cohesion and adaptability have been associated with low race-related stress [15]. Overlapping with coping strategies, yet different from them, racial identity—one's sense of belonging to a racial group—has been shown to be protective against the negative effects of racial discrimination among African Americans [66–68]. Having a positive commitment to one's own racial group has been correlated with lower levels of psychological distress and higher levels of psychological well-being [40, 69]. However, some studies have found that racial identity may not serve a protective role in the relationship between perceived discrimination and psychological health [70]. The conflicting literature may be explained by the complex process of black racial identity formation in various stages (e.g., pre-encounter, encounter, immersion–emersion, and internalization) [67]; what stage an individual is at, coupled with the coping strategies they use, may influence how they fare psychologically in the context of racism [68].

In addition to the coping strategies noted above, African Americans have historically resisted and fought racism in the legal, social, political, and economic arenas via protests (e.g., the March on Washington in 1963) [71], boycotts (e.g., the Montgomery Bus Boycott in 1955–1956) [72], lawsuits (e.g., *Brown v. Board of Education* in 1954) [73], program development (e.g., the Free Breakfast for School Children Program by the Black Panther Party, established in 1969) [74], and the creation of organizations, such as the National Association for the Advancement of Colored People (NAACP), that aim to ensure social, political, economic, and educational equality and to eliminate racial discrimination. These actions may represent beneficial strategies for coping with racism not just at the structural level but also for the individual [68]. Forsyth and Carter [68] found that African Americans who utilized community organizations and legal action as avenues to make perpetrators of racism accountable reported lower psychological symptoms.

## Stepping Forward

While literature on adaptive coping strategies for African Americans in the face of trauma and racism exists, it is difficult to locate published literature on interventions that address coping with historical trauma and racism among African Americans. The dearth of such literature suggests that it is imperative to fund and support research aimed at developing trauma and racism interventions for African Americans. However, there are promising treatment approaches currently being developed that attempt to enhance coping strategies for trauma and racism among African Americans. For example, Striving Towards Empowerment and Medication Adherence (STEP-AD) [17] is a cognitive behavioral therapy–based 10-session treatment for black women living with human immunodeficiency virus (HIV). STEP-AD utilizes the CBT framework and aims to decrease symptoms of trauma and increase adaptive coping with racism, health-related discrimination, and gender-related stressors among black women with HIV. The core aspect of the treatment is to assist black women with (1) recognizing how their experiences of trauma, racism, and other forms of oppression may lead to negative thoughts, emotions, and behaviors and, consequently, neglecting self-care; (2) processing their traumas and experiences with racism by writing and discussing the impact of these events; (3) challenging the negative thoughts that stem from trauma by viewing the negative thoughts as the words of a prosecutor and then generating helpful thoughts similar to the words of a defense attorney; (4) prioritizing and practicing daily self-care behaviors; and (5) reviewing a range of coping strategies for racism (see Table 2.1) and enhancing their flexibility in using various adaptive strategies. This approach has shown promise in a case study [17] and continues to be evaluated in a pilot randomized control trial. Similarly, “Still Climbin’”—a CBT and dialectical behavior therapy-informed group intervention aimed at improving adaptive coping in the face of discrimination faced by HIV-positive black men who have sex with men (MSM)—found an increase in functional thoughts and behaviors, humor, and other self-protective strategies (e.g., strategic avoidance of places where discrimination may be experienced) [75]. Beyond the psychological interventions that are being evaluated via research, there are clinical group approaches that aim to improve overall well-being and coping with discrimination among African-American men through discussions about identity, community, religion, and dating [76]. An earlier work by Elligan and Utsey [77] also discussed the use of an African-centered support group for African-American men facing racism. Other authors [78] have provided clinical guidelines on trauma treatments for African Americans, highlighting the need to (1) incorporate the importance of family and community, spirituality/religion, self-empowerment, empathy and nurturing, and rituals for healing; (2) work collaboratively with clients and recognize/support clients’ strengths; and (3) understand the history of slavery and modern-day racism. Providers may utilize these techniques in working with African Americans as they tackle trauma and racism.

**Table 2.1** Coping strategies for racism reviewed in the STEP-AD (Striving Towards Empowerment and Medication Adherence) intervention

*“I have the power within me” [internalized self/power]*—believe that you have the ability to not allow racism and others to destroy your core, your esteem, and your power, no matter how hard they try

*Avoid negative situations*—avoid people, places, or topics of conversations that might result in a negative situation

*Be aware/stay woke*—know that racism is something that is real and has an impact on your life and the lives of other black individuals and communities of color

*Blame the right person*—recognize that the person that is at fault is the person and/or system that has acted in a racist manner

*Be careful*—be cautious when around authority figures or nonblack individuals

*Believe that you can do it*—believe that you can deal with whatever comes your way

*Believe that you can reach your goal*—believe that you can achieve your goals, even if there are obstacles

*Do activities*—participate in activities to take your mind off issues, such as walking, cooking, dancing, listening to music, singing, shopping, hanging out with friends, going on social media/the internet, exercising, watching a movie/series, relaxation/meditation, etc.

*Embrace your roots*—celebrate your heritage and roots in various ways (e.g., dress, hair, celebrations)

*Find allies*—seek out relationships with other people (nonblacks) who might be allies

*Focus on what you value*—try to focus on the relationships and things that you value

*Humor*—try to see the humorous side of things when faced with problems

*Listen to music/sing songs*—listen to music and/or sing songs to deal with the stress of racism

*Organize with others in the community*—educate others about the impact of racism; organize a protest or boycott

*Positive thinking*—try to think about the positive things in your life, around you, and in the world

*Relaxation*—meditate, do yoga, take deep breaths, etc.

*Report the incident/legal action*—report it to an authority figure, seek legal advice, or take legal action

*Seek support*—reach out to others you can talk with and who can understand/relate to your experiences

*Self-acceptance/self-love*—accept yourself the way you are; love yourself as you are

*Self-advocacy*—in a situation, speak up for yourself or others

*Self-talk/motivation*—tell yourself that you will get through this, that it will be OK

*Sit with the stress for a bit*—try to handle unpleasant or painful feelings such as sadness, fear, and anger for a bit, because these emotions usually change with time

*Speak your truth*—speak your mind about race and racism even if others are uncomfortable

*Spirituality*—pray, read the Bible, go to church, or rely on your faith or a higher power

*Stay cool in the moment*—keep your feelings under control when you have to, then let them out when they will not make things worse

*Stay focused under pressure*—try to stay focused and clear your head under pressure

*Support black-owned establishments*—purchase goods/products in businesses owned by black individuals

**Conclusion**

Slavery in the USA and ongoing racism and oppression have subjected African Americans to a wide range of historical and present-day traumas that impact their thoughts, feelings, and behaviors. In the face of racism and oppression, African Americans strive to work through these complex traumas by utilizing adaptive coping strategies and efforts. Psychological treatments that are informed by the voices of African Americans and utilize cognitive behavioral therapy approaches may be beneficial to lessen the impacts of slavery and racism on the minds, bodies, and souls of African Americans.

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# Part II

# Contemporary Issues

# 3

# Racial/Ethnic Residential Segregation and Mental Health Outcomes

Kellee White and Jourdyn A. Lawrence

## Introduction

Over 100 years ago, W.E.B. Du Bois asserted that the problem of the twentieth century was the problem of the “color line” [1]. This quotation continues to resonate today because the color line is a salient organizing feature of many neighborhoods that undermines health equity. Racial/ethnic residential segregation—the degree to which two or more groups live separately from one another in a geographic region [2]—often evokes the practice of de jure segregation, which refers to intentional actions by federal, state, and local governments to enforce racial codes, such as the Jim Crow laws. Title VIII of the Civil Rights Act of 1968 (also known as the Fair Housing Act) legally sanctioned discrimination in the sale, rental, and financing of housing on the basis of race, color, religion, sex, or national origin. Although the government policies and institutional practices that fostered residential segregation are now illegal, the vestiges of de jure and de facto residential segregation continue to have profound implications for individual and community health.

Williams and Collins situate racial/ethnic residential segregation as a fundamental cause of racial/ethnic disparities in health because of the manner in which it differentially sorts individuals into vastly different economic, physical, and social environments [3]. Racial/ethnic residential segregation is widely considered a spatial manifestation of institutionalized racism. Residential segregation continues to play a significant role in the well-being and health of African Americans and Latinos in the USA and increasingly select ethnic and immigrant groups in the UK. Empirical research on residential segregation and health has grown substantially over the past 25 years. The findings from this body of research suggest, in general, that high levels of residential segregation are associated with poorer physical health outcomes,

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including all-cause mortality, infant mortality, and low birth weight [4–6]. Studies testing the association of residential segregation with mental health outcomes and service utilization have also grown; however, the findings from this body of research are largely mixed, with a majority of the studies demonstrating a beneficial association and several reporting adverse or null associations [7, 8].

This chapter explores the role of racial/ethnic residential segregation (and ethnic density) as a key factor involved in the onset and maintenance of mental health outcomes, utilization of mental health care services, and perpetuation of mental health inequities. It begins with a brief overview of approaches to conceptualize and measure residential segregation and ethnic density. A review of historical and recent residential segregation trends among African Americans, Latinos, and Asians in the USA is provided. This chapter also summarizes the empirical literature and patterns of population mental health outcomes by race/ethnicity. The chapter describes the processes through which residential segregation creates conditions that expose individuals and communities to stressors that increase the risk of mental health problems and limit access to and utilization of quality mental health services (e.g., providers and facilities). Additionally, the mechanisms by which segregation cultivates resources that promote resilience and mitigate material disadvantage are highlighted. The chapter concludes with remarks on future directions for research, clinical practice, and population-based approaches that have an important role to play in stimulating meaningful efforts to reduce the burden of mental health and sustain action toward achieving mental health equity.

## Measuring and Assessing Racial/Ethnic Residential Segregation

The literature makes a theoretical and analytic distinction between residential segregation (the degree to which two or more groups live separately from one another in a geographic region [2]) and ethnic density (the concentration or proportion of a specific racial/ethnic group within a defined geographic area [9]). In this section, attention is devoted to how each measure is defined and operationalized, although prior studies have discussed the choice and implications of their use in greater detail [6].

Residential segregation is a multidimensional construct, which represents distinct geographic patterns of residential mix. The following five dimensions have been conceptualized: evenness (the degree to which groups are evenly distributed); isolation (the probability of interaction between members of the same versus different racial groups); concentration (the spatial density of a racial/ethnic group); centralization (the degree to which a group is primarily located in the city core); and clustering (the grouping of racially similar neighborhoods) [2]. While the five dimensions are correlated, they do not overlap completely, and they represent unique mechanisms by which residential segregation can operate to influence well-being, health, and access to and utilization of health resources [10]. Diverse indices have been developed to represent each dimension [2, 11]. For example, the index of dissimilarity is commonly used to operationalize evenness, although the Gini index has also been used [12]. Census-based or administrative-based units (e.g., zip codes) are used to calculate residential segregation, which entails describing the distribution of individuals across microunits (e.g., census tracts) within larger macrounits (e.g., metropolitan statistical areas). An index score ranges from 0 (complete integration) to 1 (complete segregation), with scores of 0.60 generally considered to reflect high levels of segregation. Further, Massey and Denton have described high levels of segregation across multiple geographic dimensions as hypersegregation [13]. For example, an area can be considered hypersegregated if the levels of segregation are greater than 0.60 on four of the five dimensions.

Ethnic density—also referred to as neighborhood racial/ethnic composition (i.e., the proportion of blacks in a county) or ethnic concentration—is also measured using census-based or administrative-based measurements of population density. In the USA, various geographic scales have been used to capture ethnic density, such as metropolitan statistical areas (MSAs), counties, zip codes, and census tracts [6]. Subjective measures of ethnic density have also been used, albeit infrequently. A subjective measure is based on participant self-reporting and ascertains one's perception of the ethnic concentration in a defined area [14].

The multidimensional construct of residential segregation and ethnic density are two ways in which studies have conceptualized racial/ethnic residential segregation. Although these are two distinct measures, the terms "residential segregation" and "ethnic density" are often used interchangeably. Both measures are postulated to capture the impact of uneven distribution of social and physical attributes of neighborhoods, lack of access to educational and employment opportunity structures [6]. The use of formal measures of racial/ethnic residential segregation versus ethnic density may be dependent on the geographic scale at which residential segregation is defined. For example, studies that seek to capture metropolitan-level segregation typically use one of the formal dimensions of segregation, while studies that measure neighborhood-level segregation typically use ethnic density [6, 15]. In the UK, many studies use ethnic density and neighborhood-level segregation rather than measures of metropolitan-level residential segregation [16]. For the remainder of this chapter, evidence from studies that use either residential segregation or ethnic density is discussed.

## Historical Trends and Current Patterns

At the end of the nineteenth century and the beginning of the twentieth century, levels of black–nonblack segregation were modest, ranging between 0.22 and 0.47 [17]. The Great Migration of blacks from the South to urban areas in the Northeast and Midwest between 1910 and 1960 led to substantial increases in black–nonblack residential segregation. For example, black–nonblack residential segregation, as measured by the index of dissimilarity, rose from 0.50 to 0.78 [17]. This precipitous increase in residential segregation was largely attributed to legalized and institutionalized discriminatory practices in the housing market, such as redlining in mortgage lending and discrimination by real estate agents and landlords [10]. Although levels of black segregation peaked during the 1970s, the overall levels of black–white segregation have been decreasing since the 1970s [18]. Despite the declines in overall residential segregation, this conceals less favorable trends of persistently high and intense levels of segregation in many Northeast and Midwest metropolitan areas with large black populations. Researchers contend that the overall decline has been propelled by larger declines in segregation in areas with smaller black populations [19, 20]. For example, Iceland et al. showed modest declines from 1970 to 2009 in the Midwest (0.859–0.718) and Northeast (0.752–0.730), with larger declines in the South (0.808–0.571) and West (0.729–0.558) [19]. Additionally, decreases in patterns of hypersegregation have been observed. Between 1970 and 2010, the number of hypersegregated metropolitan areas declined from 61% to 32% [21]. However, the magnitude of hypersegregation in a subset of metropolitan areas has remained stable [21].

The patterns and processes of segregation vary by racial/ethnic group. Levels of residential segregation among blacks are the highest in comparison with those of other racial/ethnic groups and have been compared to South African apartheid levels [22]. Despite incremental gains in socioeconomic position, blacks—regardless of their socioeconomic status—remain highly segregated [20, 23], and this segregation continues to be qualitatively and quantitatively distinct from that of any other racial/ethnic group. In comparison, the magnitude of segregation among Latinos and Asians has been typically low to moderate [23]; however, recent trends suggest that levels of segregation increased for both groups between 1990 and 2010 [24]. For example, hypersegregation has been observed among Latinos in metropolitan areas (e.g., New York City and Los Angeles) [20, 25]. Among Latinos, the rapid growth of the population since the 1980s, combined with increased immigration, partially accounts for the rising levels of segregation. Moreover, scholars attribute Latino segregation to assimilation processes and immigrant preferences for residence in “ethnic enclaves” and access to culturally relevant resources [26]. One study compared pan-ethnic segregation patterns among Latinos and Asians to segregation patterns of detailed Latino populations (e.g., Dominicans, Puerto Ricans, Mexicans, and Cubans) and Asian populations (e.g., Koreans, Chinese, and Filipinos) [26]. The findings from that study suggested that there was a significant variation in segregation patterns across ethnic groups. For example, Mexicans were less likely than other Latinos to be segregated from whites. The researchers concluded that pan-ethnic segregation is not sufficient to capture the experiences of specific ethnic or immigrant sub-groups [27].

## Linking Racial/Ethnic Residential Segregation to Mental Health Outcomes

Observed racial/ethnic differences in mental health outcomes and service utilization result from a complex interplay of biological and social determinants that generate differential exposure to negative stressors that increase the risk of poor mental health and differential exposure to resources that promote resilience and reduce the mental health burden [3, 7, 28]. The neighborhood environment may have direct effects on health because of the differential patterns of risk and protection [29], even after individual-level characteristics (e.g., demographics and socioeconomic status) are taken into account [7, 29, 30]. Several frameworks conceptualize racial/ethnic residential segregation as a form of institutional discrimination that patterns unequal access to neighborhood economic, social, physical, and health care resources that are important for maintaining mental health, and sustains mental health care disparities [3, 31, 32]. Further, researchers have shown how constant and cumulative exposure to neighborhood economic, physical, and social stressors over the life course can be particularly detrimental to mental health [33–35]. This section briefly summarizes the pathways of neighborhood-level stressors and stress buffers that act directly or indirectly to impact mental health outcomes.

### Neighborhood Economic Environment

The neighborhood economic environment is one potential mechanism through which residential segregation may directly influence mental health. Highly segregated neighborhoods are often characterized by poverty concentration, economic disadvantage, community disinvestment, and lack of access to employment and educational opportunities [36]. These factors have been shown to lead to an increased risk of mental health problems and exacerbate poor management of mental health outcomes [37].

### Neighborhood Physical Environment

The physical conditions of segregated neighborhoods may be characterized by poor aesthetic quality and signs of physical decay, such as abandoned buildings and graffiti, which can have a negative influence on mental health [33]. A qualitative study of the experiences of families who participated in Moving to Opportunity (MTO)—a federal housing mobility social experiment conducted in five major US cities [38]—described the lived experiences of stressors associated with the physical environment [33]. For example, several participants who were in the experimental group and moved to low-poverty areas described how the change of physical neighborhood conditions enhanced their mental well-being [33].

### Neighborhood Social Environment

Residential segregation may operate via negative stressors—such as community violence—that may be associated with poorer mental health outcomes [37]. Alternative mechanisms such as enhanced social support and collective efficacy, and increased positive social capital (inclusive of social cohesion and social integration) [14, 39] often provide a buffer against negative effects or moderate the impact of neighborhood economic and physical disadvantage [7]. The findings from MTO also suggested that changes in the social environment (i.e., less violence) also contributed to improved feelings of safety, which were associated with lower levels of depression/depressive symptoms and anxiety. Studies have even shown that segregation of neighborhoods with low levels of political empowerment may additionally contribute to poorer mental health and racial/ethnic disparities [40].

The relationship between residential segregation and mental health may operate indirectly through increased social support [14, 41]. There is considerable evidence documenting the benefit of social support in terms of positive mental health [42]. Enhanced social support could include positive emotional, functional, informational, and financial support. Strong connections and supportive ties with family, friends, and neighbors are associated with positive mental health outcomes [33]. In contrast, a lack of social support, or negative social support, may increase vulnerability to stress, which is associated with a greater risk of adverse mental health outcomes [43].

The term “social capital” refers to resources accessed by individuals as a result of their membership within a network or a group that fosters collective action for mutual benefit [44]. The resources obtained through social capital may be used to buffer against stress and enhance mental health [9, 45–47]. Social capital and related concepts, including social cohesion (which signifies patterns of social interaction, connectedness, and solidarity) and values such as trust and network formation [48], are mechanisms through which residential segregation may positively affect mental health [30]. High levels of social cohesion are hypothesized to enhance mental health by fostering emotional support and diffusing information about access to mental health–related resources that reduce adverse mental health outcomes [33, 47]. For example, one study linked improved mental health outcomes among Latinos living in highly segregated neighborhoods to the social cohesion provided by social and kinship support [41]. Culturally relevant indicators of social capital have been identified for understanding the social resources that can be leveraged for health promotion in highly segregated neighborhoods. For example, Dean et al. identified block parties in predominantly black neighborhoods in Philadelphia as a unique social capital resource with the potential to buffer against the adverse effects of neighborhood deprivation [49].

## Neighborhood Mental Health Care Resources

Residential segregation is posited to shape access to health care, the quality of care and services, utilization of health care, and the availability of health-related resources that are important for managing mental health care needs [10, 32, 50]. Residing in highly segregated neighborhoods can play a role in differential access to mental health service utilization and mental health care resources, which has been shown to be predictive of racial and social disparities in unmet need for mental health services [50]. This limitation or lack of access to mental health services can contribute to poorer mental health outcomes and widen disparities among racial/

ethnic groups [50]. Studies have shown that access to providers, the quality of care, provider characteristics, and the density and type of mental health care provider available (e.g., psychiatrists, social workers, and therapists) are associated with the magnitude of residential segregation [10, 51]. One study showed that Latino segregation was associated with a shortage of psychiatrists, whereas African Americans residing in highly segregated neighborhoods were more likely to have access to nonpsychiatrists (e.g., social workers) as mental health professionals [10]. Moreover, studies have shown that providers practicing in segregated neighborhoods are more likely to be confronted with clinical, logistical, and administrative challenges [50]. Additionally, geographic differences in health care system factors, such as health maintenance organization (HMO) penetration and the payment processes and procedures of Medicaid and Medicare, also contribute to limited access for individuals and families living in segregated neighborhoods [51]. One study found that physicians who work in segregated neighborhoods are more likely to have a patient mix with a higher proportion of Medicaid patients and receive significantly lower reimbursements. Additionally, improvements in access to mental health treatment can help reduce racial/ethnic mental health disparities [50].

### Racism

Residing in neighborhoods with high levels of segregation or ethnic density may lead to better mental health outcomes because it may reduce exposure to racism, racial discrimination, and/or prejudice [7, 14, 41]. Several studies have supported the notion that living in highly segregated or ethnically concentrated neighborhoods in the USA and the UK buffers against experiences of racism and discrimination [36, 52]. For example, some studies have demonstrated that the rate of self-reported experiences of racism is lower in places where there is greater residential segregation or ethnic density [52, 53]. Another study tested the association between perceived ethnic density and depression, and showed that discrimination mediated this association [14]. Another study demonstrated that among African Americans, neighborhood racial composition and the risk of depressive symptoms were mediated through increased levels of racial discrimination [54].

## Empirical Evidence

This section provides a brief summary of the main findings of empirical studies of residential segregation, ethnic density, and mental health. For a more detailed review of the literature, interested readers are referred to systematic reviews [7, 8]. In general, the findings from studies examining residential segregation, ethnic density, and mental health are mixed [7, 8, 16]. While a majority of studies have demonstrated a beneficial association [7], other studies have reported negative [41] or null associations [55]. This is in part attributable to the heterogeneity of the results in terms of the mental health outcome assessed, the sociodemographic (e.g., gender, race/ethnicity, socioeconomic status) group analyzed, and the method used for conceptualizing residential segregation. The overall findings highlight an important and complex relationship between residential segregation, ethnic density, and mental health.

Depression, anxiety, and psychological distress are the most common mental health disorders studied in relation to residential segregation and ethnic density. Yet, the evidence from studies of residential segregation and these outcomes are inconclusive [36]. This may be a function of the different measures and scales used. For example, the most widely used scales are the Center for Epidemiologic Studies—Depression (CES-D) scale, the General Health Questionnaire (GHQ-12), the Diagnostic Interview Schedule, and the Clinical Interview Schedule. Additionally, studies have used single-item measures to capture depression, psychological distress, or anxiety. However, the evidence for psychotic disorders suggests more consistency in the protective association between ethnic density and mental health outcomes [52]. Other mental health outcomes such as attention deficit hyperactivity disorder (ADHD) [56], suicide [57, 58], and self-harm have not received as much attention.

## Race/Ethnicity

Although the overall prevalence of mental health conditions is similar across racial/ethnic groups, there is a disproportionate burden of illness experienced among blacks, Latinos, and immigrant groups [50]. Racial/ethnic and immigrant disparities in the burden, course, and severity of mental health outcomes, and in service utilization, are widely documented [50, 59, 60]. Moreover, the association between residential concentration and mental health varies across and within racial/ethnic and immigrant groups [7, 30, 61]. The mechanisms linking residential segregation and mental health vary by racial/ethnic group [30, 41], which may also contribute to the equivocal findings [41]. More specifically, the intermediary mechanisms may vary by racial/ethnic group [30]. For example, ethnic density may operate differently by racial/ethnic or immigrant group, depending on the context—in this case the country, stigmatized status, and social norms [36]. Several studies conducted in the UK have examined nonmajority groups in majority countries. A study investigating the relationship between ethnic density and mental health in different nonmajority groups such as Turkish Dutch, Moroccan Dutch, and Surinamese Dutch did not support the ethnic density hypothesis for any of the three major ethnic groups [36]. Some of these differences may be a result of the way in which neighborhoods may provide social support for transitioning to a new country and buffer against language barriers, acculturative stress, and discrimination [14, 62].

## Blacks/African Americans

The results of studies examining the association between residential concentration and mental health outcomes among blacks have been mixed. Several studies have documented protective effects of both residential segregation and ethnic density on depression and anxiety [41], but there are several studies that have documented a positive association between higher levels of concentration and a greater mental health burden [55]. Among blacks, measures of residential segregation and ethnic density have been shown to perform differently across age, gender, and country of residence [55, 61]. One study revealed gender differences where there was a stronger association between ethnic density and depressive symptoms among African-American women than among African-American men [61]. Becares et al. conducted a cross-national comparison of ethnic density and suicide among black Caribbeans residing in the USA and in the UK [52]. For black Caribbeans, ethnic density was associated with improved mental health outcomes in the USA but adverse mental health outcomes in the UK [52]. The authors suggested that the discrepancies in the magnitude and direction of the ethnic density effects were a result of migration patterns, history, and socioeconomic position [52]. Nonlinear threshold effects have also been observed among blacks. For example, in a study that measured ethnic density among a sample of blacks in the USA, the authors found a protective association between ethnic density and depressive symptoms. However, for ethnic density greater than 85%, the benefits were no longer observed, and ethnic density was associated with greater depressive symptoms [61].

## Latinos

Associations between residential segregation and mental health among Latinos has mostly been studied in a US context [63, 64]. Findings from studies, particularly those testing ethnic density and depression, have overall been mixed [9]; some studies have suggested that segregation and/or ethnic density may be protective against adverse mental health outcomes [39], and other studies have demonstrated a higher risk of poorer mental health outcomes. Protective relationships for US Latinos residing in highly segregated and high–ethnic density neighborhoods have been found [41]. For example, one study showed that lower levels of depression were associated with higher levels of Mexican American neighborhood ethnic concentration [63]. In a study that focused on mental health care service utilization, Dinwiddie et al. demonstrated that Latinos who lived in highly segregated neighborhoods were less likely to be seen by a mental health care provider, because of a disproportionate shortage of providers in these neighborhoods [10]. Study findings also vary by gender, Latino ethnic group, nativity status, acculturation, and the measure of residential segregation that is used [39]. Many US studies on Latino mental health and residential segregation have drawn inferences from studies where Mexican Americans represented a larger proportion of Latinos [41]. However, a few studies examining residential segregation and mental health outcomes have been inclusive of Puerto Ricans, Dominicans, and Cubans. Several studies have measured racial segregation by using formal measures of segregation, such as the index of dissimilarity and the exposure index [39]. Lee found that residential segregation measured by Latino isolation was a stronger predictor of depression than segregation measured by the index of dissimilarity [64]. Yet, in a study by Nobles et al., Latinos living in communities with high levels of residential segregation measured by the isolation index were found to have lower levels of mental distress [39]. Other interesting findings about residential segregation and mental health outcomes among Latinos have been related to nativity status and acculturation. The results of one study suggested that the protective association may be limited to first-generation and second-generation Latinos [39].

## Asian Americans

The evidence for associations between residential segregation, ethnic density, and mental health outcomes among Asian Americans is sparse, although studies of Southeast Asians in the UK are more common. As in other racial/ethnic groups, ethnic density has not been consistently associated with mental health outcomes, although it should be noted that the number of studies is small. One study was identified that demonstrated an association between greater levels of ethnic density and poorer mental health [41]. After controlling for social cohesion as a potentially mediating pathway, Hong et al. found that Asian Americans were more likely to report poor general mental health [41]. Another study found results that were suggestive of a protective effect but not significant [55]. Mair et al. tested whether racial/ethnic racial composition was associated with depressive symptoms as measured by the CES-D, and found that greater concentrations of Asians were associated with lower CES-D scores in Chinese women, but these findings did not reach statistical significance [55].

## Adolescents

Although much of the research examining the role of residential segregation and mental health has been carried out in adults, some studies have focused exclusively on adolescents [62, 65]. In these studies, protective associations have been observed in largely black and Latino adolescents [7, 62]. Moreover, negative associations between ethnic density and mental health have been observed for immigrant adolescents. A study examining the longitudinal association between immigrant ethnic density and Latino youth depression outcomes found that Latino immigrant density was associated with lower odds of depression among Latino immigrants but not among nonimmigrant Latino adolescents [62].

A common critique of the segregation and health literature is the sole focus on residential context and the lack of attention to exposure to other contexts such as school [24]. School-level segregation is increasingly a prominent factor influencing adolescent well-being and health. Several studies have examined school segregation, which has typically been measured using school-level racial/ethnic composition (i.e., the percentage of non-Latino white students in a school) [66]. School racial segregation is of import because it exists at fairly high levels in schools across the USA and in some areas, schools are resegregating [67]. It has been suggested that the mechanisms by which school segregation impacts health may work in different directions [67]. For example, segregated schools may have fewer available resources such as books, facilities, and advanced classes but may also protect against racial discrimination [67]. One study analyzed data from a nationally representative sample of US adolescents. It found that black students who attended predominantly black schools were more likely to report fewer depressive symptoms and that such symptoms increased as the proportion of white students in a school increased [66]. However, this association was not observed among other racial/ethnic groups such as Latinos, Asian/Pacific Islanders, and American Indian students [66].

## Research, Clinical Practice, and Population-Based Health Implications

The results from the residential segregation and mental health outcomes literature have implications that can help guide researchers, providers/clinicians, decision makers, and other relevant stakeholders in prevention strategies and intervention approaches to reduce mental health inequities and promote policies that improve population mental health. This section discusses some of the research, clinical practice, and population-based implications of residential segregation and mental health.

### Research

There are several directions for future research that can generate new knowledge to unpack the complex associations linking residential segregation, ethnic density, and mental health outcomes, and advance the field's understanding of strategies to decrease the risk of mental health problems and improve outcomes. More studies are needed to explore factors of resilience. Resilience—the process of positive adaptation achieved in the face of threats to development [59]—is an understudied element in the residential segregation, ethnic density, and mental health literature. Identification of elements and methods to measure mental health resilience among adolescents and adults is a promising research and intervention development direction.

The remaining gaps in knowledge about the relationship between residential segregation, ethnic density, and mental health relate to disaggregation of data by ethnicity and nativity. There has not been sufficient research evaluating the differential effects of residential segregation by ethnic subgroup or nativity [39]. Studies that explore the influence of nativity and immigrant generational status could improve understanding of the mechanisms underlying residential segregation, ethnic density, and mental health. They may provide clues regarding cumulative life exposures and critical timing periods. Attention to the cumulative effects of exposure to segregation along the continuum of health care has the potential to illuminate opportunities for research and action that will lead to promotion and achievement of health equity and improved population health.

## Clinical Practice/Health System

Sustained effort to strengthen mental health services provided by the health care system is one approach to minimize the influence of segregation on management of mental health outcomes and utilization of mental health services. To address these needs, adoption of a patient-centered approach that ensures the provision of culturally tailored, sensitive, and appropriate services is needed [68]. A recent quantitative analysis of depression among residents in a predominantly black, disadvantaged urban neighborhood underscored the significance of diagnosing depression as a function of the presentation of depression in patients, which may be indicative of responses to contextual stressors [68]. Additional considerations relate to mental health care financing. State Medicaid policies strongly influence the accessibility and utilization of mental health services among individuals in segregated communities. Implementation of policies that expand income standards for eligibility and the scope of services provided, increase state Medicaid reimbursements, and incentivize primary and specialist mental health care can potentially improve access to and utilization of mental health services [50]. More importantly, improving the integration and care coordination of behavioral, physical, and social services is increasingly considered an effective approach for strengthening the full spectrum of health and well-being and for fundamentally enhancing management of mental health conditions, especially for individuals residing in segregated neighborhoods [69, 70].

## Population-Based Approaches

Population-based approaches to address the connection between residential segregation and adverse mental health outcomes are likely to be more meaningful than individual-level approaches, which are not adequate to mitigate, eliminate, or address the stressors that occur at the community level. Population-based approaches that include multisector collaboration, legislation, and public campaigns have an opportunity to promote and improve the management of mental health [71].

Local health departments (LHDs) are increasingly recognized as playing a critical role in promoting community mental health and providing mental health preventive care, population-based mental health activities (e.g., surveillance, assessment, planning, and training), and stigma reduction campaigns to maximize mental health [28, 69]. Findings from a recent study demonstrated that the provision of mental health preventive care was associated with lower rates of preventable hospitalizations and a reduction in racial disparities as a result of services provided by LHDs in Maryland [69]. LHDs have the advantage of being uniquely situated to effectively engage and complement the activities of other local health entities (e.g., health systems) and allied sectors (e.g., social service agencies), particularly among vulnerable communities with limited health care access [28].

Innovative primary prevention and promotion campaigns that employ broad strategies (i.e., mass public awareness campaigns and messages that target barriers such as social stigma, negative beliefs, and social norms) have been implemented [69, 71]. Kwate performed a novel community-based intervention, which consisted of an outdoor advertising countermarketing campaign to stimulate public discourse about racism in two segregated neighborhoods in New York City [72]. Stark facts about racism were advertised. For example, one advertisement stated: "Fast food companies don't target black people; they just don't have any restaurants in white neighborhoods." Kwate showed statistically significant decreases in psychological distress among the treatment participants in the neighborhoods in which the advertisements appeared [72]. In another study conducted among low–socioeconomic status communities in the Netherlands, a community-based participatory media project used cultural resources to challenge stressful social scripts to promote mental health, help minimize stress, and impact mental health outcomes [34]. Large-scale community-based strategies that utilize cultural narratives and support resilience are promising approaches that may collectively produce positive effects on population mental health [34].

## Conclusion

Racial/ethnic residential segregation is considered a salient social determinant in the etiology of mental health outcomes, the accessibility and utilization of mental health services, and the persistence of mental health inequities. The empirical evidence, although inconclusive in general, suggests that residential segregation and ethnic density have some impact on mental health. Further, greater understanding of the complexity of the mechanisms known to mitigate the effects of residential segregation and ethnic density should be a priority in the development of effective prevention and intervention strategies. Design of culturally relevant and tailored interventions that harness the protective elements of residential segregation and ethnic density to reduce mental health disorders and improve the quality of mental health care is urgently needed. Identification of potential policy levers that will be helpful in improving mental health should aim to highlight community-level factors that may serve as opportunities to reallocate resources. Other potential areas amenable to policy development and community intervention may require an emphasis on integrated care and care coordination, and meaningful engagement of multisector collaborations to mitigate the impact of neighborhood disinvestment.

This chapter has considered the evidence on residential segregation and illuminated the processes through which it influences mental health. Renewed research and clinical and policy attention toward racial/ethnic residential segregation as a social determinant of mental health are necessary to have meaningful and sustained action to improve mental health.

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# 4

# The Intersection of Homelessness, Racism, and Mental Illness

Jeffrey Olivet, Marc Dones, and Molly Richard

## Introduction

In the late 1970s and early 1980s, contemporary homelessness emerged in the USA on a scale not seen since the Great Depression. While policy makers and the general public responded to this as a new social phenomenon, a more thorough examination of the historical patterns shows that homelessness has been endemic in this country since the earliest days of the colonial period [1]. At times, homelessness has become epidemic [2], and in the early decades of the twenty-first century, the USA is in one of those times. Despite the long-term persistence of homelessness in America, analysis of the drivers of homelessness has focused primarily on cuts in affordable housing, deinstitutionalization of the mental health system, and the challenges facing specific subgroups (e.g., veterans returning from combat, single adults with mental health and substance use disorders, youth aging out of care, survivors of interpersonal violence, and young mothers and their children).

These analyses, while important, have left out a critical aspect of the problem: the racial dimensions of homelessness have been largely absent from the conversation. Homelessness disproportionately affects people of color, with black and Native Americans being most overrepresented. More than half of all people currently experiencing homelessness are people of color. While black people comprise approximately 13% of the general population in the USA, they represent more than 40% of the homeless population [3, 4]. Even when poverty is controlled for, blacks living in poverty are more likely than poor whites to experience homelessness [5]. Similarly, the percentage of Native Americans in the homeless population is twice that of the general population [3]. It is no accident that these two groups, the most historically oppressed populations in the USA, are currently bearing the brunt of homelessness. It is the result of systemic racism.

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As we begin to understand homelessness as an issue of race, we must also consider what communities of color continue to experience: high rates of personal and intergenerational trauma, minority stress, untreated mental health and substance use challenges, community and family violence, and difficulty accessing health care systems that were not designed to meet their specific needs. Attempts to reduce the numbers of people of color experiencing homelessness will be less likely to succeed without adequate opportunities for behavioral health care and access to recovery.

A recent review suggested that a "color-blind" approach (i.e., an approach that does not respond systemically or programmatically to the disproportionate presence of people of color) to ending homelessness is inadequate, since "the risk and protective factors related to homelessness, the pathways into homelessness, and outcomes of services and programs to address homelessness" differ across racial groups [6]. In other words, to address homelessness effectively, it must be viewed through the lens of racial equity. This chapter describes the intersections of homelessness, racism, and mental health, concluding with recommendations for research, policy, and practice.

## Demographics

Since the 1980s, population researchers and ethnographers have documented demographic trends in the population experiencing homelessness, finding blacks overrepresented among both homeless individuals and homeless families [6]. National annual reports published by the US Department of Housing and Urban Development (HUD)—as well as studies of specific states, cities, and communities—have continued to document this overrepresentation [3]. Black people are more overrepresented in the US population experiencing homelessness than any other racial or ethnic group. Although people identifying as black comprise 13% of the general population and 26% of those living in poverty, they account for more than 40% of the homeless population [3, 4]. Among families with children experiencing homelessness, half (51.7%) identify as black [3]. According to a nationally representative phone survey, titled Voices of Youth Count, black youth had an 83% higher risk of experiencing homelessness than youth of other races [7]. The national representation may even obscure the disparities in some major cities: one study of shelter utilization in New York City and Philadelphia found that black people were 16 times more likely to utilize shelters than their white counterparts [8]. Even more staggeringly, the study showed that black children under the age of 5 years were 29 times more likely than white children to be in homeless shelters.

To illustrate such dramatic disproportionality, HUD found that:

> In 2015, the sheltered homeless population that is African American or Black in the U.S. was larger than the state ranked 20th among all U.S. states in the size of their African American or Black population—Indiana with 591,397. This makes the size of the Black sheltered homeless population larger than the size of the Black population within more than half of the states in the U.S. [9].

The racial groups that follow blacks with the next highest rate of disproportionality are the American Indian and Alaska Native (AI/AN) populations. AI/AN people have historically experienced homelessness at disproportionately higher rates, a trend that continues today. Although good estimates are scant—and historically, the ethnic category for AI/AN was omitted entirely from reports—there is evidence of overrepresentation dating from the 1950s [10]. In 2016, people identifying as AI/AN made up about 4.2% of the unsheltered homeless population nationally, in comparison with approximately 2% of the total US population [3, 4]. National estimates may downplay the housing insecurity experienced by Native populations. Many Native people move fluidly between urban centers and reservations, with one study finding that “People who are in trouble seem to return ‘home’ to the reservations/reserves” [10]. However, reservations may not offer secure housing despite the social safety net. In a report on homelessness on six reservations in northern Minnesota, researchers provided estimates of people who were currently homeless (9%), “doubled-up near-homeless” in substandard housing (14%), and “doubled-up near-homeless” in standard housing (77%) [11].

While the overrepresentation of black and AI/AN people among the homeless population is clear, the picture of Hispanic/Latinx homelessness is less so. In 2016, people who identify as Hispanic made up approximately 17% of the sheltered homeless population and the total US population [3]. The numbers are comparable when looking at families: about one quarter of people in families with children experiencing sheltered homelessness (24.9%) identified as Hispanic, similar to the share of Hispanics among all families with children in the USA (23.7%) [3, 4]. However, researchers speculate that such counts may be an underestimate, as undocumented people may not seek shelter, and recent immigrants may be more likely to double up or live in substandard housing [12]. For example, the Voices of Youth Count (2017) phone survey found that Hispanic nonwhite youth had a 33% higher risk of homelessness than youth of other races, while street and shelter-based counts have found lower prevalence rates [7]. In addition, the risk of immigration law enforcement may prevent people from accessing services. Approximately nine million Americans live in mixed-status families, and more information is needed to understand the relationship between service utilization, immigration status, and homelessness [13].

Additionally, people who identify as sexual or gender minorities may face victimization and discrimination related to their sexual orientation and gender expression. Voices of Youth Count found that lesbian, gay, bisexual, and transgender (LGBT) youth had a 120% increased risk of homelessness in comparison with heterosexual and cisgender youth [7]. One study found that 56% of LGBT youth in care spent some time homeless because they felt safer on the streets than in a group or foster home [14]. LGBT people of color are at particular risk of homelessness. According to the 2014 LGBT Homeless Youth Provider Survey—a survey of 138 youth homelessness human service agency providers—about 31% of LGBT youth they served identified as black and 14% were of Latinx/Hispanic origin [15].

Historically marginalized populations are more likely to experience homelessness due to structural inequity and discrimination in the areas of employment, wealth, housing, and criminal justice [16]. Individuals with multiple marginalized identities are overrepresented and often at added risk. For example, people of color experience homelessness at higher rates in families than as individuals, and with families typically headed by single mothers, these households face structural racism and sexism. LGBT youth of color face racism as well as discrimination based on their gender and sexuality.

High rates of homelessness among people of color are no accident, but instead are caused by structural racism in American society and public policy. To understand this, it is important to look at historical policy decisions that laid the foundation for such a disproportionate likelihood of homelessness.

## Exclusion from the Housing Market

While housing is not the only factor driving homelessness, it is the common requirement for preventing and ending homelessness for all groups. To discuss housing in America without discussing race is irresponsible. There is no way to separate the realities of the American housing market from America's racialized history. Housing policy, which is codified and informal, has served as an enforcement tool for the American racial hierarchy. This stark reality was aptly described by Massey and Denton as "American Apartheid" [17]. Indeed, in order to understand homelessness in America, it is important to unpack multiple policy decisions. It is also critical to understand that while the systematic exclusion of people of color from the housing market has been the product of housing policy, it did not begin or end there.

If we narrow our focus to the two groups most likely to experience homelessness in America, we can limit our conversation to black and Native American people. In this context, the geneses of many current ills are the Trail of Tears and the failure to integrate black people into the country's social fabric after the Civil War. These two unfolding events laid the foundation for the residential framework that black people and Native Americans came to occupy in the twentieth century. In both, we see that the systematic forced movement of people of color away from primarily white areas was upheld through the rule of law. The ghettoization of people of color through forced relocations (e.g., to reservations) or forced localizations (e.g., segregation) allowed for the creation of zones of disenfranchisement that were relatively easy to maintain. Whites did not need to worry about being collaterally affected by policy decisions made about these areas, because no whites lived there.

For Native Americans in North America, the history of genocide, forced relocation, land theft, compulsory cultural assimilation, forced separation of children from families, and numerous other policies enacted by colonial settlers and the federal government are integral to understanding the population's disproportionate rate of homelessness today. For example, in 1830 the federal Indian Removal Act called for the "Five Civilized Tribes" (the Cherokee, Chickasaw, Choctaw, Creek, and Seminole) from southern states to relocate to new "Indian Territory" in current Oklahoma—an action later referred to as the Trail of Tears. Despite several US Supreme Court rulings that affirmed the Native nations as sovereign nations and that the law required fairly negotiated treaties, brutal campaigns to steal and coerce land from Indian nations to white farmers prevailed [18]. Above losing their homes, people suffered from exposure, disease, and starvation over the journey, and more than 4000 died [18].

The federal government promised that the new "Indian country" west of the Mississippi would be forever sovereign Native land, but, through continuous coercion and violence, this territory shrank, and in 1907 Oklahoma became a US state. There was a large Native American population in California, and, in 1851, California Governor Peter H. Burnett stated, "A war of extermination will continue to be waged between the two races until the Indian race becomes extinct" [19]. Around that time, California passed laws to facilitate the removal of Indian culture and land, legalized the indentured slavery of Native American children, and enslaved "vagrant" adults under the guise of legal punishment [20]. Such oppressive attitudes and public policies are the historical backdrop for contemporary homelessness among Native people. Currently, inadequate housing and services, lack of economic opportunity, and multigenerational poverty drive high rates of Native American homelessness.

The history touched on here represents a brief snapshot of the atrocities Native Americans faced from the American Revolution to before the Civil War. Though tribal differences in history, sovereignty, and stability abound, structural violence continued to harm the health of most Native American communities, both on reservations and off. Since the most recent turn of the century, the population of Native Americans living on reservations has greatly decreased; in 1970, fewer than half lived in urban areas, in comparison with 61% today [21]. In her chapter for the National Health Care for the Homeless Council, discussing health care for homeless Native Americans, Suzanne Zerger writes, "This migration has been occurring over the past century and is expected to continue; historically, it reflected federal government 'relocation' policies in effect during the 1950s, though today it reflects a search for employment, education and housing opportunities which are often limited on reservations" [22].

Zerger reviews the history of the atrocities against Native Americans and the ways in which that history is the foundation for modern homelessness and disparities in health and access to housing and services [22]. In addition to the historical discrimination and racist policies that harmed Native populations, studies show continued discrimination against Native Americans trying to purchase a home or rent housing. Studies have found greater rates of rejection of loan requests, higher-cost mortgage loans, and vulnerability to predatory lending [23]. In renting, at least one study found significant levels of discrimination, primarily in the form of owners or brokers withholding information about available units [24]. Additionally, reservations see extraordinarily long waiting lists for affordable housing, overcrowding and high rates of doubling-up, and poor housing conditions [25].

