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Special Section

Racism and Mental Health Into the 21st Century: Perspectives and Parameters

David Rollock, Ph.D., and Edmund W. Gordon, Ed.D.

Definitions and theories of racism are reviewed, and the influence of racism on the American mental health system is examined, with special attention to the effects on racial and ethnic minorities of the sociopolitical climate of the 1990s. The aims of this special section are outlined and an overview is presented of the articles, which define some of the key problems of racism and mental health, describe their scope and effects, and propose approaches to remediation as we move into the 21st century.

Racism represents a perennial challenge to the mental health establishment. Whereas racism connotes a disturbance in human relationships that leads to differentially negative outcomes for its victims (and ultimately for its perpetrators), mental health is concerned with appropriate and effective adjustment to social reality. As racism persists in its traditional forms in American society, it retains the potential to disrupt individual mental health, confound the societal systems designed to promote psychological well-being, and distort the processes for generating knowledge about psychopathology and mental health.

New models of service delivery and training for mental health professionals born in the last part of the 20th century also place many people at risk for receiving inappropriate care. Current mental health practices and delivery systems have not been designed to meet the needs of ethnocultural minorities, and poor understanding of the interplay of cultural, financial, organizational, and diagnostic factors contributes to inappropriate service utilization, individual suffering, and deep social and economic costs *(U.S. Surgeon General, 1999)*.

On a conceptual level, racism can influence definitions of pathological behavior and the behavior of diverse groups of people. On a practical level, racism affects the allocation of and access to resources necessary for appropriate treatment and well-being.

The quest to understand racism and mental health falls to social science theory and research that have direct-action potential. While all social science should serve as a force for "liberation" as much as for "truth" *(Gordon & Meroe, 1991; Gordon, Miller, & Rollock, 1990)*, there is a special urgency in rooting out racism in mental health contexts because of the personal distress and social cost that mental health issues inevitably entail. The articles in this special section address ways to view the problems of racism in mental health, attempt to define some contemporary parameters of these issues, and consider approaches to remediation.

ELEMENTS OF RACISM

Definitions of racism tend to center around three elements: social attention to "racial" (phenotypic and observable) differences among individuals as

This special section was organized for the Journal by the authors, with the support and creative energies of the Interest Group on Racism of the American Orthopsychiatric Association. *Authors are at: Department of Psychological Sciences, Purdue University, West Lafayette, Ind. (Rollock); and John M. Musser Professor of Psychology (Emeritus), Yale University, New Haven (Gordon).*

members of distinct groups; belief systems concerning characteristic inferiority or superiority associated with group membership; and patterns of behavior that differentially affect the esteem, social opportunities, and life chances of members of racial groups as a function of those belief systems *(Jones, 1997; van den Berghe, 1967)*. Extending far beyond the own-group bias implied by "ethnocentrism," the social ills associated with racism can result in caste-like conditions for those identified as belonging to different races, and are intractable to the extent that "race" is defined as immutable *(Ogbu, 1978; van den Berghe, 1967)*.

Scholars differ in the extent to which they believe racism should be studied individually or structurally, in terms of beliefs or discriminatory behavior. Jones *(1997)* has discussed racism on individual, institutional, *and* cultural levels, reflecting the many ways in which racism is perpetrated, transmitted, and maintained. Similarly, Carter *(1995)* contended that the concept of "race" is pivotal in the history of American mental health concerns. However, he also argued that sociohistorical and cultural treatments of race are insufficient to inform mental health practice, because such approaches do not account for how individuals actually consider and use "race" in their daily lives.

This diversity of views is not surprising, given the analytical frameworks of different social science disciplines; the multiplicity of problems defining "race," "racism," and their proper place in research; and the importance of advocacy on the part of researchers and practitioners when discussing matters of "race" *(Yee, Fairchild, Weizmann, & Wyatt, 1993)*. However, there is some consensus that, like any cultural product, racism is transmitted across generations by reciprocal interactions between individuals and the social institutions they create and to which they are subject *(Jones, 1997; Kovel, 1970; Thomas & Sillen, 1972; van den Berghe, 1967)*.

