REVIEW

Antiracist Practice in Psychiatry: Principles and Recommendations

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The COVID-19 pandemic has amplified mental health disparities among people of color, particularly for Black, Latinx, and American Indian populations. In addition to experiencing overt hostility and systemic injustice, people from marginalized racial-ethnic groups experience prejudice and bias from clinicians that has disrupted rapport and trust in mental health systems; these experiences, in turn, have deepened these health disparities. In this article, the authors describe factors that have served to perpetuate mental health disparities and outline key components of antiracist practice in psychiatry (and in mental health practice, more generally). With lessons learned in recent years, this article presents practical ways to incorporate antiracist practices into clinical care.

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THE SYNDEMIC CRISIS AND MENTAL HEALTH DISPARITIES: A CALL TO ACTION IN PSYCHIATRY

Longstanding race-related health disparities have been at the forefront of public awareness during the COVID-19 pandemic (1). Tangible outcomes of the syndemic crisis (the co-occurrence of systemic injustice and public health crises building on one another) are increasingly apparent (2). COVID-19 coincided with increased exposure to race-related stress and trauma as a result of police brutality and hate crimes (3). This pandemic has shown how the negative impact of disease is exacerbated by societal inequities for minoritized racial-ethnic groups. Black, Latinx, and American Indian individuals have been disproportionately affected by COVID-19; they have had higher incidence of severe disease, are dying at higher rates (4–6), and have poorer quality of life in its aftermath, compared with White individuals (7, 8). In the context of the societal stressors associated with a global pandemic (i.e., job loss or insecurity, social distancing reducing social contacts and support, and increased exposure to grief and loss) (9), individuals from these minoritized groups are experiencing disproportionately high rates of mental health problems, such as depression and anxiety. For example, after the murder of George Floyd on May 25, 2020, Black people were more likely to endorse symptoms of anxiety and depression (10, 11), and recent research (12, 13) has shown that suicide rates among Black youths are at an all-time high.

Despite these disparities, racially and ethnically minoritized individuals continue to have disproportionately less access to mental health care. Lack of transportation and financial concerns are common barriers (14). However, even with an increase in mental health care coverage with the implementation of the Affordable Care Act, mental health treatment rates have not increased for racial-ethnic minority groups as they have for Whites (15). These findings suggest that not all of the barriers to mental health care access are structural. Evidence suggests that factors associated with the treatment process may be barriers to care engagement for people of color. Black youths, for example, are more likely to discontinue psychological treatment because they feel the treatment does not meet their unique needs (16). This finding is notable because, outside of schools, youths with elevated mental health symptoms are most likely to receive mental health care in outpatient settings (17). Recent qualitative work with Black men recovering from injury (18) has highlighted the fear of judgment from providers as a barrier to help seeking. Another qualitative study with Black youths and families (19) has found that both caregivers and youths expect the process of seeking mental health services to be negative.

Taken together, this work suggests that a key driving factor to this disproportionate treatment utilization has to do with the mistrust people of color have of health care systems and mental health practitioners in particular—social inequities lie at the root of this mistrust (20). Indeed, the valence of one's interactions with systems can influence the level of trust in health care settings. For example, Alang and colleagues (21) reported that for all racial-ethnic groups, those groups that reported negative encounters with police had higher medical mistrust. Furthermore, personal, vicarious, and experimentally mediated discriminatory experiences have been shown to be related to medical mistrust among Black participants (22); this mistrust has health consequences. For example, Black men with higher medical mistrust are more likely to delay routine checkups and

preventive health screenings (23). The historical medical trauma to which people of color have been subjected is a powerful reason for sustained medical mistrust (24).

To build trust and align with communities of color to support their treatment needs and preferences, psychiatrists and psychologists must implement antiracist practices in their clinical work and in their supervision of trainees. Antiracism involves acknowledging, from a systemic perspective, the ways in which marginalized groups have been subjected to, and harmed by, unjust treatment and practices and how such systemic processes continue to manifest today (25). Antiracist practice must be a part of institutional culture in a way that promotes self-awareness within a social justice framework, including in educational institutions; didactic coursework and experiential training related to diversity, inclusion, and social justice should be incorporated early in clinicians' doctoral curricula (26, 27). Given how intricately linked current societal ills and stressors have been to race-ethnicity and health care disparities, attention must also be focused on how services can improve based on what has been learned from the COVID-19 pandemic (28). The purpose of this article is to discuss how to incorporate antiracist practices in psychiatry practice. Later we discuss introspective practices that enhance knowledge of privilege and latent bias among clinicians; cultural considerations in assessment, diagnosis, and treatment planning; and the need to address barriers to mental health care.