For blacks in America, the history of housing policy has been equally devastating. Among the most egregious of these decisions was the Federal Housing Administration's policy of "redlining," which was enforced from the agency's inception in 1934 until the Fair Housing Act was passed in 1968. This policy barred the backing of mortgages in areas that were predominantly inhabited by people of color and, as a result, created both blighted zones and population-level vulnerability to housing instability and homelessness. This was done in three main ways:

1. Blocking people of color from securing the financing necessary to open small businesses, which are associated with neighborhood growth
2. Locking people out of participation in the mortgage system and, as a result, out of property ownership—the principal wealth-building mechanism for most Americans
3. Creation of a 'race of renters,' meaning that blacks and other people of color were disproportionately forced to rent

It is critical to note that these policies did not necessarily restrict *poverty* to people of color—they targeted *housing instability.* People of color, and particularly blacks, have been disproportionately housed at the whim of property owners who, by virtue of systemic racism, are disproportionately white. Such discriminatory policies created the preconditions for neighborhoods inhabited by people of color to fall into disrepair. High turnover in rental units disrupted social connection, and higher rates of poverty led to higher rates of toxic stress, violence, and other collateral issues [26, 27]. Systematic disinvestment from America's inner cities through tax codes that concentrated revenue generation in property value left communities of color more vulnerable to homelessness than suburban whites. As the social safety net (including federal investment in affordable housing) disintegrated through the 1970s and 1980s, people who came to experience homelessness were left without any support system.

As urban centers shifted away from industrial utilization where factories might be situated, they became desirable real estate again. People of color, who had previously been shunted toward living close to these undesirable locations, were once again in the way. This set the stage for myriad (and ongoing) urban renewal developments. Urban renewal refers to the practice by which cities relocate businesses and redevelop through the demolition of existing structures and the development of new properties. Both the Housing Act of 1949 and the Federal Highway Act of 1956 resulted in mass displacement of neighborhoods of color as cities sought to revitalize downtown areas, create desirable housing, and develop functional interstate networks that could link the suburbs to newly sprawling urban areas. During this process, people of color were frequently relocated—so much so that James Baldwin, speaking in the 1960s, referred to urban renewal as "Negro Removal" [28]. These mass relocations once again pushed people of color into new—often even more poorly resourced—ghettos. The parallels with forced displacement of Native people should not be overlooked.

As people of color sought to exit impoverished neighborhoods by renting in wealthier (and whiter) neighborhoods, they were met with a racist backlash. Lorraine Hansberry's 1959 play *A Raisin in the Sun* paints a powerful picture of this stark reality. In 1968, as a capstone of Civil Rights Era legislation, the federal Fair Housing Act was passed. Through the creation of protected classes against whom it was no longer legal to discriminate, the goal was to create a level platform: if you were eligible to rent, you would be able to rent, regardless of race. However, this ideal never came to pass. The Fair Housing Act has had uneven enforcement, insufficient funding for investigation, and sporadic federal attention. To date, blacks and other people of color have continued to face disproportionate barriers to renting. Research has repeatedly shown that in comparison with their white counterparts, people of color are asked to provide more documentation of income, go through more rigorous background checks, are shown units that are different from what has been advertised, and are given different information regarding fees and deposits [29, 30].

Mass incarceration has also come to have a dynamic interplay with the rental market, as both subsidized and unsubsidized housing options have increasingly barred people with a history of felonies from applying. As a direct result of drug enforcement laws and the policies of the 1980s, a disproportionate number of the approximately six million Americans who carry felony convictions (including nonviolent felony drug convictions) are people of color [31, 32]. The barring of people from participating in housing on the basis of felony status means that people of color have fewer housing options. This extends to housing subsidies as well. These same statistical trends carry over into employment, where people of color are hired less often than their similarly qualified white counterparts [33] or, again, are disenfranchised because of prior felony convictions [34]. The interaction between employment discrimination, housing discrimination, and mass incarceration creates an ongoing "perfect storm" that pushes people of color into unstable housing situations.

This historical and policy context is essential to understand who is most at risk of becoming homeless. The multigenerational experiences of oppression, bigotry, and discrimination have left communities of color vulnerable to homelessness. Such experiences also correlate with traumatic stress, minority stress, shorter life-spans, behavioral health problems, and a multitude of other health inequities. The most effective approach to ending homelessness in communities of color will include attention to mental health as well as housing.

## Mental Health and Substance Use

People of color face disparities in accessing health care, the quality of care received, and health outcomes [35]. Mental health issues, substance use disorders (SUDs), and co-occurring disorders (CODs) are often unaddressed in racial and ethnic minority communities, and programmatic responses are routinely designed by and for white people, not racial and ethnic minorities. For people of color experiencing homelessness, the disparities can be magnified, creating not only increased risk for homelessness but also barriers in exiting homelessness.

### Prevalence Studies

Methodological limitations (such as small sample sizes, lack of comparison groups, and narrow focus on specific subgroups) in research on homelessness have made it difficult to understand precisely the racial dimensions of mental health and homelessness. One study from the early 1990s found that white and nonwhite men experiencing homelessness differed only in their rates of substance use disorder, with white men reporting more alcohol use disorders, nonwhite men more drug use disorders, and white men overall reporting greater substance use disorder histories. The same study found that white women experiencing homelessness had higher rates of all *Diagnostic and Statistical Manual of Mental Disorders* (DSM) disorders except for SUDs, in which there were no differences between white and nonwhite women [36]. A study comparing treatment of homeless veterans by race found that blacks were more likely than whites to have substance use problems but less likely than whites to be diagnosed with a serious psychiatric disorder [37]. A recent review, however, found that blacks and Latinos were 3–4 times more likely than whites to be diagnosed with a psychotic disorder [38]. While this review was not focused on homeless populations, it is plausible that this trend of overdiagnosis occurs among black people experiencing homelessness as well.

It should not be overlooked that the experience of homelessness is, in and of itself, a significant trauma. People who experience homelessness almost certainly experience high levels of toxic stress, which, as a result, may cause long-term psychosocial impairment unless it is adequately responded to with appropriate supports and services. Some subgroups may experience higher rates of psychological problems, particularly once they become homeless. For example, one study found that among lesbian, gay, and bisexual youth, the majority of whom were young people of color, "homelessness was associated with subsequent symptoms of anxiety, depression, conduct problems, and substance abuse" [39].

Multiple studies have documented high rates of co-occurring SUDs with other serious mental health conditions among people of color experiencing homelessness. Kuno et al. reported high rates of homelessness in general among people in a community-based mental health system (24%) and specifically found that "those who experienced homelessness were more likely to be African American, receive general assistance, and have a comorbid substance use problem" [40]. Another large study ($n = 6424$) of individuals receiving public mental health services found that being black, being homeless, and being male were significant predictors of co-occurring substance and alcohol use [41]. Similar findings were reported by Folsom et al. [42] in an examination of more than 10,000 individuals treated for schizophrenia, bipolar disorder, or major depression in a large public mental health system. They found that the overall rate of homelessness was 15% and that homelessness was associated with being black and having a substance use disorder. However, studies of comorbidity should bear in mind the research that has revealed blacks to be at higher risk of misdiagnosis. At least one national study found that blacks have a greater likelihood of being misdiagnosed with schizophrenia [43]. The research appears to be mixed on whether serious mental illness among blacks experiencing homelessness is over- or underdiagnosed.

## Minority Stress

People experiencing homelessness report significantly higher levels of stress than housed low-income people. The stressors associated with homelessness generally can be compounded for people of color. “Minority stress” refers to stressors that are related to one’s minority status—such as racial/ethnic minority status, or sexual orientation and gender minority status—and stem from stigma and prejudice [44]. Daily stress associated with lower socioeconomic status and persistent experiences of discrimination can lead to adverse health outcomes. Studies have suggested that high rates of hypertension and diabetes in blacks, Native Hawaiians, and Hispanic/Latinx Americans may be linked to chronic stress resulting from discrimination [45–47]. Perceived discrimination and racism, particularly within housing, have also been shown to play a role in unhealthy behaviors such as cigarette smoking, alcohol/substance use, improper nutrition, and refusal to seek medical services [48, 49].

It is possible that the effects of minority stress are mitigated by various protective factors. Milburn describes how increased positive identification with one’s racial/ethnic group can decrease emotional stress, and calls for interventions that strengthen such identities [50]. One study found that black women experiencing homelessness have higher spiritual well-being scores than other homeless women [51]. The authors suggest that this increased relative importance of spirituality in their lives may have an impact on parenting, anxiety, and experiences of trauma. While these factors are not likely to stave off the full effects of minority stress, they may play a role in how people of color find strength to cope with the myriad challenges they face.

## Service Utilization

Despite the need for mental health and substance use treatment among people of color experiencing homelessness, challenges persist in delivering programs that meet their needs. One substantial challenge is the lack of continuity of care. Camacho et al. [52] found that ethnic minorities had increased use of emergency psychiatric services, and other studies have shown that people of color are less likely to receive preventive care and have fewer outpatient visits than whites [53, 54]. Nejtek et al. found that whites with co-occurring mental health and substance use were more likely than their black counterparts to receive services—findings that raise questions about the cultural responsiveness of existing programs and potential bias in services [48]. A report by the Surgeon General documented that racial and ethnic minorities have significantly less access to mental health care than white Americans [55].

Stigma around mental health and substance use can also present a substantial barrier in people of color—homeless or housed—in accessing care. One study examined the extent to which stigma-related concerns about mental health care account for the underuse of mental health services, and found that stigma about mental illness reduced the desire of immigrant women with depression to access treatment more than it did for US-born white women [56]. Another study found that those who confront prejudice and discrimination because of their group affiliation suffer double the stigma when faced with the burdens of mental illness; because of the potency of mental health stigma, many people of color elect not to seek or adequately participate in mental health treatment [57]. The negative impact of stigma has been clearly demonstrated in communities of color. These juxtapositions—increased risk but less access, more emergency care but less ongoing care—make it difficult for people of color to achieve behavioral health outcomes comparable to those of whites. A growing body of research is calling for programs to become more culturally appropriate and to target their services to people of color [58, 59].

Leadership by people of color is one strategy that agencies and systems can employ to improve the cultural responsiveness of their systems. In homeless programs and behavioral health systems, the racial identity of the staff rarely reflects the diversity of the people served, and when it does, such diversity is often found at the direct service level rather than among executive leaders and board members. Such a lack of diversity in leadership runs the risk of creating programs that are "color blind" in the worst sense of the word. While having more leaders of color does not guarantee that programs will achieve better outcomes for clients of color, it is clear that white leadership of these agencies and systems has been unable to create programs that are responsive to their needs. Homeless service agencies may gain from following the lead of other systems, such as health care, that have found that diversity at the top positively impacts outcomes [60].

Many of the findings presented here are not limited to people experiencing homelessness, but are reflective of racial disparities in behavioral health broadly. Because of its racialized nature, homelessness likely exacerbates these disparities, as does the lack of health insurance and access to care that results from poverty, homelessness, and social exclusion.

## Recommendations

National, state, and local responses to homelessness have typically lacked focus on racial equity. Instead, as the problem has stubbornly persisted on the American landscape, few research studies, programmatic responses, or policy priorities have put racial disproportionality front and center. The various strategies outlined in the following sections may offer a way forward in bringing racially conscious approaches to the work of preventing and ending homelessness.

### Research

National numbers released by HUD year after year document high rates of homelessness among black Americans and Native Americans, yet few local jurisdictions have made it a priority to examine their own data for race-related trends. The first action that can be taken by agencies, continua of care, cities, counties, and states is to examine their homeless service system data by race to understand:

- Rates of homelessness for each racial/ethnic group compared with the general population, and poverty population numbers in that jurisdiction
- Prior living situations, to determine differences in patterns of inflow by race

- Connections in and out of homelessness with other systems (e.g., criminal justice and child welfare)
- Service utilization, such as the duration of homelessness and frequency of contact with the system
- Distribution of public housing units and vouchers by race to see if this matches the demographics of people experiencing homelessness

Beyond simply documenting the racial dimensions of the problem, further research could take a public health approach such as geo-mapping to identify geographic hot spots and determine potential upstream interventions to prevent homelessness at the population level for communities of color. Additionally, more focused behavioral health services and intervention research among people of color experiencing homelessness could continue to test which interventions are effective in ending homelessness. Formative evaluations to assess the cultural responsiveness of organizations would also be helpful in determining the degree to which programmatic responses are effective in supporting recovery from mental illness, substance use, trauma, and the general distress brought on by homelessness for people of color.

All research on homelessness should integrate the perspective of people of color who have been homeless themselves. This means involving people with lived experience at all stages of the research design and data analysis, and using data to craft new solutions.

## Practice

Service agencies, programs, and direct service providers themselves play a large role in dismantling systemic racism that plays out both within their own institutions and beyond. While this is ambitious work, it can take the form of antiracist program design and specific outreach efforts to engage people of color in services. It may also include staff training that goes beyond generic notions of "cultural competence" and more toward antiracist skills building. Such training requires the commitment not only of the staff being trained but also of organizational leaders, making a sustained commitment to promote programs and policies that begin to move the needle on high rates of homelessness among people of color. As with research, all of these efforts should be informed and guided by people of color, particularly those who have lived experiences of homelessness. Integration of people with lived experience can take the form of seats on a board, paid positions within an organization, consumer advisory groups, and national trainers and consultants.

To elevate the voice of leaders of color in homeless service organizations, white leaders will need to step back, boards will need to diversify, and emerging leaders of color will need to take hold of the chance to shape programs, agencies, and systems through the perspective of racial equity. This is not to say there is no role for white allies—they are essential for any true antiracism work to succeed. But just as the mental health recovery movement has taught us to believe "nothing about us without us," this same ethos must hold true in bringing together conversations about racial equity and homelessness.

## Policy

Without dramatic shifts in public policy, programmatic efforts to end homelessness for people of color will fall short and new research will sit unused on a shelf. Policy makers must begin to move the conversation about race and homelessness to front and center in all discussions about preventing and ending homelessness. This includes elected officials, staff within government agencies, thought leaders from the philanthropic sector, and others with the ability to shape national and local policy responses. Specific policy responses may include:

1. Using data about race and homelessness to drive decision making and allocation of resources
2. Including racial equity language and strategies in all federal, state, and local plans to prevent and end homelessness
3. Developing funding streams designed to respond to the pressing needs of people of color experiencing homelessness
4. Exploring upstream prevention strategies that bring together population health and individual risk assessment and response
5. Creating equitable housing policies at the federal, state, and local levels that begin to move the needle on high rates of homelessness among people of color

### Conclusion

Homelessness in the USA is a deeply entrenched social problem. For decades, people of color (especially blacks and Native Americans) have experienced homelessness at higher rates than whites. Such disproportionality dovetails with and exacerbates racial disparities in behavioral health. This crisis has been long in the making, but it is still a crisis. Yet, current approaches rarely take into account the racial dimensions of homelessness. Because homelessness does not impact all racial and ethnic groups equally, color-blind solutions are not solutions at all, but only half measures. Through a sustained focus on racial equity in research, practice, and policy, it is possible to create local and national responses to homelessness that move our nation forward in the work to prevent and end the travesty of homelessness in America once and for all.

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# Mental Illness, Addiction, and Incarceration: Breaking the Cycle

# 5

David Beckmann, Keris Jän Myrick, and Derri Shtasel

## Introduction

At the end of 2015, there were 6,741,400 adults supervised by the corrections system in the USA [1]. This included nearly 4.7 million people on probation and parole, and more than 2.1 million incarcerated in jails (facilities run by counties holding justice-involved persons awaiting trial or convicted of minor offenses) and prisons (facilities run by state governments or the federal government, typically housing persons serving out longer sentences). This represents, by far, the highest incarcerated population of any country in the world. For comparison, China, with its reputation for imprisoning persons for minor offenses, has roughly 4.25 times the population of the USA but has a correctional population that is less than 80% of America's [2]. While the number of persons in US state and federal prisons has decreased from its peak in 2009 (from about 1.62 million to about 1.53 million), these numbers still represent explosive growth over the past 40 years. In 1977, the US prison population was less than 290,000.

But these institutions are not simply microcosms of the larger society. Americans in jails and prisons (as well as offices of parole and probation) are disproportionately black or Latino and are far more likely to have mental illness, a substance use disorder (SUD), or both. Adults—particularly men—who fall into both groups (racial and ethnic minorities with mental illness and/or SUDs) are among the persons most likely to be incarcerated in this country. This has profound effects not only on the mental health of such persons during and after their incarceration but also on the social and economic opportunities of individuals and communities. This chapter outlines two

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separate but related threads of American history: the racist laws and culture resulting in the mass incarceration of black and Latino men (what Michelle Alexander has called “the New Jim Crow” [3]); and the unintended consequences of closing most of the country’s state hospitals without adequately funding an alternative (a phenomenon sometimes called “transinstitutionalization”) [4]. Additionally, this chapter describes the modern intersection of the mental health and criminal justice systems, examining why the current system continues to fuel the problems resulting in mass incarceration. Finally, avenues for improvement are discussed—both those that are already showing some promise and others that might be considered.

## History, Part 1: Institutionalization, Deinstitutionalization, and Transinstitutionalization

The role of the criminal justice system for individuals with mental illness, as well as perpetuating social control of minority men, has deep roots. When Europeans first colonized North America, family members were typically the only resource available to care for persons with serious mental illness (SMI). Some wealthy European families were able to afford lodgings and caretakers for persons with SMI, but most such individuals lived in almshouses (the predecessors of modern-day homeless shelters) or worse [5]. Life expectancy for persons with SMI was low, as they had little access to work or resources and were often targeted for being perceived as dangerous or simply as different. Notably, most individuals of African descent in the country were slaves; any slave too ill to do his or her work was unlikely to survive for long.

The earliest intersection of mental health and the criminal justice system comes from the Massachusetts Bay Colony, which in 1694 passed a law that authorized the jailing of anyone “lunatic and so furiously mad as to render it dangerous to the peace or the safety of the good people for such lunatic person to go at large” [6]. While there is logic in protecting the population from dangerous individuals, this set the precedent of explicitly criminalizing the state of having SMI. In the 1840s, Dorothea Dix presented Massachusetts with a scathing report detailing widespread abuse in the “care” of persons with mental illness, primarily through private individual contracts. She also noted that perhaps 20% of persons in Massachusetts jails and prisons had SMI [7].

The work of reformers such as Dix resulted in a new era of psychiatry—sometimes referred to as “institutionalization”—in an effort to provide a more humane approach to those with SMI. In 1850, there were only a handful of state-run psychiatric hospitals in the country, with one bed for every 5000 individuals in the population [8]. A century later, there were at least 75 state hospitals, with the number of persons in the community per hospital bed dropping from 5000 to 300.

The state hospitals, however, were far from a perfect solution. When the numbers peaked in 1955, there were 550,000 patients in 277 state hospitals [9, 10]. Overcrowding, neglect, and abuse were common, and concerns mounted about warehousing persons with mental illness. As a consequence, Congress established the Joint Commission on Mental Illness and Health, which, in 1961, corroborated accounts of serious mistreatment within state hospital walls and recommended consideration of community-based care.

Inspired by the passionate leadership of President John F. Kennedy, the serendipitous discovery of antipsychotic medication, and the will of fiscally conservative congressmen, the historic Community Mental Health Act was passed in 1963. This heralded an era often referred to as "deinstitutionalization," a period in which state hospitals became much less prevalent in the care of persons with SMI.

While initial hopes for a robust community-based rehabilitative system of care were high, and various legislative acts were passed to create, support, and staff community mental health centers, there was never adequate funding to establish such a system of care. Congress eventually passed a budget that shifted all remaining community mental health center funding into block grants to the states, with few stipulations about how the money could be spent.

Between 1963 and 1993, as these political decisions affected state hospital funding and promoted deinstitutionalization, the number of persons in state and county psychiatric hospitals fell from 550,000 to about 80,000—about an 85% reduction [10]. Over a similar time frame, there was a new political will to build more jails and prisons, and cultural and legislative shifts resulted in these new facilities filling quickly. The population of incarcerated persons ballooned from about 220,000 to over 1.2 million over this time [11].

There is no doubt that these changes dramatically affected the lives of many individuals with SMI. In 1970, a person with SMI who had been institutionalized within the previous year would have most likely gone to a state hospital; these facilities provided almost 90% of institutional treatment to this population, with only 4% of such persons going to jails and prisons [12]. By 2007, this trend had reversed; only 15% of institutional treatment was provided by state hospitals, with nearly 70% of treatment being provided by correctional facilities (general hospitals and private psychiatric hospitals constitute the remainder of these institutions). By the 2010s, the estimated prevalence of SMI in American jails (many of which are pretrial facilities with particularly transient populations) was about 20%, *similar to the rate in the 1840s, before Dorothea Dix and the institutionalization movement*.

In the past several decades, the correctional system has become the de facto safety net for those with SMI, leading many to prefer the term "transinstitutionalization": people released from state hospitals (and those now unable to enter state hospitals) receive inadequate community services and instead end up in jails, prisons, and homeless shelters. However, this shift alone cannot begin to account for the burgeoning jail and prison populations. A large study of corrections and hospitalization data from six states during the peak of transinstitutionalization found that, at most, 16% of the increased correctional population could be accounted for by their not having a more appropriate state hospital bed [13].

## History, Part 2: From Slavery to the New Jim Crow

Understanding the even larger, but related, forces that have resulted in the enormous increase in the size of the criminal justice system requires examination of events that were occurring in parallel to those described above. Through the lens presented here, jails and prisons can be seen as having a new function: a way to warehouse individuals whom society would rather keep out of sight and out of mind, with relatively little regard given to the ostensible goals of the "corrections" system (i.e., rehabilitation). This trend has not affected only those with SMI.

The past decade has seen an increased understanding and acceptance of the role of race in the criminal justice system. This is due to the academic and advocacy work of a number of individuals and groups, perhaps most famously that of the author, advocate, and associate law professor Michelle Alexander. Her seminal 2010 best-seller, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness,* effectively argues that the criminal justice system has a number of ways—some codified into law and others manifested in how the law is selectively invoked—to maintain a caste system that systemically disenfranchises black and Latino Americans, just as Jim Crow (a name given to the collective state and local laws legalizing racial discrimination and segregation) did until the mid-1900s, and as slavery did prior to that time [3]. Alexander and others have highlighted many areas in which the criminal justice system is not (color) blind, including at the points of arrest, detention, trial, and sentencing.

Even as landmark pieces of legislation (notably the Civil Rights Act of 1964 and the Voting Rights Act of 1965) were ostensibly ending Jim Crow, new legal and policy interventions seemed designed to continue the pattern of discrimination against black and Latino individuals and communities (some have argued that this was not the intention, but it was certainly the effect). Perhaps no collection of policies has had, and continues to have, as profound an effect as the so-called "War on Drugs." This was a term first used by President Richard Nixon in 1969 and popularized after his June 1971 "Special Message to the Congress on Drug Abuse Prevention and Control" [14]. Over the course of the 1970s, this "war" reversed a trend of societal liberalization of drug policies, such as the decriminalization of marijuana possession. The US public and various advocacy groups had become concerned about SUDs being within the purview of the criminal justice system, as opposed to being treated as illnesses (the medical model of addiction has existed since the seventeenth century), but the War on Drugs reversed this tide [15].

The War on Drugs reached a fever pitch in the 1980s (and into the 1990s), driven in large part by the emergence—and the media portrayal—of crack cocaine [16]. Black (and Latino) "crackheads" were often depicted as dangerous criminals, creating significant political will to criminalize this particular type of SUD. One of the clearest and most cited examples of racially informed drug enforcement policy is that of mandatory minima for the sentencing of drug possession. The quantity of cocaine required in one's possession to trigger a mandatory minimum sentence differed starkly depending on the preparation of the drug: the amount of powder cocaine required was 100 times the amount of crack cocaine required [17]. This is notable because crack cocaine sale and use was an epidemic of poor inner cities; over 80% of individuals convicted of possessing crack cocaine were black, whereas fewer than 33% of those possessing powder cocaine and other drugs were black [18]. One putative explanation for this discrepancy was the perception of crack cocaine driving violent crime, but arrest data showed no difference in the likelihood of one form of cocaine—as opposed to another—driving violent crime [19].

This is one example of the many policies that resulted in increasing rates of arrest and incarceration—particularly of black and Latino men—through the 1970s, 1980s, and 1990s. There is significant evidence, however, that it was not merely unjust policy but also unequal enforcement of policy that led to a vast overrepresentation of these communities in the criminal justice system [20]. As arrests in black and Latino communities climbed, so did prison populations. The overall prison population increased by 84% from 1985 to 1995; over half of this increase was attributable to nonviolent drug offenses [21]. Over this same time period, the likelihood of a drug arrest resulting in a prison sentence increased by a factor of four. The effects of these arrests and incarcerations cannot be overstated, not just for the individual but also for the communities where police and courts chose to be most aggressive. David Garland, a leading sociologist in the study of crime and punishment, has described how these patterns resulted in what ceased to be "the incarceration of individual offenders and [became] the systematic imprisonment of whole groups of the population" [22].

In 2016, any illusion that the War on Drugs was not racially motivated was put to rest by reporter Dan Baum in a cover story for *Harper's Magazine.* He published a quote he had recorded earlier from the late John Erlichman, President Nixon's domestic policy chief, describing the origins of the "War" [23]. "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people," said Erlichman, on the record. "You understand what I'm saying. We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did."

## The State of Mass Incarceration in the USA

Looking at race in America through the course of the twentieth century allows us to draw a relatively straight line from slavery—America's so-called "peculiar institution"—through Jim Crow, into what French philosopher Michel Foucault called "disciplinary institutions," exemplified by jails and prisons. Understanding the history of how racial minorities, persons with mental illness, and other "undesirables" have been treated in the USA clarifies the criminal justice system's role both in warehousing those whom society would prefer to ignore and in sufficiently disenfranchising entire communities enough to maintain a de facto caste system.

Currently, walking into most jails and prisons in the US makes it obvious how much black and Latino men are overrepresented. In 2006, when the incarcerated population peaked at about 2.4 million, the rate of incarceration among white men was 412 per 100,000 [24]. In that same year, the rate for Latino men was 80% higher: 742 per 100,000. The rate of incarceration of black men was over 5.5 times that of white men: an astonishing 2290 per 100,000 [25]. While the 2010 US population was 64% white and 13% black, the jail and prison populations were roughly 40% white and 40% black [26].

This is the consequence of injustice at every level of the criminal justice system: arrest, such as unequally applied "stop and frisk" policies; detention, such as systems of bail designed to benefit those with more financial and social capital; and sentencing, such as mandatory minimum drug laws [27]. The large majority of these men (and women) are incarcerated for nonviolent drug offenses even though the rates of SUD are comparable among different ethnic and racial groups [28].

Yet, jails and prisons continue to serve as warehouses for persons with substance use disorders and mental illness. About two thirds of individuals in jails meet criteria for a substance use disorder (and this may be an underestimate, as about 85% of persons arrested are intoxicated with at least one substance) [1]. About two thirds also meet criteria for another psychiatric illness, with about half of the persons in jail having a "dual diagnosis" and falling into both categories [1]. About 20–25% meet criteria for SMI [1]. Prisons and, especially, county jails have become de facto psychiatric hospitals. The largest providers of institutional psychiatry in the country are all jails (the top three are Los Angeles County Jail in California, Cook County Jail in Illinois, and Rikers Island Jail in New York); only six states have hospitals that provide more services to persons with SMI than their largest correctional facilities [6].

The use of correctional facilities as de facto hospitals would be less alarming if the quality of psychiatric treatment were high. Case law has clarified that justice-involved persons are guaranteed "adequate" mental health treatment in prisons (on the basis of the Eighth Amendment of the US Constitution, outlawing cruel and unusual punishment) and pretrial facilities (on the basis of the Due Process Clause of the Fourteenth Amendment). But there is no clear definition of "adequate," which may not even meet the threshold typically used in the community setting—the "standard of care." The way in which health care, including mental health care, is actually delivered varies widely between states and counties, and it is compromised by a number of structural, political, and financial barriers to providing persons in jails and prisons with "the standard of care." Examples include severely restricted formularies, refusal to provide opioid replacement therapy, and for-profit management of psychiatric services.

There are additional problems faced by persons incarcerated with mental illness, particularly if they are persons of color. In 2015, the organization Human Rights Watch published a report titled *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons* [29]. As the title implies, the report was scathing and documented horrible abuses, including physical beatings, use of stun guns or chemical sprays, and other uses of force by correctional officers. Correctional officers are often given little or no training in mental illness and may be retaliating against very minor infractions (e.g., swearing, urinating in the wrong place, or wearing the wrong outfit) without any understanding of the fact that these behaviors may be a product of an individual's mental illness and not his being intentionally difficult.

There is also quantitative evidence that persons with mental illness are disproportionately targeted by these retaliations. A *New York Times* investigation found that at one New York facility, persons with mental illness made up 40% of the population but were involved in 60% of altercations with correctional officers [30]. Those with mental illness are not the only individuals more likely to be targeted, however. Although it has been less systematically studied, many accounts (and lawsuits) have suggested that the implicit (or, less frequently, explicit) biases of correctional officers result in more frequent and severe accusations of disciplinary infractions when the person is black or Latino [31]. Taken together, these ideas suggest that black and Latino men with mental illness are perhaps the group most likely to be punished harshly for minor (or absent) rule violations, resulting in more traumatic incarcerations. A *New York Times* investigation of the New York prison system found significant discrepancies in the disciplinary treatment of justice-involved black versus white individuals. Although white individuals were issued more tickets per capita for offenses that required physical evidence (e.g., drug possession), tickets for infractions that were more subjectively judged, such as "disobeying a direct order," were nearly twice as likely to be meted out to black persons [32]. A closer look at one prison found that black individuals, when compared with their white counterparts, were sent into solitary confinement almost four times as often, and for nearly 40% longer (for 125 days, on average, compared with 90 days) [32]. These disparities during incarceration makes this group particularly prone to the "revolving door" of the corrections and hospital systems.

It is difficult to find specific data aggregating tragic outcomes for persons with mental illness in jails and prisons. In 2014, there were a total of 1053 deaths in county jails (which tend to have the sickest and most transient populations) [33]. Of these, 372 (35%) were suicides. Another 24 were classified as accidents, and 25 as homicides (which included death after use of force by correctional staff). These numbers—the most recent available—are not markedly different from those for other recent years. More detailed information surrounding these deaths is not available, but trends begin to emerge when articles about high-profile deaths in jails are examined. Most of the victims have mental illness. Most are also black.

The death of Sandra Bland is perhaps the most well-known example of a suspicious and preventable death in a jail [34]. Ms. Bland was a 28-year-old black woman arrested in Waller County, Texas, on July 10, 2015, and was found hanging in her jail cell 3 days later. This case raised questions about many of the intercepts discussed in this chapter: from the questionable nature of her being pulled over while driving (for failing to signal a lane change), to her arrest (which resulted from an escalation with the state trooper, which many people feel was driven primarily by the trooper rather than by Ms. Bland), to insufficient screening and monitoring for psychiatric illness (Ms. Bland was known to have a mood disorder), to lingering questions about her death and whether there may have been foul play.

But there are countless other examples that, in some ways, have even less ambiguity. Natasha McKenna was a 37-year-old black woman with schizophrenia who died after a stun gun was used on her at the Fairfax County jail in Virginia in February 2015 [35]. Her hands were cuffed behind her back, her legs were shackled, and she was wearing a mask when a sheriff's deputy shocked her with the stun gun four times. Her death was ruled an accident, and there were no charges.

Michael Marshall, a 50-year-old black man with schizophrenia, died during a restraint by officers in Denver, Colorado, on November 11, 2015 [36]. Marshall was in jail for trespassing and because he was unable to pay his $100 bail. He was pinned to the floor and held there for 13 minutes, even after vomiting. He died from aspiration of vomit. There were no charges in this case, either.

The story of Jamycheal Mitchell, a 24-year-old black man with schizophrenia, is one of the most tragic and complete pictures of the many problems in the country's criminal justice system. Mr. Mitchell was arrested on April 22, 2016, in Portsmouth, Virginia, for allegedly stealing a Mountain Dew drink, a Snickers snack bar, and a Zebra Cake [37]. He was reportedly clearly showing symptoms of psychosis during these events. Despite his obvious mental illness and the fact that the total cost of his burgled goods was $5.05, a judge ordered that he be placed in a state psychiatric hospital and that he be held in jail without bail until a hospital bed became available. His family says that he refused to eat in jail, and he was not offered adequate assistance. On August 19, nearly 2 months later, officers found his body on the floor of his cell. His family had asked for emergency medical treatment 2 weeks earlier. While litigation around this case is ongoing, the county, the third-party vendor, and everyone else involved in Mr. Mitchell's care have denied wrongdoing.

Occasionally, these tragic cases do effect change, even if it often feels like too little, too late. Bradley Ballard was a 39-year-old black man with schizophrenia who had been arrested for violating parole by failing to report an address change [38]. A female corrections officer was offended by the way he was dancing, and he was locked alone in his cell on Rikers Island for 6 days. He was found in his cell—naked, unresponsive, and covered in feces. He had been left dying and untreated for 6 days while uniformed officers, doctors, mental health clinicians, and nurses made 57 visits to his cell without assisting him. In this case, however, his death was ruled a homicide. No one was charged, and the lawsuit was settled, but this was one of the seminal events that resulted in New York City moving away from subcontracting health services to for-profit companies. Health services at Rikers Island are currently under county control; New York continues to look for a nonprofit or academic partner to provide medical services but so far reports being unsuccessful in finding one. In June 2017, the office of Mayor Bill de Blasio released a report titled *Smaller, Safer, Fairer: A Roadmap to Closing Rikers Island*, which outlined a plan to close the facility by 2027 [39].

## Recent Changes and New Directions

Improving the disheartening state described in this chapter will require significant reforms in both the criminal justice system and the way the USA deals with mental illness. Yet there is some cause for cautious optimism. The clear abuses in the criminal justice system, combined with the exceptionally high societal cost of incarceration—an estimated *$81 billion* per year—have made reform a popular topic of bipartisan conversation, even if action so far has been modest [40]. President Barack Obama recognized the scope of the need for criminal justice reform, and indeed there was some improvement during his presidency. The incarcerated population in America has steadily, if very slowly, declined over the past decade, from its 2008 peak of over 2.3 million to less than 2.2 million in 2015 [1]. This represents nearly a 10% reduction, but it means that there are still four times as many men and women in jails and prisons as there were in 1980.

President Obama showed, to some degree, an understanding of—and commitment to—criminal justice reform, which he summarized in a special commentary for the *Harvard Law Review* in 2017 [41]. In this commentary, he acknowledged the federal government's limitations in effecting change in institutions when 90% of jails and prisons are run by state and local governments. Nevertheless, he set the tone of this national conversation by using his clemency power far more than any other contemporary president. Further, his administration led reform efforts. "Smart on Crime" policies were introduced and enacted (playing on previous administrations' use of the term "Tough on Crime" and the accompanying policies that have led to our current state of mass incarceration). Attorney General Eric Holder's memorandum of 2010 reversed the existing policy requiring prosecutors to bring charges that carried the most severe possible sentence [42]. After calling on Congress to address injustice in sentencing law, President Obama signed the Fair Sentencing Act of 2010, which eliminated the arbitrary sentencing distinctions between powder and crack cocaine. Additional laws addressing harsh mandatory minimum sentences were advanced and had bipartisan support but were not allowed out of committee by a Republican-led Congress.

The Obama administration also recognized the importance of re-entry—that even as prison populations have decreased slightly, more than one in 20 adults (looking only at black men, this number is approximately one in four) has been convicted of a felony, with repercussions that extend far beyond their time behind bars [41]. In April 2016, the president signed a memorandum creating the Federal Interagency Reentry Council, which has continued to work with corporations and institutions of higher learning to ensure that persons who have "paid their dues" to society are given a second chance.

These are just some examples of Obama-era ideas and actions. While great strides in criminal justice reform were made, and President Obama and others from his administration continued to advocate for reform, there remains much to be done if the US system of justice is to truly live up to its name. In January 2017, Donald J. Trump was sworn in as president of the United States after explicitly running on a platform of "law and order"—a notion that implies returning to a "tough on crime" mind-set that favors harsh sentences, broader powers for police and prosecutors, and the use of tactics such as "stop and frisk," which have repeatedly been shown to discriminate against black and Latino men. In the first few months of the Trump administration, Attorney General Jeff Sessions (who was confirmed over Democrats' objections about his history of racist remarks and actions) reversed a number of Obama-era policies; this included stopping the monitoring of police departments accused of unnecessary use of force against black and Latino men and women [43], and reversing the Obama administration's phasing-out of the use of privately run, for-profit federal prisons [44]. More recently, Mr. Sessions ordered federal prosecutors to seek the most severe charges and sentences against suspects involved in any crime, including low-level drug offenses [45]. As the time of writing, it remains to be seen how the Trump administration may reduce or undo the progress, however slow, of the previous several years.

President Obama rightfully recognized that meaningful reform will require changes at every level of the criminal justice system: the way in which communities are policed, the way in which people are held in jail, how criminal cases are handled in court and how those convicted are sentenced, how people in jails and prisons are treated, and how those who have served their time are helped to re-enter society and avoid recidivism. In particular, however, if American society is to move away from a system in which jails and prisons are de facto psychiatric hospitals, special attention will need to be paid to how persons with psychiatric illness and substance use disorders are treated.

The first point of contact with the criminal justice system for most people is the arresting police officers. There is growing evidence that having formal mental health programs—either mental health training for officers or the presence of trained partners who respond to calls with officers—significantly reduces inappropriate arrests of persons with mental illness [13]. In particular, the Crisis Intervention Team (CIT) is a model devised by the Memphis Police Department in the late 1980s, which has resulted in significant changes in community policing [46]. A relatively small investment—40 hours of classroom time and experiential training for police officers—resulted in improvements for communities, individuals, and even the trained officers. A review of studies comparing policing pre- and postimplementation of CIT found that officers felt more prepared and confident, and more connected to their communities. Families of persons experiencing mental health crises were more likely to call the police, and persons in crisis were more likely to be taken to the emergency room or psychiatric service (rather than to jail) [47]. Of note, the nature and magnitude of benefits was variable between sites, suggesting the importance of the culture and implementation of this program. Nevertheless, there are preliminary suggestions that the savings seen by the criminal justice system in these precincts are sufficient to make these programs cost effective.

A good deal of coverage in the popular press has been dedicated to the idea that some groups are more likely to be arrested than others (black and Latino men, those with substance use disorders, and homeless persons). What may be less familiar is the degree to which a two-tiered system of justice exists *after the point of arrest*. A large proportion of the millions of people in county jails are there because they are unable to pay bail. For misdemeanors, bail is often quite low: in New York City in 2008, for example, about 42% of bail amounts were less than \$1000, and an additional 30% were exactly \$1000 [48]. Yet in 87% of arrests in which bail was less than \$1000, the individual was unable to pay and thus sat in jail awaiting trial for an average of nearly 16 days. In addition to the unpleasantness of having to live in a jail cell without having been found guilty of a crime, this time can have serious repercussions on things such as job maintenance, childcare, and existing medical and/or psychiatric treatment.

There are various approaches to address the discriminatory consequences for poor people that the current system of bail imposes. Proposals include mandatory bail guidelines to decrease the amount of discretion given to individual judges [49]. A number of state interventions have greatly decreased the use of bail, but this does not help individuals in some of the states where this two-tiered system is most egregious. Communities have also enacted novel interventions, such as using daily check-ins in person or even by text message, as opposed to having to stay in jail [50].

Reform will require a system in which fewer people are arrested and fewer arrested people go to jail. But the *courtrooms*, where verdicts and sentences are handed down by judges (and possibly juries), are another area where persons with mental and substance use disorders could be diverted into appropriate treatment, rather than incarcerated. In the past few decades, a small number of specialty court programs have emerged, designed to divert people into treatment and allow them to avoid other legal ramifications if they comply with their treatment plans. Both drug courts [51] and mental health courts [52] have demonstrated modest improvements in decreasing the use of the criminal justice system, as well as promoting rehabilitation.

Unfortunately, some persons with mental illness and substance use disorders—particularly those in socially disadvantaged groups—are likely to still be arrested, incarcerated, and sentenced to spend time in conventional jail or prison settings. For this subset of persons, the focus must be on minimizing time spent in jail or prison, ensuring that this time provides sufficient and continuous treatment, and—perhaps most importantly—promoting a successful return to the community at the time of release. President Obama’s most enduring legacy of criminal justice reform may be his inclusion and amplification of the problems of mass incarceration in the national discourse. His most concrete contribution, however, was his administration’s work in *sentencing reform*, particularly around mandatory minimum sentencing. Like bail reform, this is another area where further reform is needed to prevent judges in “tough on crime” areas from handing out sentences laden with implicit biases or issuing draconian sentences to those seen as “lesser” (including both black and Latino persons, as well as those with mental illness and substance use disorders). As long as such people are incarcerated, the institution of state and federal guidelines clarifying protections and services guaranteed to persons with mental illness would improve the lives of these individuals.

Of all of these reforms, however, it is at the point of *re-entry* (i.e., into civilian society) where the most can be done to improve outcomes for persons with mental illness. It is an unfortunate reality that the criminal justice system is often the first point of contact for individuals with psychiatric and substance use disorders. There are a number of proposals for programs to reform re-entry, although there have been few systematic studies. One model, called Critical Time Intervention (CTI) was first developed for persons with mental illness leaving homeless shelters, and it was later adapted to serve those leaving prison [53, 54]. This approach provides time-limited support (originally for 9 months) to connect people to existing treatment and other community resources such that individuals are proficient in navigating these systems by the stage when the "critical time" has come to an end, and they are anchored in their new (noninstitutional) setting.

Using data from these and other programs, the US Substance Abuse and Mental Health Services Administration (SAMHSA) released their "Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide" in 2017 [55]. Key recommendations included early screening and treatment (at the time of booking and while the person is incarcerated) but focused primarily on ways to improve treatment continuity at the time of release. They advocated developing policies that incentivize agencies (i.e., information sharing, "warm hand-offs" between prisons and mental health providers, and cross-training between different provider types) as well as justice-involved individuals (i.e., systems of "incentives and graduated sanctions"). While these guidelines are new and have not been studied as a comprehensive intervention, they are evidence based and would undoubtedly lead to significant improvements in outcomes, while being cost effective over any significant period of time.

There is also a growing body of evidence demonstrating that myriad social programs—many of which have no direct link to the correctional system—can have a considerable impact on rates of arrest and incarceration. Perhaps the most successful of these programs is the Housing First model, in which homeless persons are provided with housing alongside robust treatment and social services, rather than housing being conditional and earned through adherence to treatment and abstinence [56]. This approach has demonstrated an increased length of housing stability and improved quality of life. Promoting residential stability, coupled with active treatment and support services, is a promising alternative to incarceration [57, 58].

Finally, it is worth acknowledging the state of the "War on Drugs." The pendulum has again changed directions, and substance use disorders are again being seen by the public through more of a health lens than one of criminality. This, too, is related to race in America: while the ongoing opioid epidemic has many parallels to the crack cocaine epidemic of the early 1990s, this new epidemic is having a far greater effect on white communities, who are beginning to view the problem in a much more forgiving way, understanding substance use disorders as a disease, rather than a moral failing.

There are various ways of moving substance use disorders back into the realm of medicine, rather than the criminal justice system, but decriminalization is perhaps the most sensible. In 2001, the Portuguese government decriminalized *all* drug use (including use of heroin and cocaine), despite staunch opposition from conservatives. The results have been quite remarkable. The rates of substance use and SUDs have remained the same or perhaps even decreased slightly [59]. More dramatic, however, is the effect on related outcomes, such as drug overdoses and blood-borne infections, the rates of which have plummeted. Portugal now leads the European Union in positive substance-pathology-related outcomes, and the decision to decriminalize has continued to gain popularity in national polls and in the endorsements of conservative politicians, many of whom opposed the move when it was enacted. If drug decriminalization could have such beneficial effects in a country such as Portugal, which incarcerates its citizens at a rate of 135 per 100,000, imagine the effects in a country that has declared a racist "War on Drugs," resulting in an incarceration rate that is five times greater, disproportionately tearing apart the lives of persons with mental illness and communities of ethnic and racial minorities [60].

## Conclusion

The relationships among mass incarceration, mental illness, substance use, and racism are complex and represent the profound effects of laws, policies, and politics, rather than science and data-driven interventions, in the approach to the most vulnerable and historically mistreated persons. This chapter has attempted to begin identifying problems in these complex systems, but it is beyond its scope to identify all potential targets of intervention. An example of an important limitation is this chapter's focus on adult men; this population constitutes over 90% of persons who are incarcerated, and structural racism has particularly targeted black and Latino men as being dangerous. However, the problems described here are in some ways magnified in other groups. The burden of mental illness among women who are incarcerated is even greater than that in men: in pretrial jail facilities for women, the estimated prevalence of mental illness is approximately 80%, with particularly high rates of posttraumatic stress disorder (PTSD) and other trauma-related disorders, and over 70% of women having one or more substance use disorder [61]. In the juvenile justice system, the rate of psychiatric disorders falls somewhere between that of adult men and adult women—approximately 70% [62].

The complicated interplay between structural racism—the driver of mass incarceration—and the fragmentation of a comprehensive system of care for the most severely mentally ill persons, coupled with the erosion of a social safety net, all contribute to the challenges described herein. This chapter has also identified promising policy approaches, clinical models, and recovery supports that can change the conversation and the trajectory from one of punishment and discrimination to one of treatment, rehabilitation, hope, and—eventually—equity.

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# 6

# Racism, Black Bodies, and Psychodynamic Therapy

Lisa L. Moore and Claire Carswell

## Introduction

The ways in which racism influences and shapes internal and external functioning and motivations of law enforcement and policy makers have been of significant attention with the occurrence of several police-involved shootings. This chapter will demonstrate the value of applying a psychodynamic lens to discussions of race and racism by using these events to demonstrate the impact of racism on internal and external functioning. Through reflection on public discourse—as well as publicly available statements from the officers involved, explaining their actions—engagement with Jones and Obourn's concept of the phobogenic object, adopting the term from Fanon's theory of phobogenesis (originally introduced as "object fear" in their 2014 article) offers an approach for considering psychodynamic/psychoanalytic frameworks of self-psychology and object relations theories [1, 2]. These statements and discursive sites offer an important context for how a black person may internalize the real threat posed by these perceptions and its influence on internal functioning. Drawing on case vignettes involving work between a black clinician, two black clients, and a white client offers additional context for exploring the ways in which the discourse on racism in the USA influences internal functioning and external responses to white fragility and violence [3].

Before continuing, it is valuable to elaborate on how the terms "race," "racism," and "violence" are understood. Race is a social construction, which cannot be erased by simply not using the word, but it is a phenomenon that has historically been used to create social, political, and economic hierarchies based on skin color. Racism is about power and privilege—specifically, the conscious and often

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unconscious application of values or norms that disadvantage one group of people versus another on the basis of actual or perceived race. Privilege is not understood to be a negative; rather, it is viewed in this chapter as the result of the social, political, and economic conditions that contribute to an individual or group having more access to resources or opportunities. Violence, as defined by the World Health Organization (WHO), captures its complexities as not only a physical experience but also one that is psychological and emotional. The WHO describes violence as:

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation [4].

