Racism and Its Role in the Mental Health Care System

Risa Yamanaka

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Dr. Marianne Marar

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Racism is a prevalent issue in the United States even to this day. There is the popular belief that discrimination against ethnic minorities, particularly African Americans, is a problem of the past – perhaps it was never solved from the beginning. The reason for this myth, Watson (2015) claims, is because the dominant (white) Americans simply choose to not discuss or acknowledge race nor the ongoing racism that occurs daily to non-whites. More people are speaking out about the undercurrent of oppression resulting in a consequence of a huge backlash by the public. Starbucks CEO, Howard Schultz recently conducted a campaign which promoted the discussion of race (Huffpost, 2015). The campaign had the right motivation but majority of these acts are as Watson (2015) states: "…often misguided, distressingly adrift, naive and tone deaf to the concerns and harsh realities that many people who suffer its (racism) pernicious effects have to deal with on a daily basis." While it is a step towards the right direction, for many institutions, they lack the knowledge and skills to incorporate the hard reality that racism and discrimination exist in people's lives – sometimes even ignoring them completely. One example of such institutions is the mental health care and the field of psychology. This essay addresses the problematic trend of psychological practices that embody the systemic oppression of ethnic minorities, mainly African Americans, in the profession of mental health care in America. Moreover, the fact that society continues to support an unjust system full of racism and inequality causes poor health and a lower standard of living in the U.S.

The mental health of minorities is at risk because this group is being attacked by covert and overt racism, microagression, and other forms of oppression on a daily basis. Brown et. al. (2000) found that Black Americans are especially at peril concerning their level of mental health that has greatly decreased due to experiencing acts of racism based on their visible characteristics (Utsey, Hook, Stanard, & Giesbrecht, 2008). According to the American Psychological

Association, experiences of racism and discrimination can have a dire impact on the psychological and physiological well-being of African Americans since they are oftentimes linked (“Physiological & Psychological Impact”, n.d.). Indeed, stress is the primary cause of negative impact on an individual’s psychological state. Hobfoll (2011) suggests that the source of mental stress stems from 3 conditions: “(a) an individual’s resources are threatened with loss, (b) an individual’s resources are lost, and (c) an individual fails to gain sufficient resources following significant resource investment” (as cited in Utsey, et. al., 2008, p. 51). All of the above can be especially experienced if an individual is a minority. Hobfoll (2011) then goes on to claim these three conditions are met such that (a) racial stigma may rob an individual’s psychosomatic resources such as having high self-esteem and socioeconomic prospects that come with majority privilege like education, (b) relentless experiences of systematic racism can lead to losses in psychological, social, and socioeconomic status, (c) unexpected racist encounters may result in the loss of an individual’s investment of time and effort or continual events of racism can hinder a person’s resources that are often difficult to recover (Utsey et. al., 2008). The Office of Minority Health, a branch of the U.S. Department of Health and Human Services, claims that the poverty level can affect mental health status of an individual, and African-Americans living below the poverty level, are 3 times more likely to report psychological issues while suicide rates for ages 10-14 increased 233% compared to that of majority Whites (“Mental Health and African-Americans”, 2014). *The Journal of Black Psychology* includes the psychophysical impact of stress related to structural racial bias against African-Americans claiming that through Lang’s (1979) research, HRV and systolic blood pressure are most commonly related to its effects (Harrel, n.d.). Much evidence implies that racism can act as a tremendous stressor to minorities and can cause harmful physical effects. A

study by Kwate, at. al. (2003) asserts that psychological impacts of perceived institutional and cultural racism is found to be the source of a variety of unhealthy behaviors such as smoking and the intake of alcohol in African-American women (Utsey, et. al., 2008). Racial discrimination prohibits minorities from living a quality of life that equals that of the majority.