INTROSPECTIVE PRACTICES THAT ENHANCE KNOWLEDGE OF PRIVILEGE AND LATENT BIAS AMONG CLINICIANS

Foundational to antiracist practice is a solid knowledge base of the manifestations of racism throughout U.S. history and the global implications of this racism. This knowledge also contributes to our understanding of the ways in which personal power and privilege influence professional interactions, particularly as they pertain to patient care. Finally, this cornerstone allows for the continuous assessment of bias. In this section, we outline components of introspective practice and self-learning that may serve as the basis for antiracist practice.

Manifestations of Racism

Race is a social construct referencing the classification of individuals based on physical characteristics, such as skin color. Racism references a set of beliefs, doctrines, and ensuing practices centered around viewing one racial group as superior, creating a system of inequality that manifests at structural-institutional and individual levels (29). Structural racism references bias in social policies and practices that disempower and oppress minoritized communities; this structural racism includes mutually reinforcing systems of media, health care, employment, housing, and education. It involves the systematic exclusion of racial-ethnic groups in housing, employment, and opportunities for building wealth. Individual racism references the unconscious and conscious perpetuation of biased, discriminatory behavior toward individuals from minoritized racial-ethnic groups. A major consequence of structural and individual racism is internalized racism, which refers to the assimilation of racist beliefs, stereotypes, and attitudes toward one's own racial-ethnic group. Internalized racism has been shown to negatively affect self-esteem, psychological well-being, and physical health (30).

Because clinical practice settings are a part of a larger ecological framework, it is imperative that individuals working in these settings are aligned in their understanding of the ways in which racism manifests. Racist experiences negatively affect individuals' views toward various health disciplines, including mental health, leading to mistrust of the medical establishment and uncertainty about the utility of treatment. This basic understanding of how racism manifests also serves as an important backdrop to understanding the impact of power and privilege.

Clinician Self-Assessment: Examining Power and Privilege Through Identity Intersection

Increased awareness of one's own identity and worldview has been identified by Sue and colleagues (31) as a foundational step toward cultural competence and is arguably the bedrock of antiracist practice. Close examination of the various facets of personal identity and group affiliations can shed light on latent privilege. This process of increased self-awareness can be guided by personal reflection; publicly available resources (32) can also provide guidance. Many of the available resources focus on exploring the intersection of identities that are either acquired or chosen (e.g., age, gender, nationality, religion, economic status) and examining how various facets of identity confer privilege or disadvantage. This self-reflection can promote greater intentionality in communication with patients and trainees and can support conversations that promote equity by avoiding oversimplification of identities or inattention to multiple identity intersectionalities. In direct and indirect ways, clinician introspection and identity assessment can affect patient assessment, diagnosis, and treatment planning. A critical evaluation of one's historical, cultural, spiritual, political, social, and philosophical links to power and privilege can facilitate an understanding of how these factors may affect patient care (33). This self-understanding, in turn, may inform a more intentional, open, and collaborative connection with patients to address their individual needs.

Bias Assessment

Clinicians often face stressful, high-intensity situations that require rapid decision making because of time constraints, high workloads, and uncertainty. These situations can enhance the likelihood of unintentional discriminatory behavior to emerge from unconscious bias—the implicit beliefs, emotions, and attitudes regarding others that are based on characteristics, such as appearance, age, race, religious

affiliation, and ethnicity. Biases are a type of cognitive heuristic, which are mental shortcuts that serve to enhance efficiency in functioning and communication. However, unconscious racial biases represent overgeneralizations about people from minoritized groups that often lead to clinicians' harmful, discriminatory behavior. These racial-ethnic biases are a widely recognized mechanism for racial-ethnic health disparities (34). Manifestations of bias include resistance to patients' treatment requests, fewer referrals to specialized treatment, inadequate pain management, and lack of empathy toward patients. Unconscious racial-ethnic biases are influenced by direct and indirect communication received throughout the lifespan and are subject to change.

Among the tools available to assess unconscious bias are the Evaluative Priming Paradigm (35), the Implicit Association Test (IAT) (36), and the Affect Misattribution Procedure (37, 38). These measures assess associations between race-ethnicity and attitudes that are involuntarily activated from memory, including beliefs related to threat, intelligence, and laziness. Because the psychometric properties of some of these measures, particularly the IAT, have been mixed (38), providers and institutional leaders should review the inherent strengths and limitations of each before implementing them. Another option for exploring bias is via mindfulness-based meditative practices. Mindfulness meditation involves increasing present-centered awareness of thoughts, emotions, and physical responses in an open, nonjudgmental fashion. These practices have been successfully used to address bias related to race and age (37, 39). By increasing awareness of thoughts or beliefs and emotional responses, mindfulness facilitates introspection and examination of contextual factors, rather than automatic, biased, or reflexive responding. This approach has been highlighted as a social justice strategy that may enhance feelings of connectedness, solidarity, and compassion for others (40).