When considering these understandings of key terms and marrying them with psychodynamic/analytic theories, one is presented with additional language and frameworks to describe what one either witnesses or experiences in the world. Applying these concepts is not about subjecting a group of people to a collective pathology; rather, it provides an opportunity to examine the pathology of power among those in positions of dominance who occupy many institutions that frame the daily experiences of people who are not privileged. Fear is a persistent presence that emerges through the development of policies, laws, and standards to reinforce behaviors that are responsible for the disciplinary rationales that justify the use of force against black and brown bodies. Fear drives a perverse scenario of "doer/done-to" that is embedded in a lack of mutuality [5]. Benjamin's doer/done-to engages a theory of mutual recognition: "the necessity of recognizing as well as being recognized by the other" [5], p. 23. In this framework, the doer (police officer) recognizes the black or brown bodies they confront but views them as distinct. The institutionalization of these behaviors that are seeking to "maintain order" dissociates personal actions and privileges from professional responsibilities. Recognizing, distinguishing, and contemplating the internal dynamics of perceiving a black child as threatening offers a platform for examining objectification with tangible implications for clinical practitioners, who are often working in broad societal contexts with black men, women, and children.

## Phobogenic Object/Object Fear

At the time this chapter was written, a 15-year-old boy named Jordan Edwards was shot in Balch Springs, Texas, by Officer Roy Oliver. He was sitting in the passenger seat of a car that was attempting to leave a party, with his older brothers. The limited information available via media outlets such as *New York Times*, *Dallas Morning News*, and CNN indicates that the vehicle was not moving aggressively when Officer Oliver shot into the car. What is notable about this is that the occupants of the car were black, the officers were white, and they were in a predominately black and Latinx neighborhood.

During the summer of 2017, a jury acquitted Officer Jeronimo Yanez on all counts in the shooting of Philando Castile; this acquittal included charges of endangering the lives of Castile's girlfriend and 4-year-old daughter, who were in the car with him when he was shot. In the recording of that call, Yanez stated, "I'm going to stop a car. I'm going to check IDs. I have reason to pull it over. The two occupants just look like people that were involved in a robbery. The driver looks more like one of our suspects, just 'cause of the wide set nose" [6]. Later, in court, Yanez testified, "I had no choice. I thought I was gonna die. And I was scared because I didn't know if he was gonna.…I didn't know what he was gonna do" [7].

In 2014, Tamir Rice was shot in Cleveland, Ohio, for holding a replica toy gun. The call preceding the arrival of officers by someone who was at the park stated, "I'm sitting here at the park and there is a guy holding a pistol. It's probably fake, but he's scaring the shit out of people. He keeps pulling it out of his pants, but he keeps pointing it at people. He's probably a juvenile. I'm getting ready to leave, he's right here by the youth center, I'm not sure if it's real or not. He's sitting on a swing now." The dispatcher stated to the officers, "There is a black man in the park who has a gun in his pants that he keeps pointing at people. Only one call was made from people in that area" [8]. The call by officers after the shooting stated, "Black male, maybe 20, black revolver, black handgun by him. Send EMS this way, and a roadblock" [8].

In 2012, Trayvon Martin was shot by a neighborhood watch volunteer, George Zimmerman. The 911 calls of Zimmerman stated, "Now he's coming towards me. He's got his hand in his waistband. And he's a black male.…Something's wrong with him. Yup he's coming to check me out. He's got something in his hands. I don't know what his deal is.…These assholes they always get away…are you following him.…Yep." The dispatcher stated to Zimmerman, "OK, we don't need you to do that" [9].

In 2014, Renisha McBride was shot by a homeowner in Michigan for knocking on his door and asking for assistance after her car broke down.

The black body represents a phobogenic object. It is a body whose very existence has been framed as worthy of a threat for simply existing. Although the homeowner who shot Renisha McBride was convicted of second-degree murder, at the time this chapter was written, no one had been found guilty for the deaths of these boys and men, though Roy Oliver had been officially indicted [10].

When reviewing the reporting of each case, one sees that all of the officers cited fear of the unknown and a presumption of malintent towards those who were shot. When looking at their responses in these situations—in comparison with those of individuals such as Dylann Roof, who shot members of the Emanuel AME Zion church in Charleston, SC, and was arrested during a traffic stop 245 miles north of Charleston [11]; or Scott Michael Greene, an Iowa man who shot two police officers in Iowa in 2016 and was arrested [12]; or James Alex Fields, the man who drove his car and killed a woman in Charlottesville, VA, during a white supremacist rally in August 2017 [13]—it is difficult to not question consequences of the construction of blackness. The processes of objectification and projection are at the core of racist practices and ideologies. Racism's persistence is dependent on individuals with power objectifying others for the purposes of justifying their own actions, often through projecting internalized and irrational fears, desires, and biases onto others. Fanon's writings on race offer one context for considering the psychoanalytic/psychodynamic perspectives on differences based on race. His context of being from Martinique, and residing in France by way of Algeria, highlights the inescapability of being racialized and of racism. Schmitt writes, "[Fanon] does not ask whether the concept of race is defensible, or whether racism is an affliction of the emotions—a kind of neurosis—or of the intellect—a form of irrationality. He asks, What does racism do to people? His answer is brief. Racism objectifies" [14], p. 33. Jones and Obourn [3] wrestled with this objectification by exploring the social discourse around Obama's election. They described the response of white naysayers as "object fear," which they now reference as a phobogenic object on the basis of Fanon's work. The phobogenic object is rooted in the idea that one's mere presence elicits fear. It is a term that holds complex meaning as it is described by Jones and Obourn: "a dissociative drive that frees the subject to turn inward towards the familiar and prevents the actualities of his involvement in encounters, privileges and actions from being felt, seen, or experienced" [3], p. 398. This also contributes to an identification with the aggressor/doer or being in the position of being done to [5].

As highlighted by Jones and Obourn, the role of dissociation grants permission for officers to not acknowledge the implications of their actions for humanity. The role of being an officer is dislocated from the act of being a person. These events further illustrate the anxiety created upon encountering a body that has been deemed worthy of fear, simply on the basis of color. What is apparent upon reflection on the events is that in each case of an unarmed individual being killed by officers, there was the generalized presumption by officers that the black body is a threat and/or is a body in need of discipline. This body is different, yet there is a recognition by officers of its potential as a threat that is informed by their own internal recognition of one's capacity for violence. The questions in each of the circumstances presented, as well as those in a historical context, revolve around the construction of the roles of *anticipation, threat, and the "othered*" object in the mind of those who are not the "othered". Additionally, when one is considering phobogenesis, there is a challenge to confront this type of thinking on the subject.

The ongoing instances of police shooting black boys, men, women, and girls—and the social discourse, in particular—further illustrate the collective anxiety associated with the intersections of power, violence, and oppression through the vehicle of racism.

The othered object representing the black body can be expanded to many, including those who identify as Latinx, those who are perceived to be from the Middle East, or many other social categories. Moss offers a framework to consider the ways in which "otherness is a component of the systematized structure of hatred" [15], p. 823. Moss states, "The other is not known through empathy and identification, but rather through the reverse process, repulsion and disidentification" [15], p. 824. To be in a position of dominance and to associate empathy and identification results in a dramatically different response from what is experienced by many black men. In a story that aired on National Public Radio [16], a black police officer—Ronald

Hampton, of Washington, DC—was interviewed about what he considers to be "policing" and why he sought to enter law enforcement. He described the job as one that focused on serving communities and de-escalating situations, and emphasized the value of knowing the community so that an officer responds not out of fear but out of familiarity [16]. Through this framing, recognition takes a stronger role than differentiation.

The association with being in law enforcement that Hampton expressed during this interview was telling. The buzz words of "protect," "defend," "guard," and "get the bad guys" were not used. Rather, the emphasis was on being able to hold a reflective capacity while simultaneously assessing a situation from the position of serving people's needs, drawing on the social and political knowledge that shapes the conditions of the people served, and not from a stance of violence. The need to not be disidentified from the constituency being served played a significant role in the responses and actions of officers in the experiences cited by Hampton in this interview. When we flip this to consider the actions of white officers over the summer, their responses reflect the repulsion and disidentification noted by Moss, but, to go further, they also project their own sense of recognizing the unknown and differently racialized body as a threat, as dangerous, and as something that is not worthy of the benefit of the doubt. In fact, what many black and brown men and women presume is that they are the targets of hatred. Being "conscious" or "unconscious" does not excuse the intentions by which actions are rationalized. The outcome disproportionately affects people of one race more than another, with examples that run the gamut from death to humiliation. The psyche for all involved revolves around the need to prepare for a threat to one's livelihood—the difference being that one reality is based overwhelmingly on defensiveness regarding one's power and social position (i.e., racism and bias), while the other reality is based on lived examples and relationships.

An additional insight that can be drawn from Hampton's comments is the idea that officers' decisions are not necessarily made in a split second; rather, they are cultivated over time. The disidentification described by Moss occurs over time, as does the construction of a phobogenic object [15], p. 836. When considering these concepts in relation to the societally constructed role of police officers, the language used to describe what is considered "threatening," and the rationales used by officers to justify their shootings, the idea that an officer's decision-making capacity is formed before an actual encounter is a logical conclusion. This also reinforces the idea that there is a lack of accountability for engaging in behaviors that lead to harm based on actions that are racist or discriminatory.

While these considerations for understanding the behaviors of officers highlight the implications of disidentification, phobogenic objects, and racism, the societal implications for the black population in the USA—across race, class, and gender—are experienced directly. When one is working with individuals in clinical contexts, the actual experiences of being a phobogenic object are felt in every element of one's life. Black men, women, and children carry the burden of being objectified in ways that dehumanize their presence. To go further, the work of Lewis Gordon potentially challenges the notion of objectification by stating that psychoanalysis is not equipped to engage with black bodies, because they are not symbolic of particular characteristics, since our society has constructed black bodies as criminal, sexual, violent, etc. [17]. As young black boys become men, the impact of their actions and the influence of phobogenesis emerge as a thematic that constructs how racism may be experienced by black men. The following cases and excerpts offer three different examples in which the influence of phobogenesis emerges in the daily lives of the two black men who are highlighted, as well as that of a white man who seeks to do work with a black clinician, expressly to address his internalized racism. Additionally, the example of a white client offers insight into the complexities of white people attempting to undo their construction of blackness as bad.

## Case Studies

### Case Excerpt: J

J is a 45-year-old black man, who was seen by one of the authors [Lisa]—a black woman and clinical social worker—for 3 years. J's initial reason for seeking treatment was to address anxiety and procrastination associated with his work performance. As the sessions progressed, a central focus of the work addressed his experience of being seen as a capable person who was not the embodiment of a racialized threat. His referral to Lisa had emerged through one of his professors from graduate school, as well as a few friends who had worked with her previously. J's expectations for his sessions were rooted in his high regard, based on the reputation of his black clinical practitioner. J maintained a belief that in each session there was a need for him to leave with a sense of a revelation having emerged. Yet, in order to engage in treatment, J had to walk through a very exclusive neighborhood that gave him great discomfort, where people crossed the street when they saw him and where on more than one occasion he was nervous about being stopped by police officers.

This experience of traveling to an office in a space that was threatening served to lessen the idealization of the black clinician, as he was reminded, when going to and from his sessions, that she had made the decision to rent an office that could only be accessed by entering into threatening territory. On days when he had therapy, he made an effort to not wear his hood up, he wore jackets that had color, and he tried to smile at others. The result of this was that each session began with a discussion of what he had experienced when coming into the office. In what ways was he having to implement safeguards so he would not be harmed by the actions of whiteness that perceived him as a threat? Who did he see on the street? Did anyone cross the street when they saw him? If he saw a police officer, did they follow him?

The clinician, who was at this time seeing multiple black men in treatment, had to confront the countertransference that emerged for failing to create a safe holding environment for these men when they traveled to the office. Yet, these experiences warranted a regular debriefing about the experience of coming to the office, a need that while difficult also brought to light how each man responded to the racism in his daily life. The clinician had to confront the limitations of selecting an office on the basis of practicality. This office was located in close proximity to another job and was affordable because of a professional connection, yet it was located on one of the most exclusive streets in the city. In order to best serve the black men who happened to dominate the practice at this time, it was necessary to create space in the therapeutic session to debrief the process of traversing this threatening terrain. This meant adding an extra 10 minutes into sessions to address this challenge before getting to case material on some days. While many clients of color appreciated being seen in a space that was associated with "success" and "making it," the location also signaled that to be black in this space was to be exceptional in one way or another that was incongruent with how the clinician perceived herself or how many of her clients felt.

Given the context of where the work was taking place, and J's needs, he demonstrated a need to have a sense of control regarding how the work would be done, given his experience of the external threats in his environment and internalized fears. The following description of the process from the first session with J reflects his use of behaviors that destabilized the clinician.

At the outset of the first session, J asked, "Do you believe in Jesus?" The clinician responded, somewhat defensively, "Excuse me? Did you just ask if I believe in Jesus?" As she tried to consider the best way of answering, J repeated his question, enunciating each word: "Do—you—believe—in—Jesus?" While the clinician is not opposed to answering questions, she likes to explore the meaning of questions with people she is working with. Was he asking her who she is? What if she said yes? What if she said no? The implications in the moment were not clear, beyond her sensing the importance of the question to J. J once again repeated his question, "Do you believe in Jesus?" The clinician recognized that he was placing her in a position to do something she does not typically do, which is to address her personal religious background and values. She responded to J's request by stating this fact, going on to share that she was raised in the black Baptist church traditions, and then asking him to share with her the importance of knowing this information.

J revealed that in the past he had spoken with a white therapist about the Holy Spirit, who then threatened to send him to a locked psychiatric ward for delusions. This experience of not trusting the literal meaning of what is said, and not being understood, is one consequence of the pathology of fear that has been constructed by the power of whiteness. There is a significant lack of trust that emerges with the persistent experience that one's intentions are not "good" but, rather, are bad or violent. The significance of experiencing this threat in the context of the therapeutic space reinforced J's suspicion and lack of trust that the therapeutic experience is one in which he could be fully seen. As the sessions proceeded, J went on to discuss the value to him of working with a black clinician. He did not want his experience of being a black man to be what was deemed the problem that needed fixing. Rather, his physiological responses, as well as his mode of thinking about himself in relation to authority generally, was something he needed to "work out," especially when the authority was in a white body.

During the initial intake, J described his childhood experience, as the youngest child in a large West Indian family, as one that was dominated by a loving mother who lavished attention on him at all times, ensuring that he had all of his needs met, yet demanding the highest possible performance in all aspects of his life. He described his father as silent, but not passive—just very self-directed and valuing the order his wife was able to maintain with the household and the children. While living up to the high moral standards was manageable for J and something that still framed how he engaged with the world, the academic standards demanded by his mother were particularly difficult for J to achieve, given an undiagnosed learning disability, which was eventually diagnosed during his time in graduate school. J often spoke of his relationship with his parents, especially his mother, as one where they "coddled" him so much that he was not adequately equipped with the skills to confront the realities of dealing with racism, thereby contributing to a sense that he was too sensitive when he experienced racism, which he noted was inescapable. J's decision to enlist in the army at the age of 18 years was described by him as "an opportunity to bring honor upon my family." J had a strong desire to demonstrate that he could be highly successful, while also being associated with an institution that would demand more respect by others.

J also revealed during the intake that shortly after enlisting he was deployed to the Gulf where he engaged in active combat. He stated clearly that he did not want to talk about his experience "over there." Rather, he often addressed—in broader, more reflective terms—what he learned about his own naiveté regarding the state of "the black man in the military and in America." These reflections alluded to the idea that one's military status grants you slightly more respect from some white people, but overall it did not change anything about how he was treated inside or outside the military. J had thought that since there is an alignment around service between officers and military, he would experience different treatment during his police encounters; he did not. There was still a persistent fear that life could be altered with a poor police encounter or with an angry outburst, or simply by being in the wrong place at the wrong time. His need to return to his parent's home because he had difficulty finding employment after leaving the army contributed to his sense of feeling "duped" by the promises of the US military.

J's sense of fear and suspicion of people's intentions remained a dominant theme in the work. Throughout the sessions, J was very direct and enjoyed challenging the clinician through attempts to destabilize her reactions. He accomplished this by abruptly posing questions to the clinician that were unrelated to the material being addressed, as well as suddenly shifting from speaking in a normal tone to speaking in a very loud tone, and concluding sessions by disclosing information that would have been best addressed within a session. In some ways, it was as if he were a drill sergeant and during the clinical encounter he was in a position of power. As the sessions continued, J would often engage in a very direct and confrontational approach for discussion. When asked about this behavior, J replied, "I just like to shake things up when it seems like you are getting too comfortable." During the initial conversation with J, his tone was very direct and specific about what he needed from a clinician. He stated that he needed someone who would not coddle him and was very smart.

J's efforts to destabilize the clinician, combined with his responses toward navigating predominately white spaces and supervisors, frames a set of behaviors that J sought to resist being projected onto him. Fanon's descriptions of how the racialized body is dehumanized offers analytic language to capture this experience. Fanon describes certain behaviors—infantilization, denigration, distrust, ridicule, exclusion, rendering invisible, scapegoating, and violence—as a lens for reflecting on how an individual either perpetuates or experiences racism. Each of these expressions of racism demonstrates the distinct ways in which racism emerges, and they also reflect the various circumstances that frame how black people are challenged to develop effective responses. These expressions of racism described by Fanon coincide with the behaviors that informed J's responses.

In the case of J, the clinician was regularly challenged to hold the transference and countertransference of representing an imperfect "holding environment" for him by not bestowing upon him sufficient skills of self-preservation versus nurturing his potential. Ironically, when asked how he views his treatment from white women, he described an experience of mutual distrust, with his distrust being rooted in the lack of effort by white supervisors to give him the benefit of the doubt. This was exemplified by the ways he described the relationships he had with current and past supervisors, who he often experienced as burdensome. In the case of J, the white female supervisor [an ongoing theme in his treatment] always began her meetings with J by praising his work ethic and drive, but in her role as supervisor, J experienced her behavior as reflecting a lack of trust in his capacities despite praising his competence. He experienced infantilization, which emerged when steps were taken to ensure that his work was completed.

Responses to racism must demonstrate one's capacity to rise above the behavior of the offending individuals, while also illustrating the ability to not be dependent on systems to "fix" the problems. The fine line asserted between distrust and infantilization for J resided in perceptions of the body itself. Jones and Obourn's description of the phobogenic object [formerly, object fear] draws on Fanon's thinking, yet what few people who address race describe is: What is the white body to the black person? What terminology exists in a psychoanalytic space of thought about race that captures J's experience of the white body as one that elicits immediate distrust? Can a white body be phobogenic to Fanon? In the case of J, his descriptions of coming into therapy reflected responses based in reality—that white bodies are to be feared. The power of white bodies is worthy not only of "fearing" but also of constructing one's life around avoiding or accommodating. The white body is also a body that elicits fear or threat.

Though the black body is constructed through the lens of whiteness as phobogenic, the shootings of black boys, and some of the ways we have seen black girls treated in some higher-profile cases in the media, illustrate that projecting a phobogenic lens onto a white body is more than understandable, given the history of racism in the USA and the violence that accompanies it. When we consider this in the context of J, one begins to appreciate his tendency to lead with distrust when encountering white people in almost any setting. The relationship of J's experience to the media representations of police-involved shootings reinforces the belief that power expressed by white people—or just about anyone who is not black in the USA—is constructed around phobogenesis and anti-blackness.

## Case Excerpt: K

K is a 50-year-old black man, who was raised by a single mother for most of his early life, until she remarried when he was in his early teens. K self-referred for treatment because he wanted to have an opportunity to discuss his challenges with living a double life in regard to his maternal relationship. Professionally, he is a very successful artist who makes a good living, but he also grew up in a profoundly challenging home with a mother and stepfather who were drug dealers. On one occasion, K visited his home during a drug raid and was arrested and charged with possession with an intent to distribute. Though he had excellent legal representation and his actions demonstrated that he was simply in the wrong place at the wrong time, the concept of being mired in a drug raid experience is one element of the double life referenced by K. Of greater significance is the reality that he had to go to various court hearings and trials involving the raid. During some of these hearings, there was a possibility he would be held in custody. Despite attending hearings with the same judge over the course of a year, one of the elements that K described as leading him to feel "complete and utter rage" was the fact that the judge never remembered his name. K was acutely aware of the fact that each time he approached the bench, the judge asked, "And you are?" Following this query, the judge looked at his paper or awaited an answer from K before moving forward.

During K's first session, this experience was one of the first items he brought up in relationship to living a double life. When the clinician [Lisa] asked if he was referencing Du Bois and double consciousness, he chuckled and stated, "Well, yeah, I am living a double life, and I suppose it's about double consciousness, too." As K prepared to share, he took an extensive pause and seemed to struggle to not tear up. He went on to say, "I could be sent to jail at any time because of my mother's foolishness. You remember when I told you about being sent away to live out in the country to get away from my mom? Well, the main reason I left is because she was into some bad stuff, dealing drugs mainly, but I used to help her out. I'm grown now, but if I go over to see her, there is still an expectation at times that I may pitch in if she needs me to."

K's commitment to his mother, despite his strong sense of being manipulated by her, was rooted in his commitment to family. K had a distrust of formal systems of social welfare, as he considered that their systemic failures, coupled with institutional and systemic racism, were what drove his mother to deal drugs. He did not blame her for engaging in illegal activities to facilitate their survival, though he had worked incredibly hard to live a drug-free life and lived over an hour away from his mother to avoid problems. As K went on to explain, he made an unplanned visit to see her when the cops raided her house. He said, "I was simply in the wrong place at the wrong time, but I got locked up, had to bail myself out and everything, it was a mess. The court case from that night is up now and I am having to go to the hearings that seem to take place each month. Every time I go to another hearing for it, I am scared I'm going to be put in jail. Each month we have had the same judge and this cracker can't remember my name. I mean this guy practically jokes with my mom, remembers her name, remembers my stepfather's name, but not mine, I just don't understand."

As the clinician went on to explore this with K, he was asked, "Do you think that maybe he sees you as trying to be above them?" K said, "Maybe; I just think he sees another uppity N**** he needs to put in his place." As K and the clinician continued to explore this dynamic, it was notable that the judge literally rendered K invisible, while also forcing him to attend these regularly scheduled hearings despite the reality that K's attorney, officers, and his own mother acknowledged his lack of involvement as a person of interest.

There is a dehumanizing component to invisibility. To not be seen not only takes away one's humanity but also conveys a sense of not even being worthy of objectification to this judge. K's accomplishments—his professional status and his capacity to build a life for himself, which are well respected in the broader world in a way that distinguished him from his mother—had no meaning. K often attended these hearings on workdays, so his presentation was professional. When considering K's experience in relationship to the experiences of black boys, who sometimes never see the people who shoot them or never have more than a Q&A dialogue with the officers, his body was also rendered invisible. Essentially, one's success, age, or size does not extend power in the context of the criminal justice system—an institution designed to address people who are found to have done "wrong."

K's discussion of a double life also offers insights into the distinct ways that he was living in two different realities. In one, he had firmly ascended beyond the challenges that his family faced. In the other, he was firmly embedded in a family dynamic from his past experiences. When considering the relationship of black boys and men with police officers and systems of justice, the double life described by K emerges well before any contact with law enforcement. The subordination of black people to systems of white supremacy in the USA has framed the distinct sets of behaviors that black women and men adopt, depending on the system in which they are engaging. When K expressed shock at his treatment, it was rooted in the fact that he engaged in respectability politics: he acquired an advanced education, had a professional job, and basically did everything he was supposed to, but that did not further his position or acknowledgment by the judge, who held significant power. When we consider the case of K, as well as J, what we confront is the reality that there is literally nothing a person can do to escape the stereotypes that accompany skin color.

As K confronted this reality through the sphere of the court case, other areas of his life further disrupted his hope that professional and financial success would lead to him being seen and not excluded from opportunities. For example, he was overlooked for a promotion at his job despite having more experience than a white male colleague. When he approached management to hear why, the response was, "You know, we didn't even think about you—we should have though; you would have been great in the position." In the context of interacting with the world, whether it was walking down the street or ordering food at a restaurant, K would describe the moments of being seen as ones where he felt his race and size (he was well over 6 feet tall) were viewed as a threat (people would cross the street or clutch their bags). In contexts where he was known, he did not feel he was viewed beyond the ways in which he performed (he worked in the arts). As his sessions with the clinician continued over time, a persistent theme was how could he be seen and be in relationship with people when he was not engaged with the more performative aspects of his work.

The influence of this experience on K's functioning shaped his intersubjective realities in his intimate relationships with women and in his processes for shaping friendships. During one period of time in K's teenage years when his mother was incarcerated, K was sent away to live with a foster family in a very rural and homogenous part of his home state that was predominately white. K described his time with this white and Catholic foster family as a core part of his development. He stated, "It was one of the best times of my life." He described the experience of living in this rural area as one where he felt seen and cared for, despite having difficulties at the school he had to attend because some of the students had not encountered a black person before. K often discussed this family when reflecting on his frustrations around race, specifically. This experience functioned as his example that it is possible to love and be in relationship across race. The experience with this family, combined with the complex dynamics of his maternal relationship, furthered the need for K to experience the mutual recognition described by Benjamin [5] earlier. This recognition blunted the adverse effects of being viewed as a threatening object by the individuals or institutional systems that made him invisible and did not recognize his efforts to not be seen as threatening. Benjamin wrote, "The crucial element we explore with intersubjective theory is the representation of self and other as distinct but interrelated beings" [5]. K's constant desire in therapy was to build his sense of community and friends. K actively sought to reject being rendered invisible by regularly being a presence and through building a community that anchored his sense of well-being and positive self-worth.

The saliency of K's experience with the court system was that despite his size and the life he had built for himself, nothing changed when it came to how he was viewed by the judge or, for that matter, the criminal justice system. He was simply another black man who was nameless. His accomplishments did not absolve him from having to serve 2 years of probation for being in the wrong place at the wrong time. The professional life he had so carefully built intersected with his past when he had to gain special permission to tour outside the country for work and had to inform his employer of the situation, well after it happened. To his surprise, he learned that he was not the first person to have to submit special letters to gain permission to travel. He learned this a year after he had completed attending court. Prior to approaching his employer, K described his fear of having to be seen differently in a space where though he may have been invisible, he had a sense of comfort that his two lives had not met. Fortunately, K's efforts to be in community with people served to mediate the stress of having to make this uncomfortable disclosure and, in some ways, facilitated a lessening of the shame he experienced by having to engage with the criminal justice system.

## Case Excerpt: D

D is a 35-year-old white man who expressly sought treatment from a black clinician. He stated during his intake, “I wanted to work with a black clinician so I could address my internalized racism.” D was raised by a single mother, but his father had significant wealth, which D reported benefiting from, leaving him experiencing significant guilt. D’s interest in addressing his internalized racism stemmed from his desire to better understand how his anxieties about being the sole white person in spaces with people of color shaped his participation in activist spaces, as well as in the context of working with youth of color in urban settings. The urgency for D to address this issue was rooted in his recent move to a new city and his desire to further engage activist-oriented spaces where he was often the only white person present because of the particular issue being addressed: police violence. D was eager to better understand his own discomfort and to explore its meaning.

At the first meeting with the clinician, D expressed visible discomfort in admitting that he was not sure how appropriate his expectations were to engage the clinician as a source for his work. He manifested this discomfort by turning red frequently, squirming in his seat, and often looking down. The clinician [Lisa] acknowledged that while she had not previously had a client specifically come to her with this particular request, she did have experience working with people around issues of racial identity development, and that his desire to address these issues appeared to be similar. What was distinct about his request was that rarely do white men or women enter therapy to actually discuss their internalized racism.

D described that he really struggled to mask his discomfort in these spaces, as well as in his clinical interactions with a black therapist. When he was in a professional capacity, it was much easier to show up, as he felt there was a rationale to justify his presence. The experience of going in as a concerned and interested community member was an entirely different context. It made him feel exposed, as if he did not belong, and he was eager to feel as though he belonged. D described going to an organizing meeting to respond to a recent police shooting: “I arrived to the meeting early because I didn’t want to be late. I sat there with my book and someone asked me if I was looking for something. When I replied I was there for the meeting, they said, ‘Really?’ and walked off.” D went on to say, “I knew that if I left that wouldn’t be OK, but I really just wanted to show up and be available to help out. I knew I shouldn’t try to do anything but listen, but why won’t they just give me a chance to show up?” When asked the question, “Why should they trust you?” it caused him to pause. He went on to articulate that there is probably a good reason why they were suspicious of him. “I hadn’t thought that my good intentions would be interpreted as anything different.”

As the sessions progressed over the course of the year, D was able to become more involved with this particular organization, and what emerged for him was his tendency in group meetings to disregard the authority of the leadership, who he found stylistically to be abrasive. When asked if he respected the leadership, he expressed the ways he mediated his participation to make it more tolerable. He chose to arrive at meetings late to avoid the group check-in, departed early if he found himself annoyed with the facilitator(s), and then offered examples about their "ridiculous responses" to hypotheticals he would pose in large group conversations regarding strategy. Each of his actions could easily be interpreted by black or brown people as signaling distrust and disrespect. When exploring how and why he perceived the individuals in leadership as problematic, what emerged was that these people were often vocal, were confident, and remained suspicious of his presence. While they did not openly disrespect him, they excluded him from certain communication chains and did not include him in the core organizing group, despite his presence from the earliest stages of the process. As D's involvement with the group developed and he continued to feel excluded, D began to openly express his discontent with other members to whom he was close, eventually leading to a division between those who wanted him to be included and those who did not. As he processed this in therapy, the question was posed, "What is the significance that the group has become divided over the issue of your inclusion? What does it mean that your expression of discontentment for not being included has led to a group of black and brown people now taking sides?" As he reflected on this issue over the course of three sessions, he moved through three different stages of understanding how his presence contributed to the divisions. Initially he believed that the division over whether he should be included in the core organizing group was not his fight and that his new friends were simply sticking up for him because they knew he was committed to the cause. At the next session he continued to overlook his role or responsibility for the group challenges by explaining to his therapist that he was merely expressing his frustrations to people who had become his friends. By the third session, he tearfully admitted that his inability to stand up for himself with the group and the fact that he allowed his black and brown friends to do so were exertions of his privilege of being seen in a group that was never designed to serve his particular needs. He was eventually able to recognize that the reason why he was excluded from the core organizing group was because these individuals had worked together longer before his arrival in the neighborhood, and they wanted to limit the leadership body to streamline decision making. Basically, it was not personal. D's initial reluctance to recognize the significance of a group breaking down over the inclusion of a white person was absolutely reinforcing the suspicions and distrust expressed by the leadership, who did not want to include him in the first place. It took time and a multitude of questions for him to recognize how his need to be seen and included contributed to attention being diverted away from the issue that needed to be addressed and toward supporting the comfort of a white man. When D started reflecting deeply on the ways he treated the leadership who intimidated him, he realized he expressed distrust rooted in their lack of friendliness with him, even though others in the group had no issues with them and regularly celebrated their leadership. There was no internal thought that their distrust of him was rooted in experiences and histories beyond him personally. When spending time with his friends from the group, D would often blame them for the challenges the group was having in recruiting participants for different events, on the basis of his belief that they were too abrasive stylistically, despite some of his friends challenging this line of thinking. He did not acknowledge the ways in which his own statements and questioning of their intentions may have contributed to eliciting division among the group.

The desire to be recognized, elicited by D, was rooted in his complex desire to operate as both a participant and a leader in community building. When asked the question, “What does it mean for you to be seen as a member of the core group?” D replied that he wanted to be viewed by others in the group as one of them. To D, to be included as part of the organizing group represented his acceptance; it signaled to him that he was somehow less racist because a group of black and brown people included him in organizing for their community. Though D’s case had some similarities to those of J and K, it differed from them in that the issue of being recognized and feeling included shaped D’s unconscious exertion of his power based on the differentiation of his racial identity. Whereas J and K both sought to be recognized so they could simply have the experience of being seen, and to soften the experience of distrust, D deployed his whiteness in an exclusively black and brown space in a way that underscored the power of whiteness to reinforce distrust. Yet for D this was in the service of fulfilling his need to be recognized as a body that was not perpetuating the violence of racism.

The work with D is an example of the ways in which whiteness can be unconsciously deployed in a space of people of color to contribute to the emergence of distrust, despite the best of intentions. As the course of treatment continued for just over a year, D began to recognize the ways in which even in a space of passivity, his own insecurities of not knowing contributed to him perceiving black and brown people in positions of leadership beyond this organization with derision. His fear that he would not be seen as a sincere supporter contributed to his framing of these individuals as lacking certain qualities and shaped his overall distrust of their presence. While Fanon’s list of the various elements of dehumanization were all behaviors that D had—at one point or another—expressed toward people of color, the complexity of how they manifested demonstrates the difficulty of naming their presence. Often, when it emerges in the context of other issues, it is not until one begins to interrogate the intentions of the “doer” that we are able to understand the actual expression of racism.

## Conclusion

Fanon’s theory of the phobogenic object and those that have emerged in response to his work, by Annie Lee Jones and Megan Obourn, as well as by Moss, Schmitt, and others, offer a valuable site for considering how the construction of racism contributes to pathologies of anti-black sentiments among those in power. Psychodynamic/analytic theories offer another language to describe the internal dynamics that contribute to black bodies constantly being viewed as threatening and dangerous, as well as a context for intersubjective realities. Despite consistent evidence, research studies and examples, the reluctance of the mental health system, police officers, our federal government, and the criminal justice system to reflect on root causes for reactions to black people as threats should be of grave concern to all. When the language used by officers to describe their rationale for killing people is considered, it is consistently rooted in perceptions that blackness equals a threat. What is also important to note in the violence of these actions is that the officers often shoot people multiple times. Rarely are these people shot once or shot in ways that allow them to live; they are shot to death.

Fanon's experience being a black man from Martinique, and entering France by way of Algeria, was specific; yet his professional identity as a psychiatrist offered him a language to describe the phenomenon of race and racism as experienced personally and professionally. As mental health practitioners, engaging a body of thought that describes the specific ways in which racism is operationalized in the context of interpersonal and institutional interactions is necessary when providing treatment for all people. Recognizing the various ways that race and racism are salient to clients across racial groups offers providers of mental health care a nuanced perspective for responding to the anxieties, fears, and concerns expressed by clients.

In two of the case studies presented in this chapter, the persistence of phobogenesis constructed a need to protect the self from the threats of whiteness, which, in the cases of J and K, had been consistently experienced in some manner at different points in their lives. It is notable that efforts to identify a term similar to phobogenesis related to a fear of whiteness or the white body does not currently exist in the reviewed literature. Fanon once wrote that the most thorough form of oppression was to force the native to accept his or her objectification [17]. The cases of J and K introduce the distinct ways that being rendered invisible and experiencing distrust shape perceptions of self. Clinicians are confronted with the narratives of men who sought out a space to be seen through their professional spheres that ultimately did not result in them being any more seen than they were prior to the engagement. The military did not legitimate J, and a professional title and a nice suit did not make the judge recall K's name. Practitioners are confronted with the reality that our tendency to define a client's success in the context of their completion or achievement of professional goals cannot be the sole standard for determining that a person is achieving good functioning. Rather, they must understand how clients negotiate the daily insults that build over time. In much the same way that J and K needed to debrief the experience of coming to treatment by walking through threatening territory, clinicians need to be mindful that they are not dismissing the influence of what may seem like minor behaviors, such as a person crossing the street, when clients come to see them.

The case of D is unique because it is a rare opportunity for exploring the ways in which whiteness is interrogated. Clinicians are offered a picture of a man who was white and wanted to be rendered invisible in spaces with people of color. Instead, he was not only seen but had to wrestle with being confronted for showing up. When considering the ways in which providers address the role of race with white clients, it is important that they are cognizant of the ways in which lack of experience of recognizing the self as a racialized body contributes to a belief that one can operate across racial groups without repercussions in how one is perceived. The case of D offers practitioners a lens to consider the ways in which the anxiety associated with cross-racial interactions elicits behaviors and responses that may unintentionally contribute to the dehumanization of black and brown bodies.

If there is one sign of hope in the context of these cases, it is the resilience of the clients themselves, as well as of a more informed society. The emergence of societal representations that resist the dehumanization of black and brown bodies offer clients such as J and K another vehicle for affirming the legitimacy of their experiences. It is important for practitioners to continue to affirm and validate the ways in which race and racism in the USA shape the experiences of clients and practices.

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# Clinician Bias in Diagnosis and Treatment

# 7

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## Introduction

A myriad of factors contributes to racial disparities in mental health care. While institutionalized racism persists through political, economic, and social structures, individual and interpersonal factors play a role as well, particularly during the clinician–patient interaction. Specifically, because of the interpersonal nature of clinical medicine, the clinician's assumptions about a patient, based upon their race, can impact interactions with, diagnosis of, and implementation of a treatment plan for the patient [1]. While patients and clinicians may not be aware of the role of racial bias in the clinical encounter, this chapter makes the argument, and provides scientific evidence, that racial bias plays an important role; this is consistent with findings from the landmark National Academy of Medicine report [2]. When individuals present to a mental health clinic with concerns about paranoid thoughts and mood changes, they expect their clinician to objectively identify the cause of their symptoms and recommend the best treatment. What usually takes place is more complex and not

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purely objective. Race may impact the care they receive. Stereotypes of racial groups exist and impact the perceptions of, expectations of, and interactions with individual members of these groups [3]. In this chapter, mechanisms for both clinician and patient bias are described, contributing to racial disparities in both diagnosis and treatment, which affect mental health outcomes. While race is a social construct and ethnicity more specifically refers to the cultural identity of an individual, in this chapter the term "race" is used as a proxy for both race and ethnicity [4].

## The Clinical Encounter

The clinical encounter is interpersonal and dynamic (Fig. 7.1), with various entry points for racial bias (Fig. 7.2). Upon meeting the patient, the provider may activate beliefs or assumptions about the patient's race and interpret the patient's behaviors within this framework. Specifically, the provider may automatically associate racial stereotypes with the individual. Stereotypes, by definition, are simplified descriptions and ideas about the members of a racial group. Stereotypes about "in-groups" (members of one's own group affiliation) and "out-groups" (others recognized as

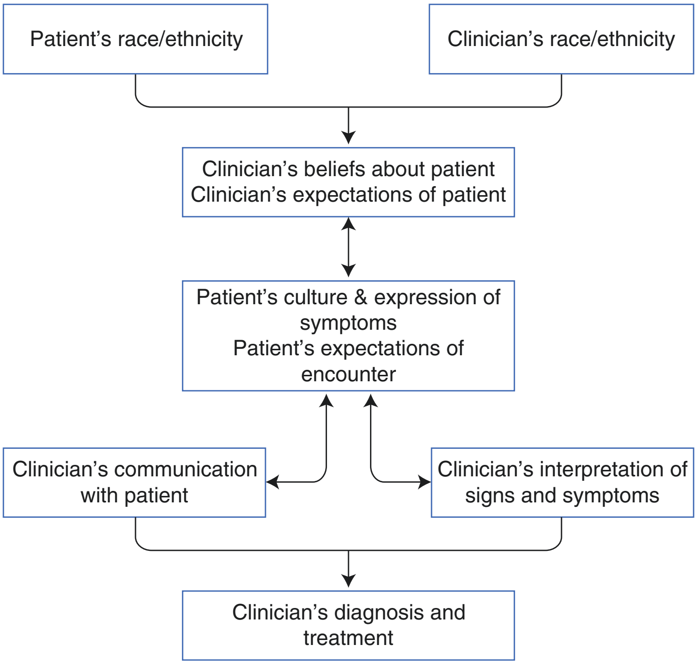

**Fig. 7.1** Patient and clinician factors susceptible to bias. The patient's race likely influences his or her cultural expression of illness, communication style, and expectations of the encounter with the clinician. These factors interact bidirectionally with the clinician's own race, beliefs about the patient, and expectations of the patient. The outcome of the interaction is the clinician's interpretation of the findings and the diagnosis, which contribute to treatment planning. These factors are susceptible to bias activated during the clinical encounter

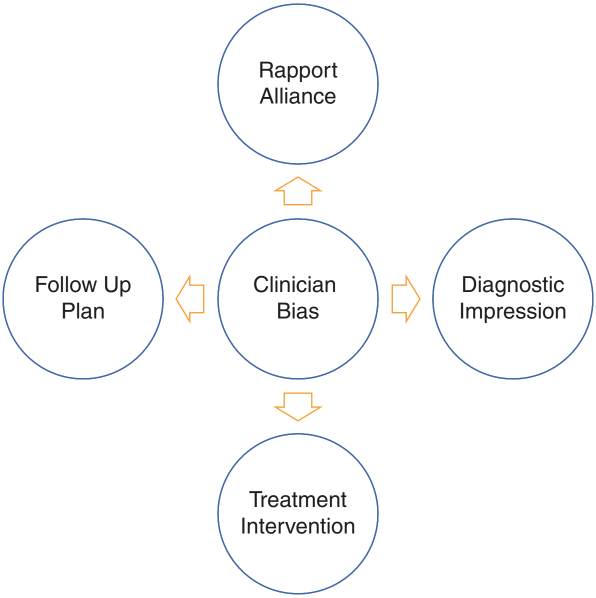

**Fig. 7.2** Aspects of the clinical encounter susceptible to clinician racial bias, including development of rapport, formation of a diagnostic impression based on findings, the treatment intervention proposed, and the follow-up plan for ongoing management of symptoms

not having the same group affiliation) are learned early in development. Exposure to societal norms via the family, the local community, and possibly media representations contribute to the formation of stereotypes [5].

In a clinical setting, bias—an attitude or belief about an individual, based on their stereotyped group affiliation—may be activated on the basis of the clinician's and patient's group affiliations. Racial stereotypes may alter the lens (assumptions, expectations) through which the clinician hears and understands the patient's concerns. The clinician's assumptions may affect interpretation of the clinical information or symptoms, as well as impacting their own interpersonal behavior. As the encounter ensues, professional decision making is impacted by expectations about the patient's ability to follow through with the treatment plan. Bias can influence the types of services offered or emphasized by the treating clinician. Table 7.1 provides examples of the ways in which clinician bias may manifest during the clinical encounter.

## Explicit and Implicit Bias

Since the 1990s, there has been increased scientific interest in understanding the issue of bias. The extant literature comprises a plethora of studies in journals of social science, psychology, neuroscience, and clinical medicine [6–8]. In response to an appreciation of the broad impact of decisions influenced by bias across health care, education, criminal justice, and human resource settings, many public and

**Table 7.1** Manifestations of clinician bias during the clinical encounter

| |
|---|
| *During development of the working alliance* |
| • The clinician exhibits nonverbal communication of hope or despair, trust or mistrust, optimism or skepticism. |
| • The clinician interacts in an overly familiar manner with the patient or, alternatively, lacks interest in details of the patient's story. |
| *During the diagnostic assessment* |
| • The clinician minimizes certain symptoms and emphasizes other salient symptoms even if they are culturally sanctioned. |
| • The clinician conducts the mental status exam through a biased lens, particularly in terms of describing the patient's behavior, eye contact, affect, perceptual disturbance, insight, and judgment. |
| • The clinical diagnosis is impressionistic rather than based on a thorough diagnostic interview with strict adherence to criteria. Questions to elicit core symptoms may not be asked. |
| *During treatment planning* |
| • The clinician provides treatment recommendations that deviate from guideline-based care. |
| • The clinician delays referrals or makes inappropriate referrals for types of treatment, services, and levels of care on the basis of a biased interpretation of symptoms and a biased prognosis of the illness and treatment course. |

private organizations have taken steps to mitigate the influence of bias. These include large American institutions such as the Supreme Court, the executive branch, and law enforcement [9]. In health care, implicit bias has been studied extensively. It is associated with disparities and poor patient experiences, although to a more limited extent within psychiatry [7]. In this section, explicit bias, implicit bias, and their impact on clinical care in the mental health setting will be discussed.

## Explicit Bias

Racial bias is considered "explicit" when the belief or attitude is overt and conscious on the part of the clinician. In this case, the clinician knows they have a preference for or dislike of certain racial groups. The clinician may be able to consciously deny and suppress actions based on the bias, but they may also consciously act on that bias. Social norms influence whether explicit biases are expressed, in the form of discrimination, hate speech, disparaging comments, or refusal to provide an equitable and expected standard of care. While more explicit biases were expressed during the time when the USA had legalized race-based discriminatory laws, explicit biases continue to be expressed in certain contexts. Clinicians may be particularly vulnerable to acting on their explicit biases during periods of fear and perceived threat.

## Case Example of Explicit Bias

Stereotype: African-American males are aggressive.

## Phase of the Clinical Encounter: Treatment Planning

> *A clinician whose neighbor was robbed by an African-American male 2 weeks prior is currently working in an active inpatient unit. Since the event, the clinician is aware of their discomfort around African-American males and recalls that when they watch the nightly news, African-American males are often profiled as aggressive or violent* [10]. *In the unit, an acutely agitated African-American male patient is having a crisis. The patient, who was initially posturing and threatening, sits down immediately in response to a show of force by the clinical staff. The clinician, who participated in the crisis event, orders restraints to manage potential aggression, despite the patient's response to the intervention and a lack of consensus among the other staff.*

Discussion: In this example, feeling acutely concerned for his/her own safety and stressed by the interaction, the clinician is aware he has recommended a highly restrictive intervention because of this patient's demographic profile and perceived increased potential for aggressive behavior.

The experience of explicit bias has a markedly negative effect on patients. Perceived discrimination is a social stressor that contributes to the mental illness burden in the USA and furthermore contributes to poor patient experiences [11]. In research studies, explicit racial bias is usually measured by self-report tools that seek to elicit racial preferences and feelings about the stated racial groups. As such, the results may be susceptible to "social desirability bias." Social desirability bias is the tendency, when answering sensitive questions, to report answers that will be more appealing or considered more socially desirable [12]. For this reason, measures of explicit racial bias have limitations, as race-based questions are considered sensitive, and this leads to a discussion of methods to detect implicit bias.

