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Race, Racism, Interpersonal Racism and Psychiatric Care

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Disclosures

- None

Objectives

1. Describe the historical and sociopolitical origin of race and racism in the US and how it relates to interpersonal racism.
2. Recognize and define interpersonal racism and microaggression
3. Identify racism in psychiatric care.
4. Develop strategies to combat personal bias and racism in daily patient care.

Rise of Racism

- Artifact of European colonization
- Used race to create hierarchy of non-Anglo-Saxon groups
- Justify slavery as legitimate part of an emerging global economy
- Religious, philosophical, political, class-based, and biological justifications for oppression.
- Perpetuated in US to protect the dominant power and privilege that white people have historically held in the past and even today.

Source: Kendi 2017

Why talk about racism in psychiatry?

- **Physicians are still making clinical decisions based on implicit racial stereotypes (over diagnosing Schizophrenia in Black patients).**

(Chapman et al. 2013 and Alegria et al. 2008)

- **Implicit bias favoring white patients (more likely to prescribe stimulants to white patients)**

(Sabin et al 2012)

- **Black and Latino patients receive fewer recommendations for treatment (neurologic disorders, trauma, ADHD) which lead to persistent gaps in mental health outcomes.**

(Ayanian et al., 2014; Saadi et al., 2017)

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Recognizing Levels of Racism

Legal

Illegal

Overt

Covert

Interpersonal

(Individual)

Institutional

(Organizational)

Structural

(Systemic)

(Slide borrowed from Dr. Shim)

Interpersonal Racism

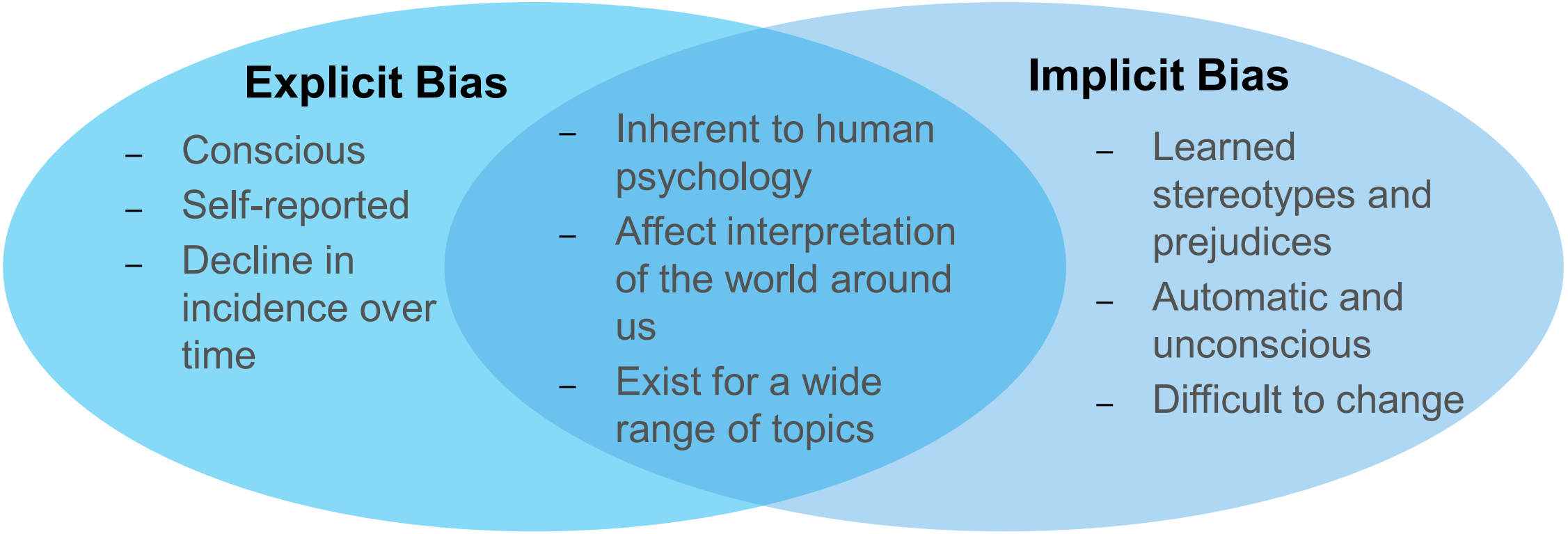
Interpersonal racism: A form of racism that is experienced between members of the dominant social group and members of a stigmatized racial minority and may be explicit or implicit.

- Can be intentional or unintentional; acts of commission as well as omission, explicit or implicit (microaggressions).