Relationship of Mental Health and Racism

As racism represents a certain codification of societal beliefs and associated praxis, so too does "mental health." The mental health enterprise in the United States is another element of culture that shapes, and is shaped by, the lived experiences of its citizens. "Mental disorder" and "coping" are in large measure defined normatively, and culturally sanctioned codes govern the training of individuals who intervene in these matters. Of course, the procedures and institutions to protect and restore mental health also are carefully circumscribed and sanctioned within culture-specific frameworks *(Frank, 1973)*.

As a belief and an action potential, racism can erode the mental health status of its individual victims and dominate the institutional and cultural mechanisms through which it operates. On an individual level, racism poses mental health problems in terms of the internal stresses it generates *(Anderson, 1991)*. While the experience of racism may lead to full-blown personal self-hatred only in a minority of cases, such occurrences generally do shape the development of reference-group orientation, an important aspect of personal identity *(Cross, 1995; Spencer, 1984)*. Experiences of racism also force patterns of adult coping that can restrict perceptions of the social environment, modes of intra- and intergroup interaction, and life-style options *(J. Harrell, 1979)*. Stressful interethnic contacts and racism have been related to their victims' general emotional experience and expression *(Vrana & Rollock, 1996, 1998)*, health and psychophysiology *(Anderson & McNeilly, 1991; Clark, Anderson, Clark, & Williams, 1999; Harrell, Merritt, & Kalu, 1998)*, and symptoms of psychological disorders *(Landrine & Klonoff, 1996)* that may be transmitted intergenerationally *(Choney, Berryhill-Paapke, & Robbins, 1995)*. Racism prompts specific adaptive child-rearing and socialization patterns *(Thornton, Chatters, Taylor, & Allen, 1990)* geared toward addressing both current conditions and successful management of later life in an oppressive mainstream *(Ogbu, 1981; Young, 1974)*. These adaptive attitudes toward racism also affect help-seeking tendencies for mental health distress *(Delphin & Rollock, 1995; Leong, Wagner, & Tata, 1995; Nickerson, Helms, & Terrell, 1994)*.

On a broader level, institutionalized racism detracts from the overall capacity of a community to promote the development of its residents *(Barbarin, 1982)*. Perceptions of institutionalized racist practices, among other community problems, have been linked to mental health functioning in both dominant and subordinate social groups *(Hendryx & Ahern, 1997; Jackson & Volckens, 1998)*.

Mechanisms of Influence

The influence of racism on the American mental health system has been described as occurring along a number of important routes. These mainly

concern identification and interpretation of deviance and distress, as well as access to appropriate resources for alleviation of mental health concerns *(Ridley, 1995; Thomas, 1973; Turner & Kramer, 1995)*.

Definition. Racism affects definitions of mental health and pathology. The mental health establishment has been described as principal cultural guardian of normality and psychological deviance *(Frank, 1973; Szasz, 1987)*. Turner and Kramer *(1995)* suggested that dominant groups "construct definitions to justify their superiority of the subjugated groups' inferiority" *(p. 7)*; these definitions range from biological to personal/social to situational, covering etiology as well as maintenance. For example, a number of classic reviews *(Prudhomme & Musto, 1973; Thomas & Sillen, 1972)* presented extensive historical evidence of the pathologizing of African-American behavior to justify institutions erected by dominant groups in American society. Further, Cervantes and Arroyo *(1994)* discussed the failure to establish validity and reliability of standard diagnostic categories among Hispanic children and adolescents. While sensitive clinicians may attend to cultural dimensions in the treatment process, Cervantes and Arroyo noted that correct diagnosis is complicated by appropriateness of the available diagnostic labels, given cultural beliefs about causes and cures of psychological symptoms, limited recognition of culture-specific syndromes, the ability of children to articulate their psychological experiences, and language barriers.