## Implicit Bias

Implicit bias results from subconscious association of stereotypical attributes with particular racial groups. These biases may differ from an individual's self-report of explicit bias. Like explicit bias, it is based on a shared and well-known stereotype within the dominant culture that associates attributes to individuals from particular racial or ethnic groups. It can be positive or negative and is usually activated automatically and involuntarily, potentially impacting clinical interactions, assessments, and treatment decisions. The potential for impact is greater in instances of stress, exhaustion, time pressure, and high emotional tone, which are often encountered in mental health treatment settings.

The neuroscience literature has also provided some insight into the brain's automatic associations, particularly how the brain applies race-based information [8]. The ability of the brain to categorize, which is an early developmental task, enables humans to interact fluidly with their environment and rapidly process information for faster decision making [5]. The network of brain regions that process race-based information has been identified through functional magnetic resonance imaging (fMRI) techniques [8]. Those consistently correlated with processing of race-based information include the amygdala, the anterior cingulate, the anteromedial prefrontal cortex, and the fusiform face area. The amygdala's role is implicated in automatic evaluation of faces, particularly their trustworthiness, evidenced by increased amygdala activity in response to less trustworthy faces and the finding that individuals with amygdala lesions do not assess untrustworthy faces accurately [13, 14]. The anterior cingulate recruits prefrontal cortical regions to network with the amygdala, and there is evidence that the dorsolateral prefrontal cortex is involved in the suppression of racial attitudes [8, 15]. In addition, researchers have found that propranolol (a nonselective beta-adrenergic blocker) decreases activity in the fusiform gyrus, a region with increased activity during recognition of out-group faces [16]. This suggests a role for the sympathetic nervous system in mediating responses to out-group faces.

For decades, researchers in social psychology have utilized the well-validated Implicit Association Test (IAT), which theoretically builds on the idea that the brain processes a significant amount of information outside the individual's awareness [17]. The IAT is geared at engaging subconscious associative tendencies of the individual. The timed test—one of those most widely used in research studies—measures how closely associated two distinct concepts are with an attribute (e.g., positive or negative, athletic or clumsy). One form of the test includes a race-specific stimulus (face presentation) and a trait presentation. The closer the individual's association between the stimulus and the trait, the faster their response time. The IAT has been used to assess evaluative differences and has revealed subconsciously held racial associations that may be consciously disavowed [17]. It is utilized in research studies as a measure of unconscious bias. Using the IAT, multiple studies have identified that physicians in general have the same pro-white bias as the general population, though there is less such bias among black physicians [6, 7, 18]. In the neurology literature, a study of spinal cord injury patients found that higher physician pro-white bias on the IAT was associated with a higher level of depression and a lower level of psychosocial functioning of the patient [19].

There is some controversy over the implications of the results of an IAT. Implicit biases themselves do not always predict clinical decisions in study design reports and, additionally, recent meta-analyses have shown a low predictive ability for behavior that is prejudiced or discriminatory [20–23]. One study found that even when physicians had high levels of implicit bias in the context of vignettes given under study conditions, there was no difference in the treatment recommendations they made [24]. While controversy exists over the predictive ability of the IAT, it is still regarded as a useful tool for researchers interested in racial attitudes [21]. Its low correlation with behavior in the study environment is not surprising, given the complexity of human interactions [25, 26]. This chapter asserts that clinician bias can manifest in various aspects of the clinical encounter and may not directly result in discriminatory behavior but may result in behaviors that perpetuate health care disparities. For example, in a study of physician implicit bias and stereotyping impacting compliance with treatment, physicians with greater implicit bias and stereotypical beliefs had a communication style that was associated with lower patient satisfaction ratings. Specifically, black patients experienced less patient-centered communication, lower trust, and lower ratings of care [27]. The impact of implicit bias on the clinical encounter is an important area of focus.

The disconnect in research studies between the pervasiveness of implicit bias based on the formal IAT and its clinical implications are worth discussing further. Implicit processing takes place in the context of higher-order cognitive functions, which may variably override actions influenced by bias. It is likely that in most cases, automatic neural networks work together to integrate a more complex picture of clients so they are not merely recognized as in-group or out-group faces. The outcome of this processing guides interactions during the clinical encounter. In the clinical context and more broadly, risk factors for acting on implicit biases may include time pressure, exhaustion, stress, and high emotional tone [28–30]. In these circumstances, decisions are made quickly and instinctively, leading to a greater reliance on the brain's subconscious associative processing of information. The clinician is most vulnerable to acting on implicit bias when there is too little time and too high a cognitive load for the executive functioning mechanisms to play their role. Implicit bias can also be enacted in clinical situations that are more complex, when the clinical diagnosis is not clear. Furthermore, biased interactions can occur when there is ambiguity in the diagnosis or the clinical presentation [31].

In one study, physicians who completed a shift in an emergency room emerged from the shift with stronger pro-white/anti-black bias [28]. Specifically, this study demonstrated that factors such as seeing a significant number of patients and overcrowding of the emergency room activated greater implicit bias, as demonstrated by a higher pro-white bias score on the IAT at the end of the shift. While this study did not explore the clinical outcomes of the patients, the results of outcome studies have been variable. One study that focused on hypertension showed no difference in treatment decisions, patient adherence, or blood pressure control [32].

Awareness of the vulnerability surrounding implicit bias and subsequent discriminatory behaviors, along with use of strategies to overcome it, can lead to improved equity in the care that patients receive.

## Case Example of Implicit Bias

Stereotype: Among African Americans, those with light complexions are seen as "better" than those with dark complexions (colorism).

### Phase of the Clinical Encounter: Alliance Building

> *Michael is a young African-American man with schizophrenia, who has been nonadherent to his appointments and medications. Today, his mother—a light-complexioned African-American woman—accompanies him to his appointment at a busy outpatient clinic. The clinician greets his mother and begins the brief 15-minute medication check. The clinician has an implicit bias favoring light complexion in African Americans. While the clinician does not think of this at the time, the clinician experiences a sense of hopefulness and optimism upon meeting the mother and expects that the mother's engagement will positively impact the patient's adherence. The clinician speaks in more technical language and has a "sense" that the patient's mother has more education, insight, and understanding of her*

*child's illness. In the brief session, the clinician advises the mother of the recommended treatment plan. After the session, the clinician is surprised that they do not follow up consistently and do not follow the recommended plan of care.*

Discussion: Racial phenotype bias toward African Americans, manifesting as a preference for light complexions versus dark complexions, is well documented [33–35]. The implicit bias favoring the light-complexioned mother led to a series of behaviors that were different from the norm. It resulted in less time being spent in developing an alliance with the mother on the basis of the mother's understanding of the illness, and more time being spent on making recommendations. This bias contributed to a session that did not advance the patient's plan of care by successfully engaging with family supports.

## Racial Bias Impacting Mental Health Diagnoses

The process of arriving at a mental health diagnosis is subject to bias. Alegria et al. [36] demonstrated that diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are not always systematically applied and that race/ethnicity can impact diagnosis through inadequate screening and through greater emphasis being placed by the clinician on reported symptoms. In their naturalistic study of 47 clinicians and 129 patients videotaped during a psychiatric assessment, the researchers coded the scripts of the interviews, assessed whether diagnostic screening questions and criterion were applied, and then assessed whether there were any racial differences in the findings. Their findings were striking. Overall, in cases where coders and clinicians did not reach the same diagnosis, it was found that specific symptoms were often not discussed by a clinician for the diagnostic criteria to be met. Furthermore, there were racial differences in the application of diagnostic criteria. Specifically, anxiety disorders were diagnosed more frequently among Hispanic patients than among Caucasian patients who reported the same symptoms. While the study did not elaborate on why these biases exist, the findings are deeply troubling. The authors concluded that a mere one quarter of psychiatric interviews accurately utilized DSM symptom criteria in applying a diagnosis. Of note, only 28% of clinicians were psychiatrists, with the majority being a combination of psychologists, social workers, and nurses. Further discussion of the findings led Alegria et al. to identify four factors that may influence diagnosis [36]. These include variance in the information received, how the criteria are applied, the process of conducting the interview, and culture/language variables. This is a helpful construct for understanding how bias may influence outcomes.

This section will discuss in further detail how clinician bias becomes apparent in the diagnosis of patients, interpretation of clinical findings, and treatment planning for different racial minority groups. Many studies have demonstrated misdiagnosis, overdiagnosis of psychotic illnesses, and underdiagnosis of mood symptoms in African Americans, given clinician bias. However, as previously mentioned, both the clinician and the patient can affect the therapeutic dyad, impacting how mental health diagnoses are determined and ultimately treated.

## Bipolar Disorder

While cultural factors play a role in diagnostic patterns, data from large epidemiological studies do not suggest there is any difference in the population prevalence of bipolar disorder between African Americans and Caucasians [37]. One study suggested that African-American patients may be incorrectly diagnosed as having symptoms of a manic episode because of a tendency to be more expressive and "colorful" [37]. In comparison with individuals from cultures where it is not acceptable to demonstrate negative emotions, an individual who is vocal and overtly loud and unhappy may have these symptoms interpreted as labile and pressured. African Americans report a significantly elevated prevalence of inflated self-esteem and grandiosity when manic, in comparison to Caucasians who have bipolar disorder [38].

## Misdiagnosis of Schizophrenia Among African-American Patients

Since the 1970s, researchers have found that African-American patients with affective disorders are at higher risk than white patients of being misdiagnosed with a schizophrenia spectrum disorder [39, 40]. Although the majority of epidemiological studies show no difference in the prevalence of primary psychotic disorders [41], African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with an affective disorder. National data on psychiatric hospital admissions have demonstrated that African Americans are about 1.8 times as likely as white patients to be diagnosed with schizophrenia and about half as likely to be diagnosed with an affective disorder [42, 43]. County data show that African Americans are about 1.5 times as likely as white patients to be diagnosed with schizophrenia and only 0.75 times as likely to be diagnosed with an affective disorder [44]. Finally, according to community mental health data, including data from state mental health departments, African-American inpatients are 1.5 times as likely as white patients to be diagnosed with schizophrenia and 0.60 times as likely to be diagnosed with an affective disorder [45].

Evidence demonstrates that these disparities are caused by multiple factors, ranging from clinician bias during the interview and formulation process to racial differences in patient presentation. Multiple studies have demonstrated clinician bias during interviews of African-American patients in comparison with white patients. In a 1988 study, 290 psychiatrists were given standardized case descriptions that varied only by patient race. Case descriptions of African-American patients were more likely to be assigned a diagnosis of schizophrenia than a diagnosis of a mood or stress-related disorder [46]. In a more recent study, 79 patients with an expert-consensus diagnosis of an affective disorder with at least one psychotic symptom (hallucinations, delusions, or prominent thought disorder) were recruited.

The expert-consensus diagnoses were derived from a transcription of structured interviews and medical records from which ethnic cues had been eliminated. Among this group of patients, African-American men were significantly more likely than white men to be clinically misdiagnosed with a schizophrenia spectrum disorder (47% versus 16% [47]). Furthermore, gender bias also influenced schizophrenia diagnoses among African Americans, with men being more likely than women to be misdiagnosed in that study (47% versus 9% [47]).

### Biased Interviews

One reason for bias in diagnostic evaluations is that clinicians may not interview African-American patients thoroughly for affective symptoms. In a study of 99 patients admitted through the psychiatric emergency room for psychotic symptoms, there was more frequent diagnostic disagreement between the emergency room evaluation and a subsequent structured interview evaluation of African-American patients compared with white patients (40% versus 22% [48]). Specifically, 58% of cases with disagreement consisted of affective symptoms that were endorsed in the structured interview but were not obtained or documented in the emergency room evaluation records [48]. Use of a standardized checklist rather than clinician-structured interviews to elicit symptoms decreased the rate of diagnosis of schizophrenia from 75% to 57% among 291 hospitalized patients, closing the racial gap in diagnosis of psychosis [49].

### Overvaluation of Psychotic Symptoms

In a study of patients with an expert-consensus diagnosis of an affective disorder, clinicians more frequently conceptualized psychotic symptoms reported by African Americans as occurring without periods of recovery and as occurring in the absence of affective symptoms [50]. Further, it was reported that culturally appropriate suspiciousness may be misinterpreted as paranoia [50]. Finally, in a study of 665 inpatients, clinicians attributed poor reality testing—including symptoms such as delusions, hallucinations, and an inappropriate affect—more strongly to schizophrenia in African Americans than in white patients, leading to its eventual overdiagnosis [51]. During clinical assessment of African-American patients, psychotic symptoms may more frequently be conceptualized as isolated and independent of an affective illness, and may be prematurely attributed to an underlying psychotic disorder.

### More Severe Psychotic Symptoms at Presentation

Another factor that may lead to misdiagnosis of schizophrenia is that African-American patients are more likely than white patients to present with prominent psychotic symptoms, which may distract clinicians and lead to a premature diagnosis. Although first-rank psychotic symptoms are common in primary psychotic disorders, they are not pathognomonic for schizophrenia spectrum disorders and are often present in mood disorders. In a study of race-blinded transcripts of interviews of patients with expert-consensus affective psychosis, African-American patients were more likely to report psychotic symptoms representative of greater illness severity [52]. In a study of 330 subjects from the DSM-IV field trials, which used a structured rating instrument, African-American patients demonstrated more severe first-rank symptoms of psychosis, such as voices commenting on behavior, thought withdrawal, thought insertion, and delusions of control [53]. Similarly, in a study of 195 hospitalized psychotic patients, with clinician bias reduced by standardized interviews and review of ethnicity-blinded transcripts, African-American patients reported higher first-rank symptoms and more total psychotic symptoms [54]. As such, existing clinician bias in interviewing and clinical assessment may be compounded by more frequent reports of psychotic symptoms by African-American patients.

### Overinterpretation of "Negative" Symptoms

Clinician bias can also emerge in the assessment of possible negative symptoms of schizophrenia. In a study of an inpatient population, clinicians attributed a blunted affect, decreased and monotonous speech, and impaired functioning significantly more strongly to schizophrenia among African Americans [51, 55]. In a study involving psychiatry residents, clinicians more frequently interpreted symptoms such as anhedonia, decreased speech, and poor eye contact as negative symptoms attributable to schizophrenia [56]. Notably, this finding was noted among non–African-American resident clinicians, suggesting that racial bias may be more prominent among clinicians unfamiliar with cultural factors such as communication barriers, communication style, wariness of mental health services, and broader mistrust of institutions, which may be more prevalent among African Americans [57].

## Underdiagnosis of Mood Disorders

During clinical assessment, clinician bias may further emerge as affective symptoms are underemphasized. In a study of inpatients, clinicians were less likely to report dysphoric and elevated mood among African Americans [55]. Moreover, talkativeness, when noted, was less likely to be attributed to bipolar disorder among African-American patients [51], while idioms of distress, including intense rumination, were more likely to be considered a psychotic symptom than a mood symptom among African Americans [52]. This is of particular concern, given that African-American patients with depression may be more likely to present with somatic complaints [50]. When clinicians are weighing symptoms and competing diagnostic possibilities, racial biases in underemphasizing affective symptoms and overattributing symptoms to schizophrenia may intercede.

## Issues Related to Children and Adolescents

### Trauma

Trauma symptoms are underidentified, underdiagnosed, and undertreated in children [58]. These shortcomings in care disproportionately affect minority youth. The

National Crime Victimization Survey (NCVS) showed that urban African Americans were more likely than whites and suburban or rural African Americans to be victims of violent crimes such as assault [59]. Similarly, according to a US Department of Justice statistical report, blacks living in urban areas were more likely than those in suburban or rural areas to be victims of violence. Studies have also shown differences in the types of trauma experienced by various racial groups. Roberts et al. identified blacks and Hispanics as having higher risks of exposure to child maltreatment, chiefly through witnessing domestic violence [60]. They found that the lifetime prevalence of posttraumatic stress disorder (PTSD) was highest among blacks (8.7%), intermediate among Hispanics and whites (7.0% and 7.4%, respectively), and lowest among Asians (4.0%). The conclusion of this study is imperative. On a national level, when PTSD affects racial minorities, it overwhelmingly goes untreated and undiagnosed. The large disparities in diagnosis and treatment indicate that something is missing.

In the 2009 National Survey of Children's Exposure to Violence, 60% of youth respondents reported experiencing or witnessing violence in the previous year [61]. Over 85% of respondents who had experienced lifetime violence had experienced or witnessed violence within the previous year, while slightly over one third of participants had experienced or witnessed *multiple* forms of violence during the year. Earlier studies had shown that lower-income and minority children are more likely to witness serious violence in their communities. Specifically, in their 1993 study, Fitzpatrick and Boldizar noted that 43% of low-income African-American school-aged children had witnessed a murder and 56% had witnessed a stabbing [62]. Seal et al. recognized and identified feelings of hopelessness, guilt, anger, and hurt in children who had been exposed to violence in an urban setting [63]. These children spoke about a general sense of paranoia and being in danger. Through their narratives, they described avoidant behaviors and hyperawareness of surroundings—symptoms of stress disorders. They expressed that they did not feel they had a chance to succeed and that their opportunities were limited.

Racial/ethnic bias can lead to misdiagnosis of oppositional defiant disorder (ODD) or conduct disorder, through explicit and implicit mechanisms. Behaviors can be misconstrued as causative, and mood symptoms can be missed or minimized. Labeling symptoms as "behavior" without completely assessing for trauma is a gross error. Oppositional and defiant behaviors may be seen in a wide variety of neuropsychiatric disorders. Racial bias affects the way children and their behaviors are viewed and assessed. Goff et al. offer a riveting perspective on racism's impact on the perception of black children in the USA [64] and suggest that black children are afforded the privilege of innocence to a lesser extent than children of other races. Further, they assert that within a criminal justice context, black boys are seen as more culpable for their actions (i.e., less innocent) than their peers of other races. African-American children and adolescents with psychiatric care needs are more likely than white youth with the same presentations to enter the juvenile justice system. African-American children are less likely to receive treatment in private hospitals or day programs, and more likely to receive care in residential treatment centers [65].

Trauma symptoms manifest differently according to a child's age and developmental level. Children may present with decreased attention, angry outbursts, aggression, school avoidance, distrust of others, difficulty in interpreting and responding to social cues, somatic complaints, difficulty with criticism/redirection, nightmares, sleep disturbance, avoidance, and emotional numbing [66]. There is a diagnostic challenge in assessing traumatized children, because these symptoms are present in an overlap between many diagnoses. While withdrawal from activities, nightmares, absenteeism, and change in school performance can be seen with multiple attention, mood, and anxiety disorders, these signs should also be highly concerning for trauma exposure. Clinically, it may be easy to misdiagnose these children with attention deficit hyperactivity disorder (ADHD), ODD, or conduct disorder, as it can be challenging to uncover histories of trauma exposure among children and identify it in relation to ongoing symptoms.

Racism affects children and can be as traumatizing as violence. Children are inevitably affected by experiences of individuals around them: they are in critical phases of development, and their mental health is especially vulnerable to racial stressors. A 2017 review by Heard-Garris et al. found that racial discrimination experiences of caregivers may lead to strain on the parent–child relationship, harsher parenting practices, and racial socialization [67]. The witnessing and discussion of discriminatory experiences may increase children's threat perception and psychological vigilance. Priest's 2017 study also concluded that perceived direct racial discrimination, as well as vicarious exposure, had significant negative effects that resulted in persistent depressive symptoms and loneliness [68].

The cognitive immaturity of children and adolescents puts them at risk for poor health outcomes such as depression, anxiety, posttraumatic stress, aggression, sleep disturbances, and somatization in response to traumatic events [69]. Superficially asking about trauma or ignoring it altogether when treating and caring for African-American children is a mistake that can have lasting and detrimental effects. Traumatized patients are at higher risk for future substance use, depression, separation, divorce, suicide, and having children with behavioral health issues. Clinicians cannot be effective without recognizing this disparity. Children who have been victimized by violence, whether directly or by witnessing it, are a special population whose symptoms and experiences must be fully explored.

## Fetal Alcohol Syndrome

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure is a new psychiatric diagnosis in the DSM-5. This is an important consideration when clinicians are assessing African-American children and other racial minorities with impulsivity and lack of self-regulation. In addition to neurocognitive impairment, patients exhibit impairment in mood or behavioral regulation, inattention, and lack of impulse control. The abundance of liquor stores in urban black and Native American communities has been recognized [70]. Individuals often turn to alcohol to "self-medicate" and treat their symptoms of anxiety, depression, and trauma disorders. In many cases, stigma about seeking mental health care is so strong that a trip to the liquor store is an easier option than making an appointment with a psychiatrist. Many mothers do not grasp the severity of the effects of alcohol exposure on the growing fetus.

Research on fetal alcohol syndrome (FAS) seeks to describe and improve the assessment of this frequently misdiagnosed condition. Bell recognized that patients diagnosed with fetal alcohol exposure (FAE) are often childlike and naïve. They have often been ostracized for most of their lives because they are “slow.” They exhibit poor judgment and poor planning ability, and they lack the capacity to foretell the consequences of their behavior [71]. Such patients may or may not have the characteristic facial characteristics of FAE: widely set eyes, epicanthal folds, a flat midface, short palpebral fissures, an indistinct philtrum, a small chin, irregularly shaped ears, and microcephaly. These patients often have multiple diagnoses, including ADHD, bipolar disorder, and schizophrenia. They are prescribed multiple medications with little or no symptom improvement. FAS occurs far more frequently than is generally believed: in 1 per 1000 live births. Although estimates vary widely, when milder occurrences of fetal alcohol spectrum disorders (FASDs) are included, the US Centers for Disease Control and Prevention (CDC) report that the frequency of FAS/FASD is as high as 1 in 100 in the USA [72].

## Substance Use

Racial bias surrounding diagnosis and treatment of substance use reaches beyond medical care. It has social implications and affects public policy. For a clinician, the social and political milieu impacts the clinical encounter with a patient with a substance use disorder. Several studies have shown that there are differences in the type, quality, and appropriateness of substance use treatment among ethnic minorities [73]. Wells and colleagues examined differences according to ethnic status in unmet need for alcoholism treatment, drug abuse treatment, and mental health treatment [74]. Their study reported that among patients needing substance use treatment and/or mental health treatment, whites were more likely than Hispanics or African Americans to receive substance use treatment or mental health treatment (37.6% versus 22.4–25.0%). Knudsen et al. found that dual diagnosis programs affiliated with hospitals and mental health centers were less likely to have African-American patients [75]. Their data also revealed a significant difference in the availability of selective serotonin reuptake inhibitor (SSRI) medications according to the racial/ethnic composition of the center’s caseload.

A literature review by Alegria et al. found that black and Latino adolescents with a substance use disorder reported receiving less specialty and informal care than non-Latino whites with a substance use disorder [76]. Two potential mechanisms of racial and ethnic disparities were identified: (1) federal and economic health care policies; and (2) regulations and provider-level factors. In their discussion of provider-level factors, the authors acknowledged that provider attitudes can be important determinants of quality of care. They cited Quintero and colleagues’ small qualitative study, which explored concepts of “culture” among behavioral health providers for adolescents [77]. In that study, clinicians’ beliefs that “Latino families avoided behavioral health providers, stigmatized mental illness, preferred clergy rather than formal treatment, devalued women’s health, and had lost hope for the future due to poverty” affected their treatment and referrals. These clinicians missed the clinical significance of marginalization, discrimination, and poverty, which could and should be addressed in treatment services.

Racial minorities are more likely than whites to be mandated to receive treatment by the criminal justice system [78]. Chasnoff and colleagues' 1990 analysis examined the rates of compulsory treatment referral among pregnant women in Florida at several public clinics and private obstetrician offices [79]. The authors reported that despite no differences among racial groups in toxicological tests for substance use, black women were ten times as likely as white women to be reported to the authorities for court intervention and compulsory treatment. African Americans arrested on drug-related charges are more likely to be incarcerated than whites with similar charges.

### A Historical Perspective

Discriminatory practices for substance use treatment are rooted in political and public discourse related to policies and treatment decisions, based on a narrative depicting black users as "dope fiends" vastly different from white users, who are depicted as susceptible to a medical illness. This distinction is not lost on patients or providers. In the past, heroin was linked to "inner city" populations, with socioeconomic and racial implications. Users were disproportionately black, and they faced severe punishments, not treatment. The face of heroin users has changed. This problem has plagued communities of color for decades. CDC Director Tom Frieden used the term "epidemic" to describe the significant, rapid increase in heroin use and overdose-related deaths. In a 2015 CDC tele-briefing, Frieden acknowledged that over a decade, from 2002 to 2013, "the landscape changed." He reported that "although we saw an increase in heroin use among nearly all groups.…Heroin use doubled among women and more than doubled among non-Hispanic whites." Recent media attention on the current heroin epidemic has focused on the increase in overdose deaths among suburban, white, middle-class users, many of whom turned to the drug after experimenting with prescription pain medications. The focus has shifted from punishment for heroin use to treatment and a decrease in stigma. Concern has moved from law to medicine. Public officials have supported and encouraged a system where heroin use is a public health problem as opposed to a criminal justice matter. Now, public opinion is that opioid use disorders should be managed by physicians and health care professionals rather than police officers and judges. This is in significant contrast to the previous harsh treatment of crack cocaine users a generation ago [80].

## Racial Bias Impacting Mental Health Treatment

### Level of Care

Beyond diagnosis, disparities in mental health treatment have been demonstrated at various levels of care. African Americans with major depressive disorder are less likely than white patients to seek professional help, with the disparity being largest when depressive symptoms are milder [81]. Rather, they are more likely to discuss mental health problems exclusively with friends and relatives. Even when they do seek care, there may be disparities in the quality of care they receive. In a study of a nationally representative sample of patients with serious mental illness in the outpatient setting, African-American patients were less likely to receive “minimally adequate” treatment, defined as prescription of evidence-based medication and at least four annual visits with a physician [36, 82]. Another study found that African-American patients on antipsychotic treatment for schizophrenia were less likely than white patients to see office-based psychiatrists [83]. Finally, in a study of public sector services for patients with psychotic disorders, African Americans used psychiatric case management services significantly less than white patients [84]. Taken together, these findings show that African-American patients are less likely to seek mental health care treatment from professionals, and when they are able to access care, they are more likely to receive inadequate standards of psychiatric care and less likely to receive treatment and case management services in the outpatient setting. Such racial disparities suggest that choices about where and to whom patients should be referred to for psychiatric services may be influenced by clinician bias.

In part because of reduced outpatient mental health service utilization, African-American patients are more likely to be treated for psychiatric illness involuntarily. In a study of New York County outpatient commitment rates, African Americans were on average five times as likely as whites to be placed in outpatient commitment [85]. This increased rate was accounted for by racial disparities in the prevalence of serious mental illness, poverty, public sector service use, history of involuntary hospitalization, and outpatient mental health service utilization. Furthermore, African Americans were more likely to be admitted to public psychiatric hospitals [86] and to be involuntarily committed to psychiatric hospitalization [42, 45]. Moreover, hospitalized African-American patients were four times as likely as their white peers to be placed in seclusion and restrained [87], although subsequent studies have shown that this racial difference disappeared after controlling for age, gender, the target of the assault that led to restraint, length of stay, and psychiatric commitment status [88, 89]. On the other hand, African Americans were less likely to be treated in private facilities and hospital units that admitted only voluntary patients [90].

## Children and Adolescents

Among children and adolescents, similar findings of racial disparities in treatment have been identified. African Americans aged 5–14 years were less than half as likely as white youth to be prescribed psychotropic medications—a difference much more pronounced than the difference in prescribing of nonpsychotropic medications [91]. In another study, a statewide survey of Maryland public school students documented that African-American students received methylphenidate at approximately half the rate of their white peers [92]. In a study of children served in the public sector, African-American children were 0.59 times as likely as white children to report past-year medication use [93]. Among children with autism, African Americans had more difficulty accessing medical care, including specialty care, medications, and acute care in a timely fashion [94]. These disparities in access to community-based care and medication treatment may have downstream effects. In a study of psychiatrically hospitalized youth, African-American youth were more than twice as likely as white youth to be secluded or restrained [95]. It was hypothesized that African-American youth may have had more serious symptoms on entering the hospital, placing them at higher risk of undergoing seclusion or restraint, given that they were less likely to receive community treatment and utilize outpatient services.

## Antipsychotics

Racial disparities have been repeatedly demonstrated in the use of antipsychotics for African-American patents diagnosed with schizophrenia, in which second-generation antipsychotics (in general), clozapine, and adjunctive medications are used less frequently, while depot medications are used more frequently. One study found that among patients who initiated treatment for a primary psychotic disorder, African Americans were significantly less likely than white patients to receive risperidone or olanzapine [96]. In another study, African-American Medicaid patients diagnosed with schizophrenia were less likely than white patients to receive clozapine (8% versus 15%) or risperidone (25% versus 31%), and more likely to receive depot antipsychotics (26% versus 14%) [83]. A study of veterans treated for schizophrenia reported that African Americans were much less likely than white veterans to receive clozapine (odds ratio (OR) 0.35) [97]. Such differences may reflect concern over serious side effects (such as agranulocytosis, diabetes, and weight gain), patient preference, or slower dissemination of medication knowledge to minorities, but racial bias must also be considered. In the inpatient setting, one study showed that African-American patients were more likely than white patients to receive high dosages of antipsychotics [98]. Finally, in another study, African Americans with schizophrenia were less likely than white patients to receive adjunctive medications in the anxiolytic, antidepressant, and mood stabilizer classes [99].

## Electroconvulsive Therapy

Racial disparities are also present in the use of electroconvulsive therapy (ECT), an effective treatment for multiple psychiatric illnesses, including mood disorders, psychosis, and catatonia. In a study of patients with a major affective disorder in a large academic hospital, African-American patients were less likely than white patients to be treated with ECT [100]. In a study of multiple hospitals, the probability of receiving ECT for white inpatients with depression (7.0%) greatly exceeded the probability for African Americans (2.0%). Although the probability of ECT access was slightly greater for white patients (62.0% versus 57.8%), the probability of use when only hospitals with ECT access were studied remained markedly greater for white patients than for African Americans (11.8% versus 3.9%) [101]. Hypotheses for this racial disparity include differences in clinical presentation, attitudes, and physician behaviors. Put together, disparities in mental health treatment emerge across multiple modalities of treatment and levels of care, which directly affect the outcomes of African-American patients with mental illness.

## Racial/Ethnic Bias in Treating Members of Other Minority Groups

### Considerations of Clinician Bias in Treating Asians

#### Racism Stress

Because of the perception that Asian Americans have achieved success, they are not seen as potential targets of racial discrimination [102], yet emerging research suggests that Asian Americans may experience levels of discrimination similar to—and in certain cases greater than—those experienced by other racial minority groups [103]. In a review studying Asian American adults, greater self-reported racial discrimination was consistently associated with an increased risk of mental health problems [102].

#### Assessment

Asian Americans have to negotiate Asian cultural patterns of ideal emotional functioning, as some Asian cultures value restraint of emotions as a sign of maturity [104], in part because of Confucian principles that prioritize social harmony. As a result, Asian American youth may be less expressive about their own negative emotions. For Asian American adolescents, the earliest symptoms of anxiety may be somatic complaints, sleep and appetite disturbance, and poor school performance [105, 106].

#### Treatment

Asian Americans utilize mental health services at a lower rate than other Americans [107, 108]. One cultural explanation for this discrepancy is “loss of face,” which can be defined as socially sanctioned claims concerning one’s character or integrity in relation to prescribed roles [104]. Asian Americans may also hide psychological problems because of fear of stigmatization [109]. Within the family context, Asian American parents may believe in keeping psychological issues within the family and be reluctant to seek mental health services [105]. As a result of stigma and other factors such as lack of culturally appropriate services, Asian Americans have the lowest rates of utilization of mental health services [110].

### Considerations of Clinician Bias in Treating Hispanics

According to the 2015 US Census, Hispanic Americans comprise 17.6% of the population [111]. They are the largest and fastest-growing minority group. They are a heterogeneous group in terms of their countries of origin, racial identities, and levels of acculturation. In large epidemiological studies, the prevalence rates of depression, anxiety, and substance use disorders are lower for Hispanics than for whites; however, higher rates are found in American-born Hispanics than in foreign-born Hispanics [112]. In a large study of Hispanics, using pharmacy data, individuals with limited English proficiency were much more likely to be adherent to antipsychotic treatment and less likely to be hospitalized [113] than individuals proficient in English (40.8% versus 35.9%) [113]. With regard to health seeking, this population tends to seek help from local community members and family support before seeking professional mental health support [114]. Disparities exist in both access to and utilization of medical and mental health treatment [115–117]. In the STAR*D (Sequenced Treatment Alternatives to Relieve Depression) trial, Hispanics with depression had greater psychiatric comorbidity and more disadvantaged social status than whites, and ultimately they had lower remission rates when treated with citalopram [118]. Hispanics are diagnosed with a psychotic disorder three times as often as Caucasians [119]. Stigma, language issues, psychosocial stressors, and immigration-related concerns impact Hispanic patients' interactions with mental health providers.

### Assessment

This section will focus on how the patient–clinician interaction contributes to disparities in assessment of this population. In developing an alliance with the patient, the culturally aware clinician should be thoughtful about factors that might interfere with the interaction. Stereotypes about Hispanics include noncompliance, difficulty in communicating and understanding health-related information, and engagement in risky behavior [120, 121]. These and other negative stereotypes are activated when clinicians interact with Hispanic patients.

There may be an interpersonal distance experienced by Spanish-speaking patients when an interpreter is needed. The interpreter may be seen as an added burden on the interaction for some, though this is not the case for all Hispanics [122]. Incorrect use of an interpreter can affect the patient–provider alliance during this sensitive period in the encounter [123].

Furthermore, the interpersonal style of interacting with health care providers can lead to bias in the alliance-building phase of the interaction. In particular, Alarcon and Ruiz describe the "sociocentrism" of the culture *simpatia*—the tendency to minimize confrontation to make relationships flow, and the acceptance of a hierarchical structure [124]. This may manifest as the patient appearing to agree with what is being discussed, and not asking questions or raising objections. Clinicians may infer that patients agree with their recommendations, when in fact they may not. It is possible that patients have concerns that they do not feel comfortable expressing.

The clinician making a diagnostic assessment must be aware of the research findings in this population. While psychotic symptoms may be overrepresented in Hispanic patients, including those with current depression, such patients in the STAR*D trial [125] did not have worse outcomes than other groups when their psychotic symptoms were untreated [125]. Furthermore, when psychotic symptoms are treated, lower doses of antipsychotics are utilized. Recognition of the need to understand the cultural significance and prevalence of psychotic symptoms can assist in treatment planning.

Hispanic patients may present with more severe symptoms because of a delay in seeking care. They also tend to be more frequently diagnosed with major depression than Caucasians and African Americans [43]. This can impact the diagnostic interview and lead to overemphasis of symptoms causing functional impairment. In a study of coded interviews, Alegria et al. found that functional impairment from depression was more likely to be discussed with Hispanic Americans than with whites [36]. Interestingly, they also demonstrated that Hispanic Americans with a history of family trauma were more often diagnosed with depression than whites from a similar background [36].

The anxious Hispanic patient may express symptoms in a visibly distressed manner. Anxiety diagnoses are more likely to be given to Hispanic patients than to Caucasians with similar symptoms [36]. In a related presentation, clinicians should be aware of the presence of stress-related symptoms in the recent immigrant; specifically, symptoms of acculturation stress may emerge during the middle of the first year after the individual has arrived in the country [124].

#### Treatment

Stigma is a prominent concern for Hispanic patients and can serve as a barrier [126]. The clinician may give a poor prognosis for patient engagement and recovery, due to the impact of stigma. Cross-cultural competence can reduce bias in working with Hispanic patients. As a group, Hispanic patients may hesitate to initiate psychiatric medication, which may result in a treatment effect delay or poor engagement [127]. However, attempts by the provider to address patients' concerns about medications can help to increase their acceptance of medication treatment. For nonpharmacological interventions, studies have identified "culturally adapted" psychotherapies for treatment of depression as being effective for immigrant Hispanics in particular. The cultural adaptation incorporates language, immigrant stories, and adjustment for literacy levels [128, 129].

Furthermore, medication dosages may need to be adjusted because of the known variability in metabolic enzyme activity among Hispanics and clinical evidence that as a population, Hispanic patients respond to lower dosages of antipsychotics [130, 131].

### Considerations of Clinician Bias in Treating Native Americans

#### Stressors

Native Americans are overrepresented among populations with a high need for mental health services [132] because of multiple stressors, including poverty, homelessness, incarceration, segregation, and intergenerational trauma, involving a history of forced relocation of tribes and assimilation under federal policies [133]. Furthermore, Native Americans are subjected to a range of stereotypes, ranging from the positive “mystical environmentalists” to negative stereotypes of being “uneducated, alcoholic bingo players confined to reservations” [134].

### Assessment

Native Americans are at higher risk for a range of behavioral health concerns, including mood disorders, suicidality, trauma-related disorders, and substance use disorders. A study of a Western US community of Native Americans demonstrated striking prevalence rates of such disorders: the lifetime prevalence of alcohol use disorders among males was 72.8%, while the lifetime prevalence of affective disorders among women was 36.8% [135]. In a community of Navajo Indians, high lifetime prevalence rates of alcohol use disorders were again demonstrated: 70.4% among men and 29.6% among women [136]. The high rates of substance use extend to other drugs, including marijuana, nicotine, and illicit substances [137]. Among a community of Southwestern American Indian tribal members, the prevalence rates of childhood sexual abuse were 49% among females and 14% among males [137]. Finally, among Vietnam veterans, Native Americans had higher rates of lifetime and current PTSD diagnoses than white veterans, with the disparities being accounted for by greater war zone stress exposure, as measured by exposure to violence, combat, deprivation, and loss of control [138]. One of the more troubling indicators of the toll that depression, trauma, and substance use take on Native Americans is reflected in their rates of suicidality. Native American adolescents report a greater prevalence of suicidal ideation, suicide planning, and suicide attempts than other racial groups [139]. The overall rate of suicide in the Native American population is approximately 1.5 times the national rate [110].

### Treatment

Despite higher prevalence rates of multiple disorders—including alcohol use disorder, affective disorders, suicidality, and trauma-related disorders—mental health services for American Indians are scarce [132, 140]. In 2003, there were approximately 101 mental health professionals available per 100,000 Native Americans, in comparison with 173 mental health personnel per 100,000 whites [141]. Given a greater need for mental health services but less availability, Native Americans frequently do not receive the standard of care for mental health services.

## Considerations for Clinicians to Avoid Bias

Considerations for minimizing clinician bias are multifaceted, and strategies fall into three main categories. These include improving clinician competence to offer culturally sensitive care, clinician self-awareness and reflection, and clinician adherence to standards of care in diagnosis and treatment. The following strategies can apply to the alliance-building phase, the diagnostic assessment phase, or the treatment-planning phases of the interaction.

## Cultural Competence

From the perspective of cultural competence, clinicians must demonstrate awareness of the existing literature about biological and cultural differences between racial/ethnic groups and how they apply to the clinical encounter. This includes knowledge of ethnopsychopharmacology and of cultural norms. Curiosity in understanding the sociocultural background of the patient can assist in deepening the alliance with the patient, increase empathy, and provide a context for understanding how to interpret symptoms [142]. These are essential for completing an accurate assessment and demonstrating astute clinical decision making.

## Knowledge About Ethnopsychopharmacology

There are differences in pharmacological responses among different racial/ethnic groups. Many physicians are not aware of these differences in ethnopsychopharmacology. Implicit and explicit biases have an impact on prescribing. Many clinicians expect that people of different racial and ethnic groups will respond in similar ways to medications. Others, because of biases, believe that African Americans require more medication because they are stereotypically more hostile and aggressive [143]. Evidence suggests that African Americans, in fact, may require less psychotropic medication because of differences in metabolism. Cytochrome P450 (CYP) enzymes metabolize most psychotropic medications in clinical use, including antipsychotics and antidepressants. Patients with relatively inactive CYP2D6 alleles, which metabolize 25% of commonly used psychotropic agents, tend to have higher plasma concentrations of these medications. Because 50% of people of African descent have reduced functionality of CYP2D6 alleles, they have slower metabolism of older antipsychotics and tricyclic antidepressants, leading to higher plasma concentrations [143]. Chronically elevated drug plasma concentrations may lead to increased side effects, extrapyramidal symptoms, and lower treatment adherence. Clinically, African Americans are more likely to develop tardive dyskinesia from first-generation antipsychotics, yet they are less likely to be prescribed or offered newer antipsychotics and antidepressants [144].

The STAR*D trial reported that African Americans may also have a unique response to antidepressants. This study showed that African Americans had poorer responses and outcomes when taking citalopram. The genetic component of antidepressant treatment response among black patients in STAR*D was explored by Murphy et al. [145]. They used genome-wide single nucleotide polymorphism (SNP) data to examine independent contributions of race and genetic ancestry to citalopram response. Their findings indicated that although socioeconomic and baseline clinical factors drive racial differences in antidepressant response, genetic ancestry, rather than self-reported race, explains a significant fraction of the residual differences.

Many African Americans have pre-existing reduced leukocyte counts, known as benign leukopenia. This is a barrier to prescribing of certain medications—notably, clozapine and carbamazepine, which are known to cause agranulocytosis. This limits the use of clozapine, a useful medication for treatment-refractory schizophrenia and other severe conditions. For several years, the UK and Canada have implemented alternative prescribing guides for minorities with benign ethnic leukopenia [146]. As of 2015, the monitoring recommendations for neutropenia caused by clozapine treatment have changed. Patients previously not eligible for clozapine treatment are now able to receive this medication.

African Americans have diminished lithium tolerance and more side effects, which have been linked to higher red blood cell to plasma ratios. As a result, African Americans with bipolar disorder may be less likely to be prescribed lithium and adhere to treatment [147].

## Awareness of Group Preferences

Awareness of African-American and other minority group treatment preferences will increase the likelihood of patient follow-up and adherence to treatment recommendations. There are increasing data to suggest that African Americans are interested in the vast array of psychotherapeutic treatments available, despite some ongoing stigma in the community regarding mental health treatment [4, 148]. Efforts to increase access and maximize engagement may include, but are not limited to, earlier initiation of treatment and identification of patient preference for a race- or gender-matched therapist.

Psychotherapy is an effective treatment for depression and may be more relatively accepted among African Americans because of stigma and mistrust. Prescribers should take this preference into consideration when managing patients and creating treatment plans. Medications may be more readily accepted when therapy is also included in management.

## Clinician Education and Active Effort to Replace Stereotypes

Clinician education is often the first step in decreasing implicit bias. In a review article discussing various strategies for decreasing bias, Burgess et al. explored the role of “individuation” in counteracting stereotypes. Specifically, this refers to undoing some of the early developmental learning of in-group and out-group categories. They argued that automatic stereotypes can be suppressed by seeing patients as individual members with particular qualities, rather than members of a social category [149]. Furthermore, affiliation with out-group members through interracial peer groups is associated with lower implicit bias [150].

The evidence for debiasing interventions is largely positive, though the durability and implications of the effect are unclear. One study provided evidence that an educational intervention decreased implicit bias for the duration of an 8-week follow-up period [151]. In a randomized controlled trial design, 91 nonblack participants took a baseline IAT and received their results, then were randomized to a control group or an intervention group. The intervention included an educational component focused on bias and the way it leads to discrimination, in addition to a strategy component that provided ways to incorporate bias reduction in daily life. Some of the strategies included perspective taking, stereotype replacement, counterstereotypical images, individuation, and increased contact with members of stereotyped groups. The results suggested that on a repeated IAT and other bias measures, the intervention group had significantly lower implicit bias, which was sustained over the 8-week follow-up period, and had greater awareness and concern about discrimination. It was not clear whether these changes affected mental health outcomes or resulted in more equitable decision making.

### Elements of the Patient–Clinician Relationship/Interaction

The therapeutic relationship between patients and clinicians is key to optimal treatment and adherence. This relationship is fragile and vulnerable to stereotyping, prejudice, and biases, both implicit and explicit. These beliefs and notions can be unintentional and subconscious, yet harmful. It is important that clinicians are aware of these biases to improve the quality of care and outcomes for their patients who represent racial/ethnic minority groups. Rapport is an important component of treatment adherence and follow-up.

Clinicians must have an understanding and appreciation of the history of racism in medicine to understand the impact of cultural mistrust on practice and treatment alliance. This will help clinicians to distinguish milder forms of paranoia (such as mistrust) as nonpathological. Recognition of this cultural norm will aid understanding of a patient's experience and reduce misinterpretation of symptoms. As Whaley identified, "clinicians must first be aware of and acknowledge racism as a legitimate concern with mental health consequences for the Black experience in America [152]." Furthermore, clinicians must realize that the black experience is a diverse one. Every patient's experience is varied, and not all patients belonging to a racial minority group are the same.

## How to Address Patient Bias Toward the Clinician

The discussion thus far has focused on racial bias from the clinician toward the patient; however, there are instances when a patient can negatively impact the therapeutic alliance by exerting racist behaviors toward clinicians of color. Thus, it is crucial to include strategies on how providers from underrepresented populations can effectively address racial discrimination exerted by patients. Paul-Emile and colleagues [153] suggest that clinicians consider a multitude of options when faced with this challenge, including the availability of other clinicians, the validity of the patient request to change clinicians on the basis of race, and the emotional or psychological ability of the clinician to deliver medically appropriate services under such conditions. If a patient is simply being racist and has no basis for requesting another clinician, accommodation does not have to be readily explored, unless the clinician is unable to provide sound care for the patient exerting this discriminatory behavior [153]. In some instances, it may be necessary and more beneficial for the patient if the clinician can indeed accommodate a patient's request for a different clinician. Paul-Emile and colleagues [153] provide examples when accommodation is appropriate, including a patient with PTSD not wanting to be cared for by a clinician from the same racial group as the perpetrator of the trauma, or a patient who belongs to an underrepresented population requesting a provider from that same population because of racism experienced in the health system, leading to mistrust of the provider. The literature suggests that racial minority populations are more likely to participate in treatment and report higher satisfaction in health outcomes when coupled to a racially concordant clinician [154]. Because of the demographics of the mental health care workforce, where whites are the majority [155], this is not always possible. However, when feasible and appropriate, every reasonable action should be made by the clinician to accommodate such a request [153, 154].

