Deconstructing Unconscious Bias in Behavioral Health Care

Making the Case to Identify Not Blame

Session 2

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Ms. Padilla has over 22+ years of public health service including curricula development and video script writing, conducts evaluation of substance use disorder treatment programs and problem-solving courts, engages in chronic disease research and prevention, and instructs behavioral health professionals, prevention specialists, and drug court practitioners on behavioral health and recovery support practices

Presenter

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Born in the Bronx and raised in White Plains, New York, Dr. Glover has spent the greater part of her adult life following her interests in science, health and improving life for the underserved. After graduating from Howard University with a BA in History, she followed her curiosity about medicine and ultimately attended SUNY Downstate College of Medicine and obtained a Master of Public Health from Columbia University's Mailman School of Public Health via the highly competitive Macy Scholars Program.

Currently Assistant Professor of Psychiatry at the Albert Einstein College of Medicine, Dr. Glover teaches psychopharmacology and aspects of psychotherapy to Internal Medicine and Family Medicine residents.

Goals

- This series was developed to provide professionals with a review of unconscious (i.e. implicit) bias and how it negatively affects interactions and service outcomes for racial and ethnic communities we work with

- Participants will become familiar with tools and activities to identify and address hidden bias in addiction, mental health, and prevention disciplines in order to collectively effect equitable outcomes for persons of color.

Four Session Blue Print

- Inequities and sources of inequities
- Focus on unconscious bias in behavioral health settings
- Understand how unconscious bias develops
- Explore hidden bias in behavioral health discipline
- Identify and mitigate bias impact
- Strategies: Cultural Humility, CLAS
- Organizational bias reducing strategies, models and leadership

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington (DC): National Academies Press (US); 2003.

Why Assess and Identify Unconscious Bias

Unconscious Bias

- **Unconscious** or hidden feelings or thoughts that are negative/hostile/violent about specific persons and/or communities.
- Can be difficult to identify, address and resolve, both by the individual who holds these biases and those who associate with them.

“But you speak so well”

Types of Microaggressions

- **Mircoassaults**: explicit epithets, discrimination
- **Microinsults:** subtle and unconscious actions
- **Microinvalidation**: unconscious communications that convey "outsider" status

American Psychological Association, Tori DeAngelis, February 2009, Vol 40, No. 2, Unmasking 'Racial Microaggressions,'
https://www.apa.org/monitor/2009/02/microaggression

Impact of Microaggressions

- The internalized shame induced by repeatedly experiencing such insults creates a hypersensitivity to social judgment, leaving one self-questioning whether perceived slights are real or imagined.
- "Facing overt discrimination is in some ways easier than encountering microaggressions because one's perceptions are easier to validate in the former."

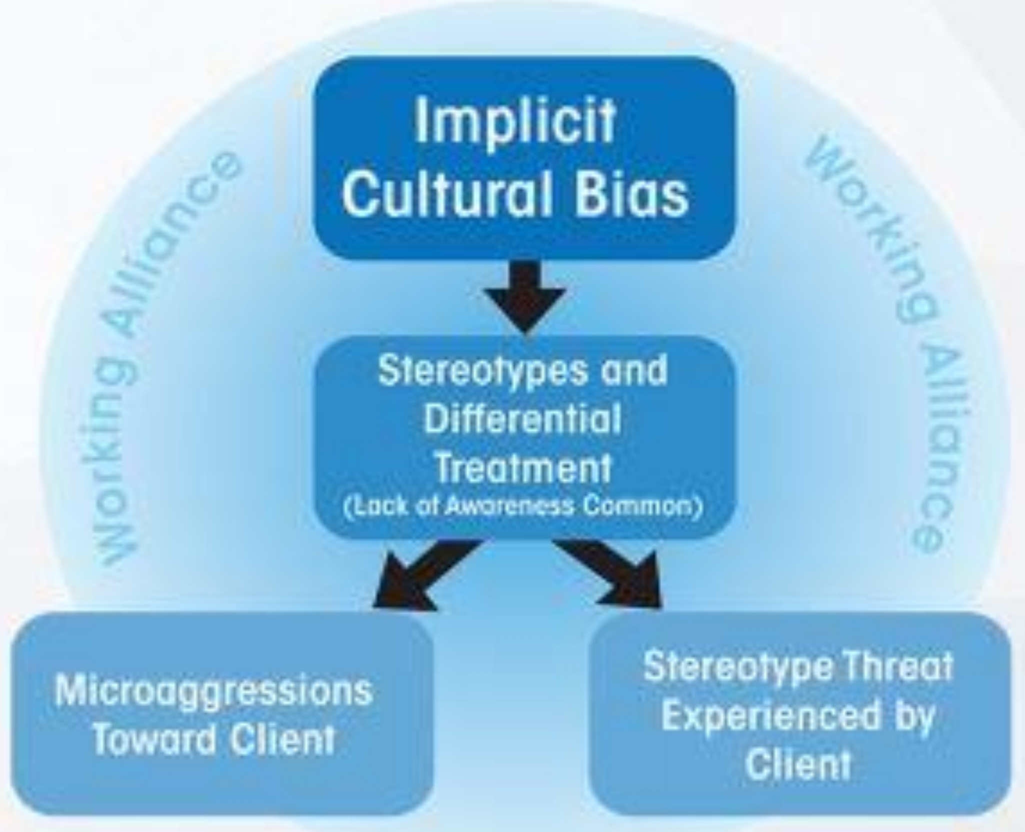
Elected Papers from William L White, Microagrressions in Recovery (More than a Concern with Political Correctness, August 19, 2016, http://www.williamwhitepapers.com/blog/2016/08/microaggressions-in-recovery-more-than-a-concern-with-political-correctness.html