Source: WCAAP Equitable Health Toolkit 2021

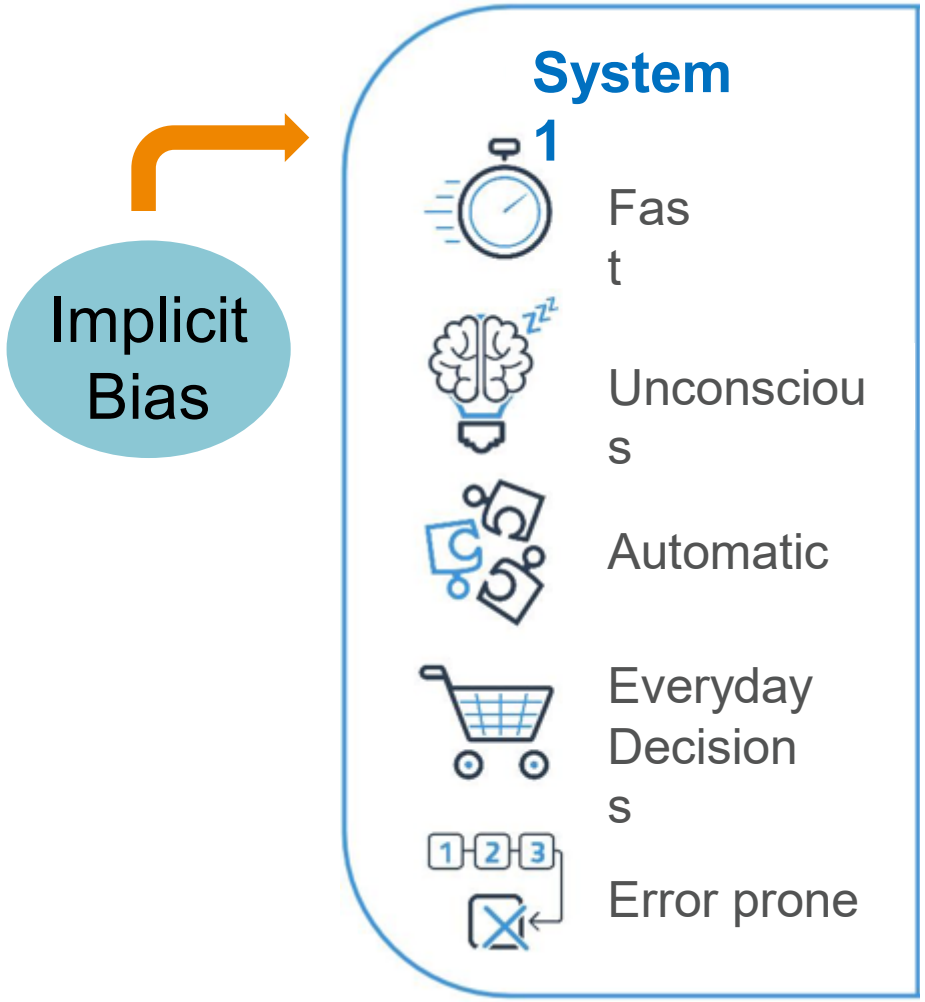
Bias

- **Bias:** prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair



Source: Heather Hsu MD, Boston Medical Center Health Equity Rounds; UCSF Office of Diversity and Outreach. Unconscious Bias.

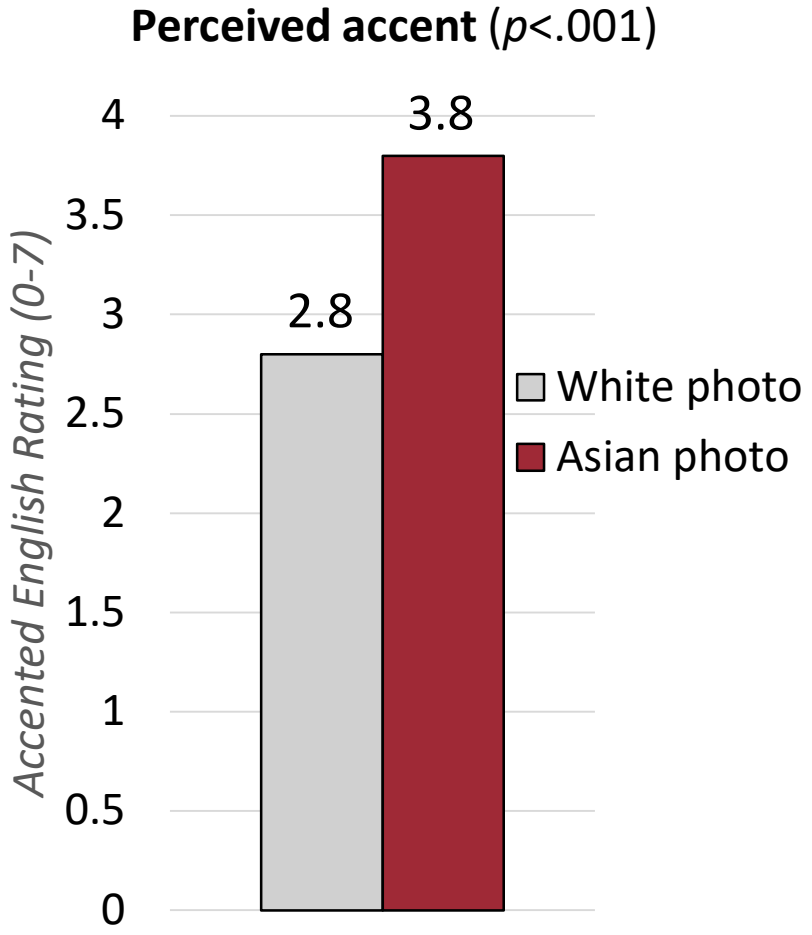
Implicit Bias & Dual Process Theory



Source: Heather Hsu MD, Boston Medical Center Health Equity Rounds; upfrontanalytics.com
Daniel Kahneman, 2011

System 1 Cognition and Racial Bias

- 450 word recorded essay read by Standard English speaker
- Random assignment to photo
- All participants hear the same recording

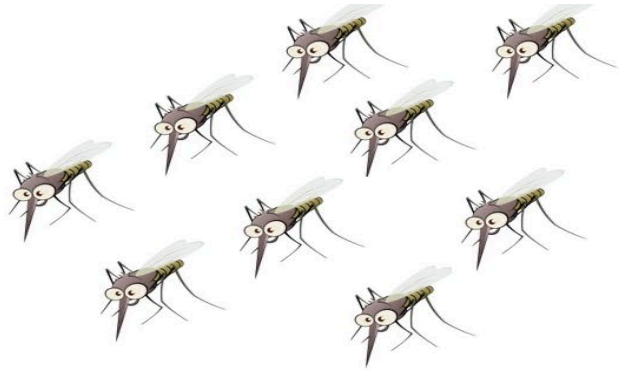


Rubin 1992; Kang & Rubin 2009

Implicit Bias and Racial Microaggressions

https://youtu.be/lqnBdsOSII8

Interpersonal Racism: Microaggressions



- The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. Those targeted include people of color, females, those with disabilities, religious minorities, and LGBTQ+ people.

Microaggressions & Oppression

- “Where are you really from?” (to US born Latino resident)
- “He’s so articulate” (about a resident of color)
- “You should smile more” or “Don’t look so intimidating” (to a man of color)
- “Is your wife a doctor?” (male resident married to a man)
- “Are you my nurse?” (to a female medical student)

"I was on call and one of the nurses interrupted me and said, 'Oh, go to room such and such, the sheets need to be changed.'"

Status leveling:

Occurs when a person from a group that has historically had lower status is assumed to belong to a lower status position

Pololi et al. 2010; see also Montenegro 2016

"I keep getting mistaken for the only other Asian American medicine resident in my program."

