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Diversity, Inclusion, and Social Justice Digest

Department of Psychiatry and Behavioral Sciences
Vanderbilt University Medical Center

Introduction of a New Charge

It has become apparent in recent months that there exists a pressing need to address issues around social justices, implicit and explicit bias, and structural racism that are pervasive within foundational policies and institutions of our country. These need to address these issues extends to STEM education, healthcare delivery and access, and specifically mental health care. The impact of destructive, deep-rooted institutional policies in mental health care has also been highlighted in many venues in recent months by the APA and AACP, and AACAP, among others. Indeed, long-standing issues of racism, segregation, poverty, exposure to violence including police violence, food and housing insecurity, and criminalization of mental health are deeply linked to increased risk for, and morbidity and mortality from mental illness, and therefore affect us profoundly as mental health care providers.

we have an obligation to address these additional issues as providers of mental health care. Therefore, we have formulated the following consensus statement and supported the formation of a Diversity, Inclusion and Social Justice Committee for the VUMC Department of Psychiatry and Behavioral Sciences.

Departmental Position Statement

The Vanderbilt University Medical Center Department of Psychiatry and Behavioral Sciences condemns behaviors, practices, and policies that perpetuate racism, sexism, homophobia, transphobia and other issues that target members of our community. Such discrimination and bigotry unjustly contribute to medical and psychological morbidity, economic inequality, and mortality. The Department is committed to ending these behaviors, practices and policies by providing an inclusive and supportive environment for our faculty, staff, and trainees, and also advocating for change in our community to facilitate better care and outcomes for our patients. This work will be facilitated by the Departmental Diversity, Inclusion and Social Justice Committee.

The Diversity, Inclusion and Social Justice Committee will disseminate regular Newsletter to keep Department members informed about the progress toward goals set forth by the department.
(1) To create a regular, accessible, and safe forum for trainees, faculty and staff to discuss how unconscious/implicit bias, prejudices, and racism affect us as individuals, department members, and mental health care providers. (2) To identify actions we can take as a department to reduce unconscious/implicit bias, especially racial bias, in the care of patients within our mental health care system at Vanderbilt. (3) To partner with a community organization to advocate for community/political change in the way we view and treat patients with mental illness, and (4) strengthen our partnership with Meharry Medical College. A regular Newsletter will keep department members informed on the committee's work and upcoming events and provide educational materials to promote awareness and self-reflection.

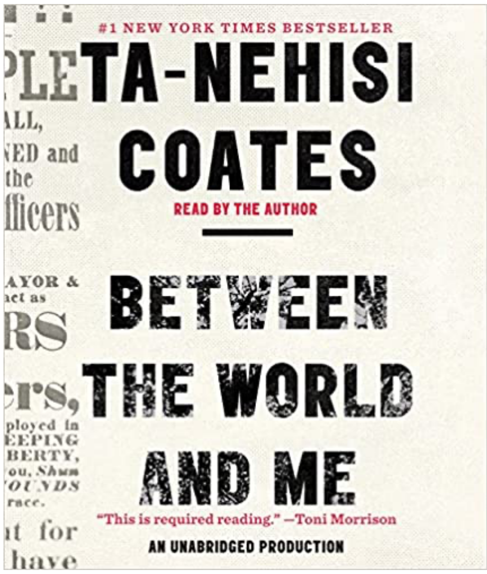
Social Forum:
December 14, 12-1 PM

Book Club Discussion

The Diversity, Inclusion and Social Justice Committee invites you to discuss:

“*Between the World and Me*”

by Ta-Nehisi Coates.



Tim Adams of *The Guardian* writes “Coates’s book is a profound and angry address to a nation that refuses to prosecute police officers who kill innocent black men and women; that pursues a policy of mass incarceration hugely weighted towards its black population; and that routinely seems to think nothing of it. It is also an intimate confession of the fears of a black American father, fears that whatever positive values he gives his son, however hard he encourages him to work in school and do the right thing, out on the streets his body, the color of his skin, will make him vulnerable to state-sanctioned attack. The book is a response to the sense of powerlessness, and fear, that evokes in him.” *Read full article:* The Guardian Article

Registration link for Book Club Discussion: Book Club Registration

For questions, comments and suggestions, please contact Kathy Gracey kathy.gracey@vumc.org

Educational Forum:
Article Review

A Black and White History of Psychiatry

Conrad J. Journal of Medical Humanities (2020)

Assaultive and belligerent?

Cooperation often begins with
HALDOL®
(haloperidol)
a first choice for starting therapy

Acts promptly to control aggressive, assaultive behavior

Several studies have reported the special effectiveness of HALDOL (haloperidol) in controlling disruptive and dangerously assaultive behavior.[1-3] Even the number of violent assaults committed by a group of criminal psychotics "resistant to maximal doses of phenothiazines" was reduced substantially during treatment with HALDOL.[1] Symptom control can be achieved rapidly, frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[2-4]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics the investigator states, "The patients remained alert and more amenable to psychotherapeutic intervention."[1] Another investigator reports that HALDOL "normalizes" behavior and produces a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[5]

Reduces risk of serious adverse reactions

HALDOL (haloperidol), a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. Hypotension is rare and severe orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, ocular changes, serious hematologic reactions and skin rashes.

The most frequent side effects of HALDOL (haloperidol)—extrapyramidal symptoms—are usually dose-related and readily controlled.

References: **1.** Darling, H.F.: Dis. Nerv. Syst. 32:31 (Jan.) 1971. **2.** Man, P.L., and Chen, C.H.: Psychosomatics 14:59 (Jan.-Feb.) 1973. **3.** Palestine, M.L., and Alatorre, E.: Paper presented Amer. Ass. Family Practitioners Annual Meeting, N.Y., Sept. 25-28, 1972. **4.** Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. **5.** Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965.

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

©McNeil Laboratories, Inc., 1974

1974 advertisement for Haldol. From Conrad (2020).

A recent article published by Jordan Conrad (full text article link) "explores two parallel histories of psychiatry in the United States and the way that these have come to influence current mental health practices. Juxtaposing the development of psychiatric care and understanding as it was provided for, and applied to, black and white populations, a picture of the theoretic foundations of mental health emerges, revealing the separate history that led to the current uneven state of psychiatric care."

The author begins by reviewing the prevailing views of 19th century psychiatric practice and theory and how such thinking was inexorably intertwined with philosophical principles that rationalized slavery and planted the seeds of unequal access to mental health care in subsequent centuries. He then described the fundamental shift that occurred in the early 20th century "placing psychiatrists into public life as its newly found emphasis on the prevention of mental illness involved two forms of social control – restrictive immigration practices and forced sterilization – each of which required medical authority to diagnose and categorize. Drawing from the increasingly accepted twin theories of eugenics and Mendelian laws of inheritance, psychiatrists set out to prevent the spread of "degeneracy" in the United States by preventing "unfit" people from entering the American gene pool." Conrad examines how systemic racism influenced modern views of mental health and resulted in incorporation of race as an axial point for differentiation in presentation, prevalence, and etiology of psychiatric illness. In his final synthesis, Conrad concludes, "In examining the history of mental illness in the United States, a number of themes emerge: the utilization of the white culture as the normal case against which others should be measured, the supposed biological inferiority of black people, and the use of psychiatric diagnoses as a way to justify racist prejudices". Conrad ends by stating "in examining the history of mental illness in the United States, reinserting black men and women into the picture, we are deepening our understanding of the origins and development of our own beliefs, actions, and attitudes. From the vantage of history, we are in a position to critically reexamine the present. We must never forget the past, but we must break ties with it."

This recent publication is educational from a historical perspective, well-written and digestible. It provides the reader with new insights into the roots of systemic racism and implicit bias in mental health. Through glimpses into the history of mental health theory and practice Conrad traces how racist depictions of mental illness, which also stigmatized persons with mental illness as violent, "assaultive," and "belligerent" (see figure above). It is only through such raw review of our past can we hope to change the future. For what it is worth, I consider this essential reading for all.

Sachin Patel

Educational Forum:

Article Review

An Anti-Racist Approach to Achieving Mental Health Equity in Clinical Care

Legha RK, Miranda J. Psychiatric Clinics of North America 43 (2020) 451-469

Legha and Miranda succinctly describe the effects of racism on clinical care and suggest a logical solution for the problem (full text article link). They propose that healthcare professionals first become more cognizant of the pervasive effects of racism, then begin to thoughtfully intervene during episodes of clinical care. The plan supports developing equitable healthcare for all people.

They begin by clearly summarizing the role that racism plays in inequitable healthcare outcomes. Their tacit conceptualization of the biological, psychological and social effects of racism led me to imagine a pervasive societal delusional disorder. The authors succinctly review healthcare inequities and the increasing demands for racial justice in recent years before they propose an antiracist approach to clinical care.

The first step in becoming antiracist is to abandon the personal false neutrality that serves as a mask for racism. Accusing others of racism only traps them, freezing them inactive. The second step is to slow down mesolimbic reactivity and pause long enough to heighten racial consciousness. Once racism can be identified and named in slow, reflective thinking one can begin to identify, describe and dismantle it in clinical situations.

Reading this concise, thoughtful and well-organized paper awakened me to understanding that my inaction, acceptance of the status quo, constitutes racism. Let's talk about it!