Stereotyping

- Discovering presence of "sex worker?" note in one's medical record as a result of initial disclosure of prior addiction and subsequent challenges obtaining health, disability, and life insurance despite decades of stable recovery and good health.
- Efforts to refute one's addiction/recovery status because it conflicts with prevailing addict stereotypes, e.g., "*You weren't really addicted*," "*Come on, one drink won't hurt you!*" "*Surely, you don't have to keep going to those meetings after all of this time.*"

Elected Papers from William L White, Microagrressions in Recovery (More than a Concern with Political Correctness, August 19, 2016, http://www.williamwhitepapers.com/blog/2016/08/microaggressions-in-recovery-more-than-a-concern-with-political-correctness.html

Behavioral Health Bias



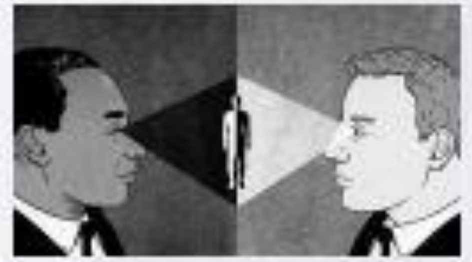
Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? a randomized study of two commonly used terms. Int J Drug Policy. 2010;21(3):202-207

Associated Factors of Racially Based Outcomes

Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? a randomized study of two commonly used terms. Int J Drug Policy. 2010;21(3):202-207

Racial Anxiety

- **Racial Anxiety** refers to interacting with people of different races which can result in a heightened level of stress and emotion.
- Persons of color have a increased awareness that they may be the victim of discrimination and violence.
- White persons fear they will be perceived as racist.



Stereotype Threat

- **Stereotype Threat** refers to a situational predicament in which individuals are at risk of confirming negative stereotypes about their group.
- Resulting sense that one might be judged based on negative stereotypes about one's group instead of on personal merit.
- Self-confirming belief that one may be evaluated based on a negative stereotype.

White Privilege

- A special or unearned right, advantage or immunity granted or available to an individual or collectively to a group based on their membership with a dominant culture.
- White privilege is an institutional (rather than personal) set of benefits granted to those of us who, by race, resemble the people who dominate the powerful positions in our institutions.
- Privilege, particularly white, is hard to see for those who were born with access to power and resources but very visible to those racial minorities who don't have it.

In Group Preferences

- Favoring members of one’s in-group over out-group members, usually delineated by culture.
- When people experience in-group bias, they tend to be more “comfortable with, have more trust in with others in that group (race, community, professional culture, etc.)
- Whites with in-group bias don’t see themselves as racists if they’re not actively or directly holding hostility or distrust toward persons of color.

Not an Easy Topic to Discuss

The potential of having implicit bias toward blacks and other minorities can be difficult to discuss and address for those with white privilege because it can entail:

- The risk of being perceived as racist
- Admitting that advantages gained are based on discriminatory practices

Unconscious Bias in the Clinical Setting

PRINCIPLES OF SOCIAL INJUSTICE

- **ESSENTIALISM**

  The belief that there are distinct, unchanging, and natural characteristics that define social groups and facilitate their categorization

- **ERASURE OF CONTEXT**

  Failure to consider sociohistorical context when seeking to understand the etiology of inequities

- **BIOLOGICAL DETERMINISM**

  The false belief that racial groups are biologically and genetically different

- **STRUCTURAL RACISM**

  "A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity"

Shadravan S, Barcelo N: Social Injustice and Mental Health Inequities. In Social (In)Justice and Mental Health, Washington DC, APA Publishing. In Press.