CULTURAL CONSIDERATIONS IN ASSESSMENT, DIAGNOSIS, AND TREATMENT PLANNING

In addition to self-assessment, it is necessary for providers to thoroughly evaluate the various ways in which patients' race-ethnicity and culture have influenced their life experiences. This evaluation provides a foundation for accurate diagnosis and treatment planning. Below, we discuss the importance of adopting a stance of cultural humility during the clinical evaluation, explore nuances of common assessment concerns, and address diagnostic and treatment considerations.

Adopting a Stance of Cultural Humility

Acknowledging that race-ethnicity and skin color affect the way people are treated in society is central to antiracist practices. Conversely, adopting a color-blind stance when conducting assessment and treatment planning can have damaging short- and long-term effects in clinical contexts. Ignoring the potential ways in which patients from diverse backgrounds experience social exclusion, discrimination, and overt hostility based on their race-ethnicity and/or skin color during assessment, diagnosis, and treatment planning can degrade rapport, setting the stage for mistrust of not only the clinician in question, but also of other practitioners in the same or other fields of medicine. This mistrust, in turn, affects adoption of treatment suggestions, with serious consequences for morbidity and mortality. A color-blind stance (often unintentionally) signals a lack of concern for these issues and potentially contributes to the patient's own self-questioning and invalidation of their responses to experiencing injustice. By asking questions that address issues of racism and by adopting a position of cultural humility, clinicians demonstrate their commitment to understanding contextual factors that affect the patient's clinical presentations. Furthermore, modeling this style of assessment to trainees serves as a potent pedagogical influence, setting a positive precedent for their practice. Later, we describe ways in which antiracist practices may be incorporated in assessment, diagnosis, and treatment planning.

Open-Ended Assessment of Race-Ethnicity

Asking patients open-ended questions about how they identify in terms of race-ethnicity validates an individual's unique identity expression and permits exploration of ways in which identity intersects with life experiences and, in turn, clinical concerns. Many extant intake assessment forms do not provide options for descriptive responses with respect to race-ethnicity and culture. Similarly, taking a checklist-oriented approach to assessing these (and other) facets of identity communicates a lack of interest in individuals' own expressions of identity and reinforces the apparent power differential. Asking open-ended questions related to race-ethnicity and culture (in addition to other aspects of identity, such as religious or spiritual affiliation) allows patients the opportunity to provide valuable information for the assessment. Most assessment forms offer classifications of race-ethnicity that are incongruent with individuals' experiences with racism. For example, individuals of Middle Eastern/North African descent are considered "White," according to the U.S. Census Bureau, but this designation poorly reflects how they are often encountered in society, which is as distinctly "not White." Asking open-ended questions about a patient's race-ethnicity can also reveal important ways in which diversity exists within these aspects of identity outside of the reductive categories available on forms and ways in which the individual's identity expression has affected their social experiences.

Structured, Semi-Structured, and Qualitative Assessment of Racial Trauma

Discussing ways in which race-ethnicity has affected patients' interpersonal interactions can reveal sources of racial trauma. These discussions can similarly bring to light how racial trauma has intersected with other aspects of identity (i.e., gendered racism) as well as other traumatic events or

life experiences. This contextual information is critical for treatment planning. Several racial trauma assessments in structured and semi-structured interview formats are publicly available (41–43) and are valuable to administer during the intake process. However, inquiring in an open-ended fashion about racial-ethnic trauma can also elicit valuable information on the breadth and depth of a patient's experiences with racism: "have there been times when your race, ethnicity, or skin color negatively affected how people or institutions treated you? This can include school, work, law enforcement, or medical settings." This inquiry indicates the clinician's willingness to hear about the patient's experiences with racial-ethnic trauma, including those traumas that occurred within medical settings. Given the frequency with which patients of color report having experienced overt racism in medical institutions (44, 45) and the clear health inequities these patients face, it is important to assess ways in which this type of racism has manifested, and similarly, how such interactions have contributed to ruptures in trust, difficulties in obtaining proper access to treatment, and skepticism toward recommended treatments.