Reid Finlayson

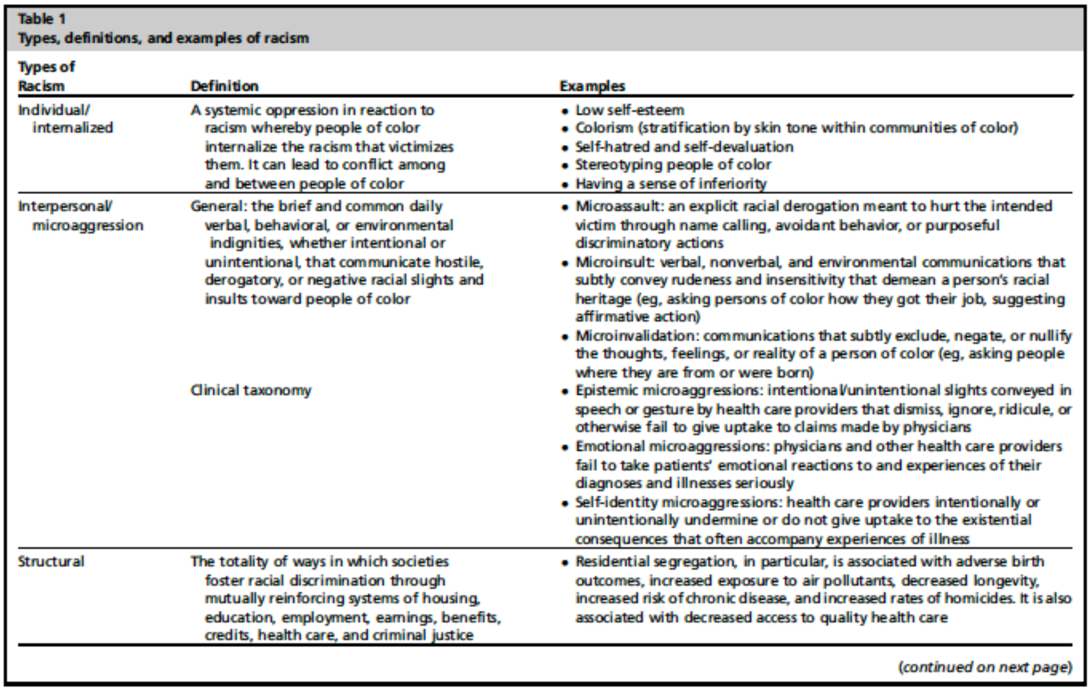


Table 1
Types, definitions, and examples of racism

Types of Racism	Definition	Examples
Individual/ internalized	A systemic oppression in reaction to racism whereby people of color internalize the racism that victimizes them. It can lead to conflict among and between people of color	• Low self-esteem • Colorism (stratification by skin tone within communities of color) • Self-hatred and self-devaluation • Stereotyping people of color • Having a sense of inferiority
Interpersonal/ microaggression	General: the brief and common daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color	• Microassault: an explicit racial derogation meant to hurt the intended victim through name calling, avoidant behavior, or purposeful discriminatory actions • Microinsult: verbal, nonverbal, and environmental communications that subtly convey rudeness and insensitivity that demean a person's racial heritage (eg, asking persons of color how they got their job, suggesting affirmative action) • Microinvalidation: communications that subtly exclude, negate, or nullify the thoughts, feelings, or reality of a person of color (eg, asking people where they are from or were born)
	Clinical taxonomy	• Epistemic microaggressions: intentional/unintentional slights conveyed in speech or gesture by health care providers that dismiss, ignore, ridicule, or otherwise fail to give uptake to claims made by physicians • Emotional microaggressions: physicians and other health care providers fail to take patients' emotional reactions to and experiences of their diagnoses and illnesses seriously • Self-identity microaggressions: health care providers intentionally or unintentionally undermine or do not give uptake to the existential consequences that often accompany experiences of illness
Structural	The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credits, health care, and criminal justice	• Residential segregation, in particular, is associated with adverse birth outcomes, increased exposure to air pollutants, decreased longevity, increased risk of chronic disease, and increased rates of homicides. It is also associated with decreased access to quality health care

(*continued on next page*)

Community Forum

Partnering with the Community for Change

The five members of the Community Forum work group have met on three occasions to discuss and to address our charge to identify organizations in the community for potential collaborative relationships. We have identified ten organizations that are actively working to advocate for groups in the community that are negatively impacted by implicit or explicit bias. These organizations focus on issues confronting individuals who are Black, immigrant or LGBTQ. We will soon identify three or four of these organizations with whom the Department might partner in working towards the goal of advocating for community and political change to reduce the negative impact of implicit and explicit bias on individual and their families who are affected by mental illness.
Want to get involved? Email Dr, Stovall jeffrey.stovall@vumc.org

Jeff Stovall

Annual Harold Jordan Lecture - February 4, 2021

Dr. Ruth Shim to deliver the 2020-2021 Harold Jordan Lecture

Ruth Shim, MD, MPH is the Luke & Grace Kim Professor in Cultural Psychiatry in the Department of Psychiatry and Behavioral Sciences at the University of California, Davis School of Medicine. She is Professor of Clinical Psychiatry, Director of Cultural Psychiatry, and Chair of the Vice Chancellor's Advisory Committee on Faculty Excellence in Diversity at UC Davis Health.

Dr. Shim received an MPH in health policy from Rollins School of Public Health at Emory University and an MD from Emory University School of Medicine. She is a member of the Board of Trustees of the Robert Wood Johnson Foundation and the American Association for Community Psychiatry. She serves on the Editorial Boards of Psychiatric Services, Community Mental Health Journal, and American Psychiatric Publishing, and is co-editor of the book, The Social Determinants of Mental Health, and the upcoming book, Social (In)Justice and Mental Health, to be published in early 2021.

In addition to the myriad of professional and academic contributions over the course of her career, Dr. Ruth Shim has committed herself to service and leadership in the field of psychiatry, and she has repeatedly engaged in efforts to further the fight toward racial equity. In a recently published opinion piece for STAT, an online publication from the Boston Globe focused on health and medicine, Dr. Shim announced her decision to leave organized psychiatry, specifically the American Psychiatric Association (APA), citing the failure of the field to examine its contributions to racial inequity. In this persuasive essay, Dr. Shim described her personal experience in the face of various barriers – both subtle and explicit – and criticized the APA for its failure to heed the clear and focused recommendations articulated half a century ago in the *American Journal of Psychiatry.* Dr. Shim's narrative account of her personal journey is presented alongside critical developments in the field, many of which failed to create or produce any lasting changes, for which she ultimately decided that leaving was necessary. The full essay can be accessed online at Ruth Shim STAT Article.

M.E. Wood and Edwin Williamson

Diversity, Inclusion and Social Justice Committee

Committee Chairs: Edwin Williamson, Terako Amison, Sachin Patel

Group Leaders: Reid Finlayson, Kathy Gracey, Jeff Stovall, Abhi Saxena, M.E. Wood

Members: Elise Scott, Sonia Matwin, Jessica Diehl, Ryan Oakley, Devin Greene, Jessica Schwartzman, Pat McGuire, Kelly Hill, Amy Gorniak, Sharee Light, Claire Ryan, Elizabeth Shultz, Alex Bettis, Sharee Light, Andrew Molnar, Alexandra Moussa-Tooks, Jennye Woolf

Journal of Medical Humanities
https://doi.org/10.1007/s10912-020-09650-6

A Black and White History of Psychiatry in the United States

Jordan A. Conrad[1,2]

Abstract

Histories of psychiatry in the United States can shed light on current areas of need in mental health research and treatment. Often, however, these histories fail to represent accurately the distinct trajectories of psychiatric care among black and white populations, not only homogenizing the historical narrative but failing to account for current disparities in mental health care among these populations. The current paper explores two parallel histories of psychiatry in the United States and the way that these have come to influence current mental health practices. Juxtaposing the development of psychiatric care and understanding as it was provided for, and applied to, black and white populations, a picture of the theoretic foundations of mental health emerges, revealing the separate history that led to the current uneven state of psychiatric care.

Keywords History of psychiatry · History · Race · Racism · Mental health

Though the intersection of mental illness and race has gained increasing attention in recent years, much of the literature focuses on cultural competency, the current imbalances in mental health treatment, and the benefits of working with diverse groups. Though this focus on the current context of how mental illness is applied to people of color provides a crucial practical corrective, it nevertheless fails to appreciate the way that the current framework of understanding mental health and illness represents a continuation of, not a break from, the way it has been historically conceived. By understanding the trajectory of how mental illness was understood to exist in the black population and how it was treated, we are given a vantage from which to identify areas of current treatment and policy that carry a prejudicial residue of our past.

✉ Jordan A. Conrad
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In this paper, I examine the history of psychiatry[1] in the United States from the mid-nineteenth to the mid-twentieth century, with a particular focus on its relevance to the black population. I will do this in three sections. In the first section, I will explore the development of the culture, treatment, and policy surrounding mental illness in the nineteenth century. With the stabilization of medicine, the birth and explosive growth of the asylum, and the rise of naturalistic explanations of psychiatric disorder, the nineteenth century had an outsized influence on the development of mental health and is thus an appropriate period to begin our inquiry. In the second section, I will turn to the twentieth century, examining how the field of mental health evolved both as a continuation of, and as a response to, the treatments and understandings of the nineteenth century. In analyzing these periods, I will first provide a broad overview of the developments within psychiatry during that time that comprise the recieved, or standard, view, and then focus on how the period's developments were applied to, or withheld from, the black population. In the final section, I will tie together the threads of history, revealing where the conceptual and theoretical fundament that justified the historical prejudicial treatment of black people with mental illnesses continues to inform mental health care and research.

Nineteenth century: Mental illness and the standard view

Despite the fairly permissive approach toward mental illness in the early eighteenth century in virtue of the belief that it was occasioned by supernatural causes (Talbott 1978; Jimenez 1986), the middle part of that century marked a cultural shift toward viewing those with mental illness as dangerous,[2] causing mental institutions to be founded, far away from city centers, to warehouse those with mental health needs. The nineteenth century shifted away from supernatural causes and began emphasizing biological causes and treatments. Eminent American psychiatrist, Benjamin Rush, experimented in this vein with low sodium diets, forced vomiting (Talbott 1978), bleeding patients, blistering the scalp in order to expel the fluids and thereby reduce pressure in the brain, and inventing "a chair that bound people like a straightjacket, and another chair in which the patient was spun until calm" (Leiby 1978, 64).

This approach changed when Philippe Pinel rejected the model of mental illness that restricted cause and cure to a purely physical etiology, arguing that the mind was susceptible to change, particularly in children, by both physical *and* environmental circumstances. American asylums followed the example of Pinel in France where humane treatment free from stress was emphasized. Though these facilities boasted incredible successes (one facility administrator reported an 82% cure rate, while others bragged of achieving a 100% cure rate [Talbott 1978]), they remained rare until the mid nineteenth century.

Having witnessed the conditions those with mental illnesses were forced to endure, Dorothea Dix urged the government to dedicate federal funds for their treatment. Although Congress passed her proposed legislation, President Franklin Pierce vetoed the bill, claiming that it was not in the federal government's purview to care for the mentally ill:

> I readily...acknowledge the duty incumbent on us all...to provide for those who, in the mysterious order of Providence, are subject to want and to disease of body or mind but I cannot find any authority in the Constitution that makes the Federal Government the great almoner of public charity throughout the United States. To do so would, in my

> judgment, be contrary to the letter and spirit of the Constitution...and be prejudicial rather than beneficial to the noble office of charity. (Pierce 1854)

Despite this setback, the states were so moved by Dix's argument that they began to individually construct state-funded facilities for the mentally ill. Though only nine states had facilities that admitted the mentally ill at the time (Nelson 2009), by 1860, twenty-eight out of thirty-three states had at least one public mental hospital (Talbott 1978).

Though Dix was successful in getting the states to attend to the needs of individuals with mental health concerns, her goal of achieving humane treatment was never fully realized. A combination of clinicians' overconfidence about the effectiveness of institutional treatment[3] generating skepticism about the viability of asylum treatment in the general population (who presumably had contact with many former asylum residents) and a rapidly climbing admission rate that necessitated more staff and greater upkeep costs draining public funds,[4] culminated in a diminishing standard of care (Maxmen et al. 1974) that returned asylums, in the last decades of the nineteenth century, to their origins as mere custodial centers.

Nineteenth century: Mental illness and the untold black experience

What is often untold, and concealed in its lack of telling, is that the account provided above is largely restricted to white people. Though facilities for people with mental illness became more common in the nineteenth century, black people appeared on admissions rosters in significantly fewer numbers, with care for those with mental illness often being left to the family. Significantly, black people were divided into two classes – those who were free and those who were enslaved – and this classification carried with it implications for medical and mental health services. For example, between 1773 and 1861, a total of one hundred thirteen free black people were admitted to the Eastern Lunatic Asylum in Williamsburg, Virginia, compared to 1,381 white people admitted in the same time period (Savitt 2002),[5] while those enslaved were not permitted to enter state facilities in Virginia until 1846.[6]

The fact that those enslaved were eventually admitted to asylums did not reflect a progressively humane attitude but, rather, an attempt to blunt the moral objection to slavery by depicting it as a paternalistic institution for the welfare of those enslaved. Mental illness among those enslaved was not attended to in any significant way until the late 1830s when, in response to the abolitionist movement, pro-slavery advocates began to employ the asylum movement's language of compassionate care to put a more humane face on the practice of slavery (Forret 2016; Leiby 1978). According to this "beneficent" principle, slave owners accepted the responsibility to care for those they enslaved – which would include medical assistance and protection – and thereby justify slavery as a price paid for this supposedly mutually beneficial arrangment.