What is Race?

- (Dumbest concept ever)
- Refers to a group of people who share biological similarities. But…
- It usually means grouping people according to physical appearance, such as skin color, with little attention to *actual* biological or genetic determinants.
- A biological construct proposed by Johann Friedrich Blumenbach in the 1800's.

Then What Happened?

The idea spread and civilizations around the world were then lumped together and classified as:

- Caucasian (White)
- Mongolian (Yellow)
- American (Red)
- Malayan (Brown)
- Ethiopian (Black)

How Did it Work Out?

- Slavery
- Colonization
- The Holocaust
- Jim Crow
- Inter-ethnic hatred based on bad science
- Stereotypes based on bad science
- Medical and psychiatric/psychological diagnoses based on bad science
- Today’s medical or mental disorder could be tomorrow’s Mongoloid or Drapetomania

Unconscious Bias look in Mental Health

- The rate of a clinical diagnosis of schizophrenia was significantly higher in black subjects than in non-Hispanic white subjects ($P = .01$).
- Controlling for age, sex, income, treatment site, education, and the presence or absence of serious affective disorder as determined by experts blinded to race and ethnicity.
- Blacks were 2.7 times more likely than non-Hispanic whites to receive a diagnosis of schizophrenia.
- Schizophrenia is **overdiagnosed** in Blacks and affective disorders are **underdiagnosed**.
- Conclusion: not all psychosis is schizophrenia, but also…
- A similar study published around the same time asked interviewers to explain the discrepancy between the participants' stated symptoms and the clinicians' diagnosis of schizophrenia. The clinicians assumed that Black participants were simply being dishonest about their symptoms.

Arch Gen Psychiatry. 2012;69:593-600, Psychiatric Services. 2012;63:875-880

Themes That Seem to Not Disappear

- Mental Status Exam, descriptions of the patient, interactions with the patient
- Hair, complexion, body habitus, and tattoos are a problem
  - Perceptions around natural hair styles, reinforcing acceptability of white traits
  - Assumes the default hair style is straight

More Examples of Bias

- My male patients kept arriving late, explaining they'd been stopped by the police, or had to go to court, or got stuck in court
- My male patients kept getting arrested
- I kept getting frustrated
- My patients who had been incarcerated had a history of trauma from the carceral system
- **Where does this leave us with respect to systemic factors?**

Cross Cultural Mental Health

- CCMH: deals with the description, definition, assessment, and management of all mental health conditions as they reflect cultural factors.
- CCMH: not just for ethnic minorities or people of exotic lands. It's also to understand the impact of cultural factors in the everyday life of majority populations in any country or continent.

Assessing Culture

- It's complex.
- It's based on the information provided by the client rather than the unsubstantiated assumptions of the clinician.
- Do: Ask the patient, "How do you identify culturally?"
- Don't: Assume someone identifies as whatever you think they'd identify as.

Aspects of Cultural Identity

- Ethnicity
- Race
- Country of origin
- Language
- SES
- Education
- Age
- Marital Status
- Sexual Orientation
- Religious/spiritual beliefs
- Migration History
- Level of acculturation

Questions to Ask after Ascertaining the Demographics

- Ask client where he/she/they were born.
- Did they migrate to (current location)?
- How?
- Was there trauma on the way to (their location)?
- What was life like for them in their place of origin?
- Who and what got left behind?
- Is the client 1st or 2nd generation?
- What are their current support systems?
- What does the family think is going on? What do they do for help?
- What result do they expect?

What I Can Do

- Keep listening and learning.
- Remain alert for ways the patient adheres to your formulation or *doesn't*.
- Note them in the formulation or assessment.
- Refer to them later if there are other aspects of clinical care that can be affected by cultural difference.
- Engage the patient about what their diagnosis means to them.
- Engage the patient about the ways their culture can support their recovery.

