Understanding the Significance of Race in the Psychiatric Clinical Setting

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The meaning of race

In order to understand the impact of race on mental health, it is important to appreciate what race is as well as the factors connected to race that influence health and mental health status. Race has been defined in terms of phenotypic characteristics, including shape of eyes and nose, hair color and texture, and skin color. While these features are biologically determined, race is actually a social concept related to how people are classified on the basis of their physical appearance (1). Race is related to, but distinct from, ethnicity, which is defined as the characteristics of a group of people who share common national, linguistic, religious, or racial heritage, and from culture, which comprises the perspectives, world views, actions, and mores of a group of people (2).

The four major racial groups in the United States are people of European descent or Caucasian; people of African descent, also referred to as black people; people of Asian and Pacific Island heritage; and people of Native American, Native Hawaiian, and Native Alaskan groups. People of mixed race are a growing population in the United States, and they are faced with significant challenges regarding how they are to identify themselves. People of Hispanic or Latino descent, more accurately referred to as an ethnic group, are the largest "minority"; they represent a broad spectrum of racial heritage, including European, African, and Native American contributions and mixtures of these racial categories. The four major nonwhite racial and ethnic groups will be referred to here as people of color. The term minority is not used, for two reasons. First, minority has a pejorative connotation despite its reference to numerical representation relative to the Caucasian population. Second, minority is becoming a misnomer given the fast-paced growth of populations of color; for example, as of 2005, four states—California, Hawaii, New Mexico, and Texas—were identified as having majorities of people of color. In many ways, populations of people of color are *emerging majorities*.

Racism and its impact on mental health

Racism has three main meanings: a belief in the superiority of a particular race; antagonism between people of different races; and the theory that human abilities are determined by race (3). Racism is a system of beliefs and behaviors that function to devalue people of nonwhite groups and exclude them from full participation in society while regarding as superior and affording privilege to people of European ancestry. In the United States and many other parts of the world, there is a hierarchy of racial membership, in which whites are dominant economically and politically and people of color are generally relegated to having limited resources and power.

The presumption of superiority of people of European descent around the world and in the United States has contributed to racism and its many historical manifestations. Examples include the enslavement of Africans, their dispersal in the Americas starting in 16th century, and the enslavement of their descendants; the internment of Americans of Japanese descent during the 1940s; the forced relocation of Native Americans in the United States and the forfeiture of their land to white settlers; and the detrimental immigration policies toward people of mixed heritage primarily from Mexico and Central America.

Racism is an underpinning of the disproportionate representation of people of color among those living in poverty and subject to the societal ills associated with poverty (4). The linkage of racism

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to poverty is further illustrated in the fact that people of color with impaired mental health are overrepresented among high-need populations, including people who are uninsured, homeless, incarcerated, or in the foster care system as well as immigrants and refugees (2).

Racism has an effect on how people are viewed and, in turn, on how people view themselves. People who harbor racist notions routinely underestimate the potential of people of color and their ability to achieve their goals and succeed in society. Racism thus has major implications for education, employment, housing, health, and mental health. Being a victim of racism and racial discrimination can predispose vulnerable populations to anxiety and generate feelings of hopelessness and low self-worth, resulting in a diminished quality of life. Concerns related to racism contribute to psychological distress, depression, anxiety, and other psychiatric states (3, 5).

RACIAL DISPARITIES IN DIAGNOSIS, TREATMENT, AND OUTCOME

Racial disparities in health status, risk of and predisposition to disease, access to care, quality of care, and disease outcome (including higher mortality among people of color from the leading causes of death) are the backdrop for the racial disparities in mental health and mental health care faced by people of color (6). Manifestations of disparities in psychiatric help seeking, diagnosis, treatment, representation in research, and outcomes are well documented. Disparate experiences of populations of color in the mental health system contribute to a disproportionately high burden of disability from undertreatment of psychiatric disorders and inadequate treatment (2).

The following are some examples of racial disparities in found in the clinical setting in the United States. Compared with their non-Hispanic white counterparts, African Americans are half as likely to receive mental health services; more likely to be diagnosed as having schizophrenia; less likely to be diagnosed as having a mood disorder; less likely to receive prescriptions for selective serotonin reuptake inhibitors or atypical antipsychotics; and less likely to adhere to psychotropic medication regimens (2, 7, 8). Asian Americans report poor short-term outcomes in psychotherapy and less satisfaction with treatment than whites. They respond to psychotropic medications similarly to whites but at lower doses (2). Hispanic patients are less likely to receive a prescription for an antidepressant. Among Hispanics, immigrants are half as likely as their nonimmigrant counterparts to contact a mental health specialist (2). Native Americans have been found to have a 70% prevalence of lifetime mental disorder, and their suicide rate is one and a half times the national rate (2).

The existence of racial differences and disparities in mental health and psychiatric care requires that clinicians be conscious, but not overly conscious, of race, carefully weighing symptom presentation, interpretation, social and environmental context, and the input of collateral informants, and using clinical judgment (9). Using the approach presented by McHugh and Slavney in *The Perspectives of Psychiatry* (10), the clinician can feel confident that all bases are covered when assessing a person of a different race by taking into account disease (with a cluster of symptoms and a cause), dimension (character traits along a bell curve), behavior (for example, substance abuse), and life story (the patient's life and environment, which shape the individual's unique experience) (10). Gathering a thorough history that addresses all four of these domains ensures that the clinician has performed due diligence in gathering a comprehensive picture of the individual regardless of race and is able to perform a sufficient differential diagnosis and arrive at a diagnosis that most accurately reflects the patient's experience.