The field of Psychology is one of many areas of study that propagates racism both as an ignorant bystander and a perpetrator of the system. According to Gray (2012), because the study of human psychology only considers objective information, the idea of racism is thought of as something abstract and therefore can never be analyzed as the ultimate cause of mental distress. If brain function is normal, then the individual is thought of as psychologically healthy despite the statistics showing otherwise. A recent report made by the Centers for Disease Control National Center for Health Statistics (2006) indicated that African-Americans have higher mortality rates, risks of various health problems such as diabetes and prostate cancer, seven times more likely to be HIV/AIDS infected, a higher risk for breast cancer, and have an overall shorter life expectancy compared to White Americans (Utsey, et. al., 2008). Researchers such as Kwate, et. al., 2003; Clark et. al., 1999; McCord & Freeman, 1990; Nazroo, 2003; V. L. Thompson, 2002; Utsey & Ponterotto, 1996; Williams, Neighbors, & Jackson, 2003, ascertained that these increasing health issues for African-Americans is intensified “by their psychological and physiological responses to chronic exposure to racism” (as cited in Utsey, et. al., 2008, p.49). One way to resolve this problem is to increase numbers of minority psychologists working in the field to better accommodate the mental and physical health of minorities. However, racial conditioning conceives automatic and unconscious responses that contribute to negative stereotypes (APA, 2003). Therefore, it is extremely important for information and awareness of the kinds of social injustices among minority populations to take place in relevant trainings

among future mental health care providers and psychologists. Findings that contributed to this new-found need for diversity mainly focused on the race relations between the Black and White Americans because of their long history of racial discrimination in the U.S (Okazaki, 2009). Furthermore, this complex connection between the two races shaped the proud African American culture of today. This high level of racial pride among the Black community is not to be mistaken as an advantage to their identity as study showed that it actually produces higher level of stress caused by race issues (Utsey et. al., 2008). Contrary to prior theory, the study concluded that any people holding a strong consciousness of racial pride may be inclined to be more aware of racial discrimination and confront them, which leads them to be targets of these incidents for showing resistance (Utsey et.al., 2008). In light of these recent studies, efforts have been put towards encouraging diversity in the workplace to inspire psychologists to be more attuned to identity and culture.

The demand to have psychologists who are culturally sophisticated and are aware of the psychological effects of racism has been acknowledged for several decades. However, it is difficult to resolve the exclusion of racism-related stressors because psychologists themselves are simply not immune to the broad impact of systemic racism. This is when the mental health care system perpetrates ongoing racism. As a human service profession, psychology must cater to all people in virtue of its studies to relieve psychological turmoil and mental illness. Thomas (2008) mentioned in the Sue et. al. (2007) article on microaggression that the perceived racism she experienced hardly called for negative emotional responses (Oakazaki, 2009). This type of bigotry that undermines the struggles of living as an ethnic minority in the U.S. is ubiquitous in psychology since its foundation as a field of science. Tate (2012) revealed that Sigmund Freud, who was known as the father of psychology and psychoanalytic theories, had a running inside

joke within his group of psychologists that his Black patients were “his negro”, implying that White culture was the more dominant (as cited in Gray, 2012, p. 5). Moreover, in the nineteenth century, black slaves who were diagnosed to have certain mental illnesses such as drapetomania for having the tendency to fight for their freedom and rights were then institutionalized (Rooks, 2012). The ideology that African Americans were inferior human beings was largely held by society and within the community of psychologists well into the 1960s. African American and other minority group psychologists experienced little employment in the field during the 1940s and 1950s among segregation (Jackson, 1992). Psychology is not unaffected by the larger community of sociopolitical framework. John H. Jackson (1992), among very few prominent Black psychologists of the 20th century, shares a brief reflection of what it was like to be a soon-to-be minority psychologist during the 1940s:

> …I am impressed with the naiveté of my fellow minority students (As well as my own naiveté) during graduate school for professional training in psychology. We were among the few African American and other minorities who had defied all intimidations and discouragement; who had remained motivated, determined, driven; and who had dared to learn and aspire to the highest level of degreed achievement – the doctoral degree. I think we believed deeply in the American Dream and the theory of the melting pot. We expected that succeeding in our studies and properly honoring the folkways and mores would earn us tickets to well-paying professional positions, professional acceptance, and the equal or fair chance for career development (p. 80).