Cultural Influences on Transference and Countertransference

- "The culture of the clinician and the larger health care system govern the societal response to a patient with mental illness."
  (US Surgeon General 2001)
- Conflicting explanatory models for the illness or the substance use
- Clinician clarity about their own cultural identity and their role in mental health treatment
- Clinician awareness of their own biases, attitudes, and stereotypes

Cultural Influences on Transference and Countertransference (cont)

- **Interethnic transference**: the patient's response to an ethnoculturally different clinician
- **Denial of culture and ethnicity**: the patient avoids discussing issues related to ethnicity and culture with the ethnoculturally different clinician
- **Mistrust and hostility**: can occur given the sociopolitical history between the patient and the clinician's cultural groups
- **Clinical anthropologist syndrome**: the therapeutic process goes off track because the therapist keeps asking cultural background questions at the expense of the appropriate intervention

Spiritual Histories

- That which allows a person to experience transcendent meaning in life
- The relationship and connectedness to this power is the essential component of the spiritual experience
- Take a spiritual history as early in the treatment as possible
- Use open-ended questions
- Acknowledge and normalize patient apprehension and distress
- Make it part of an ongoing dialogue

Pulchaski and Romer, 2000; Karasu 1999; Lo, et al 2003

Questions to Ask

- Do you consider yourself a spiritual or religious person?
- What gives your life meaning?
- Do the religious/spiritual beliefs provide comfort and support? Do they cause stress?
- What importance do these beliefs have in your life?
- Are you part of a spiritual/religious community? Are they important to you? Are they a source of support?
- What are your spiritual needs that someone should address? How would you like these needs to be addressed?

Adapted from Koenig's "Religion, Spirituality, and Medicine" Mayo Clinic Proc 12:1189-1191

Vignette 1

45 y/o Puerto Rican woman with a history of opioid use, on Suboxone, using heroin every few months, sometimes getting arrested because of her efforts to get heroin. She starts using crack as well. Patient refuses referral to a more intense program, despite your talking with her about her multiple arrests and ongoing use.

1. Referral to specialty services?
2. How do we match this patient to the kind of recovery service, the location, or the style of treatment (Lots of groups? How much individual?)
3. What role does trauma play in this treatment decision-making process?

Vignette 2

A 52 y/o African- American man is referred by her PCP for depression and non-adherence to his HIV meds and missing multiple medical appointments. Patient was recently diagnosed with lymphoma and is overwhelmed with anguish and anxiety that is interfering with his ability to function at work. Patient wears multiple beaded necklaces.

Ask Yourself the Following Questions

1. Do our diverse staff members know exactly where to find a therapist they can trust will be anti-racist and anti-bias?
2. Do my diverse employees know how to quickly connect with a therapist who will likely be familiar with their culture?
3. How long does it take to find help?
4. Can I connect my employees with structurally-competent self-management tools for support until their visits begin? How about in between visits?
5. If we've got an EAP, is it anti-racist? Is it scalable to the increasing numbers of employees now willing to get help?

Self Care for the Clinician

- Mindfulness practice
- Taking a break
- Being patient-centered when in the room with the patient so we know where to put our energy
- Are we engaged in Apps that add to our well-being or detract
  from it?

Apps for Diverse Folks

A Woman-Owned Startup Resource

- Doesn't require an app
- Powered by Alexa
- Quick turnaround time for initial session and follow up
- Diverse staff, trained in structural competency
- Available to frontline workers and first responders

Action Items

- Workplace that is as trauma-free as possible
- Hire a diverse workforce, including your on-site addiction, prevention, and mental health staff
- Connect staff to apps and programs that are structurally competent
- Qualified people are out there if you know where to look
- Create and/or partner with pipeline programs
- EAP

Online Directories for BIPOC to Find Therapists

be their partners!

- www.therapyforblackgirls.com
- www.therapyforlatinx.com
- https://www.nqttcn.com/ (Queer and Trans Therapists of Color)
- https://openpathcollective.org/ (for lower cost options)
- https://www.beam.community/ (for online mental health resources for BIPOC)
- https://www.asianmhc.org/ (for Asian community members)