RACIAL DYNAMICS IN THE THERAPEUTIC RELATIONSHIP

Because race is manifested in appearance and appearance drives prejudice, bias and the application of stereotypes may emerge in the assessment and treatment of patients who need mental health care. Information based on negative societal views of people of different racial heritage may contribute to a clinician's misunderstanding of people of color. In order to overcome stereotypes and biases, clinicians must take stock of their own racial identity and come to terms with how they view others in order to minimize the impact of their prejudices on the therapeutic relationship. Distrust on the part of the patient of color emanates from the experience of mistreatment by members of the dominant racial group.

Ridley has described several common defensive racial dynamics exhibited by psychiatric clinicians when working with a patient of a different race (11). One of these is *color blindness*, a term describing the tendency of clinicians to behave as if patients from other racial groups are no different from their Caucasian patients. In contrast, *color consciousness* describes the behavior of the clinician who acts as if the patient's problem stems solely from his or her being a person of color. Both responses are detrimental to patient care. *Racial transference*, the emotional reactions of a patient

imposed on a therapist of another race, and *racial countertransference*, the emotional reactions of a therapist of one race or ethnicity projected onto a patient of another race, play on the fixed relationship of Caucasians to nonwhite groups in terms of economic and power dominance. These reactions may be played out in both directions, from patient to clinician and clinician to patient. It is important for clinicians to develop racial self-awareness in order to prepare themselves to handle the emergence of these dynamics.

When the clinician of color is the same race as the patient, there are also potential racial dynamics at play. One example is *overidentification*, in which the clinician overly attributes the patient's problems to racism and engages in inappropriate self-disclosure. Achieving balance in considerations of racial membership in the context of psychotherapy is crucial to providing people of color with quality psychiatric care.

MINIMIZING RACIAL BIAS, ELIMINATING RACIAL DISPARITIES, AND OPTIMIZING OUTCOMES

It is well known that people of color are less likely than whites to enter psychiatric treatment, often forgoing help in any form or seeking alternative sources of support such as primary care, faith-based resources, extended family networks, or folk healing traditions. We also know that because of high levels of stigma and shame, help seeking is often postponed until the crisis point, often leading people to seek care in emergency settings, which is a less than optimal site for receiving mental health services. When people of nonwhite racial backgrounds do enter psychiatric treatment, this is a critical moment that represents the initiation of a potentially fragile relationship because of the distrust commonly held by people of color. Clinicians must handle such patients with care at this stage because people of color are known to drop out of treatment quickly and to have had fewer overall visits than average at the time of dropout.

Environments with high rates of poverty and ill health present many assaults to mental health and well-being. In these settings the availability of substances of abuse can compound the negative health and social effects of untreated mental illness in the form of co-occurring mental illness and substance abuse; risk of infectious diseases such as HIV/AIDS and hepatitis C; risk of being a victim of violent crime or of self-inflicted violence, including suicide; and risk of incarceration, homelessness, and unemployment, most of which are found at high rates among people of color. This situation is compounded by the low proportions of people of color entering psychiatry and other mental health professions. If we are ever to bridge the gaps and overcome disparities in treatment and outcomes of psychiatric illness, we must take action to increase diversity among the ranks of mental health professionals.

SUMMARY

Race is a fundamental social concept in the United States and across the world, and it has an important impact on health and mental health. Examples of racial disparities in mental health status, diagnosis, treatment, and outcome are plentiful. As the United States becomes more racially diverse, more psychiatrists and other health and mental health professionals will participate in cross-racial therapeutic encounters. Clinicians must become more cognizant of the ways in which racial differences can have an impact in the therapeutic setting. Neutralizing these differences with knowledge about the meaning of race, its historical underpinnings, its social context, the importance of racial identity in the formation of mental health, and the impact of racial difference in the psychotherapeutic relationship will improve the care of populations of color. In doing so, psychiatry could go a long way toward eliminating the racial disparities in mental health care and maximizing the opportunity for diverse populations to enjoy optimal mental health and quality of life.

REFERENCES

1. Williams DR: Race, stress, and mental health, in Minority Health in America: Findings and Policy Implications From the Commonwealth Fund Minority Health Survey. Edited by Hogue CJR, Hargraves MA, Collins KS. Baltimore, Johns Hopkins University Press, 2000
2. Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, Md, US Department of Health and Human Services, 2001
3. Clark R, Anderson NB, Clark VR, Williams DR: A note on the biological concept of race and its application in epidemiologic research, in Race, Ethnicity, and Health. Edited by LaVeist T. San Francisco, Wiley, 2002
4. Hollar MC: The impact of racism on the delivery of health care and mental health services. Psychiatr Q 2001; 72:337–345
5. Neighbors HW, Williams DR: The epidemiology of mental disorder, in Health Issues in the Black Community. Edited by Braithwaite RL, Taylor SE. San Francisco, Jossey-Bass, 2001
6. Institute of Medicine: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC, National Academies Press, 2002
7. Strakowski SM, Keck PE Jr, Arnold LM, Collins J, Wilson RM, Fleck DE, Corey KB, Amicone J, Adebimpe VR: Ethnicity and diagnosis in patients with affective disorders. J Clin Psychiatry 2003; 64:747–754
8. Diaz E, Woods SW, Rosenheck RA: Effects of ethnicity on psychotropic medications adherence. Community Ment Health J 2005; 41:521–537
9. Neighbors HW, Trierweiler SJ, Ford BC, Muroff JR: Racial differences in DSM diagnosis using a semi-structured instrument: the importance of clinical judgment in the diagnosis of African Americans. J Health Soc Behav 2003; 43:237–256
10. McHugh P, Slavney P: The Perspectives of Psychiatry. Baltimore, Johns Hopkins University Press, 1986
11. Ridley C: Overcoming Unintentional Racism in Counseling and Therapy: A Practitioner's Guide to Intentional Intervention, 2nd ed. Thousand Oaks, Calif, Sage, 2005