Jackson was rightfully proud to have entered the doctoral program and to have received the degree. According to American Psychological Association, minority students are understated in all aspects of psychological programs, especially in the doctorate stage, the most necessary milestone for an aspiring psychologist (“Guidelines on Multicultural Education”, 2003). Kite et. al. (2001) reported a similar trend of racial minorities being down played in professional psychology; APA Research Office’s (2002) data showed that less than 2% of professional

psychologists were of biracial/ethnic minorities (as cited in American Psychological Association, 2003). There is more or less a declining trend in the number of minority students to enter or even consider psychology despite the undeniably upward trend of minorities living in the United States. According to the U.S. Census Bureau (2002, 2005), there is an increase of the percentage in minority and biracial populations, particularly those of Hispanic origins, surpassing Whites (Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006). Therefore, this tremendous racial gap in the mental health workfield and the population it serves and thrives on is perplexing. According to Korman (1974), the significance of culture in clinical psychology (counseling) was only introduced in the 70's. Eventually, research that followed found that psychological approaches to treating ethnic minority patients continued to expand. One of them being the "colorblind" approach, where the racial, cultural, and ethnic aspects are essentially ignored to promote an all-mankind perspective in treating minorities of ethnic background ("Guidelines on Multicultural Education", 2003). Korchin (1980) claim that "The recognition of differences, however, is the first step toward the development of theory and research methods appropriate to the understanding of cultural diversity". Therefore, it raises the question of whether it is in fact an equal and fair treatment of patients because it is blind to the struggles of living as a target of racism – focusing only on the troubles of a typical white American. To expand on this a little further, Helms's (1990, 1995) racial identity theory proposes that individuals who were marginalized because of their race should increase awareness of their internalized oppression in order to "…commit to an elimination of oppression through deliberate, ongoing self-examination and lived experiences" (as cited in Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010). Therefore, to work in the field of psychology as a target of racial discrimination, one must become regularly in-tuned with their own lived experiences as a minority. It indicates the need to

have both supervisor and supervisee discuss the topic of race and racism towards the common goal of treating all patients in true fairness. This is not an easy feat however, as the National Asian American Pacific Islander Mental Health Association (2009) reported that 87.5% of providers of mental health care profession are White (as cited in Berger, Zane, & Hwang, 2014). Thus, Jernigan, et.al.'s (2010) study, where supervisors of both minority and Caucasians were tested, it signified a tremendous lack of awareness and dialogue about the potential psychological effects of racism towards patients of color. One supervisee claimed that she felt confused when her supervisor seemed to ignore the fact that exposure to racism was a prevalent occurrence for the client and continued to state that she felt that the clinical training was not up to par with reality (Jernigan, et.al., 2010). Subsequently, the patients' well-being is being affected because they are treated by a specialist whose full capability has not been met due to their hesitation and anxiety over going into training (Berger, et. al., 2010). The negligence of the supervisors may be due to their own internalized oppression or lack of cultural training in terms of counseling patients of minority. Interestingly enough, the only supervisor whose report came out as having established a racially progressive relationship with a trainee did not initiate the relevant conversation about race matters (Berger, et. al., 2010). The lack of awareness in racism, as Fiske (1998) mentioned, may be because that many researchers are Whites and they are more motivated to study the perception of minorities rather than the other way around (APA, 2003). In turn, white majority patients benefit more because of excess amount of research in improving their mental health rather than that of "minority" Americans.

The reality is that supervisors of color are not only targets of racial discrimination outside of their workplace, they are also perpetrators of racism. An Asian American psychologist, Stephen Murphy-Shigematsu (2010) was exposed to racist remarks by professionals of equal

standing who assumed that since he was Asian American, his biological make-up and experiences had made him culturally equipped to teach White psychologists the way of treating multi-ethnic persons. There was no regard for his educational background nor his capabilities and skills in counseling patients of all culture, ethnicity, and race – his appearance was all that mattered. One incidence recalled by him is of a Danish/European supervisee who was told to change her behavior in a way so that she is perceived as a typical white American female by her clients, ignoring the consequence of a clinical session that followed between her and her clients (Murphy-Shigematsu, 2010). The supervisor in this case puts significance in the skin color and race of a supervisee yet denies their core identity – delaying or inhibiting the process of acquiring a sophisticated racial identity – which is essential in creating a diverse workplace that deals with multiethnic clients, as evidenced by Helms's (1990, 1995) theory. Theories and methods to better and appropriately care for the mental health of an ethnically diverse population may only work through the cooperation between professional psychologists within the field.