Similarly, assessment of microaggressions, a term used to reference subtle insults, slights, and indignities experienced by people of color that signal their "inferiority" and/or invisibility (46), provides critical information on exposure to this chronic stressor. Microaggressions are a form of racial trauma that result from racial biases. They reinforce pathological stereotypes and disrupt rapport between patients and providers, with clear downstream consequences for treatment engagement; as such, they have been implicated as a source of mental health disparities (47–49). Microaggressions can occur in interpersonal and environmental contexts. These communications may occur without intention, but nonetheless, they insidiously pervade everyday experiences of people of color. Microaggressions are likely to be perceived, consciously or unconsciously, as a type of threat, which triggers a cascade of stress-related physiological responses (e.g., increased heart rate, muscle tension). Chronic encountering of these racially or ethnically traumatic events has adverse effects on mental and physical health, leading to what some theorists call "racial battle fatigue" (50, 51). Microaggressions have been consistently linked to anxiety and depression, as well as to somatic symptoms, such as headache, nausea, and sleep disturbances (52). Microaggressions are commonly experienced by people of color, and they affect various aspects of health and well-being—however, they are routinely ignored in medical settings, including during intake assessments. This disregard can contribute to the self-questioning and invalidation that often occur among targets of microaggressions; attempts to rationalize or "explain away" these stressors can lead to internalized racism, serving to degrade self-concept. Assessments, such as the Racial Microaggressions Scale (53), not only can provide useful information on the frequency of these encounters for patients of color but can also bring awareness to clinicians on how they may unwittingly perpetuate microaggressions, including by invalidating or minimizing their patients' experiences with racism.

Racial-Ethnic and Cultural Affiliation and Treatments That Address Racial-Ethnic Trauma

In addition to race-related adversity, clinicians must assess the ways in which an individual's race-ethnicity and cultural identity confer strength, examining how patients' connections to their communities may be a source of healing. Strong racial-ethnic and cultural affiliation has been shown to buffer the effects of racial trauma (54, 55), and perceptions of support from other members of one's racial-ethnic community appear to have a similar moderating effect (56). Providing a space for patients to reflect on how their racial-ethnic identity affiliation provides strength can instill hope and optimism for future outcomes and can help guide treatment planning. Current frameworks of healing from racial trauma (57) highlight ways in which social affiliations, collectivism, decolonization, and resistance promote wellness in communities of color.

Diagnostic Considerations

Assessment of racial trauma brings to light contextual factors that must be considered during diagnostic formulation. For many people of color, racial-ethnic trauma is not a focal event, but an ongoing, inescapable stressor. In light of this fact, clinicians must consider how responses to racial-ethnic trauma, including vigilance for future insults or restricted emotional reactivity, may be adaptive in the face of ongoing stress, rather than a sign of psychopathology. Information on past racial-ethnic trauma may be used to contextualize clinical presentations, address racism-related factors that influence behavior, and mitigate overdiagnosis. A relevant example is below:

> During intake assessment, a 55-year-old woman, who recently immigrated to the United States from Mexico, reported significant anxiety in social circumstances and feelings of embarrassment around others in social settings. Her scores on a microaggression inventory indicated that she often feels she is treated like a foreigner. When her psychiatrist inquired about her responses on the measure, she reported feeling exhausted by the way she is treated in her workplace. She mentioned that her coworkers often comment on her accent and approach her to ask her opinion of U.S. immigration policies. Her psychiatrist had initially considered a diagnosis of social phobia, but learning this information led him to reconsider this diagnosis—instead, he discussed microaggressions with her, validating the role that these contextual stressors played in her avoidance of social circumstances.

Treatment Considerations

Current trends in the delivery of psychiatric care show significant disparities in the medical treatments prescribed to people of color. Compared with White individuals, people of color are more likely to receive first-generation antipsychotics, higher dosages of antipsychotics (58), and

depot antipsychotics (59). People from minoritized racial-ethnic groups are also less likely to receive clozapine, electroconvulsive therapy, or treatment by a psychiatrist in the outpatient setting (60). These significant differences in dissemination of care lead to reduced symptom remission and greater chronic impairment from severe mental illnesses among racially minoritized populations.

Implementing culturally informed treatment strategies facilitates provision of equitable mental health care, especially considering the notable disparities in treatment. Culturally informed care begins with clinicians being aware of the common practices outlined above that result in patients of color receiving substandard care. The decision to offer and provide treatments that are in line with the best practices for those with a given condition should be made. Common considerations that have been made in elevating the mental health care of minoritized racial-ethnic groups include collaborating with cultural, community, or religious organizations when permitted, supporting safe behaviors that are in line with patients' values or beliefs, incorporating the input of family members (including nontraditional definitions of family) preferred by the patient, and being aware of treatment modalities that are optimal for a particular patient population (61).