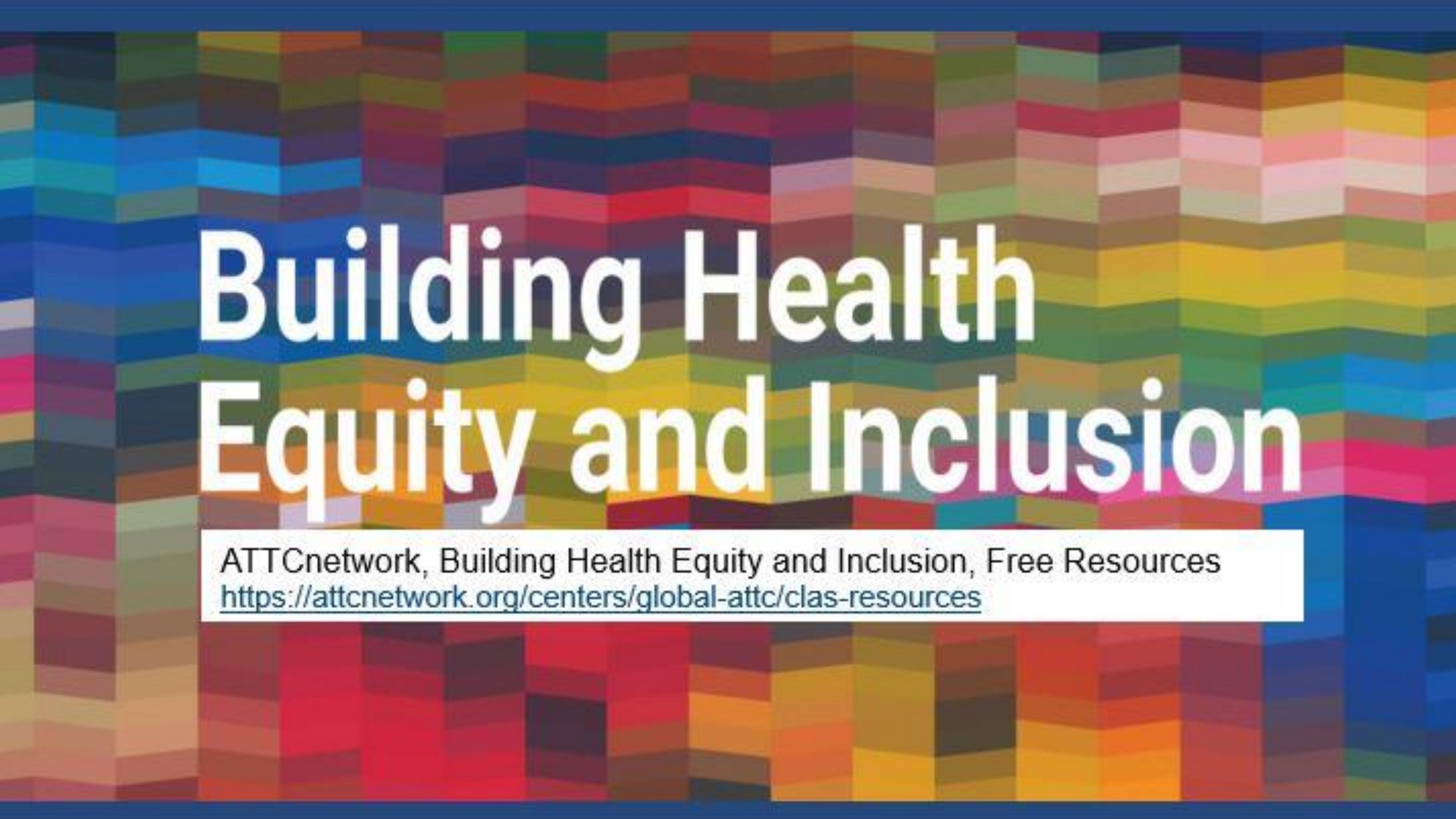
Resources

- **Bryan Stephenson:** https://hub.jhu.edu/2018/05/24/commencement-2018-stevenson/
- **Krieger: The Lancet 2017** https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)30569-X.pdf
- **Socialized racial trauma:** https://www.bc.edu/content/dam/files/schools/lsoe_sites/isprc/pdf/racialtraumaisrealManuscript.pdf
- **Perception Institute, The Science of Equality, Volume 1,** https://perception.org/publications/science-of-equality-vol-1/

Reframing with a Racial Equity Lens

Just like schemas form the frames we interpret our world with, and heuristics direct our judgments and decision-making, ***re-framing*** offers opportunities to convey social justice values…

- Offers evidence of implicit biases and more overt forms of racism by documenting disparate outcomes
- Emphasizes a need for institutional and policy change
- Points to equitable and fair solutions


Building Health
Equity and Inclusion
ATTCnetwork, Building Health Equity and Inclusion, Free Resources
https://attcnetwork.org/centers/global-attc/clas-resources