Further, what should clinicians do when patients engage in discriminatory behavior by using racial slurs or when one witnesses a colleague being victimized by racial epithets? The realm of medical professionalism includes the ability to effectively address and discourage such behaviors in health care settings. Speaking up against racism helps to decrease isolation and, at times, psychological distress, which are often felt by minority clinicians, who are likely the victims of such racist practices. Okwerekwu discusses the danger of remaining silent when one witnesses or is a victim of racism, and encourages all clinicians, regardless of their rank in the training hierarchy, to speak out against racism [156]. Indeed, training in racism, explicit and implicit bias, and structural competence are vitally important; however, it is equally crucial for clinicians and colleagues to be vocal against racist behavior to prevent the alienation and emotional turmoil often experienced by minority clinicians victimized by racism. A zero-tolerance policy must be established against racial discrimination of any kind, whether it is initiated by a clinician or by a patient.

## Conclusion

As Dolan et al. noted, "Racism may operate through overt beliefs and actions of the individual (active racism) or through less conscious attitudes in society as a whole, for example, not offering housing, education or care to ethnic groups (aversive racism)." Aversive racism impacts the quality of mental health because it acts as a chronic and pervasive stress. Failure to recognize the impact of racism on patients' mental health and experiences is a disservice. This failure prevents clinicians from understanding that much of patients' behavior is culturally appropriate, and it may prevent them from appreciating the adaptive qualities of that behavior and the strengths it represents [157]. Additionally, treating patients with the notion of "color blindness" is not helpful and can be detrimental. The color-blind clinician has the tendency to minimize or deny the impact of racial discrimination, which can also weaken treatment alliances. As Levy states, "To pretend that the color difference does not exist is to say, 'I will respect you only if we are the same,' rather than, 'I respect you in spite of our differences'" [157].

Accordingly, there are several ways to combat racial discrimination in mental health practice. These include, but are not limited to, (1) understanding and learning about implicit bias and how it can impact provider interactions and decisions; (2) advocating for effective training in structural competence—specifically, having an informed view of how various structures, social systems, and institutions can indeed propagate racist practices and affect patients from minority backgrounds; (3) speaking out against racial discrimination witnessed in the treatment milieu; (4) considering ways to accommodate patients from minority backgrounds if necessary; and, finally, (5) expanding treatment plans to include nontraditional forms of care such as spiritual and religious practices [158]. Similarly, it is paramount for providers not to endorse color blindness [159], as many minority patients are indeed treated differently because of their race and, as such, have experienced racism-related trauma. Therefore, having a provider who can recognize, acknowledge, and speak expertly about the effect of racism on the treatment paradigm is critical.

Other practices that providers can keep in mind are the need for intergroup contact, having a sense of accountability to the lived experience of patients, engaging in deliberate processing (especially when it interferes with the mental health of the provider and/or the patient), and continuing to challenge racism in the therapeutic milieu [159]. Given the multitude of challenges faced by minority providers and patients, it is important to remain vigilant against racial discrimination and promote mental health and wellness. By careful consideration of the strategies listed above, the task of combating racial discrimination is indeed surmountable.

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# Part III

# Contemporary Interventions

# 8 Hope, Resilience, and African-American Spirituality

Kean Baxter, Morgan M. Medlock, and Ezra E. H. Griffith

## Introduction

Spirituality is defined as "the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship to the sacred or transcendent" [1], p. 18. Religion is a more specific term, which refers to "an organized system of beliefs, practices, and rituals" [1], p. 18. For simplicity, the two constructs are used interchangeably in this chapter. Global features of spirituality in the general population include (1) transcendence (i.e., a relationship to the sacred); (2) finding meaning and purpose in life; and (3) dependence on God or a higher power [1–3]. Within this framework, African-American spirituality is a unique construct, largely because of its inextricable linkage to a history of forced migration and enslavement of black people, and its role in helping black people contend with the direct and indirect effects of racial discrimination. African-American spirituality has distinctive elements: (1) faith in God, which is correlated with belief in divine intervention [4–10]; (2) development of relationships (divine and human) [7, 8, 11, 12]; and (3) a "transformative and consoling dimension" that serves as a foundation of "strength, healing, protection, peace, and coping" [4, 7, 10, 13].

African Americans are more religiously involved than any other racial/ethnic group in the USA. Nearly 80% of African Americans—compared with only 50% of the general population—identify religion as important [14]. Further, most African

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Americans identify as Christian, and 50% attend church services weekly [14]. Many African Americans attend a predominantly African-American church [14], and the church is often the first place where they seek support for health and mental health problems [15, 16]. Some African Americans have wondered about the importance of religious involvement in preserving their mental health beyond what is expected, given their exposure to chronic, negative societal experiences [17].

This chapter focuses on the role of Christianity, and specifically the black church, in providing hope for and bolstering the resilience of African-American communities. The term "black church" refers to the religious institution that incorporates individual Christian congregations with predominantly black members [18]. Though it is often represented as a single entity, the black church is a culturally and theologically diverse structure, which plays a variety of roles in the lives of black people. The central function of the church is to proclaim the good news about Jesus Christ and to engage members in a transformative experience of becoming like Jesus in character and identity. Historically, the black church has also been a place of refuge from hostile societal forces and widespread discrimination. Today, many African Americans report that attending worship services, being involved in their churches, and having personal devotion time play a critical role in their coping [19].

Here, we provide an overview of the historical role of the black church in strengthening black people. We discuss the therapeutic elements of black religious experience, including components of the black church service, church-based interpersonal support, and internal effects of spiritual practice. We conclude with a discussion of the role that health care providers can play in integrating the church and its resources into the treatment enterprise. Concrete strategies are recommended for clinicians who desire to integrate spirituality into the care of African-American patients.

## Historical Overview

### Spirituality, Religion, and African Society

It has been said that "In traditional African society there are no atheists or agnostics" [20], p. 274. From the earliest times, Africans explained themselves and the world around them in religious terms. Animism is one of the traditional religions of African people, which holds that there is a supreme creator being and that physical objects contain spirits, good and bad. Ancestral worship, another religion, required homage to be paid to ancestors for success. During the Middle Ages, Islamic influence came to the continent from the North, through trade and conquest. Less understood is the history of African Jews, whose oral tradition traces their inception back as far as the time of King Solomon [21], p. 105.

Christianity also had a significant historical influence in parts of Africa, which pre-dated the arrival of Spanish and Portuguese traders. Sanneh writes on the misconception that Westerners brought Christianity to the continent: "That we should continue to use Western charts to navigate this new confluence of the gospel and

Africa is one of the paradoxical legacies of an ethnocentric Western worldview…we need to shift in our categories of data compilation and analysis to take adequate account of the new African Christian material" [22], p. xviii. Mbiti adds an additional perspective: "Christianity in Africa is so old that it can rightly be described as an indigenous, traditional African religion long before the start of Islam in the seventh century. Christianity was well established all over North Africa, Egypt, parts of the Sudan and Ethiopia. It was a dynamic form of Christianity, producing great scholars and theologians like Tertullian, Origen, Clement of Alexandria and Augustine" [23], p. 223.

It is likely that a plurality of faith traditions was practiced in a syncretistic manner in African societies, which were generally tolerant. Religion, ancestry and family, the larger society, and even the physical environment were all inextricably linked. For this reason, the transatlantic slave trade was traumatizing on multiple levels to Africans, who found their immediate and extended families sold to different buyers in Europe and the Americas. Those who survived the violence of the Middle Passage sought to re-establish families and religious practices that maintained some semblance of the most basic of their institutions, against the ever-present antagonism of slaveholders.

## Slavery and Christianity

In America, slaveholders introduced subjugated Africans to European forms of religious rituals and beliefs. In many cases, slaves were oriented to their master's interpretation of Christian practice and doctrine, while suffering from immense social trauma and separation. From the slaveholder's perspective, religious persuasion could be utilized to pacify slaves, prevent revolt, and, ultimately, justify the trade and its associated practices. Despite the inherent contradiction in slaveholders' attempts to integrate spirituality with the practice of enslavement, many Africans accepted Christianity.

As Africans incorporated Christian faith into their daily lives, distinct forms of worship emerged. Throughout the antebellum South, the phenomenon of the "Praise House" arose on the plantations. Though these houses were created with the slave masters' full knowledge, they were hardly constructed with their approbation. These rustic structures stood as an archetypal symbol of the slaves' humble spirit of resistance and transcendence despite their mental oppression and physical exploitation. Their exteriors were simple and their interiors were stark, often completely bereft of any furnishing, reflecting the nonliturgical worship style of the slaves. Here the slaves would pray, sing, and shout, sometimes during all-night sessions. Frederick Law Olmsted (1822–1903), the famed landscape architect, "recalled visiting one South Carolina rice plantation where the master had attempted to provide the plantation praise house with 'seats having a back-rail,' only to be informed by the slaves that this would not 'leave them room enough to pray'" [http://www.scencyclopedia.org/sce/entries/praise-houses/]. This space was normally utilized only on weekdays, as the slave master would insist that the slaves attend his church on Sundays, where carefully selected scriptures were twisted into proslavery propaganda. A former slave described the experience:

> The preacher came and…he'd just say, "Serve your masters. Don't steal your master's turkey. Don't steal your master's chickens. Don't steal your master's hawgs. Don't steal your master's meat. Do whatsomever your master tells you to do." Same old thing all the time.… Sometimes they would…want a real meetin' with some real preachin'.…They used to sing their songs in a whisper and pray in a whisper [http://www.christianitytoday.com/history/issues/issue-33/secret-religion-of-slaves.html].

There were also slave masters who forbade their slaves from practicing any religious activities. In these instances, slaves met in secret. Wash Wilson, a former slave, recounted such experiences within the "invisible institution" of the church:

> When de niggers go round singin' "Steal Away to Jesus," dat mean dere gwine be a 'ligious meetin' dat night. De masters…didn't like dem 'ligious meetin's so us natcherly slips off at night, down in de bottoms or somewhere. Sometimes us sing and pray all night [http://www.christianitytoday.com/history/issues/issue-33/secret-religion-of-slaves.html].

Plantation preachers presided over worship services and other important events such as baptisms, funerals, and weddings. Many preachers were illiterate but had an unusual eloquence in transmitting the gospel, or *good news*, to listeners. At times, the master attempted to control the preacher's message and to use him to control slaves' behavior. Some preachers complied outwardly with these demands while secretly propagating a message of liberation. A former slave preacher, reflecting on his experience in Texas, said the following:

> I been preachin' the gospel and farmin' since slavery time.…When I starts preachin' I couldn't read or write and had to preach what massa told me and he say tell them niggers iffen they obeys the massa they goes to Heaven but I knowed there's something better for them, but daren't tell them kept on the sly. That I done lots. I tell 'em iffen they keeps prayin' the Lord will set 'em free [http://www.christianitytoday.com/history/issues/issue-33/secret-religion-of-slaves.html].

Some would criticize the slave preacher for being the mouthpiece of the master; others appreciated the difficult position he was in and accepted his authority as being not from the slave master but from God himself. In the latter case, slave preachers were shown corresponding deference. They were also relatively privileged and afforded greater freedoms than other slaves [http://www.christianitytoday.com/history/issues/issue-33/secret-religion-of-slaves.html].

It is not hard to trace the legacy of plantation preachers from centuries past to black preachers of today. From the time of slavery until the present, black preachers have inspired their community with a message of salvation, hope, and freedom. They continue to enjoy deference and privilege among congregants, often functioning as teachers and counselors. One reason for this is that historically, black preachers have been the most educated individuals in their community. Though the educational level of many congregants today may exceed that of their ministers, preachers are respected sources of help for social and spiritual problems.

## The Rise of the Black Church in America

The black church was the first autonomous institution in America to be fully controlled by black people. The creation of an institution that was distinctly black was only partially due to preference; it was primarily a result of the discrimination and segregation that had largely been accepted by white religious institutions. The black church arose out of the traditions and liturgy of praise houses, as many plantation preachers went on to found the first independent black churches. In 1758, one of the first recorded black congregations was organized on the plantation of William Byrd in Mecklenburg, Virginia [24]. Small congregations later emerged throughout the South, attended by free and enslaved blacks. Prior to the American Civil War, itinerant preachers carried the important news regarding the conflict to slaves whose masters would have kept them in the dark. During religious meetings, they secretly prayed for the Union's victory. Historic black Christian denominations arose in this context (Table 8.1) and provided the much-needed continuity of spiritual community for individuals who found their circumstances changing.

After the war, the black church continued as the mainstay of its people and superintended their transition from slavery to freedom. The church also helped black parishioners overcome the subtler forms of oppression that emerged during the Reconstruction period. Afforded greater economic opportunity, informal black congregations came out of the shadows and began to coalesce across the South. They pooled their money, purchased land, and erected structures [http://www.digitalhistory.uh.edu/exhibits/reconstruction/section2/section2_church.html]. These structures primarily served as places of worship but also housed schools and were the venues for community events, social gatherings, and political activities. The church's importance to black people can hardly be overstated. It was the linchpin of their society. It served at once as their foundation and their crown. Dubois, writing in 1887, considered the role of the church in black communities: "The Negro church…provides social intercourse, it provides amusement of various kinds, it serves as a newspaper and intelligence bureau, it supplants the theater, it directs the picnic and excursion, it furnishes the music, it introduces the stranger to the community, it serves as a lyceum, library, and lecture bureau—it is, in fact, the central organ of organized life of the American Negro" [25], p. 228.

The importance of the church to the black community was displayed during the Civil Rights movement, as the church served as the central organizing hub for demonstrations. The National Association for the Advancement of Colored People

**Table 8.1** Historic black Christian denominations and founding dates [24] (see also http://www.amez.org; http://www.nationalbaptist.com; http://www.cogic.org)

| |
|---|
| African Methodist Episcopal Zion Church—1796 |
| African Methodist Episcopal Church—1816 |
| Christian Methodist Episcopal Church—1870 |
| National Baptist Convention, USA, Inc.—1880 |
| Church of God in Christ—1907 |
| National Baptist Convention of America, Unincorporated—1915 |
| Progressive National Baptist Convention—1961 |

(NAACP) regularly held meetings in churches. Churches also provided support for activists. For example, during the Montgomery Bus Boycott in Alabama, church taxis provided alternative transportation for protesters (see the documentary "We Shall Not Be Moved" [26]). Dr. Martin Luther King and other black clergy became the leading faces of the movement.

## Therapeutic Elements of African-American Spirituality

### The Black Church Service

The black church has played a critical role in helping its members in the process of coping with the psychosocial and health effects of racial discrimination. When identifying aspects of black spiritual experience that may also have a therapeutic impact, features of the black church service are often emphasized [27–32]. Preaching, praying, singing, shouting, clapping, and testifying are more than merely aesthetic elements. Each of these spiritual practices carries a psychospiritual therapeutic imperative.

The scriptures, understood as God's message to humanity, form the foundation of the church and its practices. Biblical narratives create opportunities for readers and listeners to interact with characters who are much like themselves, and to understand the practical impact of having a relationship with God. Biblical themes that have been emphasized in black worship experiences include Creation [Genesis 1–3], which emphasizes the common origin of all mankind as being created by God, thus shattering any artificial hierarchy that focuses on "race"; Liberation, exemplified in the story of the nation of Israel's release from bondage in Egypt [the book of Exodus]; and Salvation, which is described as spiritual freedom, made possible through a relationship with Jesus Christ [John 8:36]. Many find hope in the church's teachings about heaven, a place where the righteous will live eternally with God and there will be "no more mourning or crying or pain" [Revelation 21:4].

In the black church service, the preacher exuberantly transmits the message of salvation to an expectant audience that is seeking to be counseled and inspired, as they grapple with various internal and external stressors. Distinctively, black preachers invite listeners to engage in the message through the device of "call and response" [33]. This functions as a mechanism for listeners to express their agreement with the preacher—and on a deeper level, to accept his or her message as God's will for their lives. An example would be the preacher saying "Swing low, sweet chariot" [call] and the audience replying "Coming for to carry me home" [response]. This form of dialogue has historical roots in African tradition [33].

Music is another core element of the spiritual practice of black Christians. "Negro spirituals," now recognized as a distinct musical genre, became prevalent during the period of slavery. They were songs, but they were also much more than that. They comprised an oral tradition that transmitted Christian values while describing the hardships of slavery [34]. Negro spirituals were precursors of modern gospel music, which first became popular in the 1930s [24]. The lyrics of the famous song “His Eye Is on the Sparrow” (written by Civilla Martin and Charles H. Gabriel) exemplify how gospel music impresses the mind with spiritual truths and increases one’s sense of safety and security despite living in a hostile world:

Why should I feel discouraged, why should the shadows come,
Why should my heart be lonely, and long for heav’n and home,
When Jesus is my portion? My constant Friend is He:
His eye is on the sparrow, and I know He watches me;
His eye is on the sparrow, and I know He watches me.
Refrain:
I sing because I’m happy, I sing because I’m free,
For His eye is on the sparrow, and I know He watches me.
(Lyrics: http://library.timelesstruths.org/music/His_Eye_Is_on_the_Sparrow/)

Prayer and testimony are also central practices within the black church service. Prayer, or the act of talking to God, includes offering praise and thanksgiving, and making one’s requests known to God. Intercessory prayer has become a staple of most services and involves a leader or member praying for the concerns of those gathered. Testimony, or the “praise report,” is a period during the service when members share personal examples of God working in their lives, thus strengthening the faith of others [27, 35].

## Church-based Support System

In their seminal work, Baumeister and Leary [36], p. 497, review the “belonging” hypothesis, which states that “a need to belong is a fundamental human motivation.” They define “belonging” as participating in a group of “familiar, cooperative people who care about one’s welfare” [36], p. 499. For African Americans, the church provides a place of belonging that complements the supportive role of family members [37, 38]. Synergy exists between kin and nonkin relationships, such as those occurring in church, and many African Americans rely on these informal support networks [39, 40]. When describing their experience of church-based support, black parishioners use terms such as “fellowship,” “church home,” “place of peace,” “family,” and “community” [32]. This reflects the uncommon bond that exists among people with shared experiences, beliefs, and spiritual values. The scriptures themselves highlight the interpersonal benefit of spiritual involvement, asserting that the church is not merely a place but an experience of fellowship with God and with one another [1 John 1:3]. The black church helps its members overcome the social detachment that is a by-product of a chronic experience of marginalization [41].

A significant body of literature describes the type of support offered in black churches and the pattern of utilization by members. Taylor and Chatters [42] found that overall, two out of three church attendees received some form of support from their spiritual network. The types of support received included provision of pastoral care, exchange of spiritual material among church members, and communal responses to stressors as they arose throughout the life course. Notably, men were more likely to receive support, even though women were more active church participants. Older individuals and divorcees were less likely to receive support. In the latter case, it was suspected that the community's negative view of divorce may have contributed to this finding. More recent studies of church-based support have highlighted the provision of socioemotional support, tangible assistance, and spiritual support (defined as provision of assistance that bolsters an individual's religious commitment) [43, 44]. Tangible assistance provided by churches may include transportation, help with chores, financial aid, and support during sickness [45]. To benefit from these connections, attendance at religious services is vital.

Church-based social support has been correlated with a range of positive effects on health and well-being. Thompson and McRae [32], p. 45 found that black churches provide a sense of being connected to others, derived from "acceptance, warmth, support, a common struggle, experiences with racism and oppression, openness among members, and family traditions of churchgoing." Church involvement was also found to contribute to a shared positive affect, experienced as emotional resilience and a sense of hope. These factors likely mediate important health outcomes, with recent studies linking church support to protection against suicidal ideation and attempts [46], as well as depressive symptoms and distress [47]. Church support may also buffer the effects of financial strain on mortality late in life [48]. African Americans who are active in their churches may experience these religiously mediated health outcomes [45].

Negative social interactions are also possible in church settings. Such interactions include experiences of criticism, rejection, competition, violation of privacy (e.g., gossiping), or lack of reciprocity (i.e., the individual's expectations of the relationship not being met) [49]. Interpersonal conflicts (among members or between church members and their pastors) and conflicts over church doctrine may also occur [50]. African Americans tend to report relatively low levels of negative church interactions [47, 51]. However, when they occur, the detrimental effects on well-being can be stronger than the positive impact of the emotional support that is received [52]. Negative interactions with church members are predictive of psychological distress [51], depressed affect [52], and depressive symptoms [47]. Church members may cope with interpersonal stressors by putting a positive spin on the problem, turning the matter over to God, or taking more active problem-solving approaches [50].

## Individual Effects of Spiritual Involvement

Beyond the communal aspects of spiritual involvement, the black church affects the individual well-being of its members. The church has historically been understood as a place where the dehumanizing effects of racism are attenuated. In lieu of negative images about oneself, which are the product of widespread discrimination [53], church members participate in forming a spiritual identity that focuses on their standing as God's people. As a result, their dignity and self-worth improve. Black theologian J. Deotis Roberts explains the role of the church in defending the personhood of its members: "We must have a sound theological understanding of the nature of the black church if we are to understand its mission.…The church, as a good family, is a fellowship in which every member is 'somebody.' It has always been a place where blacks who have been 'nobodies' through the week have affirmed their dignity as persons. Among members of the body of Christ there is to be togetherness [and] belongingness, but the dignity of selfhood is to be respected and cultivated" [54], p. 80–1.

The dignity of church members is often reflected in their pristine religious dress. The role of dress in determining class has historical roots. Slaves were often forced to wear tattered clothing, or were subjected to nakedness, as a form of humiliation and a reminder of their presumed status as property. However, during their religious services, slaves made a habit of dressing up and thus began the tradition of wearing one's best clothing to church. In later contexts, black people wore elaborate attire, which included colorful suits or dresses, flamboyant hats, matching gloves and shoes, jewelry, and handbags [55]. This external showiness reflected a renewed sense of importance that resulted from participating in a validating community where church members were also eligible for leadership positions, such as deacon, elder, or preacher. However, it should be noted that young churchgoers do not tend to emphasize showy dress as much as older individuals [56]. Instead, many young adults prefer relaxed styles of church dress, which may reflect their desire to be accepted as they are. Some have been critical of showy dress in church, asserting that it has nothing to do with Christianity; rather, they see it as a prideful display of one's social advancement, perhaps used to incite jealousy in others [56].

There are important psychological effects of religious involvement that extend beyond dress and comportment. One of the well-defined constructs for understanding the internal effects of spirituality is *religious coping*, which refers to *how* individuals utilize their spirituality to cope with life's problems and reduce distress [57]. For African Americans, religious coping may attenuate the effects of racism and discrimination [24, 58].

Other studies show the broader psychological importance of religious involvement:

- Individuals may have an easier time coping with challenges when they consider their circumstances in light of a Bible character with a related experience [59].
- Considering crises in light of a personal partnership with an all-powerful Being increases one's ability to manage [59, 60].
- Coping is easier when individuals consider their lives from a divine perspective and relate to God as a caring individual who provides guidance and comfort [61, 62].
- Worry and self-blame seem to be mitigated when individuals trust God in circumstances beyond their control [63].
- Individuals who know that they are intimately known and unconditionally loved by a divine Being and have an awareness of their significance beyond the present may have stronger self-worth and self-efficacy [64].

- Seeking God's forgiveness of sins may have a positive impact on feelings of guilt [65, 66].
- Believing that God is directly involved in one's life may result in a positive correlation with perceived well-being and perspective in life [59].

### The Church and Social Activism

There is a significant overlap and interaction between the spiritual/religious life and the social life of African Americans. The social activism of the black church reached a high level during the 1960s and served a spiritual and therapeutic function through its advocacy on behalf of the oppressed. Some have argued that the contemporary church has weakened its voice on social justice issues, as some congregations have chosen to focus on matters related to material prosperity [67]. Yet, there are church leaders who focus their mission on social injustice and uplifting the downtrodden. The social and community ministry of many churches continues to be important. Some churches have broadened their mission to include substance use, homelessness, serious mental illness, and illiteracy.

## Integrating Spirituality into Treatment of African Americans

### Spiritual Issues Arising in Treatment

African-American clients who are religious may present to the clinic with a variety of concerns that are best addressed with sensitivity toward their spiritual backgrounds. Common spiritual issues arising in treatment include isolation, loss of identity, difficulty with relationships, guilt, problems forgiving, crises of hope, difficulty coping with stressors, and spiritual struggles (e.g., feeling abandoned by God). The spiritually competent clinician will be able to discuss these matters fluently, regardless of his or her own spiritual beliefs, and in a manner that helps the client uncover the source of distress and make progress in achieving resolution. Readers should review the American Counseling Association's "Competencies for Addressing Spiritual and Religious Issues in Counseling" [68] for a recent summary of approaches to addressing spirituality in treatment.

### Types of Spiritual Interventions

Providers who desire to integrate spirituality into treatment should consider whether the following interventions may be appropriate for their clients: (1) completing a *spiritual screen*; (2) taking a *spiritual history*; and (3) completing a *spiritual assessment*. Each of these treatment elements is distinct. A spiritual screen refers to a single episode of questioning about a client's spiritual or religious affiliation [69]. Common questions that are included in the screening process are "Do you identify as spiritual or religious?" and "What is your spiritual or religious affiliation?" We recommend a spiritual screen for all clients, since it can help identify individuals for whom spirituality may have clinical relevance. Patients who acknowledge a spiritual or religious affiliation should be engaged in a spiritual history. A spiritual history is more specific than a spiritual screen, and it involves engaging clients in a discussion of *how they make use of their spirituality in their coping, and how it impacts their care* [69]. The focus is not only on uncovering spiritual or religious practices, but also on understanding the role of spirituality in the client's life and clinical recovery. Thereafter, deeper exploration is possible. Spiritual assessment is an in-depth look at the client's spiritual journey with goals of identifying areas of spiritual concern and determining an appropriate treatment plan [70]. Providers may choose to integrate professional clergy into any stage of spiritual exploration. Religious clients can be significantly helped by clinicians who are willing to address their spiritual concerns. A plethora of tools that can be utilized for obtaining a spiritual history are available to assist the clinician in framing these discussions [71]. For specific strategies on how to navigate spiritual discussions with clients, readers should review the recent work of Medlock and Rosmarin [72].

## Integrating Spirituality into Treatment Planning

Mental health professionals should view the church as a potential partner in providing mental health services to African-American clients. In a recent review of church-based mental health programs, a wide array of services was identified in black religious settings. Highlighted interventions included a faith-based effort to reduce cocaine use among African-American women, a smoking cessation intervention among church members, group cognitive behavioral therapy to reduce depressive and anxiety symptoms, and support groups for family members of individuals with a mental illness [73]. Pastoral counseling is another intervention for addressing mental health concerns in religious clients. Studies show that African-American clergy are active counselors [74–76], and some are likely to utilize professional services when addressing a member's needs [75, 77, 78]. Thus, clergy may function as gatekeepers of community mental health services and may close gaps in care for those lacking sufficient access (Table 8.2).

There is a need for more intentional efforts by providers and clergy to link the informal services of the church to the formal services of the mental health system. To accomplish this, new partnerships should be forged that bring together the strengths of both systems to bear positively on the client's recovery. Religious leaders are more likely to refer people to clinicians who have a similar faith background or at least show an interest in addressing the client's spirituality [79]. Strategies for building an alliance with religious clients and their pastors include respecting the role of faith leaders in providing guidance, inquiring about the spiritual narrative that accompanies the clinical presentation, seeking out opportunities to learn about the patient's religious background and beliefs, and integrating spiritual practices

**Table 8.2** Mental health services provided in black churches

| |
|---|
| Pastoral counseling for individuals, couples, and families |
| Lay counseling, member-to-member support |
| Support groups addressing a wide array of topics, including grief, substance use, and depression |
| Community re-entry assistance for the recently incarcerated |
| On-staff mental health support by licensed personnel |
| Referral to professional services where appropriate |

**Table 8.3** Recommendations for providers

| |
|---|
| *Acknowledge* that spirituality may be important to African-American clients, contributing to their survival and resilience. |
| *Assess* the clinical function of spiritual involvement by inquiring about how the client makes use of spirituality to cope with stressors. |
| *Articulate* the clinical significance of clients' spiritual backgrounds by considering the biological, psychological, social, and spiritual elements of their presentations. |
| *Act* to integrate spiritual resources into treatment by linking formal mental health services with informal supports provided in the client's religious community. |

and religious coping mechanisms (e.g., prayer, Bible study) into treatment recommendations.

Providers should also provide clinical or psychoeducational services in religious settings. In turn, clergy should be invited to enter clinical settings, where they can help providers address spiritual concerns that weigh on clinical outcomes. Potential areas to discuss with clergy include spiritual reintegration following a crisis in mental health care, the religious community's view of mental illness, religious perceptions about current treatment (especially the role of medication versus counseling), and strategies for addressing mental health stigma. To the extent that is possible, and where it is welcomed by clients, providers should assist in connecting clients with adjunctive support services offered by their religious communities (Table 8.3).

## Conclusion

African Americans have relied on their spirituality to overcome systemic and individual challenges. The black church has been the vehicle for delivering spiritual healing, as well as mental health support, to black communities. Clinicians are urged to integrate the spirituality of black patients into mental health treatment, recognizing that many elements of the black church experience have a significant therapeutic impact. Recommendations for providers include maintaining curiosity about how their patients may utilize spirituality in recovery, and integrating the church and its resources into treatment planning.

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# Addressing Cultural Mistrust: Strategies for Alliance Building

# 9

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## Introduction

Trust is a crucial element in the provider–patient relationship and is key in developing a strong therapeutic alliance [1]. Discriminatory treatment of racial minorities, specifically African Americans, in mental health care has been well documented across the years, leading to cultural mistrust [2]. The historical underpinnings of racism have developed into a climate of cultural mistrust in the medical field and are reflected by

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the underutilization of mental health care by racial and ethnic minorities. Indeed, mistrust has been shown to be a major barrier to people of color seeking mental health care [3]. These long-standing practices as part of America's past have resulted in the current set of beliefs surrounding health care–seeking behaviors and attitudes.

## Historical Context of Cultural Mistrust

The history of cultural mistrust in the United States of America (USA) is rooted in political and social events that leading to systematic and differential treatment of individuals on the basis of their racial–ethnic identities. America's marred history has influenced the trust that individuals from a diverse set of ethnic and racial backgrounds feel toward the country's institutions. The comments below detail key examples for each racial and ethnic minority group, which have influenced these communities historically.

For African Americans, much cultural mistrust in the Western medical system stems from slavery. With limited resources and significant barriers to personal freedom, many slaves were not offered the opportunity to see health care providers and had to rely on alternative remedies from their African ancestry to cure their ailments [4]. African Americans were often denied treatments for medical issues and had to endure agonizingly painful deaths as a result [5]. During this period, slaves and "black bodies" were used as a prime source for medical experimentation and dissections. These human experiments were conducted to build the foundation of the Western medical model [6]. As slavery was abolished and African Americans were expected to assimilate into white culture, they were introduced to an American biomedical model that was not only drastically different from their familiar treatments, but also characterized them as a "lower order of human beings" [7].

Medical experimentation on black bodies beyond slavery serves as a poignant example. The most notable and notorious episode was the Tuskegee syphilis study, conducted from 1932 to 1972 by the US Public Health Department, in which researchers observed approximately 400 African-American males with syphilis to examine how the disease progressed without treatment, even after penicillin became a standard cure for the disease [8]. This case of blatant disregard for black lives and governmental racism in the twentieth century has been cited by many African Americans as the symbol and the quintessential example of their mistreatment by the scientific–medical communities [9]. African Americans encountered a Western medical system that did not understand, and did not seek to understand, the culture and mentality of their population. As a result, given the unconscionable withholding of treatment in the Tuskegee syphilis study, African Americans continue to distrust their physicians for not treating them equitably because of their race [7, 10].

For Asian Americans, the expulsion, segregation, and incarceration of thousands of Japanese Americans after the Pacific War is one of many significant examples of how Asian Americans were exploited in American history. While most of these individuals were American citizens, Japanese internment was a tragic mistake that was based on prejudice and wartime panic. Without any evidence or review process, this stereotyping led to unjust mass evacuations of approximately 100,000 people of Japanese birth or ancestry living on the West Coast of the USA [11]. Unfortunately, these prejudicial attitudes toward Japanese were shared by the population at large, as shown by public opinion polls supporting these discriminatory actions against people of Japanese descent. The internment of Japanese Americans after the Pacific War was embedded in a history of discrimination against Asian Americans. While documented events of lynching, mass murders, and legislation banning migration of people from Asia have ceased, anti-Asian attitudes have not necessarily diminished over the years [12].

A history of racism has also greatly impacted Latino American health; conquest and colonialism in Latin America established a racial hierarchy, whereby people with any indigenous ancestry or of African descent occupied the lowest social castes, while people of Spaniard/European descent occupied the highest social castes [13]. For Latinos living in the USA today, this racial hierarchy has been reaffirmed by racial attitudes toward African Americans, resulting in greater social privilege and protection from discrimination among white Latinos than among darker-skinned Latinos [13]. Darker-skinned Latino immigrants report greater experiences of discrimination than their lighter-skinned counterparts [14]. The health disparity between light-skinned and dark-skinned Latinos parallels that between non-Latino whites and blacks [15]. These health disparities may continue to persist as Latinos begin to immigrate to new urban centers, which are often residentially and socially segregated along racial lines [16].

While there has been little research on medical mistrust among Latinos, related research has shown that Latinos may be less satisfied with their health care because of perceived racism and discrimination, as well as medical mistrust [17]. Recently, increasingly exclusionary immigration policies to curb illegal immigration from Latin America have also created a climate of stress and apprehension among Latinos, resulting in worse mental health among Latinos residing in states with more exclusionary policies [18]. Immigration policies can in fact influence Latino health through multiple pathways, including persistent stress from structural racism, as well as restriction of access to social institutions, education, and health care services [19].

For Native Americans, there is a 500-year history of systematic racism, exemplified by attempted genocide, broken treaties, and forced westernization of youth [20, 21]. Early on, as Native Americans succumbed to diseases brought by white settlers, the white settlers used these apparent health disparities in survival to validate their manifesto to claim North America and indoctrinate Native Americans with European culture, thus establishing a hierarchy between themselves and the Native American population [22]. However, there is evidence that the racism that motivated North Americans to view Native Americans as inferior was rooted in the desire to take tribal lands and resources and assimilate them into American culture [23]. From the allotment of separate lands to sequester tribes, to the boarding schools that separated Native American children from their parents, there has been a long history of oppression. Even today, there continue to be efforts to curtail tribal sovereignty, prolong assimilation policies of the nineteenth century, and retain management of Native American assets by the federal government [24]. The underlying theme is one of labeling Native Americans as inferior to limit tribal independence and their rights as citizens (i.e., being able to mortgage their lands, or economic developments in tribal lands being subject to review and control by federal agencies).

Present-day health disparities among Native Americans can be linked to historical trauma, which continues to affect communities cross-generationally [25]. Subjugation by European settlers has led to centuries-long distrust and skepticism among Native American populations toward government and public institutions, as well as health care practitioners [20]. The systematic racism has been perpetuated in health care, where Native Americans maintain some of the highest morbidity and mortality rates but remain one of the most underserved communities [21]. Historically, the Indian Health Services (IHS) has been significantly underfunded in comparison with other public health care systems [26]. These health disparities emerged from the beginning of colonization, with Native Americans experiencing greater mortality from disease (tuberculosis, alcoholism, and chronic diseases) than whites during any decade [22]. Skepticism toward certain health care practices, such as in behavioral health care, may in fact result from divergent cultural views of health and health care between Native Americans and practitioners of Western medicine [20, 26]. Acknowledging historical trauma by incorporating cultural practices into clinical care is considered one method to improve behavioral health treatment and subsequently reduce health disparities among American Indian populations [27].

The latest victims of racism have been the Muslim community, with the January 2017 executive order banning entry to the USA by nationals of Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen. The rationale for the order was to protect the American people from terrorist attacks by foreign nationals admitted to the USA [28]. This also includes restrictions in the visa waiver program, voted on by Congress in 2016, allowing people from 38 countries to enter the USA with no visa whatsoever [29]. There are several reasons why these bans can be seen as coming from a source of deep prejudice. First, as Greg Myre, the international editor of NPR News emphasized: “This executive order does not include any countries from which radicalized Muslims have actually killed Americans in the U.S. since Sept. 11, 2001.” Second, even people traveling with valid visas have not been allowed to enter the USA after the ban, or were detained at airports and sent back to their countries, without any evidence of wrongdoing. This order not only has harmed many families coming to the USA for medical services but also has been damaging for foreign-born practicing physicians and international medical graduates who are trained in the USA [30]. Furthermore, Islamophobia can negatively influence health by disrupting several systems: individual (stress reactivity and identity concealment), interpersonal (social relationships and socialization processes), and structural (institutional policies and media coverage) systems [31].

As can be seen from these selected examples, a deeply ingrained historical context exists for racial and ethnic minority populations to harbor mistrust of the dominant institutions in the USA, which then translates into cultural mistrust in institutions of mental health care.

## Definition and Context of Cultural Mistrust

The term “cultural mistrust” was initially defined by Tyrell and Tyrell [32] as a “tendency to distrust whites based upon a legacy of direct or vicarious exposure to racism or unfair treatment” and may provide an explanation as to why these patterns persist. Cultural mistrust has been found to affect processes and outcomes of treatment specifically in the therapeutic alliance, which is defined as the active and conscious collaboration between a patient and a therapist. Therapeutic alliance outcomes affected by cultural mistrust include the depth of disclosures to and duration of treatment with white providers as compared with nonwhite providers [33, 34]. Even in efforts to define cultural mistrust, issues have emerged surrounding the terminology. In earlier efforts to describe this phenomenon, Grier and Cobbs [35] cited "cultural paranoia" to describe behaviors of African Americans in relation to their skepticism toward white providers. However, the term "paranoia" is coated with pathological connotations and suggests that the disbelief held by African Americans is unfounded. Therefore, that term has been vastly rejected [36]. Arguably, African-American distrust of whites is not a delusion but, rather, a manifestation of acquired experiences of facing greater discrimination than their other racial counterparts [37]. Cultural mistrust is therefore more likely linked to a history of racism and oppression of people of color by whites, which has led to the development of generalized suspicion [38]. However, this is not to imply that the said mistrust is acquired only through previous experiences; rather, it is also integrated as part of current experiences and is emboldened by constant microaggressions, mistreatment, and implicit biases [33, 39].

Current mistrust of the health care system by people of color is, without a doubt, due to a plethora of reasons. Racism in medical care cuts across genders, generations, and ethnic groups, leading to high levels of disdain toward the medical establishment [40]. As a trickle-down effect of the complex history that people of color have had with the medical system, nonwhite individuals have developed mistrust of many structural and institutional elements in the health care system. Today, more commonly, racism in mental health care is reflected by minority–white disparities in access to treatment and perceived biases [41–43]. Health care providers remain predominately white and have not properly addressed the trust dilemmas that unfold when there are cultural barriers between clients and providers [44]. Studies have shown that many people of color feel as if they cannot communicate with their provider if their provider is white. For example, they report feeling disrespected by their providers, feeling that they are unable to ask questions, and feeling as if the provider is not listening to them [45–47]. This level of skepticism has led many ethnic minorities to withdraw or withhold from treatment-seeking behaviors in order to avoid judgment. This issue is reviewed in detail in the next section.

## Cultural Barriers to Mental Health Utilization, Based on Cultural Mistrust

The 2001 Surgeon General's *Culture, Race, and Ethnicity* report supplement [3] documented the existence of striking disparities for minorities in mental health services. In sum, the report found that racial and ethnic minorities have reduced access to mental health services in comparison with whites, are less likely to receive needed care, and when they do receive care, it is more likely to be poor in quality.

The supplement suggested multiple reasons for these disparities at different levels—structural, institutional, and individual—including the potential for patient mistrust and provider bias. With increased interest in understanding causes of racial and ethnic disparities in psychiatric care, there has been an increase in articles discussing cultural mistrust and an increase in measurement tools to assess the construct. This body of literature is summarized here.

## Racial and Ethnic Disparities in Utilization of Psychiatric Services

Racial and ethnic disparities have been repeatedly demonstrated in utilization of psychiatric services. In studies using nationally representative samples of noninstitutionalized adults, whites have tended to be more likely to access mental health treatment than nonwhites [3, 48]. When utilization of specific psychiatric services is compared between nonwhites and whites, there appear to be disparities in psychotherapy, outpatient services, and psychotropic medication, but no such disparities exist in inpatient care. For outpatient psychiatric services, whites with mental illness have been shown to have greater odds of use than blacks (odds ratio [OR] 0.5, 95% confidence interval [CI] 0.39–0.55), Native Americans/Alaska Natives (OR 0.5, 95% CI 0.27–0.72), Asians (OR 0.4, 95% CI 0.32–0.60), and Latinos (OR 0.6, 95% CI 0.49–0.69) [49]. Similarly, in comparison with non-Latino white patients, Latino patients have been found to have ~37 fewer per 1000 office visits that included psychotherapy and 58 fewer per 1000 visits with a psychiatrist; these disparities have persisted over time [50].

Similar disparities are seen in psychopharmacology treatment. Blacks and Latinos are less likely to be prescribed an antidepressant than whites in ambulatory settings, and there has been no change in this disparity from the mid-1990s to now [50, 51]. Similarly, Latinos have been less likely than non-Latinos to be prescribed benzodiazepines during ambulatory visits; this disparity persisted from the mid-1990s through the early 2000s [51]. Blacks, Native Americans/Pacific Islanders, Asians, and Latinos with mental illness were less likely than whites to use psychotropic medications (OR 0.27, 95% CI 0.22–0.31; OR 0.19, 95% CI 0.08–0.48; OR 0.24, 95% CI 0.17–0.33; and OR 0.41, 95% CI 0.34–0.49, respectively). In another study of treatment of children with attention deficit hyperactivity disorder (ADHD), black and Latino children in the fifth grade with an ADHD diagnosis or symptoms were less likely than white children to receive medications (OR 0.33, 95% CI 0.17–0.62; and OR 0.38, 95% CI 0.16–0.90, respectively). This disparity persisted through tenth grade (OR 0.41, 95% CI 0.22–0.75; and OR 0.42, CI 0.20–0.86, respectively).

Although these studies regarding racial disparities in psychiatric services are compelling, most studies present only absolute disparity (relative to standards of care) or relative disparity (service use in comparison with the white population) but not both, making it difficult to fully understand the policy and clinical practice implications of the findings. Furthermore, additional research is needed to identify specific types of care within psychiatric services for which no disparity exists (e.g., inpatient care) and for which whites receive less care (e.g., in public mental health care settings or addiction services) [50]. Finally, common approaches to the statistical models used in this body of research fail to disentangle the impacts of socioeconomic status, physical health, and race/ethnicity. One proposed solution has been to create hypothetical racial-ethnic groups that retain their racial-ethnic and socioeconomic characteristics, but whose mental health status is standardized to reflect a referent group, generally whites [49, 50]. This approach eliminates the possibility that findings are attributable to differential disease distributions among racial-ethnic group populations. It simultaneously allows the researcher to assess the impact of racial-ethnic group on psychiatric service utilization mediated by socioeconomic characteristics. Nevertheless, despite these limitations, these studies illustrate the profound impact of disparities in psychiatric services, which are influenced by issues of patient cultural mistrust of providers. How disparities are influenced by cultural mistrust is explored in the next section.

## Provider Behavior, Racial and Ethnic Disparities, and Cultural Mistrust

Health provider behaviors help explain variations in psychiatric utilization across racial-ethnic groups and may also influence patient cultural mistrust of their providers. In a study of provider recommendations for treatment, although racial-ethnic minorities were equally likely to receive a recommendation from their provider to receive treatment, blacks were less likely than whites to receive antidepressant medication (OR 0.56, 95% CI 0.36–0.87) and Latinos were less likely to receive specialty mental health care or antidepressant medication (OR 0.30, 95% CI 0.22–0.44) [51]. These findings provide some evidence that disparities may persist even when provider recommendations for treatment do not. As a result, people of different racial–ethnic backgrounds have reported being less satisfied than whites with their health care providers, which in turn can have an effect on their health outcomes and desire to seek treatment [52].

## Assessing Cultural Mistrust

Racial-ethnic disparities in psychiatric service utilization may be partially attributable to patient characteristics or to provider characteristics, as discussed above. Another possible causal mechanism of the disparity is the interaction of patients and providers and the patient–provider relationship, including trust and, more specifically, cultural mistrust [52].

The Cultural Mistrust Inventory (CMI), developed by Francis Terrell and Sandra Terrell [32], is a primary measure of cultural mistrust of whites. The measure has 48 items and a seven-point Likert response format, in which 1 indicates “strongly disagree” and 7 indicates “strongly agree.” Higher scores indicate a higher level of mistrust. Terrell and Terrell developed the measure to provide a means of empirically testing the impact of cultural mistrust on outcomes across various settings, including mental health outcomes. There are four subscales of the CMI, which correspond to domains in which cultural mistrust of whites may exist: business and work, education and training, interpersonal and social settings, and law and politics.

Many measures have also been developed to evaluate trust and mistrust specifically in relation to the health system and health care providers [53]. Examples of such measures include the Trust in Physician Scale [54, 55], Medical Mistrust Index [56], Health Care Relationship Trust Scale [57], Group-Based Medical Mistrust Scale [58], Interpersonal Physician Trust Scale [59], Patient Trust Scale [60], Patient Trust in their Physician Scale [61], and Trust in Medical Researchers Scale [62]. Unlike the CMI, these measures do not assess trust/mistrust of whites and, by design, the domain in which trust is being assessed is specific to the health care context. Some of these measures have been used to assess trust/mistrust of health care providers among racial–ethnic minority groups [60–63]. However, there is little research that assesses trust/mistrust in the context of psychiatric care, and even less research that assesses racial–ethnic differences in trust/mistrust in the context of psychiatric care.

## Empirical Use of the Cultural Mistrust Inventory

Whaley [64] conducted a meta-analysis evaluating the effects of cultural mistrust on multiple domains in 18 published and four unpublished studies from 1981 to 1998. Researchers across the 22 studies that were included in the analysis used the CMI in a variety of domains, including psychotherapy, intelligence quotient testing, mentoring, career aspirations, mental illness, social networking, and acquired immunodeficiency syndrome (AIDS) knowledge. The size of the effect of cultural mistrust on the outcome varied across the studies, but this variation was not statistically significant ($X^2 = 21.59$, $p > 0.10$). Additionally, the effect sizes among the studies examining the mental health context did not differ from those in studies in other domains.