Failure to differentiate:

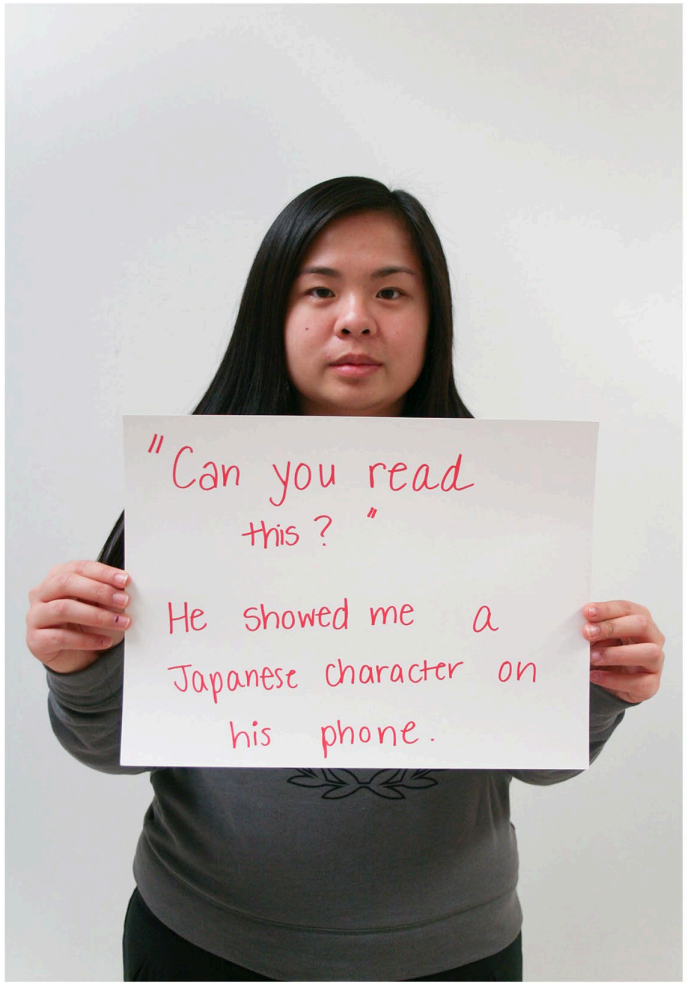
Persons from a non-White racial/ethnic group may be mistaken for one another by a person from a different group

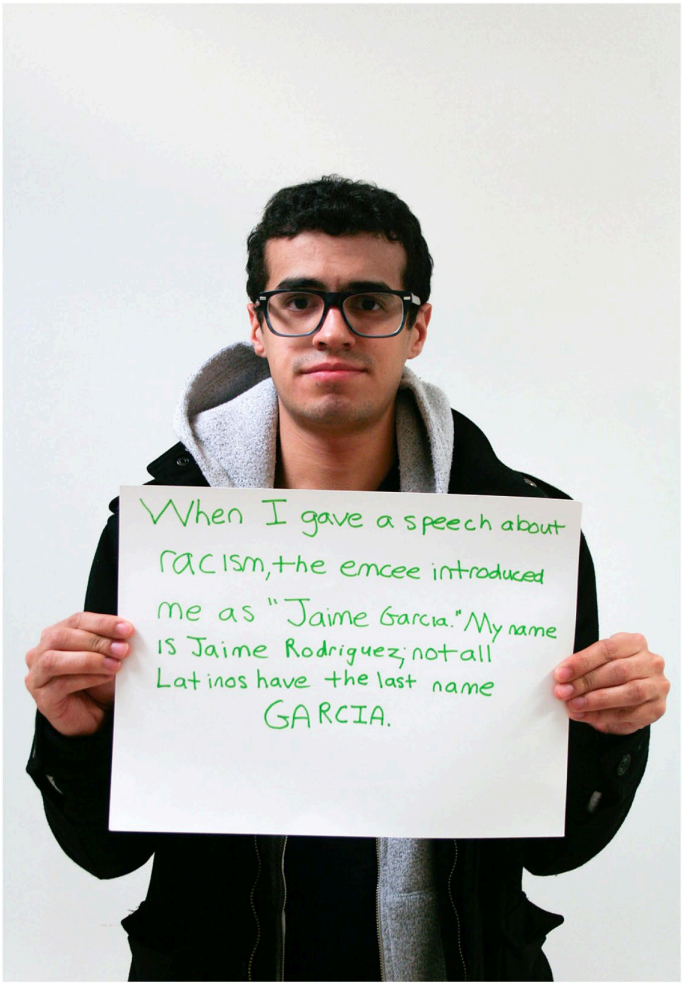
Themes	Examples
Alien in own land	“Where are you from?” or “Your English is good.”
Ascription of intelligence	“You are so articulate.”
Color blindness	“When I look at you, I don’t see color.”
Criminality	Person of color (POC) being followed in a store.
Denial of individual racism	“I have Black/Asian/Indigenous/Latina/o/x friends.”
Myth of meritocracy	“Everyone can succeed if they work hard”
Pathologizing culture	“You shouldn’t be so loud/quiet, etc.”
2nd class citizen	Assumption one can’t occupy a high-status position.
Environment	No visual representation of Black/Asian/Indigenous/Latina/o/x

The power of microaggressions lies in their invisibility to the perpetrator and, oftentimes, to the recipient

Interpersonal Racism: Microaggressions

- Microaggressions are not about having your feelings hurt
- Rooted in ”-isms”, bias and stereotypes
- Microaggressions reinforce otherness and power differences that perpetuate inequities