Not only is there oppression in the workplace, there is a complete opposition to the minority community within the professional psychology organizations. Jackson (1992) discusses "reverse discrimination" in which the majority, in this case the Caucasians, felt the fear of losing their power status, and some of them claimed that minority members had "control over White folks" (p. 84). The "colorblind" method and the prevalence of white psychologists not only halts the growth of psychology field in its entirety but it also drives away minority clients who are in much need of a mental health care provider. A study done in 2001 by the U.S. Surgeon General (U.S. Department of Health & Human Services, 2001) reported that less than 6% of Asian Americans with a mental illness sought psychiatric care while African Americans, Native Americans, Alaska natives, and Latino Americans showcased similar results (Berger, Zane, &

Hwang, 2014). Korchin (1980) proposed a reason for why this is: mental health care was simply constructed by white, middle-class psychologists who are ignorant of the cultural, racial, and ethnic issues of society and deprive the clinical practice of concepts that speak to the issues and needs of minority patients. Moreover, Parloff, Waskow, & Wolfe (1978) claim that the undeveloped racial identity of some therapists, due to institutional and internalized oppression, damage their capability to work effectively as psychologists to minority patients (Korchin, 1980). This only affects minority populations because the facilities are so Caucasian-centric that it fails to appeal to ethnic minorities who are in search of help. Among these barriers include language differences, worry of negative stereotypes and humiliation, less access to mental health facilities, bigotry and anxiety (Korchin, 1980). Due to these facts, researchers searched for a solution for the lack of patients of ethnic backgrounds seeking mental health care. One of them being, to put as many mental health paraprofessionals as possible in minority neighborhoods to provide them with professional treatment (Korchin, 1980). However, Smith, Burlew, Mosley, & Whitney (1978) of the Association of Black Psychologists pointed out the dissonance within the black community towards a policy that puts emphasis on the need for white, middle-class professionals (Korchin, 1980). It is clear that culturally competent and racially aware psychologists should be encouraged to enter the profession but the future is bleak for minority psychologists. The National Center for Education Statistics (2011) reported that majority of any psychology degrees were given to white American students and U.S. Census Bureau's data (2001) showed that the graduation rate for racial minorities were much lower than white students (APA, 2003). This evidence suggests that the Caucasian dominance in psychology deprives ethnic minorities with opportunity/access in the field and perpetuates the ongoing racism that is occurring through the mental health care system. For example, Eakin (2000) revealed that during

the 1960s, black psychiatrists such as Dr. Alvin Poussaint, a Harvard professor, proposed the medicalization of racial discrimination as a mental illness in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) but the American Psychiatric Association opposed the proposal even after it was propositioned in 2003, claiming that racism is a problem of one's culture and the medical field should not intervene (Rooks, 2012). The bigoted ideology of pre-civil rights era still remain today. However, social change can start from racial studies and competency in attending to the mental health care of ethnic minority patients and clients while institutions recruit more with a focus on maintaining ethnic minority students in all degree levels.

As one who is entering the field of psychology, it is inevitable that there will be some lack of understanding or perhaps barriers to face. Whatever these tribulations may be and however they come my way, I believe it is essential for myself and for the greater community in which I live to continue working in the field and investigating socially relevant topics. However, as society evolves, younger generations are being educated about the injustices of the past. Just as being white is a privilege both within the workplace and the broader society, being an Asian minority comes with a privilege to influence my colleagues, patients, and clients to better serve the human mental health. This is not to imply all mental health practices and research shift towards attending to minority Americans but it is to emphasize the need to equalize the system. Racism can be and is a kind of mental illness that affects millions of people living in America today. It is now time we cured it.

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