In the past decade, there has been continued research evaluating the effect of cultural mistrust within the mental health context. One vein of this literature explores the impact of cultural mistrust on mental health treatment preferences. In a study of 168 black adults with no prior experience with mental health counseling, higher levels of cultural mistrust, measured using a ten-item Modified Counselor Preference Scale [65], predicted a stronger preference for a black mental health counselor. David [66] examined the impact of cultural mistrust among Filipino Americans ($n = 118$) on treatment-seeking behaviors in a mental health service and found that higher levels of cultural mistrust were associated with lower levels of treatment seeking. David [66] used hierarchical regression modeling to demonstrate that the impact of cultural mistrust was not attributable to generational status, income, loss of face, or Asian cultural values.

Another aspect of the literature aims to explain variations in cultural mistrust. In their work with 74 young adult black males transitioning from the foster system, Scott et al. [67] found that an increase in negative social contextual experiences was associated with an increase in cultural mistrust of mental health professionals. Negative social contextual experiences were defined as negative experiences attributable to the individual's characteristics, being a member of the black community, or negative imagery projected onto black males (e.g., assumptions that they are engaged in illegal activity). In a study with a focus similar to the *negative social contextual experiences* construct, researchers Kim, Kendall, and Cheon [68] studied racial microaggressions and the impact of cultural mistrust as a mediator between racial microaggressions and well-being (as measured using the Attitudes Toward Seeking Professional Psychological Help—Short Form scale) [69]. Among their sample of 156 Asian American college students, an increase in microaggressions was associated with an increase in cultural mistrust and ultimately reduced well-being.

Taken together, the literature offers a narrative that begins to explain how the historical social context of racial-ethnic minorities in the USA influences cultural mistrust.

## Approaches to Bridging Cultural Mistrust

The following section reviews the theory and evidence for approaches to bridging cultural mistrust in the therapeutic encounter, including racial matching, language matching, a focus on cultural competence, language concordance, and use of the Outline for Cultural Formulation and Cultural Formulation Interview in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).

### Racial or Ethnic Matching to Bridge Cultural Mistrust

Matching patients with providers of their own race or ethnicity is a commonly cited approach that may address barriers resulting from cultural mistrust. In a meta-analysis of racial–ethnic matching between therapists and patients, Cabral and Smith [70] focused on three variables: patient preference for a therapist of their own race/ethnicity, patient perceptions of therapists in a racial–ethnic match, and therapeutic outcomes in a racial–ethnic match. Patients across studies showed a relatively strong preference for therapists of their own race/ethnicity and a moderate tendency to perceive therapists of their own race/ethnicity positively, but there was nearly no effect of racial–ethnic matching on treatment outcomes. Taken together, these results indicate that racial–ethnic matching may be beneficial in engaging patients in therapy but has little impact on the effects of therapy in the long run. However, the authors cautioned that the overall results masked a great deal of variability across studies. The largest effect sizes across all three outcome variables were found for African-American participants, suggesting that racial–ethnic matching may impact minority groups differentially.

Good and Hannah [71] described a case process study of an inpatient psychiatric unit in which racial matching was deliberately, if unofficially, practiced with African-American patients. They reported that nonblack mental health associates (MHAs) matched black patients with black MHAs when they perceived potential conflicts for the patient in working with white staff. However, the effects of the matching were rooted neither in cultural similarity (the MHAs were described as African and the patients as African American) nor in greater empathy or understanding (the African MHAs were described as holding negative stereotypes about their African-American patients).

In an observational study of Latino patients, communication patterns among racially/ethnically concordant and discordant patient–clinician dyads suggested that communication patterns may explain the role of ethnic concordance in continuance in care. Latino concordant dyad patients were more verbally dominant ($p < 0.05$), engaged in more patient-centered communication ($p < 0.05$), and scored more highly on a working alliance bond scale (all $p < 0.05$) than other groups [72]. When in an ethnically concordant dyad, Latino patients have better outcomes as compared to other racial-ethnic groups in concordant dyads. When adjusting for non-communication variables, Latinos in both ethnically concordant or discordant dyads had higher rates of continuance. However, when adjusting for communication, global affect, and therapeutic process variables, whites in either type of dyad had higher rates of continuance than other racial or ethnic groups. This description raises questions about what constitutes a racial–ethnic match, and in what circumstances it may be effective for patients. However, given the small numbers of racial–ethnic minority behavioral health providers relative to the proportions of those groups in the general population, this approach is not feasible in many mental health care settings [44]. On the other hand, approaches that promote a therapeutic alliance across racial, ethnic, and cultural differences between the patient and the provider will be applicable in a wider range of settings but can be difficult to operationalize and implement [74].

## Language Matching to Bridge Cultural Mistrust

Another type of matching, by language, may impact the therapeutic alliance and outcomes for non-English-speaking racial–ethnic minorities; however, in many settings, interpreters will be needed to ensure communication between patients with limited English proficiency and English-speaking providers. A large study of Chinese and Vietnamese immigrant adults receiving care in community health centers found that those who used interpreters were more likely to have questions about their care and about mental health than those who were language concordant with their providers, yet the two groups did not differ on other communication measures or in their likelihood of reporting receipt of high-quality care [73]. Those who rated their interpreters highly were also more likely to rate the quality of care they received highly.

In a study of service outcomes of adequacy of care, emergency room (ER) care, and inpatient care among Portuguese-speaking patients in ethnic-specific and non-ethnic-specific behavioral health clinics, those patients receiving care in culturally and linguistically competent mental health care settings were more likely to receive adequate care than those receiving usual mental health care [74]. The findings suggested an increased quality of care for patients who have contact with a clinic that dedicates resources specifically to a minority/immigrant group.

In a mixed-methods study on the effects of interpreter use in behavioral health encounters for Spanish-speaking patients, no differences in the therapeutic alliance were found for clients who used interpreters versus those who did not [75]. Qualitative interviews revealed a more nuanced perspective, with patients reporting a preference for bilingual providers, while appreciating the access to services provided by interpreters. In ensuring language access through either bilingual providers or trained interpreters, systems must invest in the availability of services and allow the time needed to utilize interpreters [76]. Individual providers must then use the services available, rather than relying on ad hoc interpretation from family members or untrained colleagues, as ad hoc interpretation has its risks from a quality-of-care standpoint [76]. In a literature review examining the effects of patients' limited English proficiency and use of professional and ad hoc interpreters on the quality of psychiatric care, Bauer and Alegría [77] found that the quality of care can be compromised when patients are evaluated in a nonprimary language or when an interpreter is used; evaluation in a patient's nonprimary language can lead to incomplete or distorted mental status assessment [78]. Although both untrained and trained interpreters may make errors, untrained interpreters' errors may have a greater clinical impact, compromising diagnostic accuracy and clinicians' detection of disordered thought or delusional content. Use of professional interpreters may also improve disclosure in patient–provider communications, referral to specialty care, and patient satisfaction.

## Cultural Competence to Reduce Cultural Mistrust

In studies of medical students and primary care residents, only 20% of medical students reported being well-prepared to care for patients with low English proficiency, while primary care residents' self-report of preparedness to deliver cross-cultural care was based on the amount of instruction that physicians received to deliver such care, underscoring the importance of formal education [79, 80]. The majority of therapists—from 72% to 91% across five studies—self-reported being culturally competent in their work with racial–ethnic minority clients [81]. In a survey of 689 psychologists, the majority of whom were white, more than 80% reported discussing racial–ethnic differences in at least one cross-racial therapeutic encounter within the previous 2 years [82]. Yet, the psychologists surveyed also reported that racial–ethnic differences were discussed in fewer than half of all cross-racial encounters. Little research has directly assessed culturally competent practice in clinical encounters, leading to uncertainty as to whether these self-ratings reflect actual practice, and whether the practices that are taking place have any effect on client outcomes [83]. Given that unintentional bias by providers may have a strong effect on the therapeutic relationship, it is critical to measure aspects of the therapist–client relationship that may not be recognized by the therapists themselves [83].

Cultural competence encompasses systems as well as individual therapeutic encounters. Betancourt and colleagues [84] define three levels of cultural competence interventions: organizational, structural, and clinical. They note that at the clinical level, training has often focused on a categorical approach that involves ascribing attitudes, values, beliefs, and behaviors to broad cultural groups—which may lead to stereotyping. Combining knowledge-based training with process-based training in cross-cultural communication allows for more nuanced understanding of how cultural content may or may not be relevant to individual clients [84]. There is some evidence that cultural competence training can lead to increased knowledge and awareness among providers, but it is unclear whether training also improves client outcomes [85, 86].

Cultural competence is not uniformly accepted as a core competence in therapy. Sue [87] summarizes the debate on the utility of cultural competence through a series of questions. These include whether cultural competence stereotypes minority clients, discriminates against other types of diverse identities such as social class or sexual orientation, overemphasizes external factors such as discrimination at the expense of intrapsychic factors, and creates pressure to subscribe to cultural competence in order to be viewed as nonracist. The authors respond to these debates by noting that they tend to oversimplify the concept of cultural competence and ignore a more nuanced perspective—which includes a focus on multiple intersecting identities and an acknowledgment of intrapersonal, interpersonal, and societal influences on the lives of clients. Ultimately, the authors argue that cultural competence is necessary as a response to a historical context that has resulted in systematic bias against the inclusion of culturally-specific experiences in therapy.

Qureshi and colleagues [88] note that the term "cultural competence" itself may obscure important distinctions in the types of barriers faced by racial–ethnic minority patients. A focus on culture may pertain to differences in understanding and expressing symptoms, as well as how preferences for treatment are developed and communicated. However, experiences of racial and ethnic discrimination or barriers presented by poverty, immigrant status, and other experiences linked to minority status are not "cultural" but, rather, structural challenges disproportionately experienced by members of nonwhite racial–ethnic groups [88]. Clinicians must therefore be prepared to address a wide range of possible experiences impacting their clients; however, many training models focus primarily on acquisition of knowledge, rather than on development of skills or examination of attitudes [88].

## Cultural Tailoring to Reduce Cultural Mistrust

Huey and colleagues [81] found that psychotherapy is generally effective across racial–ethnic minority groups, and they reported robust effects across groups and psychiatric conditions. The evidence for the effectiveness of culturally tailored treatments was mixed, however, leading the authors to summarize several distinct ways in which cultural tailoring may be more or less effective, including cultural tailoring for a specific ethnocultural group rather than a mixed one; matching of therapists with clients who speak their primary language; provision of tailored treatments for older, less acculturated clients; achievement of congruence in therapeutic goals between the therapist and the client; use of metaphors and symbols that match the client's worldview; adaptation of the clients' beliefs about the cause, course, and treatment of psychiatric illness; and implicit instead of explicit addressing of cultural factors.

Qualitative research can shed light on specific therapy processes valued by racially and ethnically diverse clients. In a study of 16 therapy dyads consisting of a white therapist and a racial–ethnic minority client, Chang and Berk [89] contrasted the experiences of those who were satisfied with therapy and those who were not. The characteristics reported by satisfied patients included an active rather than passive style, therapist self-disclosure, attentiveness, and a nonjudgmental and validating stance. Characteristics reported by dissatisfied patients included therapists' lack of culture-specific knowledge, lack of awareness of the dynamics of power and privilege, engagement in unprofessional behavior that made the client feel disrespected, and engagement in behaviors or nonverbal communication perceived as dismissive and invalidating. In their analysis, the authors noted the importance of negotiating and repairing ruptures in the therapeutic alliance and posited that attending to these ruptures is especially important in cross-racial therapy encounters. The authors also highlighted the importance of attending to individual differences, describing how some clients did not want issues of race/ethnicity to be central to their therapy experience and were sensitive to being treated differently because of race.

In a study of relational preferences among African-American, Latino, and white behavioral health patients with depression, all three groups endorsed similar themes (listening and understanding across all three groups, and spending time for Latino and white patients). However, the way in which these themes were defined differed across groups. For example, for the theme of understanding, African-American patients described it as understanding aspects of the patient that could not be seen on the surface, Latino patients described it as understanding the patient's feelings, and white patients described it as understanding the complexity of the patient's circumstances and choices [90]. These results highlight the importance of not only identifying patient values in the assessment process, but also operationalizing what those values mean to the individual and to the cultural group(s) with which the individual identifies.

## Use of the DSM-5 Cultural Formulation Interview to Shape Clinical Practice

Cultural formulation interviews are intended to capture the patient's explanatory model of illness [91]. Efforts to operationalize a cultural formulation interview tool for psychiatric practice led first to the Outline for Cultural Formulation (OCF) in the

DSM-IV [92, 93]. Despite wide interest in and use of the OCF, substantial barriers to its adoption and implementation were also reported; these included the format being too vague and unstructured, and a lack of clarity about how the OCF fits into standard clinical practice [94]. More recently, the OCF was revised extensively into the Cultural Formulation Interview (CFI) in the DSM-5 [95]. The current CFI is a standardized, manualized interview based on 16 stem questions and probes, which was tested for feasibility, acceptability, and clinical utility in a DSM-5 field trial [91]. The areas addressed in the interview are the cultural definition of the problem, causes, stressors and supports, the role of cultural identity, self-coping, past help-seeking, barriers, preferences, and the clinician–patient relationship [95, 96]. Twelve supplementary modules for the CFI are also available to address specific groups (e.g., immigrants and refugees).

Qualitative interviews with patients and clinicians suggest that use of the CFI enhances rapport through satisfaction with the interview, elicits both information and perspectives from the patient, and facilitates perception of data at multiple levels of awareness. For some clinicians and patients, the CFI has also resulted in better provider communication of care and recognition of communication barriers [91]. Several aspects of the CFI could provide opportunities to address and ameliorate cultural mistrust; for example, several probes reference eliciting information on subjects such as discrimination, stressors related to one's background or identity, and barriers to accessing treatment in the social context. The final question in the interview addresses the clinician–patient relationship: "Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?" [95, 96]. However, this question was revised to put the focus primarily on the patient rather than on the provider, because of problems with clinician buy-in on a question that more directly addressed the provider's role in these interactions [94]. Others have noted that despite the presence of the CFI in the DSM-5, the overall manual still relies primarily on a conceptualization of mental health that is individually focused and not embedded in a social context that includes exacerbating factors such as racism and discrimination [97]. The CFI represents an important step forward in institutionalizing and standardizing the work of cultural psychiatrists, anthropologists, and others in a format accessible to all clinicians; however, the work of directly addressing cultural mistrust must be accomplished through work beyond the clinical interview.

## Summary of Recommendations

This last section describes strategies on the individual clinical level, as well as systemic strategies for facilitating a positive alliance and reducing cultural mistrust that racial and ethnic minorities might feel when interacting with clinicians in mental health treatment.

## Clinical Recommendations

Many health care providers are becoming increasingly aware of the need to develop skills to better address issues of cultural mistrust, yet they may lack the training to do so. Below are six recommendations to increase the capacity of mental health providers to address issues of cultural mistrust in their practice.

### Providing Coaching to Mental Health Professionals

While coaching is currently available to mental health professionals, more specific training should be developed for them to effectively manage cultural mistrust and avoid (1) the cognitive shortcut of quickly making stereotypical assumptions or biased judgments of their minority patients; (2) seeing themselves as objective in their judgments of "others" when they really are not; (3) spending insufficient time in understanding the perspective of their patients; and (4) missing opportunities to connect with diverse patients when billing and medical compliance aspects override attempts to tailor the session to the needs of the patient. This might require training by cultural brokers and bringing in interpreters to at least provide a language match between the patient and the provider. In both of these circumstances, ensuring confidentiality is of paramount importance. One area to test is the idea of transnational treatment, meaning provision of some mental health care resources by people from the patient's own culture. This can be achieved through the use of telepsychiatry, which has shown promise in overcoming cultural barriers, improving patient satisfaction, and treating mental illness in racial–ethnic minorities [98–102]. One example of this approach is the DECIDE intervention by Alegría and colleagues [103], in which racial–ethnic minority patients were taught strategies to improve activation and self-management in the clinical encounter as a way to avoid the steep cultural divide between the provider and the patient.

### Bolstering Opportunities to Understand Cultural Scripts

Training programs should educate mental health professionals on how to bolster opportunities that may help them better understand their patients' cultural scripts, those aspects that help patients make sense of their life circumstances, and the options that are available to them. This might require giving professionals the emotional bandwidth to practice collaborative mental health care by teaching them how to activate their patients as a way to empower them in treatment. It also might include coaching providers on how to discover with patients what they may see as acceptable options in their treatment. Because unintentional bias on the part of providers may have a strong effect on the therapeutic relationship, having providers audiotape their sessions, and having supervisors or colleagues evaluate them, can help obtain more objective feedback on the therapeutic alliance and on communication.

### Bringing Hope and Humility to Providers

Mental health professionals should feel encouraged to maintain hope and humility in their clinical encounters with patients who feel cultural mistrust. With few resources to manage their patients' vast needs, providers sometimes become pessimistic about their ability to work with or to inspire patients who seem resistant or hostile to treatment. However, hope from providers can aid patient recovery. Offering supportive supervision to mental health providers can decrease the likelihood of eroding their hope, cultural humility, and other attitudes that may dwindle patients' cultural mistrust.

### Allowing Sufficient Time to Address Culture in Sessions

Time is often a limited resource in treatment. Therefore, it is key that mental health providers are given sufficient time to attentively listen and explore patient preferences and, particularly, to address past experiences that could reinforce patients' cultural mistrust. This might entail providers leaving behind their verbal dominance in the clinical encounter, practicing shared decision-making in treatment decisions, and being explicit about their understanding of patient directives for care. It might also imply utilizing cultural tailoring of the intervention to make sure its core elements resonate with the worldview of the patient. Having time to adapt manuals—but also sessions—to the patient's preferences, within guidelines, is also of paramount importance.

### Reading, Learning, and Discussing Historical Contexts of Cultural Mistrust

As part of the curriculum, mental health providers should be required to read, learn, and discuss the historical contexts of cultural mistrust. More than matching providers in terms of racial or ethnic backgrounds, understanding historical contexts can help providers find matching social identities to those of their patients. The patient and provider may have common ground that can be used as a way to build a similar history and to establish some shared meanings. At the same time, the provider should acknowledge differences and discuss with patients potential ways in which they might need to provide expertise, so that the provider can understand how the historical context of mistrust might bleed into their own relationship.

### Encouraging Patients to Describe Positive Experiences with Providers

Given that patients are experts in their own experiences, they should be encouraged to generate descriptions of instances that have previously helped build a relationship of respect, trust, and lack of judgment from their providers. This is crucial even when patients have initially experienced cultural mistrust toward their provider. If this is a new patient, the provider could assess past relationships that facilitated a climate of trust and respect in their past therapeutic relationships. These examples can be used as ways to ensure that the patient feels that these are important shared goals.

## Systemic Strategies

For many mental health care providers, they might be one of the few institutional resources that patients can tap into to navigate complicated governmental systems to address their needs. However, for those who experience cultural mistrust, structural racism and discrimination within systems of care are a more common challenge to mental health access. Here are four recommendations to overcome racism within systems of care.

### Assessing Discriminatory Policies Against Health Care Access

Institutions should assess whether there are policies that might discriminate or become obstacles for access to or receipt of quality care. For example, lack of linguistic competence in the professional workforce might seriously handicap the possibilities of offering minimally adequate care or in offering treatments. Community health workers trained in evidence-based treatments could, with professional supervision, help to fill this gap. For example, lack of addiction service groups for non-English-speaking patients might curtail their opportunities for recovery. One way to resolve this would be by offering higher payment for services offered in non-English languages.

### Evaluating Patterns of Mental Health Care at Organizational Levels

A health care system should seek to understand how patterns of mental health care vary by race/ethnicity, gender, or method of payment. Once potential disparities are identified, efforts should be made to evaluate whether the differences are due to provider behavior, organizational behavior, or patient preferences. Such evaluation, for example, can be done by examining patient dropout rates by clinic, by provider, or by payment method. It is then important to ascertain whether patient no-show rates and lack of engagement converge across racial and ethnic groups. This information can be used to brainstorm and address potential mechanisms contributing to these patterns. In turn, insurance programs can be requested to offer bonuses for institutions that effectively reduce the disparities.

### Coaching Administrators on Cultural Mistrust

Coaching administrators on cultural mistrust and on the historical context of cultural mistrust can encourage buy-in on the importance of eradicating institutional racism. It is important to assist leaders in being open to exploring instances of institutional racism, and how to address them. It should be assumed that everyone can benefit from coaching on these issues, with the potential to change attitudes and reduce harmful behaviors.

### Recognizing and Incentivizing Leaders to Work Against Institutional Racism

Organizational leaders should be encouraged to recognize and address institutional racism, creating a cadre of champions to lead the organization by modeling equity as a salient institutional goal. Reinforcing this message in provider orientations and as part of continuing education is of paramount importance in the development of culturally competent leaders. Making institutional racism part of the indicators of quality required by forums such as the National Committee for Quality Assurance or the Joint Commission's Pioneers in Quality program would be one way to address the problem.

### Conclusion

Issues of cultural mistrust in racial and ethnic minorities are rooted in the legacy of racism and inequity that has plagued the USA since its inception. This historical thread contributes to present-day disparities in the access to and quality of mental health care among racial minorities. However, with growing interest in the phenomenon of cultural mistrust, there is also increased recognition of the issues at stake in terms of structural factors influencing mental health outcomes. Strategies to bridge these gaps at both the individual and systemic levels provide hope for reducing cultural mistrust and eliminating racial disparities in mental health care.

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# Changing Institutional Values and Diversifying the Behavioral Health Workforce

# 10

Stephanie Pinder-Amaker and Kimberlyn Leary

## Introduction

The US Census Bureau projects that by the year 2044, half of all Americans will belong to a minority group [1]. Among the youngest Americans, that threshold has already been reached. In 2014, 50.2% of all children living in the USA under the age of 5 years were members of minority groups [2]. The impact of the shift in the US demographic toward a "majority minority" has implications across sectors, including health and health care. As the minority population increases, the health care professions will need to ensure that a diverse, culturally competent workforce is in place, including the ability to deliver behavioral health care [3, 4].

As described in this chapter, health care entities are making strides to diversify their professional workforces to reflect the populations they serve. For example, medical schools have achieved greater success with women. Women represent almost half of US medical school graduates [5]. Even so, challenges remain. In the USA, for example, the earnings gaps between female and male specialist physicians is 37%, with male physicians earning an average of $345,000 whereas the average for their female counterparts is $251,000. Female physicians of color fare even worse, earning an average of $235,000.

Thus, in medicine, when parity is assessed with respect to medical school graduation rates, the profession can claim success with respect to gender. However, when

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we drill down into a broader array of metrics, including wage and compensation, key disparities endure. Those disparities surface even more explicitly when we look at distinctions among women, where women of color face greater challenges, including earning less money for comparable work.

To truly diversify the US behavioral health workforce, it will be important to broaden the participation of underrepresented minorities, as well as to consider the specific challenges faced by underrepresented minority women in the health care pipeline. Effective intervention is likely to require a fundamental realignment of power structures and values that currently maintain the status quo. Through a lens that considers how race and gender amplify disparities, the field can better understand processes, factors, and structures impacting workforce diversity, and gain critical insights into how institutional practice and norms shape knowledge, and the tools that leaders may deploy to intervene (Fig. 10.1).

The sheer scale of driving institutional change can result in unanticipated outcomes. Unintended consequences play a role in all significant matters of public policy. The Flexner Report is one example. Abraham Flexner's report on the status of medical education, published in 1910, has been credited with the elevation and

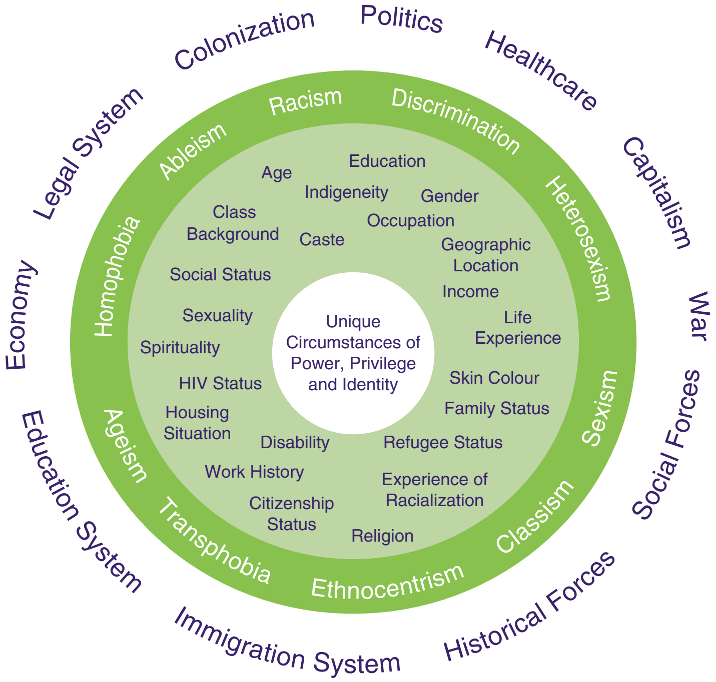


**Fig. 10.1** The Learning Network's intersectionality wheel diagram. Intersectional wheel diagram of processes, factors and structures impacting workforce diversity. (Adapted from the Canadian Research Institute for the Advancement of Women (CRIAW/ICREF) intersectionality wheel diagram)

standardization of American medical education, catapulting the USA ahead of other nations through high-quality training and professional standards. However, the report's recommendations also led to the closing of 72% of predominantly black medical schools and to admission standards that excluded most blacks from accessing medical school education for decades, while simultaneously promoting marginalization of the role of black physicians. Consequently, it was not until the 1960s that US medical schools began to actively recruit blacks; it was 1966 before blacks were admitted to all medical schools. Further, in the 1950s and 1960s, although blacks represented 10% of the total US population, they comprised only 2.2% of physicians. By 2010, African Americans, Hispanic Americans, and American Indians constituted more than 30% of the US population but accounted for only 8.7% of physicians [6].

To mark the centenary of the publication of the Flexner Report, Sullivan and Mittman [6] explored the report's enduring legacy. They noted that more than a century later, Flexner's recommendations that black physicians should serve in segregated and utilitarian roles as "hygienists and sanitarians" for black communities persist thematically in contemporary arguments for diversity in medicine. Sullivan and Mittman argue that the value of minorities in medical sciences must extend beyond the necessary and critical benefits to minority populations, service in underserved areas, and the minority's role in the primary care workforce. Rather, the "value of minorities in the medical sciences to the entire nation, enhancing educational outcomes, expanding and improving the quality of health care provided, and contributing to the breadth and depth of medical research" should be acknowledged.

Although the impact of the Flexner Report emanated from within medicine, blacks were similarly denied access to education, loans, and property in several other sectors of the nation. The GI Bill, for example, designed to help American World War II veterans adjust to civilian life, was deliberately drafted to reinforce Jim Crow laws [7, 8]. By 1946, only one fifth of the 100,000 blacks who had applied for educational benefits through the bill had been registered for college. Moreover, historically black colleges and universities, and blacks who lived in southern states, were, as with the Flexner Report, disproportionately impacted.

Although higher economic status is generally associated with better health outcomes, on many health indexes more highly educated blacks fare no better than whites with the least education. With respect to infant mortality and homicide, the interactive effects of race and gender suggest that even with the growth of the black middle class since the Civil Rights movement, many middle-class blacks do not enjoy the same outcomes as middle-class whites [9].

Further stratification may occur when gender intersects with race. In this chapter, attention is paid to both race and gender to approach the challenge of diversifying the behavioral health workforce and suggest ways to "bring more nuance and context to our approaches by acknowledging the social categories that matter most in a stratified society," as proposed by Cole [9]. This chapter looks upstream and downstream to understand the effects between and across various levels in society, including the macro level (global- and national-level institutions and policies) and micro level (community-level, grassroots institutions and policies, as well as the individual or self). By attending to these multilevel dimensions, behavioral health professions will be better positioned to address processes of inequity and differentiation across levels of structure, identity, and representation, and move the dial forward in this important realm.

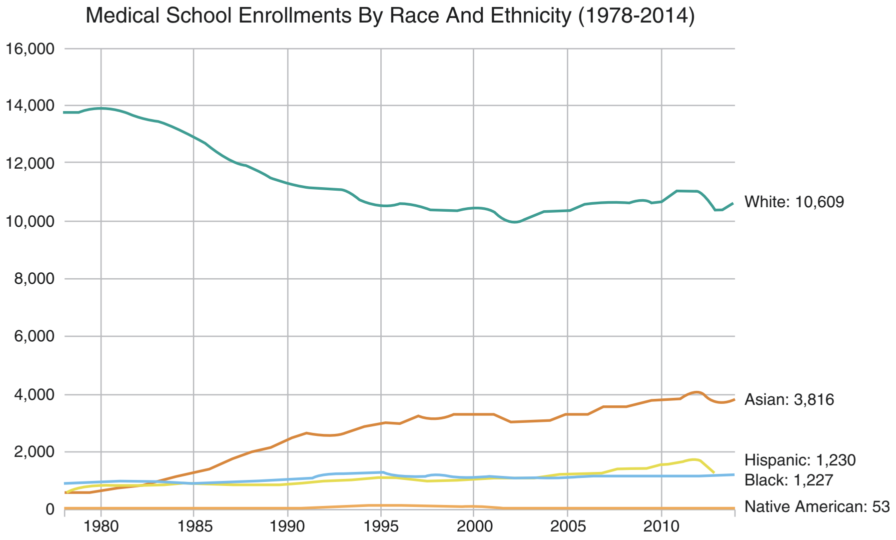
## Workforce Diversity: The State of the Professions

Workforce diversity includes multiple components and associated benefits. A diverse health care workforce adequately represents the communities in which it is working, with practitioners who possess cultural understanding and/or linguistic competence and the ability to treat recipients of health care as equal partners in improving health care status [10]. In business contexts, diversity correlates with market performance. Firms with greater diversity operate in contexts where different perspectives and life experiences can be brought to bear on critical challenges. Consequently, diverse firms outperform and out-innovate those with less diversity [11]. In health care settings and systems, team diversity is associated with quality of care and patient trust [12, 13]. A diverse health care workforce also affects population outcomes. Blacks have lower rates of mental disorders overall, but when diagnosed, they tend to have greater chronicity and severity [4, 14]. Minority health care providers may be especially well positioned to meet the needs of underserved populations, as black and Hispanic practitioners tend to practice in communities with more highly concentrated populations of diverse people [13].

Despite recognition of these benefits, the percentages of racial and ethnic minorities in the behavioral health workforce remain low, although there are some promising trends. In 2004, 6.2% of all US psychologists, 8.7% of social workers, and 24.2% of psychiatrists were members of ethnic minority groups (i.e., Hispanic, African American, Asian, and American Indian) [15]. The behavioral health professions are gradually becoming more diverse. For example, in the psychology workforce, from 2005 to 2013, the percentage of Asians grew from 2.4% to 4.3% [16], the proportion of blacks doubled from 2.7% to 5.4%, and overall, the proportion of racial and ethnic minorities grew from 8.9% to 16.4% (Fig. 10.2).

The percentages of medical school graduates by race and ethnicity have remained more stable. In 2015, almost 60% of all medical school graduates were white and nearly 20% were Asian, while only 5.17% were African American and 4.6% were Hispanic [18]. A similar pattern exists for behavioral health researchers; according to the National Science Foundation, 5.4% of all neuroscience doctorates were awarded to Hispanics and only 1.9% to blacks in 2015 [19].

Perhaps not surprisingly, the number of ethnic minority psychologists in tenure-line appointments is also small [20]. When compared with their white peers, ethnic minority psychologists are concentrated in the younger age groups (and thus in more junior positions). For example, the number of black psychologists in the workforce peaks during the ages of 41–50 years, whereas for whites it peaks during the ages of 51–60 years [21].



*Source: Association of American Medical Colleges Data Warehouse: Applicant and Matriculant File (as of May 11, 2015)*
*Credit: Alyson Hurt/NPR*

**Fig. 10.2** Medical school enrollments by race and ethnicity, 1978–2014 [17]. (See http://www.npr.org/2015/10/24/449893318/there-were-fewer-black-men-in-medical-school-in-2014-than-in-1978. This story is part of a reporting partnership that includes National Public Radio (NPR), local member stations, and Kaiser Health News. http://khn.org/syndication/ Kaiser Health News, a nonprofit health newsroom whose stories appear in news outlets nationwide, is an editorially independent part of the Kaiser Family Foundation)

In academic medicine, only 7% of medical school faculty members are people of color and only 4% of full-time members identify as black or African American, Latino or Hispanic, Native American or Alaska Native, or Native Hawaiian or Pacific Islander women [22]. The disparities are even more pronounced for academic leadership positions. Among department chairs, for example, only 3% of all chairs are women of color. Senior leadership roles in hospitals and health systems show similar disparities. Fewer than 7% of chief executive officers (CEOs) and 7.6% of chief medical officers (CMOs) are African American, Hispanic, or Native American; and only 0.7% are Asian [22].

## Workforce Diversity: Treatment Barriers and Stigma

Treatment barriers to mental health care also perpetuate the dearth of practitioners of color in the behavioral health professions. Well documented microbarriers include self and perceived stigma; cultural mistrust; fear of medication; low expectations of quality of therapeutic services; and perceptions of the typical psychologist or psychiatrist as “elderly, white, and male” [23, 24]. These patient-level microbarriers to treatment limit opportunities for young people of color to receive care from behavioral health professionals. Thus, the impact of lived treatment experience and direct exposure to behavioral health as a desirable profession are reduced. When children of color do seek treatment, it is unlikely that their therapeutic relationships will be race congruent. Children of color are less likely than white children to see their identities reflected among behavioral health practitioners. At the macro level, treatment barriers include unaffordable mental health care; lack of or insufficient health insurance coverage; few opportunities for race-congruent care, and discrimination by providers who do not accept people of color into their practices. At the same time, professional barriers facing underrepresented minority doctoral and medical students persist, including lack of exposure to the field; the high cost of education without a known path to compensation; lack of existing graduate student representation; lack of diverse role models, mentors, and faculty members in clinical and research settings; and reduced access to mentors of color, who are highly sought after by other students and university committees [24, 25]. When treatment and professional barriers converge, these factors create a reinforcing cycle that must be addressed concurrently in pursuit of a racially diverse behavioral health workforce. Fortuitously, behavioral health professionals are uniquely positioned to address many of these barriers.

In the USA, seeking behavioral health care for psychiatric illness is associated with stigma across most referent groups, and especially in communities of color. Minorities living below the poverty line are more likely to report psychological distress [26]. Suicide is the second leading cause of death for American Indian/Alaska Native individuals between the ages of 10 and 34 years. Youth of all racial groups are at increased risk for suicide; recently, the suicide rate in black youth went up from 1.78 to 3.47 per million, whereas the rate in white children decreased from 1.96 to 1.31 per million [27].

Stigma impacts help-seeking behavior as well. In general, members of minority groups seek treatment for mental health concerns at much lower rates than their white counterparts [28]. However, a review from National Survey on Drug Use and Health (NSDUH) data from 2008 to 2012 [29] indicated that multiracial adults were most likely to use mental health services in the past year (17.1%), followed by whites (16.6%), American Indians or Alaska Natives (15.6%), blacks (8.6%), Hispanics (7.3%), and Asians (4.9%). Traditionally, many African Americans remain wary of mental health and fear that getting help will lead to further stigma or worse. Those views are not unfounded. For example, historical reviews of diagnostic disparities with respect to schizophrenia and rates of involuntary commitment for black men during the 1960s point to the uncomfortable reality that mental health treatment was sometimes deployed as an instrument of political control [30]. Not surprisingly, African-American parents have reported being fearful of their children being mislabeled, mistreated, and possibly taken away from them [31, 32]. The pervasive and negative impact of a stigmatized profession, embedded within historical and systemic racism, further hinders diversity of the behavioral health care workforce. When these factors are paired with micro- and macro-level barriers to treatment, it is difficult to imagine conditions that would be less conducive to US children and students of color aspiring to become mental health professionals.

There are noteworthy efforts to normalize mental illness and to mitigate the stigma of seeking behavioral health care, including the provision of integrated primary and behavioral health care delivered through accountable care organizations. Several recent campaigns, conducted through traditional and social media, have also focused on helping communities to appreciate the importance of open dialogue about mental health and opening access to care. For example, "Change Direction," an initiative that developed after the Newtown tragedy, features citizens, nonprofit leaders, and business leaders who have come together to change the culture in America about mental health, mental illness, and wellness. McLean Hospital, a Harvard Medical School affiliate, has sponsored "Deconstructing Stigma: A Change in Thought Can Change a Life," an award-winning series of large-scale photographs and interviews with people from across the USA who have been affected by mental illness, installed at Boston's Logan International Airport [33]. In Britain, the "Heads Together" campaign includes members of the royal family, encouraging open communication about mental health [34]. These well-publicized stigma reduction efforts reach children and families who are not likely to seek treatment, and they convey positive messages about mental health treatment and the profession.

The African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA) project [35] addresses the mental health needs of African-American youth by "developing and implementing rigorous, culturally relevant, patient centered, community engaged research and clinical care." AAKOMA utilizes community-based participatory research and traditional behavioral clinical trials to develop evidence-based, culturally relevant interventions [36]. Through faith-based mental health promotion, surveys, and focus groups, it reduces stigma to engage African-American and other minority adolescents in treatment for depression.

Recently, there has been growing acceptance of the importance of mental health services among college students, including students of color. Student leaders and activists are leading the charge. On college campuses, students of color have provided first-person testimonies, asking that schools and communities provide access to mental health services.[1] In response to the death by suicide of Harvard College alum Stephen Rose, his family established the Steve Fund, which works with American colleges and universities to expand programs and strategies to support the mental health and emotional well-being of the nation's students of color [37]. Young people of color are also expanding outreach to peers about mental health, using technology and social media. A recent briefing on mental health and girls of color, sponsored by the Congressional Caucus on Black Women and Girls, included the documentary filmmaker Nicole Kenny, whose film *It Starts With Me!* [38] explores health and mental health for millennial women of color, and Nadia M. Richardson, who combines social justice advocacy and mental health awareness [39].

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[1] As an example, see https://www.theatlantic.com/politics/archive/2015/11/the-illiberal-demands-of-amherst-uprising/416079/.

## Workforce Diversity: The Impact of STEM Efforts

Considerable attention has focused on enhancing STEM (science, technology, engineering, and mathematics) pathways, especially for underrepresented minorities (URMs) and women. STEM skills play an increasingly important role in the twenty-first-century economy. There are upward of one million job openings in the USA that require computational literacy and/or some type of STEM training. Over the next 10 years, the number of STEM jobs is expected to exceed that of non-STEM positions. According to workforce projections, the USA will need one million more STEM college graduates than are currently enrolled in STEM majors [40].

Although the number of STEM bachelor's degrees earned by black college students rose by 60% from 2000 to 2014, many more black students earn bachelor's degrees in non-STEM fields; at the same time, the proportion of STEM degrees awarded to white students grew by 10% in comparison with the number of bachelor's degrees earned by white students overall [41]. STEM disparities begin early as a function of access and opportunity. As many as one quarter of American high schools offer only one core course in math and science (e.g., algebra, geometry, biology, and chemistry) [42]. Only half of US high schools offer a course in calculus [42]. The College Board reports that of the 30,000 students who took the computer science advanced placement exam in 2013, <20% were female, about 3% were African American, and 8% were Hispanic [43]. The same report indicates that no female students took the test in Mississippi and Montana. No African-American students took the test in 11 states, and no Hispanic students took it in eight states, although those groups constituted 3% and 8%, respectively, of all test takers. Students who arrive at university without a background enabling them to participate in college-level math and science coursework are not likely to have the skills to progress.

STEM engagement by underrepresented minorities may also be mediated by the lack of role models. For example, many young children display a science–gender stereotype; when asked to draw a picture of a scientist, they typically draw a male figure [44]. Popular media may play an important role in the construction, reproduction, and transmission of images of STEM, including the persistence of gender and race stereotypes associated with STEM careers [45]. In general, images of diverse others in media, television, and film are limited. For example, in a study of 400 films and TV shows, the study noted that only one third of speaking characters were female (33.5%), despite the fact that women represent just over half the population in America [46]. Fewer characters with dialogue (28.3%) were from nonwhite racial/ethnic groups, even though they represent 40% of the US population. The report also found that half of the films and television shows that were analyzed did not include Asian characters with dialogue, and more than 20% of shows had no black characters with dialogue [46].

Many young people may be more inclined to consider STEM careers when they observe role models to whom they relate enjoying their work and feeling fulfilled by it [47]. The recent success of the film *Hidden Figures* [48], portraying the work of African-American women who served as "computers" supporting the early US space program, is noteworthy. Entities ranging from NASA to the National Math and Science Initiative have used the film as a catalyst to engage underrepresented minorities and girls in STEM outreach activities—events that included a prescreening of the film at the Obama White House [49].

STEM mentorship can be complicated and challenging for students to negotiate. Graduate students and early-career professionals are particularly dependent on recommendations from senior faculty members. This dynamic can be exacerbated within the STEM fields since advancement may depend on a senior professor's sponsorship or invitation to work on funded research. One in three women science professors report harassment, and female postdocs who are pregnant or parenting may face subtle or explicit pressure to return to work early after giving birth so as not to disrupt the trajectory of research projects [50].

Implicit forms of bias affect STEM engagement as well. For example, in a randomized double-blind study of science faculty members from research-intensive universities, senior faculty members rated the fictitious application materials of a student—who was randomly assigned either a male or female name—for a laboratory manager position [51]. Faculty members were significantly more likely to view the applicant as more competent and hirable when they believed the applicant was male as opposed to female. These decisions portend the long-term impact. The offers made by faculty members to the applicant they assumed was male included a higher starting salary and expected provision of more career mentoring.

STEM pedagogy may also affect engagement by underrepresented minorities. Active learning, peer-led, and problem-based approaches to STEM teaching show evidence of closing achievement gaps between underrepresented minority students and their peers [52]. Many students, including underrepresented students, respond affirmatively when science is taught in an inquiry-based manner and when STEM is treated as a vehicle to solve real-world community problems, rather than an abstract competence in and of itself. For this reason, the University of Alabama has pioneered pathways that pair STEM majors with real-world training in business and entrepreneurship [53]. There is a strong research base showing that active learning in STEM enhances learning for students of all demographics but is especially impactful for women and underrepresented minorities, likely because these techniques require peer engagement and promote inclusion [54].

Likewise, studies of mentorship and sponsorship among underrepresented minorities affirm their importance. In a study of undergraduate women of color in computer science, mentors were an important influence on women's decisions to pursue graduate school, their choices of doctoral program, and their decisions regarding whether to stay in or leave the graduate program [55]. The National Institutes of Health have called for research on evidence-based mentoring, such as the Culturally Aware Mentoring program developed by Angela Byars-Winston, aimed at helping mentors to become aware of and mitigate personal assumptions, biases, and privileges that may operate in their research mentoring relationships [56]. Web-based solutions to matching mentees with mentors in STEM and medicine include Dr. Ebony McGee's launch of www.blackengineeringphd.org, the goal of which is to improve the interest and opportunities of black PhD engineering students entering faculty positions and winning tenure. Virtual mentoring is provided for premedical students nationwide by www.diversemedicine.org, whose mission is to increase ethnic and socioeconomic diversity within the field of medicine, and its eMentoring platform is supported by a mentoring curriculum and an online community that facilitate mentor training and participation.

While women have achieved parity for PhDs in biological and medical sciences, their enrollment continues to lag in some of the most entrepreneurial fields, such as bioengineering, mechanical engineering, civil engineering, and materials science [57]. Women scientists in these fields also seek fewer patents. However, female STEM PhDs whose first postdoctoral employment was in (or funded by) industry are just as likely as men to participate in patenting and entrepreneurship. While financial support is important, the relevant variable may be that sponsored postdoctoral students are linked into networks and a collaborative infrastructure essential to effective scientific entrepreneurship.

Taken together, these efforts to broaden participation in STEM suggest that underrepresented minorities and women with academic STEM backgrounds are a small, elite group with many career options. They are also the same students who are well positioned to enter psychology doctoral programs and medical schools, and, later, residency programs. Thus, with intention, a STEM pathway can be a behavioral health pathway. However, the mental health professions may be competing with other sectors such as the lucrative technology and engineering sector at a time when the field of health care is undergoing considerable change and health care financing is at a nexus of political turmoil. Thus, engagement of underrepresented students in mental health professions may require an integrated suite of initiatives, including:

- *Enhancing the Image of Mental Health*
  - Professional organizations need to work with media writers, producers, and actors to identify potential opportunities to promote positive and diverse representations of mental health professionals and the mental health professions.
- *Reducing Implicit Bias*
  - Health care entities should provide evidence-based implicit bias training in clinical and research settings that train psychologists and psychiatrists.
  - Universities and research sites receiving federal funds should be required to demonstrate equitable training and working environments that foster the success of all employees, including women and members of other underrepresented groups.
  - Voluntary training and affirmation of equitable practice should be promoted for nonfederally funded projects.
  - Accredited internship, postdoc, and residency training sites should be obliged to endorse Culturally and Linguistically Appropriate Services (CLAS) recommendations.

- *Promoting the Use of Transparent and Disaggregated Data*
  - Universities and research sites receiving federal funds should be required to report on the gender and racial composition of trainees and faculty members.
  - Voluntary reporting should be promoted for nonfederally funded projects.
- *Enhancing Mentoring and Sponsorship*
  - Faculty opportunities to learn evidence-based mentoring techniques, especially those that are culturally sensitive, should be offered.
  - Opportunities for sponsored research on mental health and behavioral health practicum opportunities to be provided for undergraduate students.
  - Mentoring activities for faculty on par with other kinds of academic commitments should be incentivized.
  - The breadth and support of Substance Abuse and Mental Health Services Administration (SAMHSA) minority mental health fellowship programs should be expanded.
- *Ensuring Holistic Attention to Career–Life Issues for Postdoctoral Fellows and Early-Career Professionals*
  - Opportunities for healing and learning of coping strategies in response to race-based incidents should be provided.