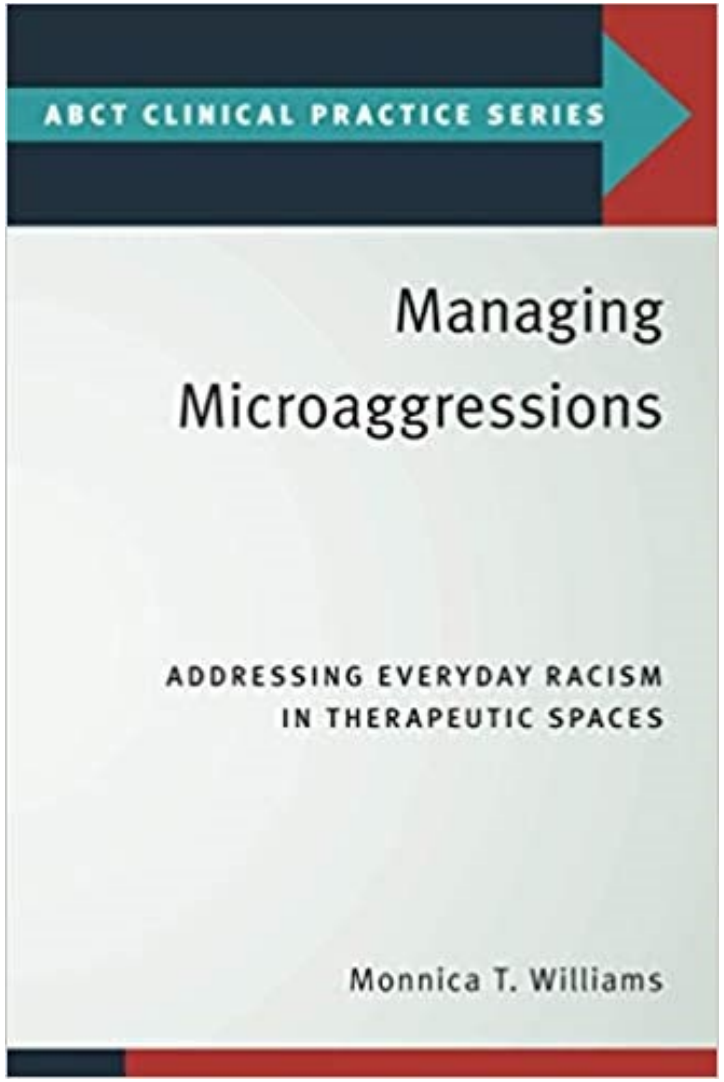
Harm of Microaggressions

- Poor academic performance
- Career changes
- Burnout
- Moral distress

Micro-traumas:

- Biological Impact → Worsened mental health, inflammation and cardiovascular Dz, cognitive decline, increased cortisol and low infant birthweight in Black women. (Wiliams, 2020)

Managing Racism in Therapy Sessions



- Education to correct pathological stereotypes (e.g., “Actually, the data show that most Black people are not poor. . . .”)
- Socratic questioning (e.g., “Do you imagine that all Black people feel that way?”)
- Challenging of assumptions (e.g., “What if we ask that person rather than assume?”)
- Behavioral Experiments (e.g., “Let’s see what happens when you express concern to your co-worker about his experience of racism”)
- Exposures to reduce interracial anxiety (e.g., spending prolonged amounts of time in mostly Black spaces).

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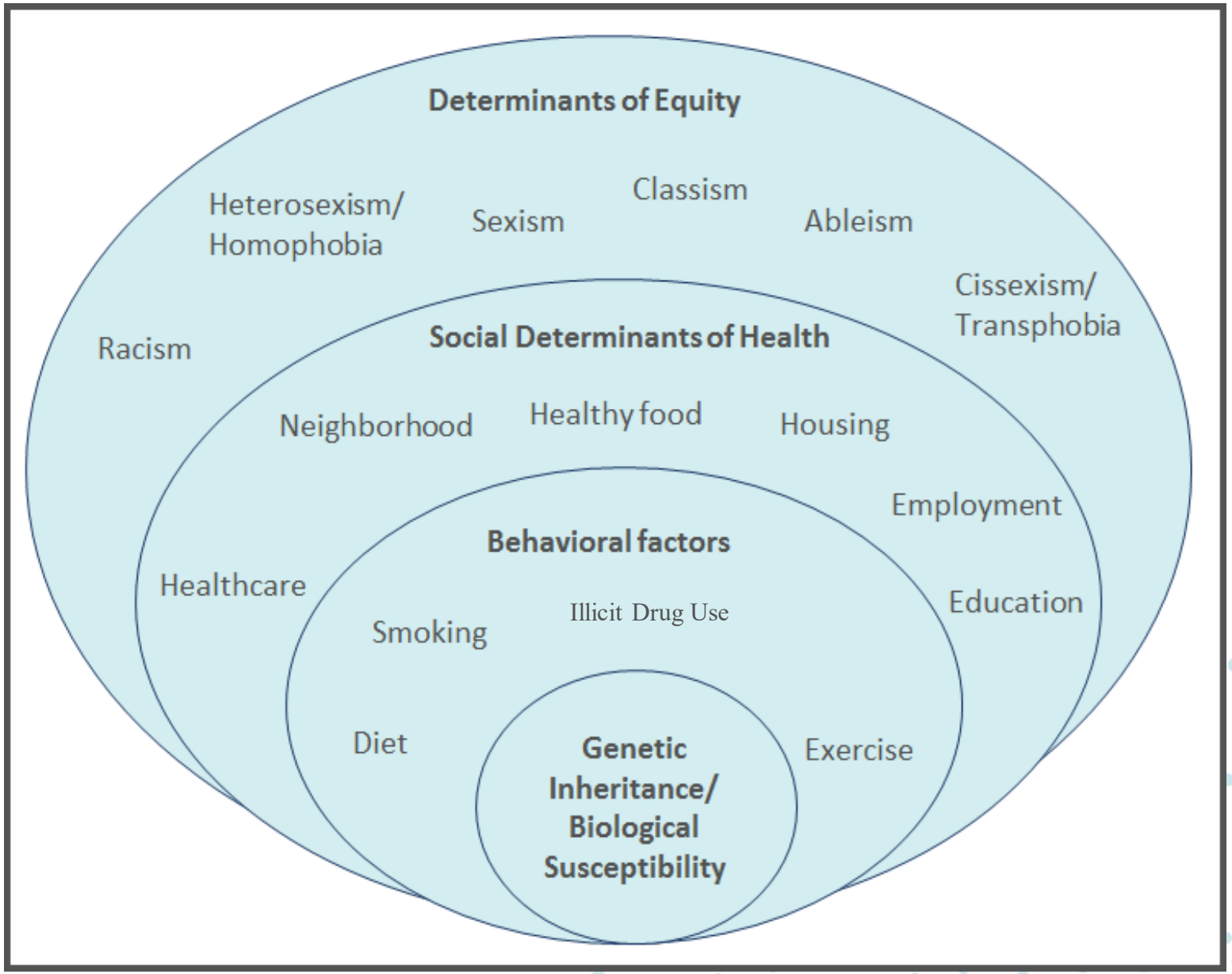
Examining Bias in Psychiatric Care

- How might our System 1 thinking and impact our formulation, diagnoses and treatment plan?
  - ✓ Do your research → read up on how bias may exist in psychiatric care (Formulation, Diagnosis? Treatment?)
  - ✓ Incorporate this knowledge to System 2 thinking in your care.