Given this background, some physicians felt it was possible to diagnose those who resisted enslavement as suffering from a mental illness. It was thus that physician Samuel Cartwright coined two new diagnostic terms. The first, drapetomania, was identified by a single symptom: the uncontrollable urge to escape slavery.[7] The second, dysaethesia aethiopica, had symptoms that included disobedience, destroying property, and refusing to work. This was to be the beginning of a trend of a "scientific" rationale in psychiatry empoloyed for the purposes of racial control.

Advocates of “protective paternalism” could be found at nearly every corner of American life. John Galt, superintendent of the Eastern Lunatic Asylum between 1841 and 1862, reported that enslaved people fared better than free men and women because they “were removed from much of the mental excitement, to which the free population of the union is necessarily exposed in the daily routine of life,” arguing that by not having to care for necessities of living and provided work which “strenghten[s] the constitution and enables it to resist physical agents, calculated to produce insanity” (Galt 1853, 82-83), enslaved people were innoculated against mental illness. In an article in the *American Journal of Insanity*, another author wrote that “Insanity prevails to a greater extent among the white and free colored population than among the slaves. This is thought to be due to the freedom of the latter from care and anxiety, and from intemperence and other excesses (“Dr. Dunglison’s Statistics of Insanity in the United States,” 1860, 111). This sentiment was shared by public officials as well: the secretary of Maryland’s board of health warned of the potential detriment freedom would have on the mental health of the black population: “Unrestrained freedom has had the effect of multiplying their desires and wants, but together with them it has also multiplied greatly their disapointments, and in very many instances the price of liberty to them has been the prison, the almshouse and the insane asylum” (Chancellor 1877, 14-15) and the ex-vice-president of the United States, John Calhoun, testified to Congress that “The African is incapable of self-care and sinks into lunacy under the burden of freedom. It is a mercy to him to give him the guardianship and protection from mental death” (Wood 1885, 11). Even activists such as Dorothea Dix drew a distinction between Native-Americans and black people, writing that, as the former were not “protected” by slavery, “The colored population is more liable to attacks of insanity than the negro” (Dix 1848, 2).

As a result, fewer slaves were admitted to asylums because, despite the paternalistic principles by which slaveowners held themselves to account, (1) black people were thought to be protected from mental illness in virtue of their bondage, and (2) paying for a slave to receive treatment was contrary to the economic productivity slavery was meant to provide. Slaveowners were therefore incentivised to understand non-dangerous disorders as simple idiosyncrasies that could be addressed by discipline or sale (Savitt 2002). As a result, Joseph Cox stated that “During 15 years practice in and around the neighborhood of Petersburg I can call to mind no case of a slave that remained as a confirmed lunatic” (249) and that, in order to shed responsibility to provide paternalistic care at an asylum, slaveowner Robert Watson reported to the census that an enslaved person, Solomon, was only “slightly deranged,” or, *temporarily* insane, and thus still capable of labor (252).

In practice this meant enslaved black people were routinely undiagnosed and untreated. Believed to be in their natural state of bondage, enslaved black people were considered immune to those mental illnesses from which their free counterparts suffered. However, free black people were not unencumbered by prejudicial views about their mental inferiority. The 1840 census revealed that that rates of mental illness among black people were significantly higher in Northern states than they were in Southern states, with Maine claiming one in every fourteen black people to be “insane” (Jarvis 1844). The contrast with Southern states is stark: New Jersey, which had the lowest rates of insanity among black people (one in 297) in the Northern states, had more than twice the rate of its neighbor below the Mason Dixon line, Delaware (one in 697), which had the highest rates of insanity among Southern states (Jarvis 1844). Caught between the transparently prejudiced “protective paternalism” that prevented black people in the south from receiving treatment and the pervasive discriminatory beliefs about black inferiority that overdiagnosed those in the North, black people were in an inextricable tension with the field of psychiatry. After carefully reviewing the statistical methods, physician Edward Jarvis published a detailed refutaion of its findings, writing:

> Here is proof to force upon us the lamentable conclusion that the "sixth census" has contributed nothing in the statistical nosology of the free blacks, and furnished us with no data whereon we may build any theory respecting the liability of humanity, in its different phases and in various outward circumstances, to loss of reason or of the senses […] So far from being an aid to medical science, it had thrown a stumbling block in its ways, which will require years to remove. (Jarvis 1844, 83)

In those cases where slaveowners recognized mental health needs in their bondsmen, they frequently did so in city poorhouses, jails, and hospitals (Forret 2016). Within institutions, race served as a powerful tool for classification and diagnosis. Owing in part to the moral treatment advocated by Pinel, psychiatric wards were often segregated by race on the grounds that mixing races would result in conflict among the residents. Just as slaveowners argued half a century earlier, white physicians and asylum superintendents in the late 1800s argued that black people's inferior physiology made them more susceptible to crime and disease (Haller Jr. 1970).

As the century came to a close, the population of the United States was changing dramatically which many took as a cause for concern. Prior to the Civil War, the population was roughly thirty-one million, but by the turn of the century, the population had skyrocketed to over seventy-five million (Smith et al. 2013). Though the United States had previously accepted about fifteen million immigrants between 1815 and 1890, in the decades straddling the turn of the century, the immigrant population not only doubled but were predominantly from Eastern and Southern Europe (Smith et al. 2013). Indigent and with behaviors and beliefs that seemed strange to many Americans, these new immigrants were admitted to state institutions in extremely high numbers (Talbott 1978). Combined with an increasingly free black population threatening to demand the right to vote and receive education, the situation led many white people to believe that America itself was in a period of decline. In order to combat this perceived cultural decay, restrictive immigration laws were enacted and involuntary sterilization became a widely accepted form of social control (Conrad 2018).

In the process of actuating this new plan, the scientific categorization of those determined to be unwanted gained increasing significance. Diagnoses became of central importance to mental health and social explanations of mental illness gave way to an era of biological explanations. Nathaniel Shaler, Dean of the Lawrence Scientific School at Harvard, for example, claimed that "Despite the strong spring of life within the race the inherited qualities of Negroes to a great degree unfit them to carry the burden of our own modern civilization" (Shaler 1884, 703). Samuel Cartwright held a similar view, writing, "The nerves of the spinal marrow and the abdominal viscera, being more voluminous than in other races, and the brain being ten per cent less in volume and in weight, he is, from necessity, more under the influence of his instincts and *animality*, than other races of men and less under the influence of his reflective faculties" (Cartwright 1850, 212). This trend was to continue into the next century.

Twentieth century: Mental illness and the standard view

In the decades just prior to the century's end, the recovery statistics boasting 100% cure rates within asylums were reexamined and found to be grossly exaggerated and based on the ratio of those "cured" among those discharged from asylums rather than among those admitted (Grob 1983, 39). Partly as a result, the field of psychiatry became the subject of severe criticism in the medical community which claimed that psychiatrists were essentially custodial figures divorced from the rest of medicine which utilized scientific research and appealed to biological causes (Durham 1989). With the emergence of the mental hygiene movement, psychiatrists were able to shift their area of focus from treatment to prevention, from asylum organization to scientific research, and from patient care to the analysis of disease (Grob 1983; Durham 1989), effectively answering the medical community's charge. However, it also propelled psychiatry into public life as its newly found emphasis on the prevention of mental illness involved two forms of social control – restrictive immigration practices and forced sterilization – each of which required medical authority to diagnose and categorize. Drawing from the increasingly accepted twin theories of eugenics and Mendelian laws of inheritence, psychiatrists set out to prevent the spread of "degeneracy" in the United States by preventing "unfit" people from entering the American gene pool. Cloaked in a scientific terminology, psychiatrists were now charged with "explaining, diagnosing, and treating physical and intellectual differences" (Nielson 2012, 68) in the service of maintaining the psychological and genetic health of a growing American society.

It is worth dwelling, for a moment, on the degree to which the eugenics movement took hold of the psychiatric, educational, and legal landscape. So beguiled by the opportunity to reconstitute the U.S. and eradicate all forms of degeneracy, incredible measures were taken to ensure its success. For instance, Harry Clay Sharp, a prison physician in Indiana in 1907 who began forcibly sterilizing inmates without any legal authority to do so, was soon thereafter granted this authority by the state legislature passing a sterilization law (Stehney 2004); Woodrow Wilson, then Governor of New Jersey in 1911, signed a bill into law that allowed those understood to be "unfit" to be sterilized (Grenon and Merrick 2014); and the early leaders of the field of social work, such as Mary Richmond, Jane Addams, Sophonisba Breckinridge, and Edith Abbot, were all advocates of eugenics as a method of addressing hereditary mental defects (Kennedy 2008). The American Psychological Association formed a committee in 1912 on forced sterilization and in 1913, advocated the use of sterilization of people with mental illness to prevent their multiplication (Fischer 2012). By 1940, thirty states had laws that permitted involuntary sterilization of those residing in state-run institutions (Grob 1983; Fischer 2012).

Treatments and understanding of mental illness changed rapidly in the second and third decades of the twentieth century. With the prevailing opinion being that mental illness must have a somatic origin and psychiatry still attempting a reconciliation with the broader medical community, a number of experimental methods to treat mental illness through treating the individual's physiological state emerged. These included injecting patients with malaria in order to cause extreme fevers, inducing hypoglycemic states (that could then be relieved by administering sugar) through injections of insulin, and injecting metrazol (a drug that would cause epileptic-like convulsions), all in order to treat psychosis (Grob 1983). At roughly the same time, the prefrontal lobotomy was also rising to prominence in the United States (Freeman and Watts 1937), cementing its place as a viable treatment in the 1940s and 1950s.

In the years following World War II, the eugenics movement gradually died out. As the U.S. public learned of the atrocities inflicted by Nazi Germany in attempting to control the gene pool and American veterans returned home with emotional disturbances and mental illnesses, public sentiment shifted away from social Darwinism. In 1942, the Supreme Court ruled that procreation rights are fundamental,[8] formally putting an end to federal support of sterilization programs. Nevertheless, these practices continued well into the twentieth century.[9]

During the post-war period two other significant innovations emerged: the rise of psychoanalytic talk-therapies and the advent of antipsychotic drugs. Prior to the 1920s, psychoanalysis was, with some exceptions (see below), viewed with skepticism within the United States in part because it could not be operationalized to fit an asylum style of treatment. However, following the war, with an increasing number of veterans experiencing non-psychotic symptoms but who nevertheless were in need of psychiatric services, the mental health community was forced to shift its focus from psychosis to neurosis. Within the context of the mental hygiene movement, which already stressed the importance of sex and sexuality, psychoanalysis was well suited to gain purchase in United States psychiatry. It was thus that "[f]or the first time in history, the depressed businessman or the anxious housewife would seek out the services of a psychiatrist, and if the psychiatrist lived in New York, Boston, or Washington, chances were that he would be oriented to psychoanalysis" (Shorter 1997, 166).