## Making an Impact on the State of the Professions

Taken as a whole, diversifying the health care workforce will require changes on many fronts. For example, it will require recruiting a broader, diverse group of students into health care training. Some students may be especially receptive to opportunities, enabling them to meaningfully engage with their communities of origin to meet comprehensive health needs. Recruitment efforts should align with these students' values. For example, student loan repayment programs for those who practice in underserved communities provide another avenue to make graduate education more accessible and inspire an ethic of service where it is most needed [12]. A holistic approach to graduate admissions may allow schools to identify promising physicians and psychologists by considering the student as a whole, and not just his/her performance on traditional metrics such as Graduate Record Examinations (GREs) and Medical College Admission Tests (MCATs).

Diversifying the broader health care workforce will require earlier and strategic intervention across the educational ecosystem, especially with respect to uneven access to STEM subjects, college readiness, mentoring and networking, and access to research and preprofessional internship and other experiences. There is widespread recognition that these proximal outcomes are related to distal conditions. Pipeline gaps begin early in the educational ecosystem because of inequalities in primary and secondary educational opportunities [4]. Blacks and Latinos are more likely to attend high-poverty schools than their white and Asian American peers [58]. High-poverty schools have fewer resources; consequently, students are exposed to less rigorous curricula, have fewer opportunities for advanced placement courses, and may contend with teachers and counselors who expect less from them than their white peers [59]. Addressing these and other preprofessional education disparities will also require increasing diversity among the faculty and leadership in K-16 schools [4]. Along this educational continuum, mentoring should be focused and sustained, with a greater emphasis on computational literacy. Mentors may also need to detail, in direct and specific ways, how they achieved their levels of success and, importantly, how to become more active in professional organizations [20].

Evidence-based approaches addressing the underrepresentation of women in science have led to increases in gender bias awareness and self-efficacy to promote equity in academic departments [60]. These recent findings may have implications for increasing faculty racial diversity in STEM doctoral departments as well. In an application of a gender bias “habit-breaking” intervention, researchers at the University of Wisconsin–Madison demonstrated an 18% increase in women being hired postintervention [61]. A related study suggests that prejudice habit-breaking interventions (similar to the previous model) produced enduring changes in peoples’ knowledge of and beliefs about race-related issues, and that these changes may be even more important for promoting long-term behavioral change than changes in implicit bias [62]. Both interventions are based on the premise that unintentional bias is similar to a habit that can be broken with sufficient motivation, awareness, and effort. These emerging evidence-based approaches move the field beyond mere awareness of the deleterious impact of implicit bias and toward actions that promote positive hiring outcomes.

Diversifying the behavioral workforce will require simultaneous attention to additional obstacles. In many behavioral health settings, turnover is high and clinicians are increasingly asked to do more with fewer resources. There is also continuing stigma associated with behavioral health and substance use, which extends to providers [13]. A survey of 139 minority behavioral health providers working in Michigan showed that although most respondents felt personally valued by their employers and believed their organizations fostered inclusive climates, more than half felt they had limited opportunities for career advancement, despite being interested in leadership positions and possessing the necessary credentials [13]. Forty-one percent of respondents felt it was unlikely they would ever become a part of the senior leadership team at their organization, and 50% felt they had not received sufficient support to grow into a leadership role [13]. Thus, even when recruitment of diverse candidates is successful, these factors, which negatively impact workforce morale, may undermine retention efforts.

The lack of workforce diversity in organizational leadership may be relevant to expanding diversity within the behavioral health professions as a whole. Expanding the number of diverse leaders in academic health care and in senior leadership positions in clinical settings may be one means of strengthening recruitment and retention outcomes. Employers may need to divert resources to support career advancement and to formalize promotion opportunities. For example, the Commonwealth Fund Mongan Fellowship in Minority Health Policy at Harvard University is a year-long fellowship focused on health policy, public health, and management for physicians committed to transforming health care delivery systems for vulnerable populations [63]. Joan Reede, the director of the fellowship, notes that the program's pedagogy is interdisciplinary: "a combined training that leads to a degree at the School of Public Health or the Kennedy School of Government here at Harvard, but it also involves leadership training and a great deal of mentorship from our alumni and individuals across the country who understand the need for this kind of diversity leadership.…[It involves] site visits across the country to various agencies, and projects that they work on with communities and organizations so that they can better learn how to address the needs of those organizations, and how to partner, collaborate, and help other individuals and entities better address the needs of populations" [13]. To date, this program has graduated over 130 physician leaders dedicated to health equity.

Developing similar competencies across professional health care training is possible if existing policies are expanded to require standardized mechanisms to assess adequate inclusion of cultural competence, health equity, and diversity requirements for accreditation, credentialing, and licensing. The Division of Professional Licensure in the state of Massachusetts, for example, has exacting standards for demonstrated competence in "racial/ethnic bases of behavior with a focus on people of color," including graduate study of cross-cultural psychology, psychology and social oppression, and racism and psychology. Regardless of seniority in the field or an existing license to practice outside Massachusetts, applicants whose training falls short of these standards must remediate the missing coursework to obtain a license to practice.

Individual health care settings also have an important oversight role to play in ensuring culturally competent practice in all health care settings. One progressive step could be for all health care settings to set a date by which they will meet the national CLAS standards [64]. These standards are intended to advance health equity, improve quality, and help eliminate health care disparities. In 2013, the *Blueprint for Advancing and Sustaining CLAS Policy and Practice* was launched on the Think Cultural Health website (www.thinkculturalhealth.hhs.gov/clas). This guidance document describes each standard's purpose and components, and provides strategies and resources for implementation. The CLAS standards and the blueprint illustrate an intersectional approach to impacting workforce diversity in health care settings (see Appendix).

Also at the individual health care setting level, behavioral health institutions can take responsibility for shifting institutional values in order to prioritize and address diversity issues and inequities more effectively. The Harvard Medical School affiliate McLean Hospital, through strategic planning efforts, institutional leadership, and resource allocation, is transforming its hospital culture and practice to support its explicit values of diversity and inclusion. A diagram depicting these endeavors (Fig. 10.3) reflects attention to all hospital stakeholders (e.g., patients, families, staff, and community) across all mission elements of the institution (e.g., patient care, education and training, and research). Importantly, visible engagement and commitment by senior leadership have invigorated these endeavors in the past 5 years [65].

Currently, the only federal programs for addressing the diversity of the behavioral health workforce are the SAMHSA Minority Fellowship Program (funded at $4 million) and the Health Resources and Services Administration (HRSA) Graduate

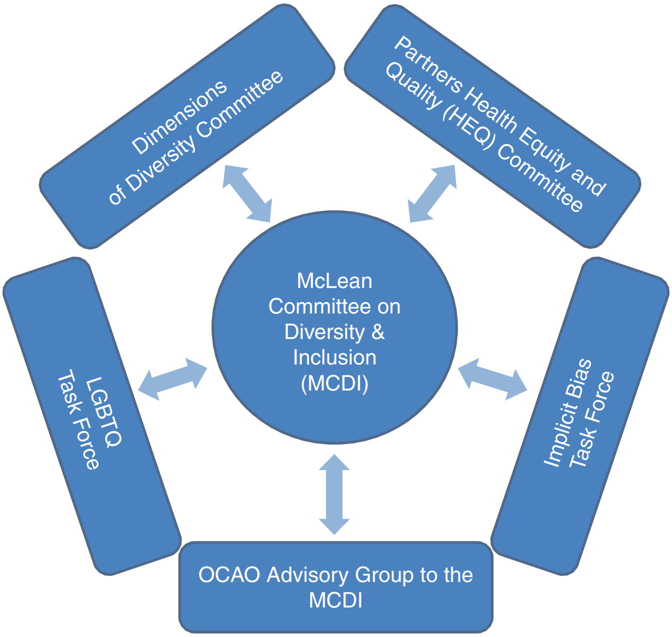

**Fig. 10.3** McLean Committee on Diversity and Inclusion (MCDI) diagram

Psychology Education Program (funded at $2 million). Seven grantee organizations administer the program, including the American Psychological Association, the American Psychiatric Association, and the Association for Addiction Professionals. The American Psychological Association offers a minority fellowship, which funds graduate study integrated with a mentoring and career development program, focused on advancing the life experiences of ethnic minority communities [66]. The American Psychiatric Association offers several minority fellowship programs for psychiatry residents and medical students interested in serving minority communities, along with mentoring and travel awards for medical students [67]. The American Psychiatric Foundation also sponsors the Diversity Leadership Fellowship to enable residents and early-career psychiatrists to attend national professional meetings and engage with relevant councils within the Association of Black Psychologists.

Behavioral health affinity organizations, including the Association of Black Psychologists and the Black Psychiatrists of America, also offer important portals for early-career professionals to network and to participate in collective action on behalf of minority communities. For example, the Association of Black Psychologists sponsors a journal and national convening, as well as “emancipation circles,” a program on community engagement [68]. Emancipation circles are a global grassroots network of self-help groups focused on mitigating stereotypes, internalized racism, and the emotional legacies of slavery, discrimination, and systemic bias. The Black Psychiatrists of America also work within communities on initiatives such as “Get a Check-Up from the Neck Up," partnering with local area churches, fraternities, sororities, schools, and other community organizations to provide mental health screening for depression, posttraumatic stress disorder (PTSD), and anxiety disorders, enhancing access to care provided by culturally competent behavioral health providers, and community health education [69].

## Conclusion

The exemplars highlighted below illustrate established and more recent multilevel interventions. Several of the recommendations advanced in this chapter are embedded within these innovative models. Notably, each program connects to and relies upon other sectors for maximum effectiveness. These interventions are especially critical for countering the enduring and collective impact of racism and classism in America.

*Exemplar*: The Center for Multicultural Mental Health (CMMH) is located at Boston Medical Center, affiliated with the Boston University School of Medicine, and provides clinical services that reflect culturally competent practice of community-based mental health services and inpatient services to the residents of Boston and the surrounding communities [70]. It includes a clinical training center (the Center for Multicultural Training in Psychology), an American Psychological Association (APA)–accredited predoctoral internship training program, and the Institute for Multicultural Practice and Research (IMPAR), which is a multicultural research and behavioral health services program.

The services of CMMH have historically been provided primarily to a racially and ethnically diverse, urban, low-income population. This target population is at increased risk for mental health problems, substance use disorders, and poor health outcomes. Currently, CMMH provides services (i.e., assessment/diagnosis, counseling, referral, training, and consultation) to community-based organizations throughout the city, ranging from community health centers (providing health, substance use, and mental health services), to houses of worship and recreation centers. CMMH is staffed by multicultural, multiethnic, and multilingual doctoral-level, licensed psychologists and psychology interns.

*Exemplar*: The Disparities Research Unit at Massachusetts General Hospital generates health and health services research to shape policy, practice, and service delivery to reduce disparities and improve the well-being of diverse populations. The unit and its faculty serve as principal investigators on several National Institutes of Health–funded research projects on topics that include social context, depression, and anxiety; culturally-specific interventions for migrant Latinos with co-occurring substance use and mental health problems; and patient–provider communications and the therapeutic alliance. The goal of this work, and of the unit as a whole, is to use evidence-based approaches to enhance service provision for multicultural populations [71].

*Exemplar*: The Harvard Medical School affiliate McLean Hospital's College Mental Health Program (CMHP) partners with regional institutions of higher education (IHEs) to deliver Mental Health Matters (MHM), a campus-based psychoeducational group series for underrepresented minority undergraduate, graduate, and professional, and medical school students. The MHM group intervention promotes mental health and academic success by addressing issues at the intersection of racial/ethnic identity, student status at predominantly white IHEs, and mental health. Examples of the topics include Imposter Feelings and Mental Health; Removing Cultural and Other Barriers to Seeking Help; Minority Status Stress; Managing Micro-aggressions in Academic Settings; and Balancing Social Justice Activism with Self-Care and Academics. Research findings relative to all topics are presented. Students convene in a designated safe space on campus to provide and receive support, process and heal from racialized incidents, and learn evidence-based coping strategies (including self-care, cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) skills, and student activism) for managing microaggressions and other stressors within the academy. The multipurpose MHM model addresses training needs of psychiatry residents who wish to provide community outreach and work with students of color, while exposing URM students to racially diverse psychologists and psychiatrists, as role models and mentors. The partnership requires that following 1–2 years of service delivery and staff training by CMHP staff, IHEs institutionalize the program on their campuses by training existing or hiring new behavioral health staff to assume the roles of MHM facilitators. Qualitative feedback solicited from graduate student participants and growing student participation for consecutive semesters reveal that the program has been especially well received by black, Latino, and international students. Graduate students of color who are isolated in their respective programs have embraced the opportunity for support and coalition building across academic departments. As the MHM model expands, future research should document the number of staff trained to deliver the program on college campuses and behavioral outcomes (i.e., retention and graduation rates, and service utilization) among participants.

The forces that contribute to the dearth of mental health professionals of color are multifaceted and complex. Successful attempts to diversify the behavioral health workforce will require multilevel and sustained interventions that address policy, programming, and practices across the educational and health care ecosystems. Strategies for increasing the presence of women in medicine and the STEM pipeline reveal approaches that might be adapted for racial equity as well. However, the unique confluence of stigma, racism, and barriers to mental health treatment must be acknowledged and addressed if STEM scholars of color are to perceive and pursue careers in behavioral health as gratifying and desirable options.

## Appendix

### National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The national CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

*Principal Standard*

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

*Governance, Leadership, and Workforce*

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

*Communication and Language Assistance*

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

*Engagement, Continuous Improvement, and Accountability*

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

## The Case for the Enhanced National CLAS Standards

> Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
> —Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people [72]. Currently, individuals across the USA from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age [73], such as socioeconomic status, education level, and the availability of health services [74]. Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the USA, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion [75]. Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services [76, 77]. By providing a structure to implement culturally and linguistically appropriate services, the enhanced national CLAS standards will improve an organization's ability to address health care disparities.

The enhanced national CLAS standards align with the US Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities [78] and the National Stakeholder Strategy for Achieving Health Equity [79], which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced national CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these standards will help advance better health and health care in the USA.

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# Medical Education and Racism: Where Have We Been and Where Might We Go?

# 11

Derri Shtasel, Andrew D. Carlo, and Nhi-Ha T. Trinh

## Introduction

Medicine and medical education live in the same majority culture that has institutionalized racism and discrimination through its laws, policies, practices, normative beliefs, and unequal distribution of opportunities, goods, and services [1]. Not surprisingly, medical practice and training reflect these assumptions, biases, and narratives, and health care inequities related to race and ethnicity are well established [2]. Nevertheless, medical education has only recently begun to provide students and trainees with the necessary knowledge, skills, and attitudes to mitigate their racial biases and provide high-quality care for an increasingly culturally heterogeneous patient population [3].

To date, most medical educational efforts to address health disparities have centered on the need for health professionals to develop cultural competence, and most of this work has been at the level of undergraduate medical education. Over the past decade, there has been growing recognition that while teaching cultural competence broadens understanding of differences influencing health care behavior, it is an insufficient heuristic to address inequities. For example, some assert that teaching cultural competence is not sufficient, since "there is a distressingly common failure to connect the idea of diversity with the underlying core concept of social justice in

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health care" [3], and others say we must go "beyond notions of 'cultural competency' to consider issues of power and privilege, difference, and identity in fostering a professional self committed to fairness and justice" [4, 5]. There are few descriptions, however, of curricula in the medical literature that directly consider the impact of racism on access, diagnosis, and treatment. Accordingly, this chapter reviews the evolution of mostly indirect approaches that have been used to teach about racism in medical education, provides an example of a racism-specific psychiatry residency clinical and didactic curriculum, and discusses challenges and opportunities ahead.

## Teaching Cultural Competence

Racism in health care, as an educational concept, is often bundled with other well-described and important disparities related to sex, gender, sexual orientation, socioeconomic status, and ethnicity. Education on these and other related disparities is often termed "cultural competency education" (or "training") [6, 7]. Some of the earliest adopters of cultural competence curricula were the first to overtly bring the notion of racism (albeit indirectly) into medical school lecture halls. Early innovators appear to have been motivated primarily by the realization that the American population was increasingly diverse (with respect to language and culture). According to one author, "Making sure that the health care provided to this diverse population takes account of their linguistic and cultural needs constitutes a major challenge for health systems and policy" [8]. Although educators and policy makers as early as the 1970s and 1980s [9, 10] noted that culture impacts care for everyone, investigators in the 1990s began to identify the unique impact that cultural differences had on racial and ethnic minorities. Examples of care disparities were identified in the realms of diagnosis, treatment, communication, and other aspects [8]. Still, these clear inequities were largely ascribed to cultural and linguistic differences, with the word "racism" rarely being explicitly used.

By the year 2000, 87% of US medical schools had courses in which cultural issues were presented in one or more of the lectures, and 8% of schools had separate courses specifically addressing cultural issues [8]. Betancourt's widely cited 2003 framework of cross-cultural (or cultural competence) medical education noted three primary components or goals: (1) promoting awareness of attitudes (including self-reflection); (2) facilitating knowledge acquisition of cultural issues; and (3) developing the ethnographic skills in a clinical setting to understand the cultural context of illness for a given patient [11–13]. Although the significance of racism and prejudice were mentioned in Betancourt's writings, they were mostly listed alongside other forms of disparities and discrimination. In fact, few studies at the time mentioned racism as a primary focus of educational curricula. In their 2005 educational intervention review, Beach and colleagues demonstrated that only two of 34 reviewed studies on cultural competence or cross-cultural training mentioned racism directly. Further, their review noted that some authors theorized that the use of words such as "racism," "discrimination," or "bias" in cultural competence training could lead to an increased incidence of racial stereotyping. One study, for example, demonstrated that following an intervention that taught specific cultural information, students were more likely to believe that Aboriginal people were all alike [14].

Shortly afterward, however, Gregg and colleagues [15] identified problems in the efforts of multiple medical schools to teach cultural competence without a specific focus on racism. They asserted that "in attempting to address racial and ethnic disparities in care through cultural competence training, educators too often conflate these distinct concepts. This leads to an inappropriate collapsing of many of the forces affecting racial and ethnic minority populations—such as poverty, violence, and racism—into the less threatening concept of culture" [1]. In the following years, medical education research argued for the need to move away from a primary goal of cultural competence (where one learns about various cultures in a way that could be viewed as a "cultural safari" [1]) toward one of a "critical consciousness…of the self, others and the world" with "a commitment to addressing issues of societal relevance in health care" [3, 11]. Still, racism was not a primary pedagogical focus.

In 2009, Eiser and colleagues [13] posited that to provide culturally informed care to African-American patients, physicians must have a clear understanding of "the legacy of slavery, Jim Crow discrimination, the Tuskegee syphilis study, religion's interaction with health care, the use of home remedies, distrust, racial concordance and discordance and health literacy" [13]. Some specific suggestions were for physicians to be knowledgeable of African-American ethnic social history (including the legacy of slavery and the other major events mentioned above), racial concordance/discordance, home remedies (which may be used preferentially by African Americans of certain religious backgrounds), health illiteracy, and religious beliefs. It was theorized that an emphasis on these areas could result in improved health care for African Americans and a reduction in disparities.

More recently, in 2015 the CHANGES (Cognitive Habits and Growth Evaluation Study) [16] showed that a multicomponent curriculum focused on racism could successfully reduce implicit bias in medical students [1]. The authors focused on three domains with an established impact in changing attitudes and behaviors: the formal curriculum (consisting of distributed educational materials and explicitly taught sessions), the informal curriculum (consisting of informal organizational culture largely delivered through the behaviors of faculty members and other role models), and the amount and favorability of interracial contact (including interactions with African-American clerical staff, allied health staff, medical students, and physicians). The final analysis, which included self-report data from 3546 students at 49 medical schools throughout the USA, showed that (1) completing the Black–White Implicit Association Test [17] during medical school was a statistically significant predictor of decreased implicit racial bias; (2) students' self-assessed skills regarding the provision of care to African-American patients had a borderline association with decreased implicit racial bias; and (3) hearing negative comments from attending physicians or residents about African-American patients and having unfavorable versus very favorable contact with African-American physicians were statistically significant predictors of increased implicit racial bias [14].

Brooks and colleagues [18] sharpened the focus on teaching directly about racism and prejudice through a 1-hour, small group, case-based curriculum for rising third-year medical students, which focused on clinical skills development. Students used clinical vignettes to identify racial bias as a vehicle for direct discussion about racism in medicine. The racism-specific educational objectives were direct: teaching medical students how to address physician bias; understanding the use of interpreters in hospital settings; and identifying structural factors that contribute to patients' clinical presentations. Other approaches to teaching medical students about bias have done so by including this in a legal framework emphasizing the line between health disparities and illegal discriminatory behaviors [19], as well as by including bias in the context of teaching structural competence [20]. In the latter instance, the authors state explicitly that racial biases impact health care both inside and outside the room, through individual physician–patient interactions and more upstream policy and societal decisions [20]. Most recently, in parallel with the national conversation on racism and the deaths of African Americans at the hands of the police, specific antiracism curricula have been proposed for medical students, including one that emphasizes antiracism pedagogy and structural competence [5].

Despite growing recognition and attention to teaching about racial inequities in undergraduate medical education, much less has been written about cultural competence training or racism-specific curricula in the *postgraduate* or *medical residency education* setting. A review in 2000 [21] demonstrated that the number of family medicine residency programs teaching about "multi-cultural issues" had increased from 25% of those surveyed in 1985 to a significantly higher percentage in 1998 (58% of responding programs had an informal curriculum on multicultural issues, and 28% had a formal curriculum). In 2011, the John Hopkins Internal Medicine Residency Program created a social justice curriculum titled "Medicine for the Greater Good," emphasizing health disparities; specifically focusing on epidemiology and geographic epidemiology, health literacy, and advocacy; and developing deeper understanding of patients through community-based clinical encounters [22]. The authors of this chapter are not aware of any other literature describing racism-specific curricula at the graduate medical education level.

## Current Educational Activities: Massachusetts General Hospital

Established in 2009, the Massachusetts General Hospital (MGH) Division of Public and Community Psychiatry has enhanced resident training in race equity through new clinical rotations, creation of an annual symposium, development and implementation of a didactic curriculum, and, most recently, a 2-day visiting professorship. A fundamental principle in all of these activities is that they are "curricular"—i.e., all residents participate—rather than being elective opportunities that inevitably self-select for residents already interested and invested in these areas. Through embedding of these activities in established structures, it is made explicit that teaching and learning about racism is valued and part of what is considered core knowledge for all trainees.

## Clinical Rotations

Two rotations intentionally address racism through their venue, population, and rotation-specific didactics. In the PGY-2 year, a six-week community psychiatry rotation is sited in a Department of Mental Health homeless shelter. African Americans are disproportionately represented in the homeless population in the USA: while they are 13% [23] of the general population, they are close to 40% of the homeless population [24]. A retrospective chart review of this shelter's population [25] was consistent with broader trends; approximately 50% of the sample identified as African American, and more than 75% of all patients in the sample had a history of legal charges. Residents learn about the epidemiology and sociodemographic characteristics of homelessness; they listen carefully to individual patient narratives, write reflection papers, and participate in guided discussion about the intersection of serious mental illness, homelessness, the criminal justice system, and racial inequities. In their PGY-3 year, residents spend 1 day/week for 8 weeks at a local jail. As in the case of their shelter-based rotation, the population is disproportionately men of color, but the lens of corrections provides a different perspective and a starker example of structural racism [26] while at the same time exposing residents to inmates (patients) similar to those they see in other community-focused clinical rotations.

## Formal Curriculum

In 2015, the MGH Division of Public and Community Psychiatry elected to add a racism-specific module to its formal lecture series. With leadership from residents, a sequential curriculum with lectures in each year of residency training was created. Organized around Camara Jones's three tiers of racism [1]—structural, interpersonal, and internalized—formal lectures were supplemented by preassigned readings and tailored to the residents' developmental trajectory. The emphasis for PGY-1 residents, many of them new to Boston, is "Structural Racism and Neighborhoods: Impact on Mental Health Access and Outcomes." Residential segregation is used to illustrate a racism-specific social determinant of health while familiarizing residents with history that is part of their patients' experiences. Specific learning objectives for this lecture include understanding the impact of institutional racism on access to housing and recognizing the psychosocial impact of segregated housing and its relationship to mental health access and outcomes.

In the PGY-2 year, "Racial Bias in the Diagnosis and Treatment of Psychosis" is taught. A case-based approach is used to help residents learn to identify causes of racial inequities in the diagnosis and treatment of psychotic disorders, supported by relevant literature and followed by an interactive discussion around strategies to reduce racial bias and its contribution to diagnostic errors and treatment inequities.

The PGY-3 lecture "Personally Mediated Bias: Does It Affect Psychiatric Treatment?" is co-led by residents and focuses on interpersonal racism and its impact on the mental health of African Americans. To frame the discussion, the concept of racial microaggressions is defined and explored through a case presentation. Learning objectives include residents' being able to discuss the relationship between implicit bias and inequities in mental health treatment, identify types of implicit bias and stereotyping (e.g., microaggressions), and identify strategies for reducing implicit bias (e.g., microaffirmations).

Finally, the PGY-4 lecture "Twenty-First Century Policies for Dismantling Structural Racism" takes a big-picture look at the major components of structural racism that affect the mental health of African Americans, and asks residents to identify (or imagine) two policy interventions that could mitigate these.

A full description of the 4-year curriculum can be found in *MedEd*PORTAL [27].

## Informal Curriculum and Institutional Culture

In addition to the formal lecture sessions, the Division of Public and Community Psychiatry has facilitated several residency-wide lunch or dinner sessions, discussing topics such as the disproportionate representation of minorities in the criminal justice system, police violence and brutality toward minorities, and minority health care inequities. Other discussions throughout the residency have occurred without planning and were largely impromptu in nature. These conversations and dialogues were, in part, thought to be a result of the curriculum leading to greater comfort in discussing race and social injustice, mirroring a national conversation catalyzed by a series of minority deaths at the hands of the police. Although the formal curriculum was a part of the standard residency didactic curriculum and included only members of the defined residency classes, the subsequent lunches, dinners, and discussions attracted medical students and residents from a range of hospital departments.

## Visiting Professorship in the Division of Public and Community Psychiatry

Through linking two departmental events—an afternoon public psychiatry symposium for the psychiatry department and community partners (which includes speakers and a poster session), and an endowed psychiatry department grand rounds focused on minority mental health—a 2-day "visiting professorship" was created. Residents not only attend these events but also have several group and individual opportunities to meet with the faculty guest through their participation in clinical rotation–based rounds, small group discussions, and individual career conversations. With the visiting professorship now in its second year, the visiting professors have been national leaders in minority mental health research and/or mental health services, advocacy, and leadership—including the current President of the American Psychiatric Association.

## Future Directions

### Faculty Development

The literature describing teaching about racism makes clear the need to start with the faculty [28]. Faculty members are usually ill-equipped to discuss issues of race, privilege, and minority status; some provide tone-deaf answers, such as the idea that racism no longer exists, as we live in a "postracial" era [28]. As faculty members themselves have had little formal training regarding complex issues of racism in psychiatry, they must be engaged in conversations that will better prepare them to address these complexities. Although cultural sensitivity training and unconscious bias training have become more standard, they are only a starting point. Acosta comments that "faculty need not only the ability to recognize prejudice but also the tools to speak up against it when they witness it.…Faculty development should encourage and facilitate fluid discourse on high-stakes issues such as racism, internalized dominance, internalized oppression, and the invisibility of privilege" [28]. However, without practice, open conversations about racism can be stressful, causing faculty members to avoid or minimize the impact of discrimination on trainees, patients, and colleagues.

One way to foster intentional, honest faculty development in this regard is to provide a framework and practice to address these issues with their trainees. The "courageous conversation strategy and protocol" developed by Singleton is one such strategy [29]. This protocol requires a commitment from educators to adopt four agreements that define the conversation process:

1. Stay engaged.
2. Speak your truth.
3. Experience discomfort.
4. Expect and accept nonclosure.

To support the four agreements, the strategy also includes six conditions to keep participants focused on the subject matter at hand:

1. Establish a racial context that is personal, local, and immediate.
2. Isolate race while acknowledging the broader scope of diversity.
3. Develop an understanding of race as a social/political construction of knowledge, and engage multiple racial perspectives to surface critical understanding.
4. Monitor the parameters of the conversation by being explicit and intentional.
5. Establish agreement around a contemporary working definition of race.
6. Examine the presence and role of whiteness and its impact on the conversation.

This framework provides important guideposts for faculty members to gain practice in dialoguing about racism, first among themselves in mandatory faculty trainings, and then with their trainees. Of note, discomfort talking about race is inevitable; learning to acknowledge and confront one's discomfort is the goal. Acosta and others argue that “Like any lifelong learning skill, dialoguing about race with members of other races and ethnicities requires frequent practice and the desire for continuous improvement” [28].

## White Privilege

Faculty members must recognize and address white privilege and its impact on their teaching, their clinical care, and their assumptions about trainees of color [28]. Unrecognized social privilege—an underpinning of unconscious biases—is a contributor to health inequities and influences interpersonal interactions with trainees and with patients. Once faculty members are able to have more constructive and effective dialogue with residents, tailored exercises can be used to focus on areas of white privilege in residency didactics. The aim of these exercises would be to further develop resident and faculty “cultural humility,” defined as a state of openness toward understanding and respecting important aspects of other people’s cultural identities.

Holm and colleagues [30] have developed the interactive Privilege and Responsibility Curricular Exercise (PRCE), aiming to raise participants’ awareness of privilege in their everyday lives and work environments, and to improve their understanding of the impact that privilege has on their own and others’ lived experiences. They describe three sections of the PRCE activity: (1) participant self-reflection of privilege; (2) small group debriefing; and (3) large group discussion. The PRCE asks participants to self-select statements of privilege that apply to them. Each of the 22 statements references one or more social categories and experiences reflecting dominant societal norms—for example, “If I ask to talk to the person in charge, I will be facing a person similar to me,” or “If I walk through a parking garage at night, I don’t have to feel vulnerable.” Participants read the statements and keep track of statements they feel are true for them. Debriefing then occurs in small groups of five participants to increase the safety of sharing; dialogue can begin with simple, comfortable questions that graduate toward highlighting differences among participants. After a small group debriefing, the facilitator then engages the full group in exploring participants’ reactions to bring many perspectives into the conversation. To amplify reflection and awareness, facilitators encourage self-disclosure and awareness of the need for humility and empathy. Lastly, the facilitator reiterates the activity’s purpose and summarizes the exercise, defining “privilege” as unearned advantages that one might take for granted while simultaneously not recognizing that others lack them.

## Residency Didactics

In addition to the core areas described earlier (paralleling Camara Jones’s three levels of racism [1]), as well as addressing white privilege, residents would benefit from going beyond cultural competence to learn about cultural humility, structural competence, and the tenets of an antiracism curriculum [5, 20, 31]. Tervalo and Murray Garcia [31] describe cultural humility as incorporating "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient–physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations." While emphasizing the importance of multicultural learning, they underscore the need to go beyond finite content about particular cultures, since this will always be incomplete, and instead approach patient interactions with humility and the need to "say that they do not know when they truly do not know." Metzl and Hansen [20] go further, by moving from the level of individual patients to broader social institutions and policies. They describe structural competence as "(1) recognizing the structures that shape clinical interactions, (2) developing an extra-clinical language of structure, (3) rearticulating 'cultural' formulations in structural terms, (4) observing and imagining structural interventions and (5) developing structural humility." They posit that understanding patients' experiences of stigma and their specific cultural background will not reduce health disparities. Instead, it is necessary to go upstream and identify neighborhood, community, and environmental factors; access to healthy food and health care; and a range of social determinants of health. "Clinicians require skills that help them treat persons that come to clinics as patients, and at the same time recognize how social and economic determinants, biases, inequities, and blind spots shape health and illness long before doctors or patients enter examination rooms [20]." This is material that psychiatric residents need to learn.

Challenging educators to think critically about the underlying assumptions of their pedagogy, such as "objectivity" and "neutrality," Wear et al. reference an "anti-racist" pedagogy that "seeks to provide students with the ability to critically reflect on the ways in which oppressive power relations are inscribed in their own lives and the lives of others." An explicit goal is to "move beyond comfortable, deeply rooted views of the world" and instead accept the risk of students' discomfort and unease as part of the learning process [5].

## Embedding in Clinical Services

In addition to content-specific curricular material, both for the faculty and for residents, Hardeman [32] describes the need to develop "critical self-consciousness"—the ability to understand how society and history have influenced and determined the opportunities that define our lives. She identifies several core components:

1. Learn about, understand, and accept the United States' racist roots. Structural racism is born of a doctrine of white supremacy that was developed to justify mass oppression involving economic and political exploitation.
2. Understand how racism has shaped our narrative about disparities.
3. Define and name racism.

Hardeman further argues that providers need to "center at the margins"—shift their viewpoint from a majority group's perspective to that of the marginalized group or groups. This framework lends itself to clinical encounters with patients and other staff, diagnostic formulation, and quality and safety activities. For example, Brooks describes experiences where race is deliberately ignored in discussions of health inequities or where supervisors prioritize learning opportunities with white patients [18]. Okwerekwu describes numerous personal experiences of racism that others (in positions of greater power) ignore or minimize, including one where "a patient called me a 'colored girl' three times in front of the attending physician. The doctor did not correct the patient nor did she address the incident with me privately" [33].

Faculty members and co-residents need to speak up and name racism, and need to have such discussions become normalized across clinical rotations. Routine case formulations and presentations can incorporate structural factors in addition to standard clinical material, with treatment plans being developed that reflect this understanding. And "centering at the margins" is a perspective shift; it requires clinicians to be aware of the factors influencing their narratives—but also those that shape their patients' narratives, making it necessary to redefine what is "normal." Residents are required to participate in quality improvement and safety activities—areas that lend themselves to a race equity lens. Examples might include evaluation of whether there is differential appropriation by race of scarce resources (such as inpatient psychiatry beds) by residents in emergency services, or a review of how often race is used as an "identifier" in clinical write-ups and presentations.

### Conclusion

Attention to teaching about racism in medical education continues to increase, with greater frequency at the medical school level than at the residency level of training. This chapter has described the national evolution of these efforts, ongoing work at Massachusetts General Hospital to develop a formal curriculum, and a range of areas warranting further development, including faculty development. At a minimum, these include learning about the history of institutional racism, the role of white privilege, the meaning and practice of cultural humility, and development of structural competence. Faculty members and residents need to learn how to talk about race and racism. Ideally, this can be accomplished through a combination of didactic lectures, clinical experiences, and longitudinal/embedded processes. As Nivet describes in his commentary on "Diversity 3.0," issues of race and racism must "be integrated into the core workings of the institution and framed as integral for achieving excellence" [34].

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# Racial and Ethnic Minority Mental Health Advocacy: Strategies for Addressing Racism

# 12

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> "Not everything that is faced can be changed; but nothing can be changed until it is faced."
> — James Baldwin

## Clinician Advocacy

The last 10 years have revealed a significant increase in articles discussing clinician, physician, and health care provider advocacy [1–6]. A 2009 endorsement by the American Medical Association (AMA) states that "Physicians must advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" [7]. Scholars such as Earnest and colleagues define physician advocacy as "action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise" [1]. They note that advocacy is not limited to addressing individual patients' needs; rather, it is a broader practice that addresses root causes of societal struggles and inequities.

As Dobson and colleagues examine the role of the physician as a health advocate, they note that "The main barrier to productive conversations about the place of health advocacy appears to be a lack of clarity around what a physician should do as a health advocate and how this should manifest in daily practice" [8]. Additionally, Croft and colleagues note that development of the physician advocate begins with "experiences that improve a physician's ability to advocate along a continuum, from

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issues arising for individual patients to those affecting health care policy" [3]. One critical facet of their conceptualization is the viewpoint of advocacy education not as a supplement to a workload but, rather, as "an organizing force, one that can increase physician's awareness of their professional ecology" [3]. Furthermore, as Dharamsi and colleagues point out, "medical systems that tend to focus largely on the individual relationship between the physician and the patient, with little attention to the doctor's role and responsibilities to society, will face difficulty serving vulnerable groups" [2]. Thus, building advocacy skills hinges on conceptualizing a comprehensive definition of physician advocacy, as well as a mechanism for building the necessary skills and abilities.

Arguing against the need for clinician advocacy, Thomas Huddle remarks that "Advocacy must remain an occasional and optional avocation in academic medicine, not a universal and mandatory commitment" [9]. The authors of this chapter disagree with that sentiment and maintain that clinician advocacy is essential for academic medicine and medical training. Though physicians such as Huddle have argued that forms of advocacy could threaten objectivity or serve as a distraction [9], the authors agree with Croft and colleagues [3], who maintain that the medical profession cannot afford such a simplistic argument as to why advocacy should not be a part of academic medicine and medical practice.

In working toward a unified definition of physician advocacy to address racism, the work of the nineteenth-century physician and anthropologist Rudolph Virchow must be considered. Virchow wrote that:

> Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the answers for their actual solution.…The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction [10].

Simply put, the physician advocate addresses race and racism by identifying, understanding, and responding to the intersection of the social, political, and economic barriers that influence and constrain patient care. Armed with this understanding, we turn now to the role of advocacy in addressing racism, with a particular focus on the field of psychiatry.

## Historical Accounts: Addressing Racism Within the Field of Psychiatry

Advocacy exists in response to a stimulus (e.g., a social, political, environmental, or economic stimulus). It is important to trace the history of mental health advocacy back to the time of American slavery, when diagnoses of mental illness were overwhelmingly dominated by racism and the perceived inferiority of African Americans [11]. Mental disorders thought to be peculiar to enslaved men and women included "drapetomania" and *dysaethesia aethiopica*, the former referring to the tendency to run away from slave owners [12] and the latter being described as "a form of madness manifest by 'rascality' and 'disrespect for the master's property' that was to be 'cured' by extensive whipping" [13]. African Americans were structurally and ideologically segregated from the rest of American health, and many states had mental hospitals devoted only to African Americans [14]. As Metzl notes, "even at the turn of the twentieth century, a leading academic psychiatrist shamefully claimed that 'Negroes' were 'psychologically unfit' for freedom" [13]. These racial attitudes, born out of slavery, continued to determine the diagnosis and treatment of African Americans [15]. Throughout the twentieth century, medical professionals commonly believed that if African Americans had mental disorders at all, they were much more likely to be diagnosed with disorders such as psychosis and schizophrenia, while rarely being diagnosed with affective disorders such as depression and bipolar disorder [16]. Historically, African Americans have experienced limited access to the mental health system, have been more likely to be involuntarily committed, and have received suboptimal mental health treatment [15, 17, 18].

Historically black colleges and universities (HBCUs) served as early sites for advocacy against racism. Founded shortly after the end of the American Civil War, both Howard University and Meharry Medical College provided training for African-American clinicians, including psychiatrists and other mental health workers. Both institutions were often considered to be ahead of their time in promoting community mental health care for African Americans. One of the first professional forms of advocacy emerged with the founding of the National Medical Association (NMA). This organization was established in 1895 because African-American physicians were not allowed to join the AMA until the 1960s. Included among the group's sections was a section dedicated to psychiatry and behavioral sciences, and indeed much of the literature on racism and African-American mental health has been published in the *Journal of the National Medical Association* [19]. In 1957, Dr. E.Y. Williams founded the Department of Psychiatry at Howard University College of Medicine, which included a biopsychosocial model of African-American mental health, addressing such issues as racism and discrimination [20]. Shortly afterward, Dr. Lloyd Elam founded the Department of Psychiatry at Meharry Medical College, which also addressed the impact of racism on mental health [21]. Both departments had faculty members who were actively involved in their local communities and offered services to the indigent at a time when many mental health services were absent in African-American communities [21].

The social and political unrest of the 1960s and 1970s generated further collaborative professional activism. The Black Psychiatrists of America association was founded in 1967 to address racial and ethnic issues that the more mainstream psychiatric organizations were not prioritizing, including the experiences of black physicians in the field of medicine and also the emotional and psychological development of African Americans in the USA. Dr. Chester Pierce served as the group's first president. The issue of racism in psychiatry was a key point of discussion at the 1969 annual meeting of the American Psychiatric Association (APA). Members including Drs. J.A. Cannon, James P. Comer, Chester Pierce, James Ralph, and Raymond Wilkerson led a protest insisting that the APA not only grant to its African-American members all rights and privileges of full membership but, most importantly, take immediate steps to improve the mental health care of African Americans in the USA. The APA responded positively by appointing African-American psychiatrists as observer consultants to its councils, boards, and task forces [22]. Moreover, the APA formed various committees, including a Committee on Black Psychiatry, a minority caucus, and an office of minority affairs. Two leaders of this office, Drs. Jeanne Spurlock and Annelle Primm, were both very effective in terms of advocacy for racial and ethnic minorities [15, 23].

The establishment of new organizations and creation of specific structures within organized psychiatry to address the role of black psychiatrists and the mental health needs of minority patients were direct outgrowths of physician advocacy. In parallel were other efforts to promote race equity in the field of psychiatry. For example, in 1970 a group of psychiatrists—Drs. Melvin Sabshin, Herman Diesenhaus, and Raymond Wilkerson—published an article in the *American Journal of Psychiatry* in an effort to advance the conversation on racism. This article, titled "Dimensions of Institutional Racism in Psychiatry" [24], was written specifically to white psychiatrists and mental health professionals. The authors noted that "When confronted with crises in black–white relations, most white psychiatrists tend to focus on the helping role that they can play in resolving these conflicts for *other* organizations rather than looking closely at the ways that psychiatry has perpetuated myths of black inferiority" [24]. Highlighting phenomena such as the lack of data about black Americans' mental health needs, the lack of mental health services for black Americans, and the racialized obsession with black psychopathology, Sabshin and colleagues argued for a more systemic focus on institutional racism within psychiatry—this is still very relevant to today's conversation regarding race and racism.

Other examples of advocacy include research and scholarship addressing racist commentary written about African-American patients, the subjects of race and mental illness in the criminal justice system, and research on the intersection of race, gender, and mental health. These efforts were led by psychiatrists such as Drs. Carl Bell, Ezra E. Griffith, and Phyllis Harrison Ross [25, 26]. Dr. James Carter's work on racism and its impact on mental health is an example of clinician research and scholarship as a tool for advocacy. His 1992 article titled "Racism's Impact on Mental Health" challenged mental health professionals to reassess their viewpoints on racism [23].

Dr. James P. Comer, one of the founders of the Black Psychiatrists of America, once remarked that "Psychiatrists working with individual patients are not going to make the big difference for the black community." Dr. Comer's sentiment is not unlike that of statements made by black civil rights activist Stokely Carmichael to a group of mental health professionals in 1968. Carmichael expressed that he focused not on the individual in society but, rather, on the institution and, in particular, institutional racism. He stated that institutional racism is "less overt, far more subtle, [and] less identifiable in terms of specific individuals committing the acts, but is no less destructive of human life" [27–29]. Comer and Carmichael's comments similarly draw attention to the differences between individual, institutional, and structural levels of racism. Even though numerous prominent physician leaders have made considerable contributions in addressing race and racism within psychiatry, and despite the call made by Sabshin and colleagues in 1970, there remains a significant need for more advocacy to address both structural and institutional racism. The work done by groups such as the Black Psychiatrists of America remains invaluable, but, in order to make more institutional change to address race, there is a need for more systemic advocacy.

## Framing Racism: Anthropology and Sociology in Conversation with Psychiatry

This chapter's framework for the development of antiracist advocacy strategies is shaped by anthropology, sociology, and psychiatry. Insights from anthropology and sociology provide guidelines for developing strategies that move beyond cultural competence to address the structural formation and reformation of racial bias in society in general and in medicine in particular.

The perspectives of medical anthropologists are particularly useful for shedding light on issues and concerns of health, illness, and healing, because of their examination of how the health of individuals, larger formations, and the environment are affected by "a range of interrelationships…including: cultural norms and social institutions; micro and macro politics; and forces of globalization" [30]. Alternatively, sociology seeks to identify the causes, consequences, and characteristics of the social world(s) in which we live. More specifically, medical sociologists focus on the social determinants of health (society's structural components) by exploring the relationship between the material conditions in which people are born, live, and die, and how these determinants intersect to influence health and wellbeing. When combined, these disciplines provide robust insight into the examination of society's problems as "public issues rather than simply personal troubles" [31]. Without contributions from social sciences, public issues such as race and racism, and the production and reproduction of health inequality, are not completely understood. Regrettably, until very recently, the medical profession relied only on an interdisciplinary model rather than on a multidisciplinary model of education.

In 2011, the Association of American Medical Colleges (AAMC) called for "rigorous training in social and behavioral sciences," noting that "a complete medical education must include, alongside the physical and biological sciences, the perspectives and findings that flow from the behavioral and social sciences" [32]. Until that time, the core of medical education had centered on histology, chemistry, and pathology, which represented the holy trinity of knowledge, and the physician–researcher represented the model practitioner [33]. Such a basic science curriculum left little, if any, room to address cultural and philosophical aspects of health and health care. While the 1910 Flexner Report was foundational for medical education, even Flexner noted in 1925 that "scientific medicine in America…is today sadly deficient in cultural and philosophic background" [34].

In 1948, a generation after Flexner's lament regarding the deficiencies of medical education, the World Health Organization offered a social and theoretical framework describing health as a "state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity" [35]. Today, researchers have begun to empirically recognize how the absence of cultural aspects and, in particular, psychosocial aspects of health and well-being [36], as well as the role of race and scientific racism [37], result in an incomplete understanding of, and response to, a patient's disease. This transgression raises a range of questions. Chief among them, for this inquiry, are the following: How does racism influence a patient's disease, as well as their experience of illness? Which disciplines can offer the robust framework of analysis necessary to unpack the impact of racism on the practice of medicine?

In answering this question, readers should turn to Jonathan Metzl and Helena Hansen for a new model of engagement when searching for methods to address racism in health and health care. Metzl and Hansen note that social scientists "add important conceptualizations of structure as a system that produces and reproduces the social world, and that is thus deeply linked to culture because it provides the system of values affixed to bodies and disease" [28]. The "structural" contribution of social scientists shifts the discussion of race and racism away from the individual, as the unit of analysis (i.e., the interaction between the clinician and the patient), toward the forces of society. The social forces of society—the customs and beliefs, recreated in institutions (e.g., hospitals and schools) and codified in law—interact to create and recreate a disparate distribution of power. More specifically, a structural approach recognizes "the economic and political conditions that produce health inequalities in the first place" [38].