Examples:

1. Attention Deficit Hyperactivity Disorder
2. Oppositional Defiant Disorder/Conduct Disorder
3. Schizophrenia



Distal

Proximate

Deconstructing Bias in Psychiatry: Moving Beyond Individual-Factors

Structural:

- Racism
- Hetrosexism
- Sexism
- Transphobia
- Classism
- Political Violence

Social/Environmental:

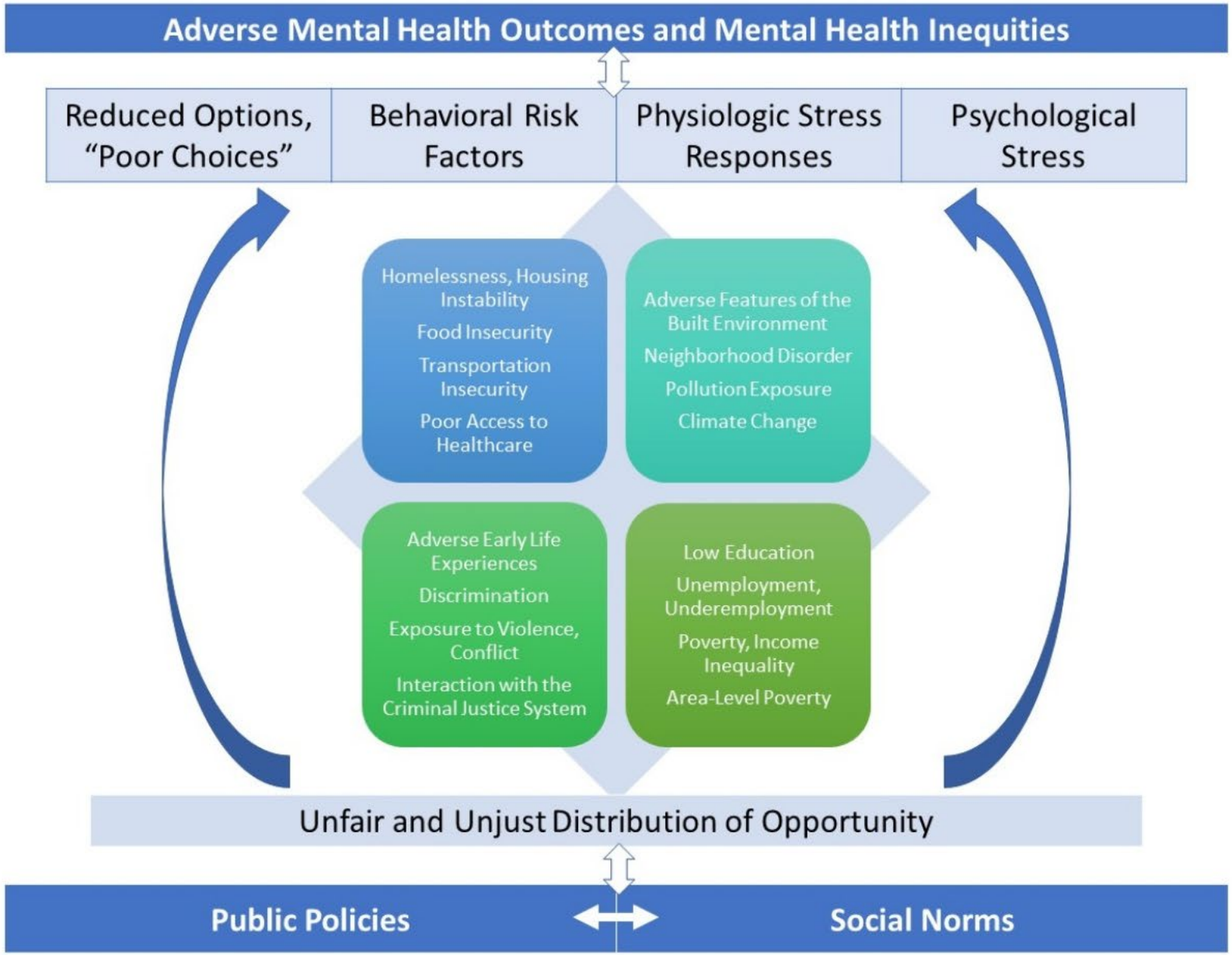
- Parental Psychopathology
- Parental Antisocial Behavior
- Poor Parenting/Parent-Child Relationship*
- Marital Discord
- Child Abuse/Neglect
- Structural Poverty
- Education-Prison pipeline

Behavioral Risks:

?Illicit Drug Use?

Individual Characteristics:

Temperament
Low IQ/Learning Disorders
Brain Injuries
Genetic Predisposition



Shim RS, Compton MT. The social determinants of mental health: psychiatrists' roles in addressing discrimination and food insecurity. Focus. 2020 Jan;18(1):25-30.