As psychoanalysis was shining its brightest, chlorpromazine (marketed under the name Thorazine), the first antipsychotic medication, hit the U.S. market in 1955. The effect this had on American pscyhiatry is difficult to overstate. As one physician in Montreal, who received the drug prior to the United States, remarked after administering chlorpromazine to his patients with schizophrenia, "a lot of hallucinations, delusions and thought disorder had disappeared. In 1953 there just wasn't anything that ever produced something like this – a remission from schizophrenia in weeks" (Shorter 1997, 252). Then, in 1958 and 1959, iproniazid and imipramine, the latter of which was the first of the tricyclic antidepressants, were introduced in the U.S., signaling the beginning of the psychopharmacological revolution.

The advent and popularization of psychotropic medications was the last straw for the asylums. Asylum treatments had been criticized as inhumane since the 1930s, with Dr. John Maurice Grimes coining what would become a rallying cry for the rights of people with mental illnesses in his call for "de-institutionalization, with the definite aim of paroling all parolable patients" (Grimes 1934, 113). This was followed in a 1937 joint survey of psychiatric hospitals by both the U.S. Public Health Service and the National Mental Hygiene Committee, which found gross overcrowding and cruel conditions to be prevalent. Though America's entrance in World War II slowed the demand for immediate reform for psychiatric hospitals, by 1944 New York State's Mental Hygiene Department issued a report stating that the asylums were more custodial than treatment focused and that though "The war has accentuated some of these problems arising from inability to provide adequate curative care [it] has not caused them" (New York State Comission to Investigate Care of the Mentally Ill, 1944,16). It was thus that when chlorpromazine was released to U.S. markets, providing a plausible alternative to asylum treatment, the psychiatric community enthusiastically embraced it and began discharging residents at an alarming rate.

Residents in state-run psychiatric hospitals climbed from 15,000 in 1903 to 445,000 in 1940 (Grob 1983, 180), peaking in 1955 at 558,992, before rapidly dropping to 196,436 in 1975 and 109,939 in 1985 (Bagnall and Eyal 2016). With tremendous hope in psychopharmacological treatment but without any other source of support in the community, now receiving hundreds of thousands of formerly institutionalized patients (the first support and advocacy group for people with mental illness, the National Alliance on Mental Illness, for instance, was founded twenty-six years after the process of deinstitutionalization began), resulted in many residents being pushed from one institution to the next. This is revealed in admission rates to psychiatric institutions, which rose from 178,003 to 376,156 between 1955 and 1975 and in the average amount of time residents spent receiving asylum treatment, which decreased from 421 days to 143 between 1969 and 1982 (Bagnall and Eyal 2016). All of which points to a system whereby residents are admitted in staggering numbers, rapidly discharged, and then admitted again, sometimes to a different institution, in a cycle known as *transinstitutionalization.*

Twentieth century: Mental illness and the untold black experience

With the growing use of perceived biological differences between races as an explanation for mental illness at the end of the previous century, the eugenics movement had a particularly strong impact on the black population in the United States. Setting out to explain mental and ethical degeneracy as a product of these differences, physicians became focused on identifying the psychiatric disorders "natural" to each race as well as the different ways disorders presented themselves across races. This became increasingly important as the United States prepared to enter World War I and needed a way to evaluate potential recruits. Separating white and "colored" recruits, psychiatrists reported identifying problematic psychiatric features in black soldiers diagnosed with mental disorders more quickly than white soldiers and were more likely to discharge them than recommend treatment (Dwyer 2006).

Outside of the military, a similar picture prevailed. This is made clear when we examine physicians' views at St. Elizabeths hospital in Washington D.C. Washington D.C. is particularly notable because in the decades just after the century's end, it became home to a substanial black middle-class with educated students and professors at Howard Univeristy, while simultaniously a majority of black people remained in abject poverty (Gambino 2008). Thus, there was a broad range of educated and uneducated, poverty-stricken and relatively affluent black men and women in the city.

St. Elizabeths was administered by Willam Alanson White between 1903 and 1937, during which time he became a leading figure in the mental hygiene movement, interpreting almost everything as falling within the purview of psychiatry (White 1917; 1938). Though White was, in many ways, unlike his contemporaries, inviting black students at Howard University to attend his lectures alongside white students and even speaking there in 1910 (Gambino 2008), he nevertheless expressed typical psychiatric prejudices of the time. For example, he explained to the U.S. House of Representatives that for black people, physical labor is "the natural form of work to engage in. That is what they can do; what they are accustomed to, and pracitcally all they can do" (U.S. House of Representatives 1907, 876).

Many of the psychiatrists at St. Elizabeths followed in White's footsteps, publishing on psychopathology using race as an axial point for differentiation in presentation, prevalence, and etiology in *Psychoanalytic Review*, a journal founded by White and his colleague, Smith Ely Jelliffe. Representative of this thinking was John Lind, chief medical officer of Howard Hall, the highly guarded forensic wing of St. Elizabeths hospital. In what now appears as brazen racism, Lind attempted to distinguish whiteness from blackness, writing that "the current conception that the present-day African has reached levels only slightly inferior to the white race" is not nearly discriminatory enough and "is held most extensively in regions where the Negro is infrequent and by persons having to do only occasionally with individuals of this race and then, only with selected specimens" (1916, 303), going on to explain that:

> The Negro, studied judiciously by those who are competent, appears to be at a much lower cultural level than the Caucasian. It is true that with his talent for mimicry, recalling to us in some measure our jungle cousins, he is able to present a remarkably exact, albeit superficial representation of the white man. But no one who has associated with Negroes is willing to believe that this resemblance extends much below the surface. It would be strange indeed if a race as low in the social scale as the Negro is in his native land could inherit by a half-century of juxtaposition all those group ideals which were only acquired by the Caucasian in several thousand years of evolution with all the advantages of climate in his favor. (Lind 1916, 303)

The differences between the races were so pronounced to Lind that he wanted to ensure that behavior suggesting mental illness in a white person would not qualify as evidence against a black person's mental fitness and so counselled against misdiagnosis, claiming that there was an incommensurability in disorder presentation between black and white populations:

> To sum up, then, it might be said that there are two things to be kept in mind especially, in the mental examination of the negro, one is, not to jump to conclusions, the other is, not to take what he says at its face value. Examine each statement carefully to see whether he actually means it as he says it or not. Remember that his vocabulary is limited, that he does not speak your language. After you have decided that he actually does mean the statement as it is given, consider whether or not it is in accord with his psychology, his supersition, his prejudices, and his theology, in short if it is what you would expect of a person whose great gandfather was perhaps a cannibal; and finally remember that if … there is a doubt in your mind as to whether he is crazy or not, he probably is not. (Lind 1914a, 1287)

Lind went on to explain this differentiation in psychoanalytic terms,[10] stating that the mental life of a black person is less complex than a white person's, and as a result, their wishes and dreams must be simpler as well.[11] Drawing on case examples, he reported dreams such as: wishing to receive a pension in the absence of a disability, dreaming about escaping from prison, dreaming about being free from prison and being "out for a good time with the girls" (Lind 1914b, 298). These wishes, Lind explains, were of such an unmediated quality, absent any censor thought to be foundational to the conscious and pre-conscious, that they were evidence of a more primitive mind. Ultimately, Lind concluded:

> Although Freud has recommended to the study of child psychology as a valuable aid to the understanding of abnormal adult psychology, it must be remembered that in his country there is no such race as we have here whose psychological processes are simple in character and so readily obtainable. Perhaps to the American investigator, the Negro might prove as valuable and more accessible than the child. (Lind 1914b, 300)

The belief that black people were mentally inferior to white people, having neither the subtlty of emotions nor the command of them that the white race possessed, was widely held by psychiatrists at St. Elizabeths. In 1905, White hired the first woman, Mary O'Malley, to the permanent medical staff in an attempt to bring the hospital into the twentieth century. Appealing to this supposed lack of subtlty in the psychology of black people, O'Malley explained the lower rates of suicide as a product of an innate biology:

> Their sorrows and anxieties are not staying in quality, and do not make a sufficiently lasting impression on them to create a desire to end their life; they also lack the courage and steadiness of purpose to destroy themselves. (O'Malley 1914, 327)

This understanding of black people as emotionally volatile yet curiously not volatile *enough* to commit suicide was common enough within institutions that the clinical director for Georgia State Sanitarium explained that:

> The average negro, in his normal environment, is happy, active, boisterous, quick to notice, emotionally unstable and is constantly on the lookout for excitement. His normal emotions become exaggerated with slight cause and their voluble expression is accompanied by motor activity. (Green 1916, 620)

And based on this assessment and the criteria for mental illnesses available to him, he concluded:

> … it would appear that this race possesses the very traits which should lead one to expect that manic-depressive psychosis would hold a prominent position among the mental disorders affecting it and that, furthermore, it would more frequently be manifested in the manic form which, as a matter of fact, it is." (621)

For Green, then, an entire race appeared naturally predisposed to bipolar disorder.

Another physician at St. Elizabeths, Arrah B. Evarts, explored the difference in the way dementia praecox (what is now schizophrenia) appeared among black and white patients, applying a genealogic explanation to the former:

> During its years of savagery, the race had learned no lessons in emotional control, and what they attained during their few generations of slavery left them unstable. For this reason we find deterioration in the emotional sphere most often an early and a persistent manifestation. (1914, 394)

As a result, Evarts explains, black people are naturally susceptible to schizophrenia, again attributing to an entire race a propensity to mental illness.

There is a close relationship between this perceived simple-mindedness and emotional instability with a perceived hyper-sexuality among black people that was considered not just psychiatrically interesting but dangerous. When examining the increase of syphilitic paralysis among black patients, physicians determined that a culture of sexual insouciance was the cause:

> Before their animal appetites all barriers which society has raised in the instance of the white race go down, as though without power of frustrating… them. These appetites are gratified to such a degree that the result of these vices is a factor which has probably done more than all others to produce mental disease. (O'Malley 1914, 318)

Indeed, psychiatrists at this time attended closely to the perceived perversity of black people. Hunter McGuire and Frank Lydston wrote in this vein that they

> fail to see any difference from a physical standpoint between the sexual furor of the negro and that which prevails among the lower animals in certain instances and at certain periods . . . namely, that the furor sexualis in the negro resembles similar sexual attacks in the bull and elephant, and the running amuck of the Malay race. (McGuire and Lydston 1893, 17)

However, once again, the absence of 'extreme' behaviors (e.g., public masturbation, playing with feces) among these patients was viewed as an indication of mental inferiority (Gambino 2008):

> As this race exists in Africa, its sexual instincts are peculiarly unrestrained, and although they have learned much moderation, these desires are usually fully satisfied with no feeling of having done wrong. This will account for the fact that the ordinary sexual perversions are seen among precox patients of the colored race much less frequently than among those of the white race. (Evarts 1914, 397)

In a remarkable case of "heads I win, tails you lose" reasoning, the failure of black patients to perform behaviors readily identified as "sexual perversions" is counted as evidence of a lack of mental subtlety.

With the emphasis on heredity and eugenics, the perceived hyper-sexuality of the black population was understood to be particularly problematic. One reason for this is that it was believed that black men would target and rape white women, threatening the future of whiteness. This was a common concern at the time, reflected in the number of books [12] that emerged at the turn of the century lamenting that "the Nordic race was being overwhelmed, particularly in the United States" (Brophy and Troutman 2016, 1882). In each of these books, the story was roughly the same and equally grim: white people had, until recently, dominated other races around the world but are losing grasp of this role and with it the very continuation of their lives.[13] The perceived hyper-sexuality of the black population was thus understood to be a direct hazard to the continuation of whiteness in the United States.