Etiology. Racism underlies aspects of explanations of the etiology of mental disorder and deficiency. Social Darwinist rationale (supporting exclusionist social and economic policies) has undergirded deficit models of psychopathology *(Thomas & Sillen, 1972)* and intellectual performance *(Gould, 1981; Helms, 1992)* applied to diverse ethnic groups from the very foundations of American psychology, psychiatry, and psychoanalysis.

Evaluation. Mental health evaluation processes—assessment and diagnosis—have been developed and their results interpreted in ways consistent with the needs, concerns, and skills of those in socially advantaged positions *(Gordon & Terrell, 1981; Padilla & Medina, 1996; Rollock & Terrell, 1996)*. Research is still needed not only to disentangle issues of clinician bias and diagnostic validity from true epidemiological differences *(Zhang & Snowden, 1999)*, but also to determine how diagnostic procedures themselves may be culturally grounded and differentially perceived *(Terrell, Terrell, & Taylor, 1980)*.

Service delivery. Racism affects direct service providers, including the availability of ethnoculturally diverse therapists and other mental health service providers, the comfort and attitude of these personnel in working with ethnoculturally diverse populations, their attention to prevention in contrast to treatment and remediation, and the cultural appropriateness of the major models of mental health service delivery that they learn and employ *(Bernal, 1990; Lorion, 1991; Ridley, 1995; Rigazio-DiGilio, Ivey, & Locke, 1997; Townsend, 1995; Whaley, 1998)*.

Institutional structure. The organization and structure of mental health institutions and programs also can convey systematic disadvantage as a function of race, ethnicity, and culture. Often, such systems are designed at variance with folkways and the life-styles shaped by a socioeconomically subordinate position *(Zane, Sue, Castro, & George, 1982)*, and fail to address the interaction among the multiple social systems that exacerbate family and individual difficulties *(Boyd-Franklin, 1998)*. In contrast, services with ethnically similar clinicians and experience in dealing with clientele of color encourage better use and promote better outcomes on the part of ethnic minority consumers *(Snowden, Hu, & Jerrell, 1995; Yeh, Takeuchi, & Sue, 1994)*.

Research. Research on mental health problems is open to racist assumptions from culture-bound epistemology *(Gordon et al., 1990)*, to limited and improper applications of scientific method *(Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Turner & Kramer, 1995)*, to the ways in which research concerning race, ethnicity, and social disadvantage is communicated and used *(Gordon & Meroe, 1991; Yee et al., 1993)*. Racism also may impede critical evaluation of treatments for specified disorders, including understanding ethnocultural influences on mainstream approaches, and the utility of group-specific interventions. For example, overreliance on assumptions of human homogeneity has contributed to underrepresentation in (supposedly universally applicable) behavioral therapy research *(Jones, Brown, Davis, Jeffries, & Shenoy, 1998)*. Similarly, there has been underattention to substantial differences among groups in biological response to the most commonly used

psychoactive medications, and to cultural mediators of medication response, including compliance or concurrent use of indigenous therapies *(Lawson, 1998; Lesser, Smith, Poland, & Lin, 1997)*.

Training. Each of the foregoing intersections between racism and mental health is perpetuated by training systems that fail to provide relevant direct service skills, promote research into relevant populations or problems, encourage attention to prevention and to oppressive social contexts, or contribute to the numbers of well-trained professionals of color *(Ridley, 1995; Turner & Kramer, 1995)*.

For the purposes of this special section, these concerns will be discussed primarily in the contexts of definitions and theories, research and assessment, and services and training.