Ralph Moore's definition

"The things you can't CBT your way out of"

- Lack of adequate schools
- Lack of adequate work
- Lack of adequate transportation
- Lack of adequate housing
- Lack of adequate food
- Lack of a sense of security
- Institutional racism

Slide borrowed from Larry Wissow

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ADHD & System 1 Thinking: Understanding Origins of Bias & Inequities

- Treatment allows for adaptive functioning at school and promotes opportunities for learning.
- **MAJOR** disparities and inequities with under-diagnosing and under-treating Black and Latino children.
- Barriers:
  - **Interpersonal Racism:**
    - Clinicians are more responsive to white parents who are more likely to solicit ADHD diagnosis and treatment.
    - Less likely to diagnose Black girls with ADHD and less likely to use “gold standard” treatment.
  - Structural Poverty (access)
  - Language (if one parent speaks English more likely to be diagnosed)
  - Screening at PCP (parents may not report)
  - Stigma (and distrust)

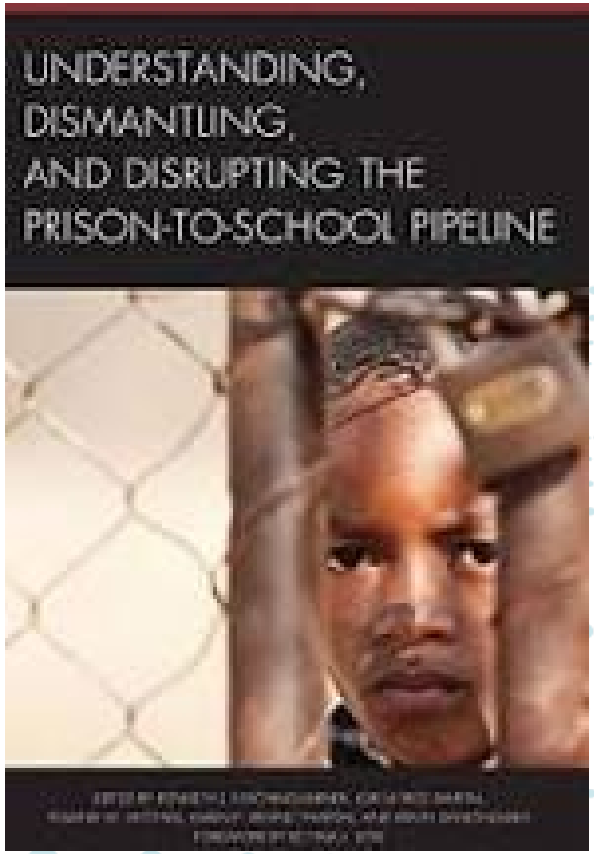
From Under-Diagnoses to Over-Representation: Black Children, ADHD, and the School-To-Prison Pipeline

Myles Moody[1]

Published online: 18 January 2016

Abstract This study argues that the under-diagnosis of attention deficit hyperactive disorder in Black children is a result of racism that is structurally and institutionally embedded within school policing policies and the tendency to not recognize Black illness. The purpose of this research is to examine how micro-processes lead to structural inequality within education for Black children. It seeks to better understand how institutional racism and flawed behavioral ascriptions lead to the under-diagnosis of attention deficit hyperactive disorder (ADHD) in Black children and how that may also contribute to their over-representation in the "school-to-prison pipeline." The goal of this study was to review ethnographic, empirical data and examine the ways (1) how racism within some schools may contribute to the under-diagnosis of ADHD in Black children, (2) how their under-diagnosis and lack of treatment leads to their over-punishment, and (3) how they are over-represented in today's school-to-prison pipeline phenomenon, possibly as a result of such disparities.

Keywords Under-diagnoses · ADHD · Children · Racial disparities · Disabilities · Discipline · School-to-prison pipeline



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Structural:

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Social/Environmental:

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- Child Abuse/Neglect
- Structural Poverty
- Education-Prison pipeline

Behavioral Risk Factors:

?Illicit Drug Use?

Individual Characteristics:

Temperament
Low IQ/Learning Disorders
Brain Injuries
Genetic Predisposition

ODD and CD: Etiology

Structural:

- School
- Neighborhood
- Structural poverty
- School to prison pipeline
- Trauma

“Family Level”:

- Disorganized attachment
- Harmful parenting skills
- Family stress
- Family discord
- Neglect

>>

Individual Level:

- Difficult Temperament
- Neurobiological
- Low birth weight
- Fam Hx of Psych

ODD & System 1 Thinking: Understanding Origins of Bias & Inequities

Academic Psychiatry (2020) 44:95–102
https://doi.org/10.1007/s40596-019-01127-6

COMMENTARY

Unconscious Bias and the Diagnosis of Disruptive Behavior Disorders and ADHD in African American and Hispanic Youth

Matthew C. Fadus[1] · Kenneth R. Ginsburg[2] · Kunmi Sobowale[3] · Colleen A. Halliday-Boykins[1] · Brittany E. Bryant[1] · Kevin M. Gray[1] · Lindsay M. Squeglia[1]

Received: 29 May 2019 / Revised: 22 September 2019 / Accepted: 26 September 2019 / Published online: 11 November 2019

Differences in Mental Health Counselors' Diagnoses Based on Client Race: An Investigation of Adjustment, Childhood, and Substance-Related Disorders

Kevin Feisthamel[1], Robert Schwartz[2]

[1] Portage Path Behavioral Health, The University of Akron
[2] Department of Counseling, The University of Akron

The Process and Implications of Diagnosing Oppositional Defiant Disorder in African American Males

Marc A. Grimmett, Adria S. Dunbar, Teshanee Williams, Cory Clark, Brittany Prioleau, Jen S. Miller

TPC
The Professional Counselor
Volume 6, Issue 2, Pages 147–160
http://tpcjournal.nbcc.org

doi:10.15241/mg.6.2.147

ODD & System 1 Thinking: Understanding Origins of Bias & Inequities

- **MAJOR** disparities and inequities with over-diagnosing Black and Latino children with ODD and CD.
- Barriers:
  - **Interpersonal Racism:**
    - Black children are often viewed "less innocent" than white children.
    - Providers are more likely to over-pathologize behaviors of Black and Latino/a/x children to align with ODD and CD more than white children ("more dangerous and disobedient").
    - These same behaviors in white children tend to be diagnosed with conditions such as mood, anxiety, development, or adjustment disorders.
    - Less likely to consider broad differential of comorbid disorders as potential explanations for behaviors.

  - These diagnoses severely limit access to medications, therapy, and other supportive services → Increases juvenile justice system involvement and increased polypharmacy, including use of anti-psychotics.

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Social/Environmental:

- Healthcare
- Neighborhood
- Access to foods
- Structural Poverty
- Housing
- Employment
- Education
- Justice-Invovled

Behavioral Risk Factors:

?Illicit Drug Use?