Without explicitly endorsing Green's (1916) or Evarts's (1914) thesis that all black people are naturally predisposed to bipolar disorder or psychosis, psychiatric scholarship in this era seems to take emotional volatility of black people for granted, attributing it to an inherent biological trait:

> Healthy negro children are bright, cunning, full of life and intelligent, but about puberty there begins a slowing up of mental development and a loss of interest in education, as fun and sexual matters begin to dominate the life and have the first place in the thoughts of the negro. The untoward effect of excesses and vices are potent factors in the production of mental diseases. Motion, rhythm, music and excitement make up a large part of the life of the race. All negroes have a fear of darkness and seldom venture out alone at night unless on a mischief bent. (Bevis 1921, 412)

> Two features which almost anyone will concede as characteristic of the race are 1. the capacity for so-called laziness and 2. the special ability to dance. The capacity

> for laziness is the ability to go to sleep or simply do nothing for long periods, when it fits the need of the situation. The dancing represents special motility patterns and tendencies. These two features present themselves in the behavior problems that come to us and may be an expression of specific brain impulse tendencies. (Bender 1939, 217-218)

In a striking case of racist and tendentious analysis, Bevis's and Bender's claims reveal not only the degree to which the view that black people were emotionally unstable had cemented itself in the conventional wisdom of psychiatry, but also the plasticity of justifications that could be marshalled in favor of that position. Echoing this view even more perniciously, Charles Prudhomme, a psychiatrist at Howard University, attributed this alleged emotional instability to a social ancestry of violence:

> First, he will take to flight through an impulse of self-preservation as the sight of blood certainly excites his basic instincts, one in which his ancestral heritage lived by in their environment of the survival of the fittest […] Secondly, however, if the opposition suffers the inflection with bloodshed, his psychology is actual aggression also regressive since there seems to awaken within him the galditorial [sic] sense to kill which is instinctive—this is the psychology of the Negro and the razor. (Prudhomme 1938, 204)

Here, Prudhomme, in a not-so-subtle argumentative maneuver, links black people, in virtue of a perceived biologically determined emotionality, to an inherent disposition toward violence and aggression.

An important implication of the scholarship above is that black men and women are more *projective* than *introjective*. Rather than succumb to depression or anxiety, for example, as white people might, black people are more likely to experience mania and psychosis; rather than engage in private sexual perversions, black people's sexuality is wanton and aggressive; and, crucially, rather than succumb to suicidality, black patients are violent. In this way, psychiatry supported the view that black people, particularly those with mental illnesses, presented a threat to others, and thus contributed to the social attitudes on black criminality (Summers 2010).

It was within this context that, when World War II emerged and with it another round of psychiatric evaluations to screen prospective soldiers, these distorted racist assumptions prevailed. For the entire period of 1940-1945, more black men were turned away from Selective Service than white enlistees. Reasons cited for these rates was a lack of education and higher syphilis rates as well as "constitutional psychopathic inferiority, criminal records, and sexual psychopathy" (Dwyer 2006,125). Expressing the difficulties of making such assessments, one physician at a local draft board reported:

> The colored men offered me the greatest difficulty in diagnosis […] Poor cultural, occupation and educational backgrounds often made it difficult to decide whether they were defective, preschizoid, or just colored. (Dwyer 2006, 127)

The pathologization of the entire race had become, by this time, a stable fixture of the psychiatric orthodoxy.

This pathologizing would continue with new effects following the end of the war and into the psychopharmacological revolution. Enthusiasm for the new psychotropic medication, chlorpromazine, was sweeping the psychiatric community so forcefully that it was administered to many patients for whom it was not indicated. Indeed, chlorpromazine, a medication for psychotic disorders (though it initially showed some promise with depressive symptoms as well) was applied so routinely that at Willowbrook State School, a school for children with intellectual and developmental disabilities now infamous for its inhumane treatment, it was administered *as a punishment* to five fourteen-year-old black girls who snuck into a dance (Hill 2016).

With the unprecedented success of psychotropic medications and the deterioration of the asylum systems, the deinstitutionaization movement began. In 1963, President Kennedy signed the Community Mental Health Act (CMHA) which was designed to fund community-based health care facilities in support of the deinstitutionalization movement, providing locations where treatement could be received in the least restrictive enviornment. However, by placing the responsibility of the care of people with mental illness back into the hands of the community, communities that were already disadvantaged struggled to accommodate the influx of people with special psychiatric needs. This was particularly true for predomenantly black communities which "tended to lack the necessary resources (fiscal and political) to participate in creating mental health services at the community level" (Hudson and Cox 1991, 47). As a result, private facilities were predominantly used by white people, whereas black and other people of color were far more likely to be readmitted to a state-run psychiatric facility (Kramer et al. 1973; Robinson and Johnson 1986).

Inside these facilities, very little appears to have changed in terms of the view that black people were more likely to possess psychotic symptoms. In 1969, among all U.S. state and county mental hospitals, the most frequent cause of admission for the "Non-White" males and females was schizophrenia at 35.6% and 51.5%, respectively (in comparison, only 18.6% of white men and 33.2% of white women were admitted with a diagnoses of schizophrenia) (Kramer et al. 1973, 424). Perhaps equally as revealing is that white men and women were admitted with a diagnosis of neuroses more often, at 4.2% and 15.2%, respectively, whereas "Non-White" men and women were admitted for this reason at only 1.8% and 8.8% (Kramer et al. 1973, 424). These admission rates perfectly echo the views of physicians nearly six decades prior who asserted that black people are constitutionally disposed to psychosis and lack the emotional subtlety for neuroses.

The combined assumptions that black people were more prone to schizophrenia and that powerful drugs could be used to control this disorder were soon to be exploited by pharmaceutical companies in their marketing to physicians and mental hospitals. In a 1974 advertisement for Haldol (an antipsychotic medication which came to market in the United States in 1967), a black man is depicted stepping out of his car with his fist clenched in anger and staring aggressively at the reader. The question at the top of the page asks, "Assaultive and belligerent?" which it answers on the next page: "Cooperation often begins with Haldol" (McNeil Laboratories, Inc 1974, 732-733). In a series of advertisments for Stelazine (another antipsychotic medication), the drug appears in the foreground in pill and liquid form with indiginous tribal paraphernelia unsubtly placed close behind (Smith Kline and French Laboratories 1976a, 1004-1005; Smith Kline and French Laboratories 1976b, back cover). Another advertisment pictured two "staffs used by the Heviosso (lightning God) cult in medical ceremonies among the Ewe of Tongo and Fon of Dahomey," which it claims are "Basic tools of primitive psychiatry" and which are juxtaposed on the next page to the "Basic tool of Western psychiatry" with an advertisment of Thorazine's uses and effects listed beneath (Smith Kline and French Laboratories 1976c, 472-473). While not a direct statement about the inherent psychological instability of black people, these ads depicting angry black men and indigenous symbols of "primitive" races in the immediate aftermath of the protests and riots of the late 1960s and the civil unrest of the 1970s could not have been misinterpreted.

The persistently negative view of black people seems to have created disproportionately negative deinstitutionalization outcomes as well. We have already seen that black people were far more likely to be placed in public psychiatric facilities than their white counterparts who were much more likely to receive outpatient mental health services. Deinstitutionalization did not remediate this disparity; as hospital admissions decreased, black communities simply received fewer services. The relative paucity of individuals re-institutionalized to psychiatric facilities is plausibly explained by a series of legislation that made it difficult to provide involuntary psychiatric treatment.[14] However, even when involuntary psychiatric treatment would be legally permitted, police officers responding to public indecency or other minor offenses report that it is easier to arrest suspects rather than issue a mental health referal (Green 1997).

Though simultaneous with the rapid decrease in hospitalization, the population of jails and prisons rose from 185,780 in 1955 to 315,974 in 1980 (Grekin et al. 1994), it is unclear whether those numbers correlate directly with one another. One reason for this caution is that the median age in prisons in 1986 was twenty-eight, which suggests that many of those incarcerated were not old enough to have participated in the deinstitutionalization movement of the prior two decades (Grekin et al. 1994). Nevertheless, the established belief in the tendency toward psychopathy among the black population, the increased likelyhood of an encounter with the police ending in arrest for people with mental illness (Teplin 1984), the amount of people with mental illness in U.S. jails and prisons, [15] and the disproportionate representation of black people and in particular black men in the penal system (Robinson and Johnson 1986), all point to the net effect of the deinstitutionalization movement as simply shifting black people from psychiatric settings to penal ones.

Tying together the threads: Twenty-first century mental health

In examining the history of mental illness in the United States, a number of themes emerge: the utilization of the white culture as the normal case against which others should be measured, the supposed biological inferiority of black people, and the use of psychiatric diagnoses as a way to justify racist prejudices. Far from isolated, temporally situated events, these form a relatively stable pattern of beliefs about and behavior toward the black population that have, over time, changed in modality and appearance but which contain the same underlying assumptions about race and mental illness. Over and over, the belief that black people are either predisposed to or naturally evince bipolar or psychotic symptoms appears, not from outlying perspectives on the margins of the mental health community but from respected authorities: physicians in the eighteenth century justifying slavery, popular writers espousing the view that people of color are taking over the white race, scientists advocating an aggressive eugenics policy, psychiatrists restricting access to serving in the military, and advertisments created by pharmaceutical companies depicting black people as violent and black culture as primitive and savage. There are thus in effect two distinct histories of psychiatry in the United States. The standard view is an account of a frequently oppressive, but largely progressive movement from painful and moralized treatment to the provision of the most effective care in the least restrictive environment. However, this account leaves black people on the margins and footnotes of psychiatric history. The untold history of black mental health and illness in the United States reveals a tendentiously gerrymandered disorder criteria designed to match racist characterizations of black people built upon erroneous and prejudicious biological and genealogical beliefs.

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Several studies have reported the special effectiveness of HALDOL (haloperidol) in controlling disruptive and dangerously assaultive behavior.[1-3] Even the number of violent assaults committed by a group of criminal psychotics "resistant to maximal doses of phenothiazines" was reduced substantially during treatment with HALDOL.[1] Symptom control can be achieved rapidly, frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[2-4]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics the investigator states, "The patients remained alert and more amenable to psychotherapeutic intervention."[1] Another investigator reports that HALDOL "normalizes" behavior and produces a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[5]

Reduces risk of serious adverse reactions

HALDOL (haloperidol), a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. Hypotension is rare and severe orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, ocular changes, serious hematologic reactions and skin rashes.

The most frequent side effects of HALDOL (haloperidol)—extrapyramidal symptoms—are usually dose-related and readily controlled.

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For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

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Basic tools of primitive psychiatry

Mankpo: Sceptres or staffs used by the Heviosso (lightning God) cult in medical ceremonies among the Ewe of Tongo and Fon of Dahomey. *Right,* staff with leopard's head, bared teeth and tongue (Ewe, Togo). *Left,* staff with ram's head—the sacred animal of the Heviosso—in the form of a serpent symbolizing the fire-spitting rainbow God of healing (Fon, Dahomey).

From the collection of the Segy Gallery, New York City.

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- Especially useful in agitated, violent or anxious schizophrenic patients
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Before prescribing, see complete prescribing information in SK&F literature or *PDR.* The following is a brief summary.