RACISM AND OTHER "ISMS"

Racism is neither unique nor independent in its deleterious effects on individual mental health, clinical judgment, and the operation of mental health knowledge-generation or service delivery systems. Pierce *(1995)* has argued that power relationship dynamics are central to racism, sexism, and other forms of discrimination. On institutional and cultural levels, these matters concern the ability to define norms and deviance, and compel compliance with them. On an individual level, subtle and covert biases based on race, gender, and other characteristics operate in similar ways to guide the attitudes and behavior of members of advantaged groups, even as overt biases have become socially unacceptable *(Dovidio & Gaertner, 1996; Pinderhughes, 1989)*. Relevant questions include how the victims of such bias cope and resist, how the oppressed differentiate individual from collective messages on the part of the oppressor, how the oppressed maintain hope and self/group esteem, and whether and how oppressor and oppressed can ever have their needs met simultaneously *(Pierce, 1995)*. Appreciation of the total orchestration of personal characteristics and individual responses to concurrent forms of oppression, such as poverty and sexism, may illuminate the most useful paths to diagnosis and intervention *(Carter, 1995)*. Thus, taking racism out of the mix of forces acting on and being responded to by an individual or group can seriously skew even well-intentioned efforts.

Perhaps one of the most common correlates of American racism is its association with economic injustice and its related social effects. Many social scientists sensitive to the dynamics of ethnicity and racism have disputed simple "culture of poverty" notions of the 1940s and 1950s, which had subsumed ethnocultural differences under the banner of social class *(Valentine, 1968)*. However, a number of contemporary social scientists have pointed to the decline of overt aversive racism accompanied by increasing economic disparities. This phenomenon has prompted some to consider that the major impact of racism in the last decades of the 20th century is through its linkages to barriers to economic participation *(Wilson, 1980)*. At the very least, social class has been shown to play a significant role in the mental health status and care of consumers of color. Kessler and Neighbors *(1986)*, for example, have demonstrated that ethnicity and socioeconomic status interact significantly to produce differences in psychological distress. Designing culturally responsive systems of mental health care demands attention to the confluence of social and economic obstacles to obtaining treatment. In light of recent changes in the American health care system, these obstacles may include financial access to choice of mental health service delivery outlets *(Snowden, 1999)*.

The existence of sexism raises similar questions about the adequacy of addressing ethnicity/race alone in discussions of mental health. While gender is associated with its own unique stressors, many women of color subordinate their gender-related concerns to the issues of racism that they share with their men *(Comas-Diaz & Greene, 1994)*. In so doing, they also bear silently the stressors associated with sexism within their own ethnic communities, which in turn may contribute to sex differences within ethnic communities in disorder prevalence *(Rieker & Jankowski, 1995)* and treatment *(Mays, Caldwell, & Jackson, 1996; Padgett, Patrick, Burns, & Schlesinger, 1994)*. Common elements in mental health interventions concerning gender and ethnicity often include raising of consciousness and clearing of cognitive distortions, recognizing diverse contexts of oppression, affirming self- and group identity, increasing self-mastery and autonomous dignity, and working for self- and social improvement *(Comas-Diaz, 1994)*.

Heterosexism exerts similar pressures, and often points up the "homogenization" that racism—and culture—can encourage in communities of color. The coping and adjustment of lesbians of color, for example, are often complicated by cultural beliefs that emphasize family ties and family honor, spe-

cific gender-role traditions, heterosexual privilege, and reproductive sexuality for survival, as well as the subordination of other oppression-related concerns to the primacy of racism *(Greene, 1994; Jones & Hill, 1996; Nakajima, Chan, & Lee, 1996)*.

The common pathways and interpenetration of racism with other "isms" suggest that it best not be considered in isolation. Indeed, racism is but one form of communicentric bias that distorts our knowledge base and effectiveness in social science fields. At the same time, the peculiar history of racial and ethnocultural relations in the United States, as well as the importance of description as a basic tool to forge new knowledge and understanding *(Gordon et al., 1990)*, can make a focus on racism per se useful.