Individual Characteristics:

Temperament
Low IQ/Learning Disorders
Brain Injuries
Genetic Predisposition

Schizophrenia & System 1 Thinking: Understanding Origins of Bias and Inequities

- Early views included explanations of a “weak psyche” of women before the 1940’s and 1950’s.
- Diagnoses shifted in 1960’s to a “behavioral disease of dangerous, rage-filled Black men in the setting of political and social discord of civil rights movement.” –> “Protest Psychosis”
- Psychiatrist Racial Bias→ “Black psychiatric patients had higher measures of hostility than white psychiatric patients, stemming from delusional beliefs that their civil rights were being compromised or violated” (Metzl 2010, p. 101)

Schizophrenia & System 1 Thinking: Understanding Origins of Bias and Inequities

- Psychiatrists continue to overestimate violence in Black patients while underestimating violence in white patients (Hicks 2004).

- Black patients have higher rates of being hospitalized involuntarily, receive higher [anti-psychotics], involuntary Rx, and higher seclusion and restraints (Rost et al. 2011).

- Psychiatrists continue to over-diagnose Black men with Schizophrenia and paranoia (7 x) and underdiagnosed mood disorders compared to white men (Gara et al. 2019)

Tools to interrupt personal racial bias

1. Reframe the encounter	• Ask: "What **needs** are unmet?" • What **social and structural factors** am I leaving out?
2. Consider interpersonal dynamics	• Ask: "What biases am I **perpetuating / amplifying?"**
3. Use institutional support & training	• Utilize **clinical resources** (e.g., social w**ork**) • Connect patients to institutional **support programs** • Continue to educate yourself about racism in psychiatry

Source: Olszewski, Aleks, MD"The "Difficult" Patient: Tools to Interrupt Bias in Patient Handoffs", Patient Safety Conference at Seattle Children's Hospital, June 3, 2020.

Tools to interrupt personal racial bias

4. Recognize your and others' biases

- Ask: "**What biases are associated with this diagnoses & treatment?**"
- Ask: **What automatic thoughts** (system 1) are most likely biased in this clinical encounter?

5. Challenge your and others' biases

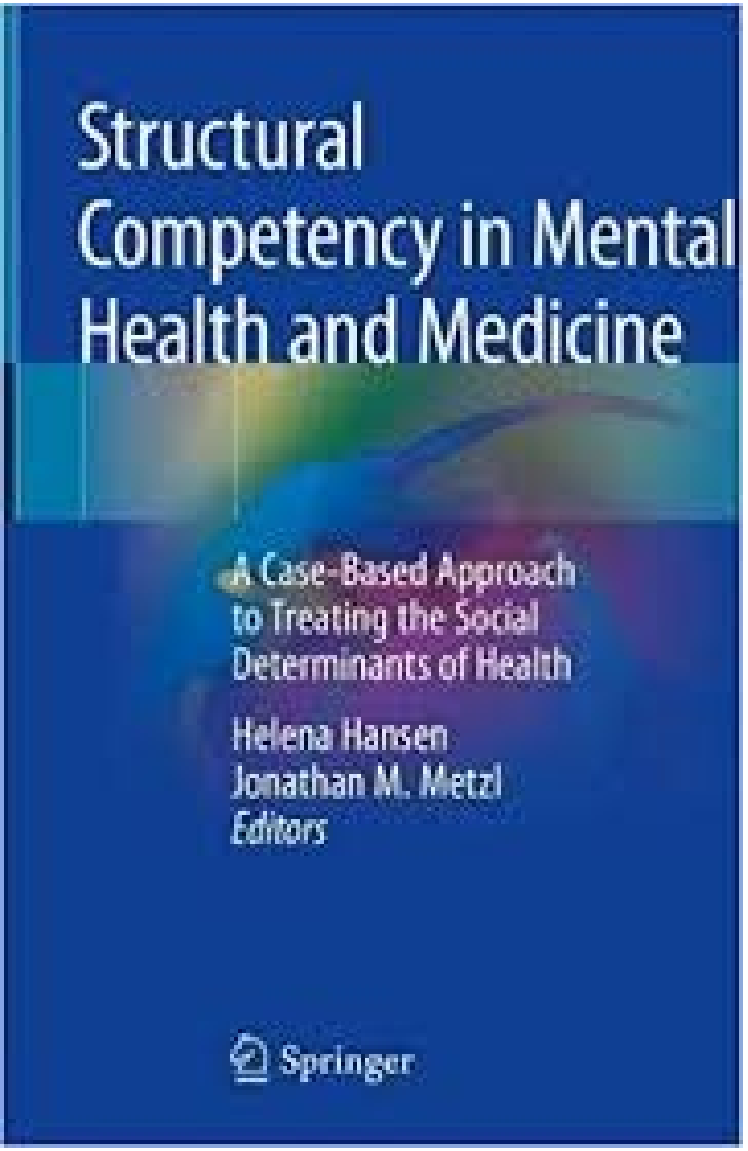
- Ask: "**If this patient were [XYZ], would I be thinking of a different diagnosis or treatment?**"