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders. For control of the manifestations of manic-depressive illness (manic phase).

Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudo-parkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema.

NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

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Philadelphia, Pa.

For effective management of schizophrenic symptoms.

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However, this history is incomplete. The foundational conceptual and theoretical understanding that has caused these prejudicial themes to emerge continue to inform our understanding of mental health and illness. Black men and women are still understood to be deviations from the norm of white male mental health. For instance, it has been observed that diagnostic instruments developed in Euro-American samples, including the Diagnostic and Statistical Manual (DSM), are routinely applied to people of color without any adjustment of scaling norms (Williams 1995; Adebimpe 2004; Schwartz and Blankenship 2014), which suggests that the former population is considered "baseline" or "normal" and that all others are deviations.

More pernicious still is that the view that black people, and in particular black men, are somehow inherently aggressive, emotionally volatile, and disposed to psychotic disorders, which appears to have persisted in the twenty-first century. It has been repeatedly observed that black people disproportionately receive diagnoses of psychotic disorders compared to the white-european population (Snowen and Cheung 1990; Lawson et al. 1994; Strakowski et al. 1995; Eack et al. 2012; Hamilton et al. 2018) despite a lack of evidence of genetic predisposition in this population (Wiener 2009) suggesting racial bias in diagnosis (U.S. Department of Health and Human Services 1999; Office of the Surgeon General 2001). Moreover, young black children are most often referred for mental health services due to aggression, overactivity, and defiant behaviors (Kataoka et al. 2002) though studies indicate that males tend to express depressive symptoms through externalizing behaviors which may cause others to misinterpet depressive symptoms as signs of aggressive disorders (Lindsey et al. 2017). Similarly, one study found that black youth are four times more likely to be physically restrained than their white counterparts after acting in similar ways (Bond et al. 1988). Complicating matters still is that black men and women are likely to experience barriers accessing health care services (Griffith et al. 2010; Lo and Cheng 2011). Thus even if there is a mental health need, access to services is likely fraught, potentially resulting in the exacerbation of symptoms or non-professional treatment.

In this current state of psychiatric care, the threads that connect us to history are laid bare. Understanding black youth as aggressive and black people more broadly as especially subject to psychotic disorders both resemble early twentieth century psychiatric accounts of an instinctive "galditorial [sic] sense to kill" (Prudhomme 1938, 204) and as not having the subtlety of emotion for neuroses. Although much has changed in the United States in the intervening period, the black population is still considered by the psychiatric community as brutes.

The purpose of reengaging the history of mental illness in the United States is encapsulated by Faulkner's famous quote: "The past is never dead. It's not even past." Casting our eyes to history in this case does not mean that we are breaking contact with the present; rather, in examining the history of mental illness in the United States, reinserting black men and women into the picture, we are deepening our understanding of the origins and development of our own beliefs, actions, and attitudes. From the vantage of history, we are in a position to critically reexamine the present. We must never forget the past, but we must break ties with it.

Endnotes

[1] In this paper, I use "psychiatry" as shorthand for the mental health profession more broadly, including psychologists, social workers, and mental health researchers.

[2] A quote by Francis Fauquier, Governor of Virginia, highlights this fact very clearly "…a poor unhappy set of People who are deprived of their Senses and wander about the Country, terrifying the Rest of their Fellow

Creatures. A legal Confinement and proper Provision, ought to be appointed for these miserable Objects, who cannot help themselves. Every civilized Country has an Hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavor to restore to them their lost Reason" (Kennedy 1906, 12).

[3] This overconfidence is exemplified in Horace Mann's statement on the effectiveness of the new treatments available in psychiatric hospitals: "Until the period comparatively recent, insanity has been deemed as an incurable disease […] It is now most abundantly demonstrated, that with appropriate medical and moral treatment, insanity yields with more readiness than ordinary diseases" (Massachusetts Commissioners Appointed to Superintend the Erection of a Lunatic Hospital at Worcester; Mann, Horace,1796-1859; Taft, Bezaleel,1780-1846; Calhoun, William B.(William Barron),1795-1865; Massachusetts General Court 1832, 19-20).

[4] The State Lunatic Asylum in Utica, New York, for example, had over six hundred patients in 1884, 2 % of which slept on the floor due a lack of beds (Grob 1983).

[5] It should be noted that the records between 1801-1821 are incomplete, and do not report on any white admissions to the asylum, though two free black men are listed (Savitt 2002, 259).

[6] Even when they were admitted, it appears that they were not truly given equal access. Between 1846 and 1861, only fifty-five slaves and seventy-six free black people were admitted to the Eastern Lunatic Asylum, whereas eight hundred thirteen white people were admitted in the same period (Savitt 2002, 259).

[7] Cartwright explained his position thus: "If the white man attempts to oppose the Deity's will, by trying to make the negro anything else than "the submissive knee-bender" (which the Almighty declared he should be), by trying to raise him to a level with himself, or by putting himself on an equality with the negro; or if he abuses the power which God has given him over his fellow-man, by being cruel to him, or punishing him in anger, or by neglecting to protect him from the wanton abuses of his fellow-servants and all others, or by denying him the usual comforts and necessaries of life, the negro will run away; but if he keeps him in the position that we learn from the Scriptures he was intended to occupy, that is, the position of submission; and if his master or overseer be kind and gracious in his hearing towards him, without condescension, and at the same time ministers to his physical wants, and protects him from abuses, the negro is spell-bound, and cannot run away" (Cartwright 1851).

[8] *Skinner versus Oklahoma* (1942).

[9] Virginia, for example, had sterilization laws until 1973 (Fischer 2012, 1099), and social workers in North Carolina were found to be advocating sterilization as late as 1977 (Conrad 2018).

[10] While Freud's work does not make claims to racial distinctions in his analysis of psychopathology, many of his followers in the United States did (Thomas and Sillen 1974). A number of articles in early volumes of *Psychoanalytic Review*, for example, paid particular attention to the mental lives and presumed psychopathology of black people. See Evarts (1914); Lind (1914b, 1916); Prudhomme (1938); as well as White (U.S. House of Representatives 1907).

[11] Less than a decade later, Bevis (1921) would claim that "It is the conscious or unconscious wish of every negro to be white. This is brought out in his dreams, in the hope of being white in the eternal life and in his delusions" (412).

[12] See, for example: Popenoe, P & Johnson, R.H., 1918. *Applied Eugenics*. New York: The Macmillan Company.; Grant, M. 1916. *The Passing of the Great Race or The Racial Basis of European History*. Abergele: Wermod & Wermod (it may be noted in passing that Adolph Hitler wrote a letter to Grant wherein he referred to this book as his "bible" [Ummel 2016, 392-393]); Stoddard, L. 1920. *The Rising Tide of Color Against White World-Supremacy*. New York: Charles Scribner's Sons.

[13] Stoddard's preface makes this concern explicit in catastrophized terms: "The subjugation of white lands by colored armies may, of course, occur, especially if the white world continues to rend itself with internecine wars. However, such colored triumphs of arms are less to be dreaded than more enduring conquests like migrations which would swamp whole populations and turn countries now white into colored man's land irretrievably lost to the white world" (1920, vi).

[14] See: *Lake versus Cameron* (1966), which established that patients be treated in the "least restrictive setting"; *Wyatt versus Stickney* (1971), which asserted the constitutional right of all psychiatric patients to "(1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans" (Wyatt versus Stickney, 334 F. Supp 1341, 1343 (M.D. Ala. 1971)); *O'Connor versus Donaldson* (1975), which ruled that an individual must present an immediate danger to him/herself or to others; *Olmstead versus L.C.* (1999), which declared that those with mental illness were protected by the Americans with Disabilities Act (1990).

[15] In joint report the Treatment Advocacy Center and the National Sheriff's Association (2014) revealed that about 356, 268 people with severe mental illnesses were incarcerated in the United States in 2012 compared to only 35,000 in psychiatric facilities.

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An Anti-Racist Approach to Achieving Mental Health Equity in Clinical Care

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KEYWORDS

- Racism • Antiracism • Implicit bias • Health disparities

KEY POINTS

- Racism is an important determinant of health and health disparities, but few strategies have been proposed to eliminate racial discrimination from clinical care.
- This article proposes a novel antiracist approach to clinical care that takes into account the racism shaping the clinical encounter and historical arc of racial oppression embedded in health care.
- This approach can be implemented into clinical care, may reduce the harm done by racism, and could serve as a template for antiracist service provision in other sectors, such as education and law enforcement.

Racial minorities in the United States experience higher rates of mortality, greater severity and progression of disease, and higher levels of comorbidity and impairment than do their white counterparts. Repeatedly, racism is found as an important determinant of these health inequities.[1,2] Individual discrimination functions as a psychosocial stressor that triggers physiologic, psychological, and behavioral responses, ultimately leading to downstream mental and physical consequences.[3–6] Repeated day-to-day indignities, such as being treated with less respect than others or receiving poorer service at restaurants and stores, accumulate over time, resulting in the more rapid development of coronary heart disease and the birth of babies lower in weight.[7,8] Black infants are 2 to 3 times as likely as their white counterparts to be born prematurely and/or with low birth weights. Because more than half of African American people report discriminatory experiences in multiple sectors of daily life, and more than 70% of Americans harbor implicit biases toward African American people, racism is an important public health concern.[9]

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However, clinical care interactions, which potentially treat the downstream consequences of racism, also are vulnerable to racial bias. A third of African Americans report experiencing racial discrimination during clinical care with their physicians.[9] Furthermore, multiple studies have shown pro-white implicit bias among physicians, particularly white physicians, and this bias is significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes.[10–12] For example, minorities with the same presenting characteristics and symptoms have been shown to have physicians order less appropriate cardiac procedures than they do for similar white patients.[13] Minorities experience poorer quality of care, decreased access to care, and fewer preventive services. Pain, in particular, is systematically undertreated among black Americans, children and adults alike, relative to white Americans.[14,15]

Health disparities are complex, the outcome of a multitude of factors that function beyond and within medicine. Factors in the former category include the social determinants of health, health insurance coverage, and availability of quality care. Within the realm of health care, strategies to reduce health disparities have focused on increasing diversity in the workforce, training clinicians in cultural competence and implicit bias, and adapting evidence-based treatments to address the health needs of minority communities.[16–18] However, these strategies have not substantially decreased documented health disparities over time, particularly those related to life expectancy, infant mortality, malnutrition, and diabetes.[1,19] Few strategies have been proposed that target racial discrimination in clinical care.[20] This oversight stands in the face of a predominantly white physician workforce and a majority white male medical leadership that does not mirror the diversity of the broader population.[21,22] Its absence is rendered more visible by the medical profession's legacy of racism, including scientific experimentation and exploitation of enslaved individuals and communities of color.[23,24]

Demands for racial equity and justice in health care and other institutions, such as criminal justice and public education, have mounted in recent years.[20,25] Medical students have been particularly vocal about challenging medicine's relative silence about racism and holding academic medical centers accountable for promoting racial justice in their training and clinical care.[26–28] Antiracist efforts have called for more than just the absence of racism; instead, demanding the dismantling of unjust structures that perpetuate racial inequity in clinical care, training, and research and promoting policies that create justice for all.[29,30] Furthermore, teaching the history of discrimination and injustice for minorities has increasingly been implicated as the necessary foundation for deconstructing health inequities created by racist policies.[30] Despite this growing support and the established role of racism in clinical care, antiracist clinical approaches have not been codified. Striving to fill this gap, this article articulates an antiracist approach to clinical care focused on thoughtfully illuminating the racism shaping providers' and patients' lives and clinical interactions, challenging the historical arc of racial oppression embedded in health care, and preventing undue harm by eliminating racial discrimination in the clinical encounter. Recognizing that achieving equity in the clinical encounter is complex and multifactorial, it focuses on racism because it is frequently overlooked, despite its deleterious impact.[31]

This article highlights the legacy of slavery and the African American experience in particular. The authors acknowledge the need to develop similar approaches focused on the experience of American Indian, Alaska Native, First Nation, and other indigenous communities and the legacy of their collective genocide. The authors believe a similar approach can be adapted to consider the needs of their and other racial, sexual, and gender minority communities. As the adverse effects of discriminatory practices, such as the rescinding of Deferred Action for Childhood Arrivals (DACA), police brutality, and legalizing discriminatory practices toward gender and sexual minority members are enacted, the need to curb discriminatory practices in health care becomes more immediate.[32–35] Health care workers face a unique responsibility to develop and implement anti-discriminatory practices. They also have an important opportunity to codify these practices and, it is hoped, pave the way for others, including teachers in the education system and police officers in the law enforcement, to do the same.