Recent Shifts in Practice and Policy

Historically, the gatekeeping function of mental health has varied depending on what the "gate" has been designed to keep in and keep out, and the state of the science used to justify those conclusions. In the aftermath of World War II, through the height of the civil rights movement, several developments took place that are relevant for understanding current interactions of racism and mental health. Against the backdrop of the revolution in psychotropic drugs that made successful intervention possible with many individuals previously considered unreachable, Turner and Kramer *(1995)* noted that there were parallels between the Civil Rights Act of 1964 and the Community Mental Health Centers (CMHC) Act of 1963. Advocates of both measures were concerned about substandard mental health care for African Americans, and they saw racism as a form of societal "mental illness" that the nation must address with sensitivity and with new models of commitment, implemented on the local level but supported by federal involvement.

This optimistic approa . was severely challenged in the intervening decades. Massive deinstitutionalization following the 1963 CMHC Act—also made possible by the introduction of new classes of powerful psychoactive medications—was not matched by the development of local facilities to care for those with mental disorders. In the 1980s, racial violence and civil rights losses mounted, threatening not only access to educational and economic participation but access to social services at a time when ethnic minority populations were increasing *(Jaynes & Williams, 1989; U.S. Commission on Civil Rights, 1992)*. Mental health services continued to fragment, and access became narrower in the early 1990s due to the radical downsizing of state mental health facilities *(Lutterman, 1994)*, coupled with transfer of public monies into private-sector mechanisms designed to take over governmental responsibilities for mental health care. Increases in the general population, a rise in drug arrests, and the lack of proper community-based mental health facilities set the stage by the middle 1990s for an overrepresentation of people of color (African Americans and Latinos in particular) among the ranks of the homeless, incarcerated, and underserved *(Turner & Kramer, 1995)*.

Privatization of mental health services contributed to fragmentation and further limited access by focusing on cost-effectiveness rather than service needs, and supporting medication-based treatment models for narrowly diagnosed problems at a time when dually diagnosed substance abusers and adolescents with chronic problems were becoming more prevalent *(Brooks, Zuniga, & Penn, 1995)*. While more affluent and majority-group consumers turned to support groups, private facilities, and private insurance to address their mental health needs, less affluent and ethnic-minority individuals had to make do with what was left of public services once their limited financial resources were exhausted.

The gains in biological and genetic understanding of mental disorders came to dominate treatment models, even as the need increased for culturally competent and socially circumspect mental health care for an increasingly diverse American public. Conservative backlash against the gains of the civil rights era managed to replace public funding for those in economic need with calls for "personal responsibility" *(Brooks et al., 1995)* and "color-blindness." Even in mental health circles, despite research indicating the efficacy and efficiency of ethnic-specific service delivery systems, proposed increases in such services have been challenged by concerns over "segregation" *(Sue, 1998)*.

SCOPE OF THE SPECIAL SECTION

The linkages between racism and mental health continue to unfold, renewing the challenge to understand them, put their influence into perspective, and develop appropriate means of analysis and intervention. The contributions to this section attempt to advance this effort at both micro and macro levels.

They begin with consideration of the locus of the problem. In dealing with racism, mental health professionals are confronted by a serious question about the nature of the analysis—about whether racism should be addressed on the individual or the institutional level. The way this question is answered has implications for the training of mental health professionals, the evaluation of their competence, and the soundness of their theoretical models. (Indeed, the determination made could call into question the value of providing direct mental health services at the current stage of our social science knowledge.) Next, the extent of racism's effects are presented in terms of our understanding of the ways in which the circumstances and experiences associated with racism affect the mental health status and functioning of its victims. The final contributions address remediation. Given the toll racism takes on individual well-being, and the overall effectiveness and efficiency of our systems of care, several authors present approaches to service delivery, the training of clinicians, and the personal journeys of transformation that are necessary to effect helpful change.

The article by James Dobbins and Judith Skillings examines the individual dimension of racism. Acknowledging that racism can be characterized from several different levels, the provocative framework of a disease model is used to explore how racism as a social power imbalance is translated into pathological behavior on the part of its individual beneficiaries. The authors use this mental health framework to describe the negative effects of racism on its perpetrators—including their passive support for subtle societal racism—and discuss means to ameliorate these symptoms.