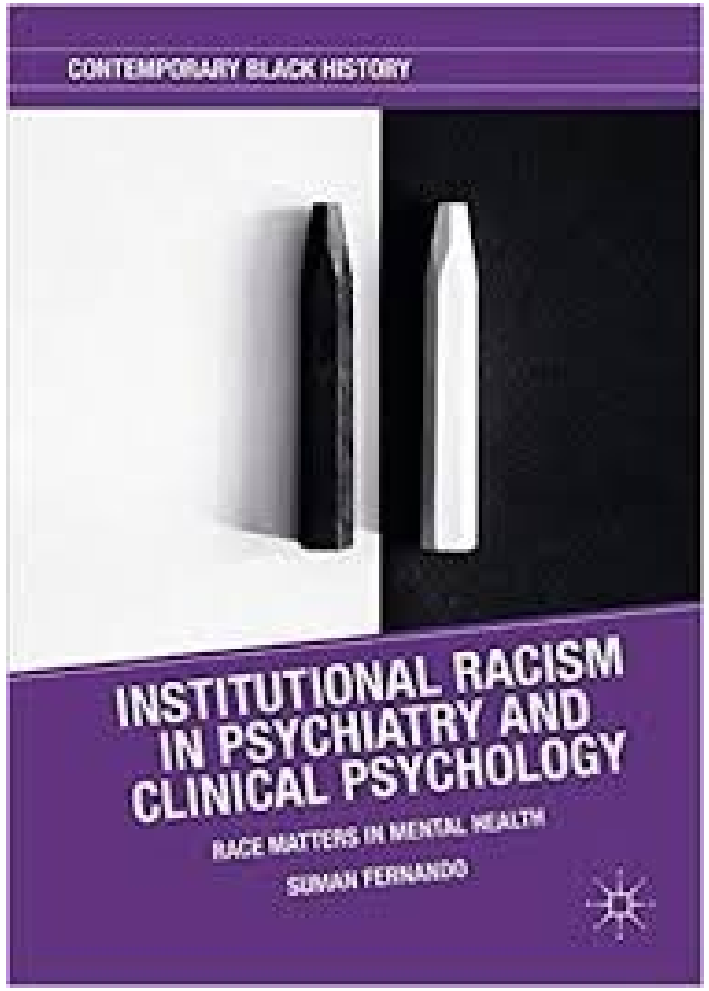
6. Practice Honoring Counter story-telling

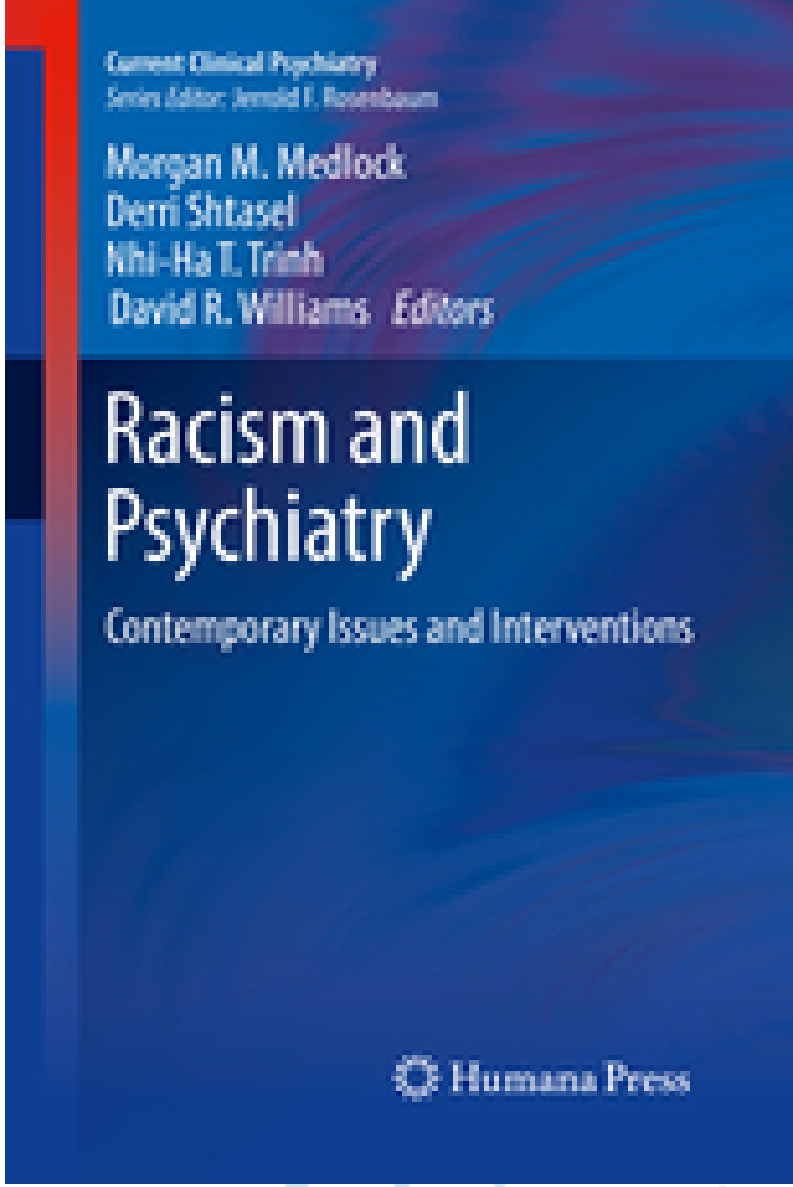
Solorzano & Yosso (2002)

- **Listen:** Openly to the lived-expereinces of "those people whose experiences are not often told".
- **Listen:** To how BIPOC stories can exposé, analyze, and challenge deeply-entrenched narratives of racial privilege.

Modified from Oringial Source: Olszewski, Aleks, MD"The "Difficult" Patient: Tools to Interrupt Bias in Patient Handoffs", Patient Safety Conference at Seattle Children's Hospital, June 3, 2020.


Structural Competency in Mental Health and Medicine
A Case-Based Approach to Treating the Social Determinants of Health
Helena Hansen
Jonathan M. Metzl
Editors
Springer


CONTEMPORARY BLACK HISTORY
INSTITUTIONAL RACISM IN PSYCHIATRY AND CLINICAL PSYCHOLOGY
RACE MATTERS IN MENTAL HEALTH
SUNAH FERNANDO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Questions?

Roberto.Montenegro@seattlechildrens.org

Responding to Microaggressions: You can act in the moment or later

You committed a microaggression	• If you recognize it, apologize (now or later) • If it is pointed out to you, believe the person • Don't get defensive • Learn more about why your action was a microaggression
You witnessed a microaggression	• Interrupt the behavior (e.g., say "ouch!") • Name the offense • Support the target publicly (e.g., "that's not funny") or privately (e.g., "I'm so sorry the patient said that to you") • Support someone else who is speaking up • Talk privately with the offender later • Amplify ideas or suggestions that are ignored
You received a microaggression	• Choose to speak up or not • Rely on allies • File a complaint • Seek out a community of support

•Ashburn-Nardo et al. 2008; Heilman & Haynes 2005; Nelson et al. 2011; Plous 2000; Rattan & Ambady 2014