In our antiracist approach to medical care, the authors advocate enacting the following practices, which are highlighted in a case example in **Box 1**.

AN ANTIRACIST APPROACH TO CLINICAL CARE

Admit to Being Racist to Become Antiracist: Clinicians Are More Likely to Do Harm When They Deny Their Racial Biases

Racial and ethnic inequalities, including health inequities, are well documented in the United States, originating from colonial America and persisting, even worsening, today. However, racism is infrequently and inadequately cited, taught, or targeted as the root cause of these inequities.[31,36] Its power derives from the denial and obfuscation of its existence; for example, through the practice of racial discrimination while using nonracial language. Policies such as the war on drugs and stereotypical terms such as welfare queen are key examples. Despite disproportionately targeting or being applied to people of color in a harmful or derogatory way (respectively), they are socially acceptable because they avoid using racial slurs and are expressed in ostensibly racially neutral language.[37]

Leading antiracist scholars, including Ibram Kendi,[38] head of American University's Center for Antiracism, have, therefore, argued that confessing to the racism that each person possesses is a first step toward becoming antiracist. Because racism begins not with the prejudice of individuals but with the policies of political and economic power, Kendi[38] argues that the word racist should be treated as a plain, descriptive term for policies and ideas that create or justify racial inequities, not a personal attack. People are racist when endorsing or supporting racist ideas and policies, and, conversely, they are antiracist when endorsing ideas and policies that promote racial equity. "Not racist," the descriptor that many Americans instinctively adopt, is not the opposite of racist because it claims false neutrality that serves as a mask for racism. Everyone, every day, through action or inaction, speech or silence, is choosing in each moment to be racist or antiracist. Frequently, people are both. Racist as a pejorative accusation that singles out individuals only ensnares people in racism's trap and freezes them in inaction.[38]

Racism pervades multiple systems in the form of housing segregation, educational achievement gaps, as well as health disparities.[36] Health care workers possess power and authority in the clinical encounter, and their patients, by contrast, are vulnerable and dependent on them. For this reason, they are uniquely charged with the responsibility of deliberately acknowledging and owning bias to avoid doing harm. An antiracist approach to clinical care proposes that every clinical interaction be considered either racist or antiracist, perpetuating racism in clinical care or championing against it. Thus, antiracism becomes the guiding framework for all interactions, and identifying and acknowledging racism becomes an opportunity to challenge it with an antiracist clinical intervention. This opportunity is missed when racism is denied, such as by suggesting that socioeconomics matter more; or when defensive emotions, such as anger, guilt, and helplessness, reinstate the racial equilibrium

Box 1
Case study: antiracist approach to clinical care

A 14-year-old female child, self-identifying as black, is brought to a psychiatric emergency room by police in handcuffs after her mother calls 911. The child tried to overdose on her antipsychotic medications, and her mother physically restrained her to stop her. She arrives in the emergency room moving uncomfortably in the restraints, and staff request IM medication

Admit to being racist so as to become antiracist: clinicians are more likely to do harm when they deny their racial biases	Conscious of her own racial background, the child psychiatrist recognizes the risk for advancing discriminatory behavior in the clinical encounter and instead deliberates regarding how to comfort and treat the child in an antiracist manner. She gently communicates that cuffing her was coercive and wrong: "I am so sorry that happened to you when you were suffering and needing help. We want to help you here, not harm you or make you feel worse"
Slow down: pause, heighten racial consciousness, and challenge racism	When staff request IM medication, the clinician refuses and instead pauses to do a brief chart review while considering how racism is operating in the child's life and could enter the clinical encounter; eg, by giving IM medication, failing to mitigate harm, or missing an opportunity to render treatment. She notes previous diagnoses of attention-deficit/hyperactivity disorder and oppositional defiant disorder and a history of behavioral challenges at school
Name and identify racism to challenge it: diagnosis determines treatment	The psychiatrist inquires whether her teachers are white or black and whether she ever feels singled out. The child immediately says that all of her teachers are white, that she is the only black child in her special education classes, and she often feels targeted as "the bad kid." After the child reports still feeling suicidal, the child psychiatrist contacts her mother to discuss hospitalization. The mother adds that the child, who has repeatedly been suspended for behavioral challenges, has been seeing a primary care physician for medication because no child psychiatrists in the area accept her insurance. The child psychiatrist discusses with the mother the risk of children of color being disproportionately punished and funneled into the school-to-prison pipeline
Learn the legacy of racism in American medicine to avoid perpetuating it	The child psychiatrist writes a school letter clarifying diagnosis and recommending supportive, rather than punitive, interventions. The antipsychotic prescribed for agitation is stopped, and an antidepressant is started. These therapeutic interventions are directed at the legacies of communities of color not receiving medical care, as well as

	organized psychiatry's not challenging racism and advancing clinical and research practices reinforcing ideologies of black criminality and violence
First, do no harm: prevent the toxic exposure of racism in the clinical encounter	During team rounds, the psychiatrist discusses the child's history of being harshly disciplined for distress and recommends therapeutic interventions that avoid force and encourage verbalization instead. She calls the mother regularly to assist with barriers in accessing care and to foster collaboration. During the monthly physician meeting, she discusses the police's practice of unnecessarily handcuffing children, explains why doing so can be racist, and elicits strategies to decrease this practice and to standardize other antiracist clinical practices

Abbreviation: IM, intramuscular.

and prevent meaningful dialogue. Racism is everywhere, rather than nowhere, and clinical care interactions become an opportunity to dismantle, breaking through the wall of silence in health care and beyond.[36,38,39]

Slow Down: Pause to Heighten Racial Consciousness and Prepare for Challenging Racism

Psychologist Daniel Kahneman's[40] work describing how people think both fast and slow is a helpful lens for helping clinicians focus and translate knowledge of racism at the structural level into direct antiracist clinical action during the patient encounter. The fast, automatic brain, governing 95% to 97% of behaviors through the mesolimbic pathway, works from unconscious associations and beliefs. The slow, more deliberate and thoughtful brain, associated with the prefrontal cortex, is activated far less frequently. Even if, in slow thinking, people work to avoid discrimination, it can easily creep into fast thinking. Snap judgments rely on all the associations people have derived, from fictional television shows to news reports. Stereotypes, both the accurate and the inaccurate, exist, both those people would want to use and ones they find repulsive. Implicit or unconscious bias reflects both human nature and socialization. It lives deep within people's brains, governing almost everything they do. Developing an understanding of the power of implicit bias enables people to develop practices to minimize the impact of their unconscious tendencies to categorize, generalize, stereotype, and discriminate. Pausing long enough to heighten racial consciousness can challenge clinicians' implicit biases, thereby curbing discriminatory behavior, and instead positioning them to dismantle the racism shaping the patient experience.[40] Subsequent steps provide practical tools to thoughtfully and deliberately enact an antiracist approach.

Name and Identify Racism First to Challenge it: Diagnosis Determines Treatment

Having consciously rejected the denial of racism, reframed all clinical actions as racist or antiracist, and cemented a foundation of slowed, reflective thinking, naming and identifying racism in clinical care is the next step toward constructing an antiracist approach. With shared language and clearer understanding of how institutions and systems are producing unjust and inequitable outcomes, antiracist clinicians are better equipped to work for change. Countless scholars have emphasized naming and identifying racism as a key step toward dismantling it, bearing in mind that most people do not consciously identify as having racist behaviors or acknowledge their implicit biases, and much racism is disguised.[38,41,42] Shared language and clear vision regarding how individuals, institutions, and systems are producing unjust and inequitable outcomes equip antiracist clinicians to work for change.[43] Kendi[38] specifically says, “The only way to undo racism is to consistently identify and describe it—and then dismantle it.” In addition, the diagnosis, the proper identification of racism, then determines the treatment of combating it.

Racism has been defined in a multitude of different terms, and the lack of consensus regarding a clear definition speaks to the failure to mount a meaningful national dialogue regarding racism, to implement a core educational strategy for eliminating racial bias, and to materialize a truth and reconciliation process to redress human rights atrocities committed during slavery and the American Indian genocide.[43] Despite this, a multilevel framework that captures internalized, interpersonally mediated, and institutionalized/structural elements to define racism are most frequently cited, Camara Jones’[42] framework being the best example.[41,42] Many definitions of racism also emphasize its historical origins, noting that race is an artificial construct, rooted in and used to justify and legalize slavery, and constructed on the foundation of white supremacy.[36,43]

Table 1 provides definitions and examples of racism using a multilevel framework.[31,42]

Because almost all interracial encounters are prone to microaggressions, this kind of racism is particularly important to integrating an antiracist approach to clinical care.[41] Microaggressions specific to clinical care have been linked to poorer physical health and health service use[44,45] One paradigm emphasizing the harm experienced by the victim, rather than the act committed by the aggressor, argues that clinical microaggressions can undermine physician-patient relationships, preclude relationships of trust, and therefore compromise the kind and quality of care patients deserve.[46]

Ibram Kendi’s[38] work complicates the typical 3-tier multilevel frameworks of racism by emphasizing the racist policies and ideologies that provide the breeding ground for the various levels of racism. Linking racist policy and interpersonal racism, he argues that “racial discrimination is an immediate manifestation of an underlying racial policy. When someone discriminates against a person in a racial group, they are carrying out a policy or taking advantage of the lack of a protective policy.”[38] Racial policy, in turn, is sustained by a racist ideology. “The only thing wrong with black people is that we think there is something wrong with black people,”[37] a summative statement Kendi emphasizes repeatedly.

Therefore, although clinicians should be directly attuned to the risk of committing racial microaggressions (the racism most explicitly manifested at the interpersonal level), they should also be conscious of potentially advancing the racism operating at the policy, ideological, and individual levels during the clinical encounter. Racism operating at one level reinforces and derives from racism operating at other levels. Policies that create a 2-tiered system of health care through private versus publicly funded systems of care, with racial minorities over-represented within the public system, are important to consider. Clinicians are in key roles to advocate for antiracist policies for insuring more equitable care.[47] By identifying the policies and ideologies shaping patient experience, diagnosis, treatment, and care, antiracist clinicians are better equipped to traverse racial bias, render just and high-quality care, and to even advocate against structural racism. Coercive clinical practices and diagnosis provide 2 key examples.