The proposition that racism is a clinical syndrome is critiqued in a commentary by David Wellman, who raises concerns about the theoretical and practical limitations of conceptualizing racism in individual terms. As a sociologist, Wellman emphasizes the structural character of racism that maintains inequalities in ways not addressed in individual formulations. He argues that characterizing racism as a disease can be counterproductive to the struggles against racism, both by removing individual responsibility and by diverting attention from social power imbalances. He further points out the ways in which medical-model approaches to issues involving race relations traditionally have served the status quo.

Three articles present issues that help to define the scope of the problems posed by racism. In the first of these, Anderson Franklin and Nancy Boyd-Franklin describe how the pervasiveness of racism—specifically the small, everyday affronts and slights—prompt important adaptations on the part of its individual victims. These "ordinary" experiences of racism can erode a sense of personhood and effectiveness, and the authors examine the ways in which this gives rise to both positive and negative responses in the case of African-American men and boys.

Shelly Harrell picks up on the definition of racism as a systemic interaction between groups, but discusses the impact on its individual victims by integrating major research findings within a modified transactional stress model. In this way, the psychological impact of racism is examined as a result of the interplay of individual characteristics, mitigating and aggravating situational and environmental factors, and the specific pathways through which racism comes to touch the individual. Harrell's multidimensional framework also contemplates separate domains of impact, based on the critical person-environment transactions.

The study by Sumie Okazaki illustrates shifting parameters of the problems of racism and mental health by highlighting a possible side-effect of one type of structural intervention. A popular recommendation for reducing racism in service delivery has been to design mental health services tailored to the needs of particular ethnocultural groups. While existing data suggest that such efforts do increase service utilization among targeted populations, Okazaki's data both extend and complicate this picture by indicating that, for seriously mentally ill Asian-American patients, stigma does not play as big or as definitive a role in mental health help-seeking as theory and speculation might suggest. One hopeful explanation for this counterintuitive finding is that stigma was effectively neutralized by the availability of culture-specific services for the patients in this sample (and, presumably, for this cohort). Still, the findings challenge future researchers to explore further individual-level and family-level differences in the meanings of acceptance of psychological disorder and its associated shame and stigma.

The final two articles consider options for minimizing the presence of racism among mental health practitioners and in our systems of service delivery. Anti-racism training, designed for and led by mental health workers, has become an increas-

ingly common approach to dealing with systemic prejudice, individual racism, and initial steps toward cultural competence within organizations. Charles Ridley, David Chih, and Ronald Olivera note the often scattered and atheoretical efforts at incorporating cultural issues into efforts at training clinicians for work with diverse populations. They attempt to link theory and practice by proposing the concept of "cultural schema" to elucidate different groups' systems of values and meaning, as they intersect with and diverge from the American mainstream. Cultural schema can be used systematically to modify and direct common clinical wisdom in the treatment of individuals from disparate ethnocultural groups. Similarly, Jeffrey Ring's personal reflections generate practical suggestions about interventions to enhance clinicians' sensitivity and reduce intergroup tensions. However, Ring adds a crucial but often underestimated dimension to these efforts by describing some of the correlated, and often painful, processes of personal development that individuals must undergo in order to become effective leaders.

Cultures, and their effects on individual behavior, are not static; they change in response to personal, political, and social realities. The formulations and recommendations that may be useful for dealing with the problems of racism and mental health on the threshold of the 21st century are, therefore, specific to the times and circumstances in which we live. The contributors to this section present a number of innovative approaches to analyzing and dealing with issues of racism that confront our mental health establishment today. By better understanding our own times and circumstances, and addressing their attendant problems more effectively, we can both improve conditions for racism's victims now, and set the stage for even more effective management of the challenges that await this diverse nation in the generations to come.

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For reprints: David Rollock, Ph.D., Associate Professor, Department of Psychological Sciences, Purdue University, West Lafayette, IN 47907