Culturally informed treatment strategies may also involve allowing space in sessions to address culturally relevant factors that have been shown to positively affect mental health, such as racial identity (62, 63), race socialization (64), and processing of racial stressors and traumas (65). Comprehensive strategies to help instill hope and to connect to socioeconomic and emotional resources (i.e., connection to cultural groups) may also be indicated in helping people of color to manage any chronic stressors (66). Mandara and colleagues (67) reported that among a sample of Black adolescents, an increase in racial identity over time was associated with a decrease in depressive symptoms, even when accounting for variance linked to self-esteem. This finding highlights the potential impact of this culturally specific correlate of well-being on mental health among people of color. Furthermore, racial-ethnic socialization, or understanding one's race-ethnicity as it relates to one's position in the world, can buffer against the negative impact of racial-ethnic stress and trauma, especially when paired with the appropriate cognitive-behavioral strategies that help one navigate difficult race-based circumstances (68). Because people of color may frequently encounter racial-ethnic stressors, allowing space in the therapeutic and treatment environment to process and make meaning of such experiences can promote healing.

Finally, because of the comorbid nature of chronic pain syndromes and mental health conditions, including major depressive disorder and anxiety disorders, adequate acknowledgment, validation, and management of chronic pain is essential to the improvement of patients' mental well-being. Despite this recommendation, disparities have remained consistently present in the management of chronic pain among racial-ethnic minority groups when compared with non-Latinx Whites (69). The result of uncontrolled pain syndromes brings a higher rate of impairments in physical ability, cognitive processes, sleep, sexual function, and perceived quality of life (70). These impaired states affect one's mental health considerably and widen the disparity between non-White and White individuals.

ADDRESSING BARRIERS TO MENTAL HEALTH CARE

Clinicians must increase their awareness of the multiple and substantial barriers to accessing evidence-based interventions experienced by racially and ethnically marginalized populations. Recognizing common and unique barriers to care access can inform clinicians' strategies for addressing these barriers and for connecting patients with needed resources. Both structural barriers (i.e., lack of insurance or transportation) and attitudinal barriers (i.e., stigma, mistrust) impede mental health service utilization (71). Although mental health stigma is notable in the general population, it is an even more significant treatment barrier (in different ways in different communities) for people from minoritized communities (72). In racially and ethnically minoritized populations, distrust of the general medical and mental health system, along with experiences of racial discrimination in clinical settings, further impede desire to engage in care (73). Additional barriers are caused by lack of mental health professionals with cultural competence or adequate representation of minority groups. The limitations in options for care are further heightened for patients who do not speak English as their primary language. Furthermore, Black and Latinx populations are more likely to be uninsured or underinsured compared with White individuals, limiting their ability to pay for mental health care (74). These individuals are faced with financial burden that limits their access to mental health care because of competing needs for available funds. In addition, individuals who live in resource-limited areas, especially rural areas, have decreased availability of mental health facilities, thus impeding their access to care (75).

Although usage of telehealth services has increased because of the COVID-19 pandemic, these services may not be as readily available to minority racial-ethnic groups. In addition, questions remain about the efficacy of these treatments and whether they are culturally appropriate. Nonetheless, one study evaluating the effectiveness of telehealth treatments, such as virtual cognitive-behavioral therapy, showed positive results in reducing depression and anxiety scores at 6 months among Black patients, even though no impact of the treatment was found among non-Latinx White patients (76). To address disparities related to insurance status, Medicaid eligibility expansion, reduced copays for mental health services, and improved mental health specialist reimbursement for Medicaid beneficiaries are essential (74).

CONCLUSIONS

In this article, we have described foundational elements of antiracist practice in psychiatry, highlighting the roles of introspection and bias assessment for clinicians, assessment of patients' experiences with adversity related to race-ethnicity, cultural considerations in diagnosis and treatment, and common treatment barriers experienced by marginalized populations. We have underscored the importance of providers engaging in reflective practices to unmask potential blind spots (i.e., unexamined prejudice and bias that may negatively and unconsciously affect patient care). We have also discussed recommendations for assessing patients' individual experiences and how such assessment can appropriately inform diagnosis and treatment planning. Addressing structural and attitudinal barriers to mental health care requires a willingness to explore new methods to reduce these disparities (e.g., the use of virtual treatment modalities). Continued exploration is needed as we continue to learn from our experiences, including those encountered during the COVID-19 pandemic. Attention to these critical areas will move the field of psychiatry to a place where antiracism is foundational, creating a space for increased feelings of safety, trust, and treatment engagement.

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