The problems of race and racism as public issues must be addressed at the structural level of society. This analysis allows for examination and interpretation of the various patterns of social behavior within the world where we live. Moreover, this theoretical approach—which combines anthropology, sociology, and psychiatry—allows for examination of the multiple forms of racism and analysis of the production and reproduction of ideas and beliefs about people, including the inferiority or superiority of races, classes, and genders [39]. Armed with this understanding, an antiracist framework can provide a lens to address the structural impediments contributing to disease, illness, health and health care.

## Race and Racism

In order to identify strategies for addressing racism, the authors believe that it is important to define race and racism. Race is not viewed as a biological construct. Instead, the authors rely on Michael Omi's and Howard Winant's definition of race, which they frame as "a concept that signifies and symbolizes social conflicts and interests by referring to different types of human bodies" [40, 41]. With this definition, they emphasize the social construction of race but also highlight how the phenotypic continues to matter [41]. Dr. Camara Jones, in her well-known essay "The Gardner's Tale," identifies three levels of racism: personally mediated, internalized, and institutional [42]. Personally mediated racism is defined as "prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race" [42]. This can be intentional or unintentional. Jones argues that this is what most people think of when they hear the word "racism." Jones defines internalized racism as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth" [42]. The third level of racism that Jones addresses is institutional racism, which is defined as "differential access to the goods, services, and opportunities of society by race" [42]. Jones notes that institutional racism is structural, hence the frequent use of these terms interchangeably. By use of the term "structural," Jones asserts that institutional racism has been "codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.…Institutionalized racism manifests itself both in material conditions [i.e., in education and health care] and in access to power [i.e., in differential access to information]" [42].

Jones uses her essay to illustrate these levels of racism and ultimately asserts that systems-level change requires institutional racism to be addressed [42]. Critical race theorists Joe Feagin and Zinobia Bennefield similarly argue that medical education needs more instruction regarding systemic and structural racism at the macro level. Writing about structural racism and the US health care system, they note that "Part of the work that needs to be done is to also shift the perception about racism, so that yes, healthcare providers are addressing personally mediated racism and forms of discrimination, but [also] that there is more emphasis on strategies to address structural and institutional racism" [29]. Within the field of psychiatry, there is a significant need for more advocacy to address the multiple levels of racism. As was illustrated in the US Surgeon General's supplemental report on mental health, racial and ethnic minorities have less access to mental health services than white Americans and are less likely to receive needed care [17]. In a study of ethnic and racial health care disparities, McGuire and colleagues found that the values of overall spending on outpatient mental health care for African-American and Latinx populations are about 60% and 75%, respectively, of the amount spent on care for whites, after the need for care is taken into account [43]. Research has also shown that African Americans are less likely to receive evidence-based psychotherapy and lack exposure to effective treatment, which clearly reduce the likelihood of recovery and increase the illness burden [44–46]. In comparison with white Americans, African Americans are less likely to receive specialty mental health services, even when potential confounders such as socioeconomic status, educational attainment, and gender are controlled for [47]. Additionally, African Americans with serious mental illnesses are far more likely than whites to be involuntarily hospitalized, to use crisis intervention services, or to be brought to the emergency room by law enforcement [48–50].

Advocacy is a key tool for addressing racism and the ways in which racism affects health care delivery and health outcomes for racial and ethnic minorities. In the following sections, the authors provide strategies for advocacy against racism in four areas:

1. Explicit antiracism training
2. Changes in medical education curricula
3. Social justice advocacy
4. Research advocacy

## Strategy One: Explicit Antiracism Training and Dialogue

While there is significant advocacy in the mental health field regarding stigma and prejudice against people with mental disorders [6], the majority of these programs do not center race and racism in the conversation. Advocacy in response to power imbalances that occur at the interpersonal, community, or organizational levels is essential to developing the moral character and ethical action required to undo the choke hold of racism. There is a need for an antiracism framework to understand how institutions and legislation reproduce society's prejudicial attitudes and beliefs regarding ethnic and racial minorities, resulting in differential treatment of minorities and differential access to, and distribution of, resources. As advocated by Stergiopoulos and colleagues, such program content must focus on "transforming these unequal social relations and restoring power imbalances" [51]. The training must be thoughtful and deliberate, with institutional support and well-defined measures that *all* participants must meet at some level [1].

In an article on race and racism in medical education, David Acosta and Kupiri Ackerman-Barger maintain that medical school faculties do not necessarily possess the tools to implement racial discussions and dialogues, and that the first step in addressing racism must begin with faculty training [52]. Like Earnest and colleagues, Acosta and Ackerman-Barger note that faculty development should be "intentional and it must stimulate deep introspection, a willingness to be honest, and a commitment to change" [52]. They also argue that this faculty training should extend beyond the more traditional and "safer" approach of completing online modules or simply reading books and journal articles on race and racism [52]. They suggest that academic health centers should implement approaches from other fields that can foster the needed dialogue and training to address resistances and obstacles that health care providers may encounter when talking about race and racism.

Developing the knowledge, skills, and abilities to reflect on and understand the inextricable relationship between race and racism in the USA begins with study. Resources such as the People's Institute for Survival and Beyond, RacismReview, and Project Implicit are excellent training resources. The People's Institute for Survival and Beyond facilitates workshops on undoing racism. Established in 1980, the institute offers workshops and consultations around the country to assist "individuals, communities, organizations and institutions [to] move beyond addressing the symptoms of racism to undoing the causes of racism so as to create a more just and equitable society" [53].

RacismReview provides scholarly content and strategies proposed by scholars and researchers from the USA, Canada, Europe, and elsewhere. The website is "intended to provide a credible and reliable source of information for…members of the general public who are seeking solid evidence-based research and analysis of 'race,' racism, ethnicity and immigration issues" [54]. In continuous operation since 2007, this website provides a range of resources, including a bibliography and documentary sources.

Lastly, Project Implicit provides an interesting approach to race by educating the public about "hidden bias." The Implicit Association Test (IAT) measures "attitudes and beliefs" about race, gender, and other topics. When visiting the website, participants can choose the Race IAT, which "requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black" [55]. While this resource is not as explicitly antiracist and focuses on biases beyond race, the project provides insight into bias and assessment of it, allowing groups to further explore how race and racial preferences are socially constructed.

Incorporating an antiracism lens into the field of psychiatry represents an important step toward undoing racism. This helps clinicians and providers to be more mindful of how racism is experienced and how it can contribute to unequal outcomes. Engaging clinicians and providers in recognizing and responding to unequal treatment helps sharpen their recognition, analysis, and response to social injustice. As noted earlier, HBCUs train the majority of African-American physicians and have long histories of addressing issues of racism and poverty in their medical school curricula. The curricula of some of these institutions may serve as models for incorporating antiracism pedagogy. Partnerships between HBCUs and predominantly white institutions (PWIs) have been found to be productive for encouraging advocacy [56].

## Strategy Two: Clinician Advocacy and Social Justice

The authors believe there is a great need for more social justice clinician advocacy within medicine and, specifically, in psychiatry. One place to begin is with existing entities such as the advocacy and policy groups of the APA. These groups can explicitly discuss the impacts of structural racism on vulnerable populations in the USA as a form of advocacy. Especially when one considers broader issues of poverty, the criminal justice system, educational disparities, and their impact on mental health, there is a need for psychiatrist advocacy.

Other opportunities for physician and physician trainee social justice advocacy include organizations such as WhiteCoats4BlackLives, the medical student–run organization born out of the National White Coat Die-In demonstrations, which took place in December 2014 [57]. The mission of the organization is to "eliminate racial bias in the practice of medicine and recognize racism as a threat to the health and well-being of people of color" [57]. The group prioritizes such goals as raising the awareness of racism as a public health concern and advocating for funding and promotion of research on the health effects of racism. The group also encourages physicians and physician organizations to publicly recognize racism as a public health issue. As a student-led group, WhiteCoats4BlackLives also emphasizes the need to prepare future physicians to be advocates for racial justice.

In an article titled "Remembering Freddie Gray: Medical Education for Social Justice," Wear and colleagues argue for the incorporation of social justice in medical curriculum and training. Achieving this, they maintain, begins with "the willingness of educators to examine uncomfortable realities that are exceedingly difficult to confront…the messy landscapes that are America's legacy of racism, brutality, violence, poverty, hopelessness, and despair" [58]. While their work focuses on medical education, we believe that physician organizations can adopt many of the suggestions for deeper social justice engagement. These physician organizations can implement a small group model, whereby physicians receive the opportunity to engage in critical reflection on issues of power, privilege, and oppression. This type of social justice framework allows physicians the chance to reflect and strategize about advocacy and social justice platforms on both community and national levels.

## Strategy Three: Changes in Medical Curricula

Medical education in the USA needs to address the impact of race and racism, particularly the history of racism in medicine and racial bias in decision making [25, 57]. In particular, there is a need to discuss the history of medical racism in the field of psychiatry, as mentioned in this chapter's introduction, as well as the ways in which racist folklore continues to linger in the field. An example comes from a 1921 article about black Americans from the *American Journal of Psychiatry*, which stated:

> The alien ancestors of most of the families of this race were savages or cannibals in the jungles of Central Africa. From this very primitive level they were unwillingly brought to these shores and into an environment of higher civilization for which the biological development of the race had not made adequate preparation [59].

Many white psychiatrists expressed similar sentiments during the earlier decades of the twentieth century [25]. As medical historian John Hoberman notes, included in this literature are numerous confessions by these doctors that they "simply do not understand their black patients" [25]. This type of history should not be silenced in medical education, as the history of physician racism and racial folklore shape health care delivery. While today this type of racialized thinking is less pervasive among physicians, there is a need for more education and awareness about deeply embedded racial folklore and bias in the field of psychiatry and more broadly in medicine. One strategic way to address this gap in education is through curricular changes. Medical curriculum standards need to place less emphasis on the celebration of diverse cultures and more on education that involves critical analysis and reflection on power, marginalization, oppression, and disparities [29, 58].

Rather than solely focusing on the subject of cultural competence, medical curricula need to include the concept of structural competence [28] at both the undergraduate and graduate medical levels. Structural competence is defined as:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g. depression, hypertension, "non-compliance," trauma) also represent the

> downstream implication of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, [and] medicalization, or even about the very definitions of illness and health [28].

Cultural competence allows physicians and trainees to better hear and examine the "cross-cultural" aspect of patient stories, which enhances clinical dialogue but does very little to address the relationship between clinical symptoms and sociopolitical and economic systems [28]. Physicians need to listen to both individual stories and structured stories.

Curricula and pedagogy that focus on advocacy need to be dynamic and engaging. Subject areas such as health advocacy, the social determinants of health, structural competence, and ethics must provide learners with the opportunity to move from knowledge to practice [2]. Dharamsi and colleagues suggest that trainees need to be part of a community of practice that works closely with other providers within the health care system. This in turn creates the opportunity for more expansive service learning and interprofessional collaboration and advocacy. Because of recent amendments in accreditation standards for service learning, there is an opportunity for academic medical centers to develop more innovative approaches to education about physician advocacy.

Medical ethics plays a key role in medical education and can serve as a source of authority for undoing racism. The source of professional conduct of physicians does not arise from some abstract notion of good or bad. Rather, the assessment of professional conduct arises from an understanding of, adherence to, and action in upholding the AMA Principles of Medical Ethics [60]. Principle III states that "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." Because of the historical legacy of slavery and its enduring structural and institutional racism, the need to recognize and respond to the legal structure is key. Whether it is done by confronting policies, practices, rules, or laws that maintain inequity, antiracist work is an ethical obligation to not only speak truth to power but also fight in turn for the elimination of racism. Thus, undoing racism not only represents an obligation not to harm patients but also demands that we address how the actions of the social system in which we live are harmful.

Lifelong learning remains a fundamental guideline for the medical professional, reflected in the AMA Principles of Medical Ethics. Specifically, principle V states that "A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated." Developing an antiracist framework requires consulting with or making referrals not only to those outside one's scope of practice but also to those outside the traditional network. Clinicians are obligated to promote good outcomes for their patients and collaborate with other experts to develop and implement an antiracist framework that serves to uphold the ethical obligation to promote good outcomes by constantly engaging in sharpening their skills, knowledge, and abilities in addressing racism and its impact on patients' well-being.

## Strategy Four: Research Advocacy in Psychiatry

Research advocacy within the field of psychiatry includes the need to address racial and ethnic representation in research studies and clinical trials. Data have shown that racial and ethnic minorities are often not included in psychological, biological marker, or treatment studies [17, 61]. Some investigators claim that such study participants cannot be found, often because of a lack of knowledge, lack of relevant social contacts, or lack of awareness of how to reach out to people of color [15, 62]. Moreover, the history of mistreatment, including the Tuskegee syphilis study, does not encourage research participation by such groups [62, 63]. Yet, research indicates that African Americans will participate as often as other groups when given the opportunity, despite fears that research may be harmful [62, 64]. The Surgeon General's supplemental report on mental health reviewed racial and ethnic minority participation in clinical trials and noted that the numbers of such trial participants were very small in comparison with white Americans [17]. There is a need for increased population diversity in clinical trials. Increased research advocacy can lead to greater participation and also to improved knowledge about research, so that underrepresented groups can be partners in developing relevant research strategies. Strategies for clinical trial recruitment and retention include clear communication about the research, open dialogue about direct benefits for participants, and development of community advisory boards to help guide clinical research trials [64]. Programs could also include explicit discussion with racial and ethnic minorities about the history of medical experimentation in the USA—a practice that both addresses racism and empowers research participants in the process.

An additional area of advocacy includes research on racial bias in diagnosis. In a recent study, researchers found that African Americans with affective psychosis were overdiagnosed with schizophrenia despite the use of experts as multistage reviewers of patient interview transcripts [65]. Clearly, there is a need for additional research in this area. An important factor is the absence of people of African descent in field trials of diagnostic instruments. The field trials for the DSM-5 paid special attention to racial and ethnic representation, but there is a need for more research to study the potentially unique ways in which African Americans and other racial and ethnic minorities express their idioms of distress.

A final area for research advocacy lies at the intersection of mental health and the criminal justice system. US jails and prisons hold a disproportionate number of individuals who have substance use and mental health issues [66]. In addition, racial and ethnic minorities—in particular, African Americans—are overrepresented in the criminal justice system [66, 67]. Further evidence has shown racial disparities in mental health treatment among incarcerated populations. Persons of color are less likely than white inmates to receive treatment [66, 68]. These intersections of race, mental health, and criminal justice provide additional avenues for research advocacy to address structural racism. This type of research advocacy could focus on police encounters, access to care, research on mental health services for populations in the criminal justice system, and mental health treatment for formerly incarcerated individuals.

## Conclusion

This chapter has introduced and defined the concept of clinician or physician advocacy, and has provided definitions of racism. The authors have shed light on historical accounts of physician advocacy to address racism within the field of psychiatry, and have shown why there is still a need for this type of advocacy in the present day. Antiracist strategies in four different areas are offered: training, social justice, curricula and education, and research. Clinician advocacy, particularly to address racism, is a necessary component of academic medicine and should play an active role in health care delivery. There is an urgent need for more advocacy in the US medical profession—advocacy that explicitly addresses multiple levels of racism. As Sabshin and colleagues noted nearly 50 years ago, "The only means to counter institutional racism is to create new and powerful antiracism mechanisms that will operate continuously and publicly throughout the country in all aspects of the psychiatric care system" [24].

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# Clinical Toolkit: Providing Psychotherapy in a Contemporary Social Context

# 13

Kali D. Cyrus and Asale A. Hubbard

## Introduction

Psychotherapy, more than any other intervention for psychological issues, is recognized as a cornerstone of treatment. Yet the demand far outstrips the supply, and access is often inadequate to meet the needs of populations. In particular, the underserved are disproportionately affected, and providers' experiences in serving diverse populations are limited. One can then imagine the downstream consequences as the population of the USA continues to diversify: how will mental health professionals gain the expertise needed to recognize biases so they are able to provide better care for these individuals? More importantly, how will underrepresented minority groups gain access to mental health professionals who are competent to provide identity-specific psychotherapy in a contemporary social context? Unfortunately, the latter question is beyond the scope of this chapter, but what follows is an attempt to address knowledge gaps for providers eager to enhance their skills for working with patients from minority backgrounds. The chapter describes how the current sociopolitical context leads to emotional oppression, disproportionate resource allocation, and a reliance on racial minorities to articulate this suffering to their mental health providers, who often represent the race in power. The chapter also outlines how mental health providers—whether they are racial minorities or not—can share the emotional labor by changing attitudes, gaining knowledge, and learning skills to use as a means of redistributing power.

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**Clinical Consideration: Introduction to the Patient, Stan**
Stan is an African-American male in his mid-20s, who has lived in a large urban city in the Midwest for most of his life. He grew up in a predominantly black neighborhood with two working-class parents (his father was a policeman and his mother was a teacher). After high school, he completed college, received his MBA, and now works as a consultant in a top firm. He is one of three African Americans in a firm of 200 employees. Since the presidential election of 2016, he has felt increasingly isolated from his colleagues at work. He has perceived a negative undertone in some comments from his boss and coworkers related to race, resulting in uncertainty, mistrust, and difficulty confiding in colleagues. At the suggestion of a close friend, he decided to see a therapist. Realizing he would not be comfortable discussing these issues with a white therapist, he hoped to find a black provider. However, there were none with availability, so he has his first appointment with an older white male therapist today.

## How the Broader Sociopolitical Context Impacts Patients' Experiences of Accessing the Mental Health Care System

The literature is rife with evidence of the sociopolitical factors leading to the underutilization of mental health services by racial and ethnic minorities [1–4]. The reasons for these disparities in mental health care stem from a broad spectrum of causes ranging from individual to chronic, systemic barriers. Research has shown that when racial and ethnic minorities seek mental health treatment, they are more likely than their white counterparts to terminate treatment early [5–7], to be seen by a primary care provider or in the emergency room [7], and to receive a lower quality of care than whites [7]. Racial and ethnic minorities also report receiving poorer care, such as decreased access to a usual source of care, problems seeing a specialist, and delays in care while waiting for approval [8]. Impressions of poorer care have also been correlated with decreased satisfaction with clinical interactions, such as perceived discrimination from providers [8]. Additionally, minority patients have been found to have beliefs that they would receive better care if they were of a different racial/ethnic background [8]. For Asian and Latino populations, language barriers have been found to be an important factor in reducing the use of mental health care [9]. Betancourt et al. [10] identified additional barriers such as limited clinical hours, long wait times, lack of interpreters, and difficulties accessing specialty care. Specific structural barriers such as lack of time, unreliable transportation, lack of adequate childcare, low insurance coverage, and high costs have also been implicated in contributing to mental health disparities [11, 12].

To appropriately consider the sociopolitical context of a patient, the complex link between socioeconomic status (SES) and race must be taken into consideration. Generally, SES comprises a set of economic and social factors within society, which are also influenced by race. Therefore, when one is treating a patient from a racial minority group, it is important to consider how the income, educational attainment, and health of that population are affected by inaccessible privileges that have been offered to white patients. For example, in thinking through the barriers to treatment of a black patient in the USA, the impact that slavery and the consequences of continued institutional oppression have on black people is important to consider, as are the ways in which socioeconomic factors impact the patient's individual life as a black person [13, 14]. After familiarizing themselves with this contextual knowledge, mental health professionals must also serve as advocates to help their patients overcome systemic obstacles and provide effective care. For example, the barriers for a patient to attend an appointment at 2 p.m. will depend on their occupation, access to transportation, and other factors such as the cost of treatment. They must be both in a financial position to miss income-producing activities on that particular day and still able to meet their personal and professional obligations. They must have functional and ideally safe transportation, including the means to legally register, maintain, fuel, and park their vehicle, or a reliable public transportation system with services to and from their residential location to the clinical office. Utilizing public transportation is time consuming, and in many municipalities it is inadequate to bridge the inherent limitations of lacking reliable access to a vehicle. The cost of simply accessing mental health care goes well beyond an ability to afford costly and limited insurance or public health options. Statistically, racial and ethnic minority populations tend to have fewer economic resources, which present challenges to accessing care because of institutional factors that are rarely recognized or addressed by the current system [7–14].

**Clinical Consideration: Anticipating the Needs of Stan and Racial Minority Patients**

With the above considerations in mind, there are a multitude of factors that may impact the therapeutic dyad. For a therapist striving to build a racially sensitive therapeutic relationship with Stan, it is important to provide psychoeducation about mental health treatment, as this may be his first time engaging with a mental health provider. Prior to the first meeting, providers may conduct phone consultations to assess the fit, and this serves as an important opportunity to demonstrate awareness and sensitivity to cultural factors that may impact care. Psychoeducation may include information about the background (identity statuses), training, education, experience, and role of the provider in therapy. The therapist should describe what to expect in therapy (from what occurs during each session to the typical course of symptom reduction). Additionally, the therapist should discuss with Stan his coping skills and what type of support he is looking for in therapy. The discussion should cover potential structural or systemic barriers that would prevent Stan from engaging in treatment. Transparent conversations about fees, insurance, transportation (ability to park or take public transit), communication (by e-mail, secure messaging, or phone), and the number of sessions will offer Stan the opportunity to decide if both the therapist and the mental health treatment plan could be a fit for his needs.

In addition to systemic barriers, the ever-changing dynamic created by the personal attitudes and beliefs of both patients and providers should be considered. More specifically, the therapist is accountable for ongoing self-examination of attitudes and beliefs that may be counterproductive to establishing a racially sensitive climate for the patient. The influence of implicit bias among mental health providers has been shown to exert a significant role in maintaining racism-influenced disparities [15–17]. From the patient's perspective, stigma and negative internalized beliefs within racial and ethnic minority communities cannot be underestimated as factors that prevent patients from taking the initiative to seek care [15–17]. Racial and ethnic minorities may also hold beliefs about how to address and acknowledge mental health concerns, based on their cultural background (e.g., going to church, religious healers, spiritual practices, wisdom from elders, etc.), that do not include engagement with the health care system [15]. Therefore, for mental health providers to be prepared to effectively treat a diverse array of patients from racial backgrounds, it is imperative that they commit to ongoing self-exploration and education of their relationship to the racial "other."

**Clinical Consideration: The White Therapist and Stan**

Throughout the therapeutic relationship, the therapist should collaborate with Stan and support his agency by eliciting feedback about his experience in therapy. As with other patients, it is necessary for the therapist to remain mindful of the interaction between Stan's psychosocial environment and his presenting concerns. As noted above, given the different cultural perceptions regarding seeking mental health care, the therapist should investigate the extent to which stigma, or negative internalized beliefs, influence Stan's presentation and could impact the therapeutic dyad. The therapist should also assess any reactions he/she has to Stan from the context of his/her own identity, which in this case happens to be an older, white, male therapist. As a white provider (or a provider of a different racial and ethnic background from Stan's) it is important to be aware of and acknowledge any implicit biases specifically about Stan or in working with a black patient. It is also important for the provider to anticipate possible reactions Stan may have during the interaction as a result of racial discordance. Given Stan's initial concerns about dealing with racially charged comments from white coworkers, the therapist should be prepared for Stan to have some level of resistance to trusting a white provider. The therapist could initiate a conversation about identity statuses by asking Stan about his current experience of working with him as an older white man. This is a moment of vulnerability for the therapist but communicates to Stan that the therapist is aware of inherent power differentials and cultural differences. Pre-emptively, bringing these identity statuses into the room (age, gender, race/ethnicity) also shows Stan that therapy is a place where you can and should discuss the impact of race. Given Stan's upbringing and current presenting concerns, one may hypothesize that Stan will want to engage in conversation about his experiences related to being black. He may test or examine social cues from his provider to assess whether or not it is safe to discuss race and if the therapist is open to hearing his experience.

Disparities in diagnosis are also of great concern, as psychiatrists and other mental health professionals have been found to overdiagnose minority patients with psychotic disorders [4, 18], fail to identify and diagnose minority patients with affective disorders [4, 19], or fail to provide racial and ethnic minority patients with the same quality of care as their white peers [4, 12]. Despite an increased emphasis on cultural competence, training programs in psychiatry, psychology, and social work have failed to reduce racial and ethnic disparities in mental health care [10]. It is imperative that mental health providers not only acknowledge the disparities in mental health care that are prevalent in racial and ethnic communities but also actively strive to recognize these deficiencies, internally and systemically. This is critical to improving access to high-quality, equitable care for minority populations.

Implementation of empirically proven tools such as the Cultural Formulation Interview (CFI), a patient-centered assessment in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), may improve providers' awareness of cultural factors that influence mental health diagnosis and treatment [20]. The CFI [20] consists of 16 questions that allow the provider to gain an understanding of cultural variables that frame how the patient views their clinical experience, such as learned coping strategies, barriers to treatment, and preferences in working with the provider. The CFI provides a platform to open a genuine dialogue about the patient's experience while minimizing reliance on assumptions [20]. The questions framed in the CFI help providers elicit pertinent information leading to recommendations that are relevant to the specific cultural context of the patient.

Another helpful tool for unbiased provider and patient communication is the ADDRESSING framework [21]. This framework allows for exploration of the patient's feelings about group membership and which individual identities may be particularly salient to their presenting concerns in psychotherapy. The framework includes strategies for discussing multiple identities that may intersect, such as age, disability status, socioeconomic status, religion/spirituality, race/ethnicity, nationality, gender identity, and sexual orientation.

**Clinical Consideration: Stan, Months After Starting Therapy**

Months later, Stan is feeling more isolated at his job because of comments made by his colleagues and boss about an increase in gang violence among black people. Stan's mistrust in his work environment is likely to enter the therapeutic relationship. As the extent of his perceived isolation at work intensifies, he may worry that his white therapist thinks he is being "too sensitive" or that he is "misinterpreting his experiences." He is already questioning whether the events at work are as harmful as he sees them, because while he feels uncomfortable, no one else in the office seems to notice. Therefore, the more socially isolated Stan feels, and the more he discusses his fears in therapy, it becomes more likely that he will question his reality. It is imperative for a therapist, who may already be perceived as "different" from the patient worried about racism, to provide validation and empathic understanding. Stan needs to know that the therapist understands how real the threat of racism can be, while reassuring him that his feelings are valid. This will provide the underlying conditions to facilitate a corrective emotional experience about an issue that is incredibly sensitive. Using the CFI [20], along with clinical judgment, the therapist begins to understand how Stan views his current level of support, salient identity statuses (male and black), and coping style. Information collected by using the CFI, along with Stan's presenting symptoms, can be used to formulate a biopsychosocial–spiritual understanding of Stan's current functioning and diagnostic picture.

Additionally, the therapist's use of the ADDRESSING framework [21] bridges the discussion about the different identities Stan holds and how they manifest and/or intersect in different contexts. For instance, Stan grew up in a predominately black neighborhood and now works in a predominately white environment. The therapist can discuss what function Stan's black identity serves in each of these environments. Stan may report that he is more aware of being black in the context where he is only one of a few African Americans. He may also explore how his relationship with the white men he works with are very different from those with his black childhood friends. This would also be a good time for the therapist to inquire about how Stan's relationship with him, a white male, compares with his relationships with his white coworkers and black childhood friends. For a therapist of a different race, starting and participating in these conversations convey an openness that others of a different race in Stan's life may not display. While this fosters trust, the therapist must be careful not to place the burden on Stan of being his educator on the black experience. Seeking consultation with other mental health providers, as well as reviewing relevant literature, may help the therapist strive toward cultural competence [10]. For example, it may be necessary to consult books, journals, lectures, or blogs on the arts and humanities such as sociology, history, and religious studies. Stan is likely to appreciate such efforts in therapy, which will undoubtedly strengthen the therapeutic alliance.

Even when providers wish to explore the impact of race, culture, and identity with their patients, they may be reluctant to initiate these conversations because of the uncertainty of how to engage in a culturally sensitive manner that does not offend patients. Yet, consider the far-reaching ramifications of failure to explore these factors: recovery is what is ultimately at stake. It is imperative that providers utilize tools and evidence-based approaches that fit their practice style. The ability to tailor care, which addresses the unique issues among racial and ethnic minorities, is no longer a specialized skill; it is *necessary* to provide competent care. Mental health professionals must push to transcend the challenges presented in the contemporary social context. This is necessary to reduce disparities in care and ensure that treatment reflects the needs of the modern era—an era in which embracing diversity is a strength, not an inconvenience in performing the obligations of employment.

In fact, exploration of each patient's unique worldview results in twofold benefits to the therapist: it provides increased data to support interpretations, and it conveys interest in the patient. On a small scale, these behaviors will likely help to strengthen the therapeutic alliance. However, on a large scale, these behaviors lead to an enhanced understanding of how human complexity may manifest. By achieving greater awareness of how minority "labels" play out in a variety of ways, a more nuanced and intersectional understanding of identity results. Instead of achieving this enlightenment within the patient encounter, the therapist stands to benefit from an increased awareness of how these labels are applied outside the office and within the larger society. Therefore, a routine train ride could reveal knowledge about the "other" that was previously invisible. For example, a lone racial minority person on the same train car that the therapist has failed to notice every morning may elicit thoughts the next morning about why that person is the only racial minority person on the train car. Impediments in a society structured around the norms of the white majority may become more visible. It is imperative that mental health providers recognize their own context and how that context differs from their patients' contexts, and that they are dedicated to observing the invisible dynamics that influence the surrounding context during the patient-to-provider interaction.

**Clinical Consideration: Talking About Race and Racism in Therapy**
Many therapists may shy away from discussing race, out of fear of what may happen when they do so. However, avoiding talking about race with Stan, or simply focusing on symptoms without acknowledging the context in which those symptoms occur, would be a disservice to Stan. In fact, avoiding the topic of racism would be therapeutically insensitive and could result in an early termination of therapy. Being vulnerable, acknowledging biases, and showing empathy will aid in formulating a more accurate, context-specific diagnostic impression. The therapist's effort to truly understand Stan's worldview and put himself in Stan's shoes lays the groundwork for creating a corrective emotional experience.

## Addressing Racial Identity and Self-Concept in Treatment

The prior discussion outlines the extent to which mental health disparities in access, treatment, and outcomes for racial minorities permeate the sociopolitical context. In order for psychotherapy to be effective for people of color, the therapist must acknowledge the nuanced and obvious impact of the broader context in individualized treatment settings. It is essential that psychotherapists recognize how racial identity and self-concept contribute to patients' psychological frameworks, and to their own lives. More importantly, providers must be dedicated to using their understanding of racial identity and self-concept in supporting patients' resilience in the face of ongoing racial oppression and racism-related traumatic experiences.

A strategic starting point for the therapist is to consider how societal systems of oppression fit into their preferred approach to psychotherapy with individuals from minority backgrounds. The therapist's history of training in psychodynamic, behavioral, cognitive, and/or humanistic approaches will influence how patients' concerns are heard, how patients' mental health symptoms are conceptualized, and how best to collaborate in developing solutions [22]. Concepts from these theories will be discussed, but the psychodynamic and psychoanalytic approaches, which focus on the importance of unconscious motivations in understanding internal conflict, will serve as the foundation of this discussion on the ideas of racial identity, self-concept, and possible interventions [22].

## Defining Self-Concept and Identity

The words "identity" and "self" are often used interchangeably. Although related, these words have different implications. The concept of identity refers to an individual's belief about him or herself, while self-concept refers to an individual's ideas about him or herself that are shared by others [23]. Additionally, descriptions of self-concept are associated with the emotions evoked by this self-perception, whereas identity refers to the cognitive impressions of the self [24]. For example, a woman with a black mother and white father may have a self-concept of herself as "sensitive, outgoing, and perceptive," while her identity is that of a biracial, female millennial.

Examining how an individual's identity or self-concept develops is a prerequisite to thinking about how racial identity or racial self-concept manifests in the therapeutic setting. There are multiple theories outlining the development of identity; however, Erik Erikson's psychosocial theory is the most relevant to this discussion. Per Erikson, individuals face various conflicts that should be resolved as they progress through life. The fifth stage—identity versus role confusion—occurs as the adolescent (ages ~12–18 years) attempts to secure an identity, mainly in relational and occupational terms, that fits within society and will be consolidated throughout life [25]. Failure to establish this identity results in role confusion, whereby the adolescent is unsure about his role in society, leading to internal conflict [25].

On the other hand, researchers are not exactly clear on how self-concept develops, but most agree that it begins within the first year of life [24]. Self-concept is built upon the perceptions that individuals generate about themselves over time on the basis of personal experiences. According to the psychologist Carl Rogers, self-concept is based on three components: self-image (how you see yourself), self-ideal (how you wish you could be), and self-esteem (how much you value yourself) [26]. While early work by Erikson and that of others such as Rogers provide an initial understanding of identity and self-concept, early theories may not appropriately capture how major physical (or mental) characteristics disproportionately drive the formation of identity. The following sections will outline the potential impact that having dark, or black skin tones could have on the formation of black identity during various historical contexts.

**Clinical Consideration: Addressing Stan's Self-Concept**

Often the application of Erikson's and Rogers's theories to "race" is not explicitly discussed in training programs, which was the case for Stan's therapist. However, using these theories as a framework, the therapist may begin to wonder about Stan's adolescent experiences living in an urban area that was predominantly black, but attending high school in a predominantly white, suburban part of town. Undoubtedly, Stan grew up with friends in both settings, but one wonders about his self-esteem or confidence about himself when interacting with other adolescents in his community or when at his classmates' homes in the wealthy suburbs. Was he attracted to individuals in his neighborhood or church, who were mostly black, or to individuals in his class, who were mostly white? Does he consider himself handsome in the milieu of his school or capable enough to date someone from his neighborhood, even though he may have been considered an outsider because he did not go to the local school (self-image)? Did he compare himself with his male peers, wishing to be more like his black neighborhood friends or his white classmates?

## Self-Concept and Identity in a Racial Context

Given these approaches to identity and self-concept, one can intuitively imagine the impact that being a racial "other" can have on securing an identity within society or solidifying one's image, ideal self, or value in the world. While these concepts begin forming in childhood, they are continuously transformed throughout adulthood as the complexity of personal experiences intensifies on the basis of the historical context of racial and ethnic groups within society. To capture the transformations that a racialized "other" may experience into adulthood, various theories have emerged that do not exclude the developmental theories discussed above, but supplement how self-concept or identity can be morphed by major historical events. Additionally, it is important to consider examples of key historical traumas that span a variety of marginalized groups. Examples include the normalized harsh treatment of the Japanese in internment camps during World War II, the post-9/11 period when profiling of Arab travelers increased, or the current initiative to build literal and metaphorical walls to ban Mexican immigrants. While some form of racial trauma is consistent across minority groups, this section focuses on the development of black identity and self-concept within the USA.

A prerequisite to the conversation about black identity and self-concept is first a discussion of the seminal work of Clark and Clark in the 1940s. Their work showed that African-American children between the ages of 3 and 7 years were more likely to attribute positive characteristics (i.e., niceness) to a white doll than to a black doll, as an illustration of internalized racism. Their findings contributed to the US Supreme Court's ruling in the landmark case of *Brown v. Board of Education*, ruling that racial segregation of the public school system was unconstitutional.

For decades, the interpretation of Clark and Clark's results suggested that black children have a poor sense of self-concept and show a preference for Eurocentric values [27]. However, later work debunked this idea, positing that increased racial awareness was linked to a preference for majority-based racial attitudes, as in a "white bias" [28]. Studies showed that children who were more racially aware but also more well adjusted—or better able to differentiate themselves from others with less egocentrism—had a positive self-concept while endorsing the preferential racial attitudes [28]. These findings suggest that although the black children preferred the white doll when asked, it was not necessarily an indication of poor self-concept but, rather, possibly increased awareness that "white" characteristics were widely accepted as better. Racial awareness was found to be associated with the child's knowledge of racial stereotypes; thus, early messages about race may be instrumental in the formation of a patient's burgeoning racial identity [28]. However, additional findings suggest that these perceptions may be malleable by social forces such as education about black culture and buffering of negative stereotypes by black parents and the community [28]. Therefore, it is imperative to investigate the sociopolitical history that is pervasive during the childhood context of patients. Knowledge of these historical dynamics is key to understanding the downstream effects of how racial identity may manifest in the present moment.

The somewhat contradictory conclusions offered by Clark and Clark, and later research about black identity and what constitutes a positive black self-concept, can be elucidated by later work on identity development. Although minimal, Erikson's thoughts in 1968 on identity for blacks were largely based on an exploration of work by "Negro" writers. Erikson's work suggests "an absence of identity, or at any rate, the almost total prevalence of negative identity elements" [25].

However, it was not until the development of the Thomas and Cross models of Psychological Nigrescence in 1970 and 1971, respectively, that an in-depth examination of black identity formation occurred [27]. While these models are not generalizable to every black person, the process of undergoing nigrescence, or becoming black, is a seminal moment for every black person at some point in life. Thomas's model begins when the individual has already started to change their black identity: transitioning from seeking cues for identity formation from whites, anger toward self and then coping with anxiety about blackness, finding a connection to a larger black community, and solidifying their unique blackness [27]. The Cross model describes the transition from an old identity of blackness that is altered after a seminal racist encounter. Per Cross's model, the intensity of the racist encounter leads to a complete immersion in blackness, followed by an exit from psychological defensiveness, and culminates in a resolution of conflict where anti-white feelings decline [27].

It is worth mentioning that other theories of ethnic or racial identity formation have emerged from Thomas's and Cross's work on black identity. Most notable is Phinney's three-stage model of Ethnic Identity Formation, which has led to the development of models such as the Asian American Identity Model proposed by Kim [29, 30]. According to Phinney, stage one describes an unexamined ethnic identity, when a child has not given much thought to his/her ethnic identity or it is derived from others [29]. After a period of socialization, where the individual consolidates messages about their ethnicity from the environment, stage two begins, which is an ethnic identity search. As in Cross's model, stage two is often initiated by a significant experience that highlights the ethnicity in question, such as an experience of discrimination [29]. The third stage is that of ethnic identity achievement, when a stable, internalized ethnic identity, realistically set in the larger context, is achieved [29].

**Clinical Consideration: Putting Stan's Identity in Context**

Using the theories of psychological nigrescence, Stan's therapist may want to explore how Stan has come to conceptualize his black identity, and how this has changed over time, in order to understand the present moment. Did Stan's idea of himself as a black male alter as he traversed the different settings of his life: neighborhood, high school, college, and now? It would also be important to investigate what cues, and from whom, Stan used to form his black identity. Further, is Stan proud and comfortable with his sense of blackness in some settings but not in others? The answers to these questions are extremely valuable in interpreting the impact of the election results on Stan's psyche, how to harness his feelings of anger, and how to reconnect with himself and those around him.

## What to Do with All of This

While the above information is key to understanding the individual experience of patients from racial minority backgrounds, the conflict experienced by racial minority groups cannot be overlooked. Chapter 7 highlights the disheartening extent to which disparities exist for minority populations. One blatant manifestation of this disparity is the drastic shortage of minority mental health providers. Therefore, cross-cultural training emerges as a necessary part of training for white providers, who will inevitably be called upon to care for minority patients. For providers from any demographic, examining self-identity and the various sociopolitical environments that have informed identity development throughout life is integral to helping patients do the same.

For providers of the majority race, understanding white identity formation is important when caring for minority patients. While there are multiple models of white identity development, the White Racial Identity Development (WRID) model, which was proposed and later revised by Helm, includes stages similar to those of the racial minority models discussed above [31]. The first stage begins with the individual being unaware, misinformed, and without conscious awareness of the benefits of white privilege [31]. After this stage, the individual realizes that his/her notions about people of color are different from those expected, leading to the development of pro-white feelings and a desire to protect his/her privilege [31]. In the next stage, a positive white identity begins to form, which sets the stage for misconceptions about race being replaced with accurate information [31]. Finally, the individual achieves a positive white identity and mobilizes against the eradication of racism [31].

To best illustrate how self-exploration of a therapist's majority racial identity is therapeutically essential when caring for a patient from a minority background, see the continuation of the case below.

**Clinical Consideration: Therapist Explores His Own Racial Identity**

After a few sessions, Stan's therapist, John, becomes aware of intensely negative countertransference feelings. Not only is John uncomfortable, but he also disagrees with some of Stan's concerns about the racially motivated maltreatment of African-American men by white individuals. John does not believe that he, as a white male, is guilty of ever behaving in this manner. John's best friend growing up was James, a black boy his age, who lived next door with his Nigerian-born parents, who were both physicians. John wonders if his reactions to Stan are due to a difference in his upbringing compared with that of James, his closest example of another black man [32]. John discusses his thoughts with his personal psychotherapist, who asks John about messages he has received from his family and friends about people of color throughout his life. While John's parents and friends have never used racial slurs or spoken negatively about people of color, John realizes that his parents never had James's parents over for a meal, none of the guys in his college fraternity were black, and James (whom he has not spoken to in 3 years) is actually the closest black friend he has had. John starts to question if something is wrong with this and, further, if he has blind spots that are contributing to the negative countertransference.

While this description of John's inner monologue may seem rather specific, its core is reflective of what typical multicultural training leads to: thwarted attention from white identity formation due to a hyperfocus on the racial minority experience. How often has John engaged in thinking about his identity as a white male and its relationship to injustice, oppression, and the structural institutions around him? However, as a good therapist, John recognizes his instinct to reject the notion that Stan is being mistreated because of his race. He thinks through the evidence to support this—such as the fact that he himself has never been treated in that way because of his race, nor has he witnessed this type of treatment, and he works in a comparable milieu among highly educated individuals. While John finds it reassuring that his parents have never displayed racist behaviors, he cannot make sense of why all of his closest friends look exactly like him. He wonders if he is actually racist. This questioning reflects the emergence of cognitive dissonance, which is the first step in the process of racial socialization. Although uncomfortable, socialization is key to undergoing racial identity development and must occur for the individual to gain a stable sense of racial identity. However, many members of the majority race do not complete the process of socialization, because of invisible social rules established by the majority that stifle dissonance, or awareness of their role in discrimination against others. Therefore, if John's goal is to help Stan uncover how his childhood, upbringing, and past behavioral patterns relate to the present, John will have to allow himself to do the same to uncover the implicit lessons on race instilled by his parents.

Steps toward long-lasting, effective racial socialization must be multitiered and targeted toward altering knowledge about how racial dynamics affect interactions, skills in addressing dynamics that arise, and attitudes that shape the ability to be open to learning why and how to address unjust racial dynamics [33]. To accomplish a change in attitude, knowledge, and skills directed toward racism, there must first be a redistribution of attention to how the majority group thinks about their own race. This may first require a change in attitudes or acceptance of beliefs they had not previously considered. For example, talking about race openly does not make one a racist [34]. Race should be viewed not as a subject that is "taboo" but, rather, as a meaningful identity characteristic. Also, every race, including the white race, has personal meaning and should be explored by the individual [35]. By accepting the importance of how race influences social dynamics in everyday life, therapists gain increased awareness and thus the potential to gather more data about how racial tension contributes to conflict. As a result, the therapist can develop a more sophisticated understanding of the role of race in interpersonal interactions, and more opportunities to acquire skills to manage conflicts related to race as they occur in treatment [36].

As comfort with the role of race as a psychological mediator increases, so does the ability to freely participate in conversations about race that are often "taboo" in certain circumstances. More conversations lead to increased learning and knowledge about race that can aid in debunking false beliefs, stereotypes, and other inaccurate assumptions that cause barriers to understanding others. Once informed with knowledge about the history of race, and the misuse of race to hurt others, one can start examining one's own responses when an issue related to race is raised [33]. By having a better understanding of how race can be used to oppress others, individuals can intentionally work toward noticing how race impacts their thoughts, feelings, and actions for harm or for good use [36].

**Clinical Consideration: Racial Concordance in Therapy**

It is worth discussing how Stan's treatment would differ if he were working with a provider who was black or from another racial minority group. Race concordance between the patient and provider is associated with higher rates of patient satisfaction, but the findings do not clearly suggest improved treatment outcomes [34]. For example, it is likely that if Stan happened to seek treatment from a black woman (which is more likely than him seeking treatment from a black man, given the demographics of mental health providers), there is no guarantee that he would have better treatment outcomes. Racial concordance does not excuse the provider from exploring the patient's ideas of race. In fact, it may be more important to discuss the topic to ensure that the provider and patient do not assume that the other shares a similar perspective or has had a similar experience as a person of color. Additionally, providers of the same race are still expected to think about how race may influence their interaction with the patient. Specifically, internalized racism can be particularly harmful if it is unexamined by the provider or may lead a patient to seek treatment with a therapist from a different racial background [37]. A black therapist could find himself or herself associating Stan with violence or unreliability, as studies have found that black providers may be susceptible to these biases when treating black male patients [38]. Stan could also stir up negative messages of intrinsic worth or capabilities within a black provider, or vice versa [39]. Regardless of the race of the provider, research shows that patients are less satisfied with care when the provider does not bring up cultural issues that the patient feels are important [40]. Therefore, it is safe to assume that racial minority patients typically want to discuss race, so providers of all races should broach this topic in treatment.

## Conclusion

The effectiveness of psychotherapy is determined by the ability of the provider to meet the diversity of patient needs, which are often influenced by the surrounding sociopolitical context. Therefore, conflicts present within the larger society may manifest as conflict between the patient and the provider in the clinical encounter. At times, the patient may present with needs that pose internal challenges for the therapist because the two of them have markedly different socializations with respect to race, gender identity, or socioeconomic status. The beginning of this chapter outlined how the severity of inequality in society can lead to significant disparities in access to, quality of, and outcomes of mental health treatment. As a result, mental health providers from majority racial backgrounds can develop a subjective lens that does not overlap with that of racial minority patients. Therefore, it is imperative that therapists proactively educate themselves about current and historical sociopolitical forces governing their society. Additionally, mental health professionals must also examine how their identity, by virtue of external systems of oppression, may present a barrier to the patient's ability to feel safe. A commitment to learning the history that creates social barriers is necessary. For example, consider studying the long-lasting impact of topics such as colonialism, religious persecution, and inequitable distribution of resources by race. It is especially important for therapists to learn the history of groups that differ from their identity. For mental health professionals, not having personal experiences of racism, sexism, ableism, or other forms of discrimination that patients have faced does not excuse from the need to know about these concepts. Although it is impossible to know the history of oppression for every unique combination of race, gender, and other identities, it is necessary to have a basic awareness of what the therapist's identity may symbolize to the patient in the clinical encounter. The therapist will also be required to conduct ongoing investigation of how one's identity or self-concept influences inner thoughts, feelings, and actions in response to individuals who are different. In the contemporary context in which clinicians now work, it is no longer an option to seek this knowledge; it is a requirement.

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