Table 1
Types, definitions, and examples of racism

Types of Racism	Definition	Examples
Individual/ internalized	A systemic oppression in reaction to racism whereby people of color internalize the racism that victimizes them. It can lead to conflict among and between people of color	• Low self-esteem • Colorism (stratification by skin tone within communities of color) • Self-hatred and self-devaluation • Stereotyping people of color • Having a sense of inferiority
Interpersonal/ microaggression	General: the brief and common daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color	• Microassault: an explicit racial derogation meant to hurt the intended victim through name calling, avoidant behavior, or purposeful discriminatory actions • Microinsult: verbal, nonverbal, and environmental communications that subtly convey rudeness and insensitivity that demean a person's racial heritage (eg, asking persons of color how they got their job, suggesting affirmative action) • Microinvalidation: communications that subtly exclude, negate, or nullify the thoughts, feelings, or reality of a person of color (eg, asking people where they are from or were born)
	Clinical taxonomy	• Epistemic microaggressions: intentional/unintentional slights conveyed in speech or gesture by health care providers that dismiss, ignore, ridicule, or otherwise fail to give uptake to claims made by physicians • Emotional microaggressions: physicians and other health care providers fail to take patients' emotional reactions to and experiences of their diagnoses and illnesses seriously • Self-identity microaggressions: health care providers intentionally or unintentionally undermine or do not give uptake to the existential consequences that often accompany experiences of illness
Structural	The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credits, health care, and criminal justice	• Residential segregation, in particular, is associated with adverse birth outcomes, increased exposure to air pollutants, decreased longevity, increased risk of chronic disease, and increased rates of homicides. It is also associated with decreased access to quality health care

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Table 1
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Types of Racism	Definition	Examples
Policy	Any measure that produces or sustains racial inequity between racial groups; policy defined as written and unwritten law, rules, procedures, processes, regulations, and guidelines that govern people	• Slavery and Jim Crow • Voter suppression • Policy brutality/mass incarceration • School-to-prison pipeline/pushout • Housing segregation/redlining
Ideology	Any idea that suggests one racial group is superior or inferior to another group in any way	• Black criminality/violence; white innocence • Black female hypersexuality; white female sexual purity • Black anger/violence; white people as saviors or promoters of peace • Black family as a so-called tangle of pathology • Strength/resilience of black people, suggesting they have superhuman abilities to tolerate hardship • Inferiority/ignorance of black people; superiority/intelligence of white people

Coercive clinical practices such as the use of seclusion, restraint, and intramuscular medication administration are typically used depending on clinical assessment of acute risk for violence or danger to others. This assessment, in turn, is based on clinical factors such as the mental status examination, recent medical history, and response to medication. However, noticeably absent from clinical guidelines is a consideration of racism and discrimination.[48,49] An antiracist approach expands this clinical assessment by first acknowledging the high risk of abusing power, actualizing pervasive racist ideologies regarding black violence and criminality, and traumatizing people of color with their injudicious use. It then carefully considers the risk for advancing the disproportionate use of punishment and violence against people of color, a phenomenon well documented in law enforcement (eg, police brutality, overpolicing of black communities, and mass incarceration of communities of color) and school settings (eg, oversuspension and expulsion and the resultant school-to-prison pipeline), with needed care.[50–52] Within this paradigm, a young black man arriving in restraints to an emergency department (perhaps brought in against his will on a legal hold by police), is likely to have been victimized by overpolicing of his local community and should be spared additional force when at all possible. Recalling that all actions are either racist or antiracist, antiracist clinicians instead make the experience as therapeutic and treatment oriented as possible; for example, by outreaching family, explicitly acknowledging the toll of racism preceding the clinical encounter, and verbalizing a commitment to avoid its perpetuation in care.

Diagnosis is another key conduit for discriminatory practices that demands a slowed, more reflective consideration of the insidious influence of racist ideologies and policies that are common throughout systems of care. Children of color are frequently embedded in segregated school systems with poor racial concordance between students and teachers/principals who are predominantly white, and these students often experience standardized testing practices and curricular content that is discriminatory.[37,38] They are subjected to harsh disciplinary measures, less frequently offered mental health treatment of behavioral challenges compared with their white peers, and are more likely to be funneled into the juvenile detention system and prison settings.[51–54] Adultification is a common racist ideology undergirding these practices. Closely intertwined with criminalization, it involves seeing children of color as older, more culpable, and less in need of nurturing and support than their white peers.[52] When assessing their disruptive behaviors, in particular, antiracist clinicians go beyond a cursory examination of symptoms, weighing deliberately the sociopolitical context in which their behaviors emerge. Avoiding overpathologizing or even condemning the child, they instead diagnose the racist structures causing detriment. Similar to exercising caution with coercive clinical practices, they can avoid disproportionately diagnosing conduct disorder and oppositional defiant disorder among children of color.[55] Challenging the adultification these children endure, antiracist clinicians can instead work closely with schools and teachers to provide more supportive and treatment-oriented approaches that nurture and protect their healthy development. Explicitly acknowledging the racism children experience validates and supports parents and families, renders structural racism more visible, and potentially protects against further harm.

Learn the Legacy of Racism in American Medicine (and Beyond) to Avoid Perpetuating It

Identifying the historical origins of inequities is considered a key step to understanding why black people are treated poorly and differently in the health care system.[30,56,57] These historical arcs are complex, interrelated, and not openly acknowledged in medical training and care by organized medicine. However, their identification is the foundation for codifying antiracist clinical practices to challenge them. American medicine was no different from other major American institutions by serving as a vehicle for legitimizing slavery, the backbone of the burgeoning US economy in the nineteenth century. Common medical school pedagogies involved determining whether or not enslaved people were sick or feigning illness and how best to provide treatment of aberrant behavior, which often consisted of disciplinary measures more accurately resembling human rights abuses and torture.[58] Myths about physical racial differences were used to justify slavery, eventually giving rise to the scientific racism that fueled imperialism and colonization in the nineteenth and twentieth centuries.[59]

American psychiatrists pathologized enslaved people who attempted to risk their lives by running away or who refused to work, diagnosing them with illnesses such as drapetomania or dysesthesia aethiopica. The prescribed treatment was whipping. In the 1960s, psychiatrists characterized angry politically active black men involved in the civil rights movement as having a reactive psychosis. Antipsychotic advertisements from that era sometimes featured angry, threatening cartoons of black men. Pathologizing the emotional and behavioral experiences of black people, rather than condemning the racist policies and practices being protested against, reflects a larger pattern of blaming the individual, rather than condemning more macro-level racist policies and practices. It also perpetuated a narrative of racial difference by suggesting a propensity to violence and criminality among black people.[37,60] This legacy lives on; for example, through the overdiagnosis of disruptive behavior disorders among children of color, caused by implicit biases and inadequate consideration of the disproportionate punishing and policing of these children in school settings.[55] Similar concerns might be raised when accusing a patient of color of malingering. Remarkably, during the Jim Crow Era when white people lynched thousands of black people, massively suppressed black voting rights, and willfully denied black people access to health care, organized psychiatry offered no condemnation of the white rage and white supremacy behind it.[37,61,62] Further underscoring organized psychiatry's complicity with racism and white supremacy, this silence was despite the substantial efforts black psychiatrists made to draw attention to racism's far-reaching impact on black mental health.[63,64]

More recently, a study examining biological causes of violence and its link to parenting practices used juvenile detention records to identify the siblings of violent youth and then used the now-banned drug fenfluramine on more than 30 children, all of whom were children of color. Only when family members sought legal support did the study come under scrutiny. Although the associated academic institutions, Columbia and Mount Sinai, were investigated, neither was formally sanctioned. In addition, several preeminent medical publications did not note any concerns regarding the ethics, risk of racism, or public outcry in publishing study findings.[65] The attempt to link violence to individual biology, rather than the larger social forces of poverty, unemployment, and overpolicing, has long been a focal point of psychiatry and a conduit for advancing a narrative of racial difference and the ideology of black criminality.[23,24]

These examples draw attention to (but do not fully describe) the racism embedded in American medicine and the key role that justifying slavery played in the growth of the medical profession in the nineteenth century.[66–68] Nonetheless, they articulate key trajectories regarding the legacy of slavery in the profession (highlighted in **Table 2**) and provide insight into how racial bias originated in health care. Antiracist clinicians consciously articulate how American medicine and psychiatry were no different from other major American institutions (economic, educational, legal, housing,

Table 2
Legacy of racism in health care directed against African American people

Examples of Arcs	Historical Examples	Contemporary Manifestations
Physical exploitation and human rights abuses	• Scientific experimentation on enslaved people (alive and deceased); perfecting experimental surgeries (eg, cesarean section and ovariotomy) on enslaved women before performing them on all women • Medical school pedagogies focused on maximizing labor and reproductive capacity of enslaved people • Forced sterilization programs, including unnecessary hysterectomies as practice for medical students or as part of eugenics programs (so-called Mississippi appendectomies)	• Coercive clinical practices directed at people of color (disproportionate reporting of cases to child protective services; overdiagnosis of schizophrenia; excessive use of restraints) • Fenfluramine study on children examining link between biology, parenting, and aggression
Narrative of racial difference	• Medical forefathers such as Benjamin Rush (so-called father of American Psychiatry) laid racial inferiority foundations, categorizing black people as subhuman, different from white people, and biologically inferior • Leading psychiatrists pathologizing resistance to slavery • Experimentation on enslaved people justified by belief that they are biologically different (eg, more resistant to pain) • Scientific racism and the pseudoscience of racial difference based on unscientific, descriptive practices, such as phrenology, craniotomy	• Medical students still believe black people experience less pain • Diagnostic frameworks/fallacies for people of color (overdiagnosis of schizophrenia/ psychosis and conduct disorders)

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Table 2
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Examples of Arcs	Historical Examples	Contemporary Manifestations
Denial and segregation of medical services	• Flexner Report's closure of all but 2 of the 7 historically black medical schools, worsening the physician shortage for black communities • Reconstruction was the nadir of black health status, with staggering death rates among black people caused by poverty and poor housing and sanitation following abolition • Established in 1847, the AMA gained control of hospitals, the medical education system, and professional societies; it supported segregation as its official national policy until 1968	• Racism in health care delivery (not offering treatment to people of color)
White male predominance	• Barring black people from entering medical school during the nineteenth century • AMA allowing local medical societies to ban black physicians until the 1970s	• Crisis of black male physicians (no improvement in >35 y) • Limited number of black faculty • Predominance of white male department chairs
Silence	• AMA did not apologize for barring black professional advancement until 2008 • Organized psychiatry did not speak out regarding fenfluramine study • Some sources estimate that nearly 60% of all enslaved women were sexually assaulted and nearly 1 out of 3 enslaved children were separated from their parents; there has never been any formal acknowledgment of this trauma and its aftermath	• No formal plan to address the legacy of racism and slavery in medicine • Lack of commentary regarding reparations for health care • Lack of antiracist medical training • Lack of recognition of the contributions of black people who were experimented on or exploited

Black (physician) activism	• Fannie Lou Hamer's campaign for reproductive justice (forced sterilization, Mississippi appendectomy) • Ida B. Wells' antilynching campaign • NAACP pushing for universal health care (1950s) • Black physicians desegregated major American hospitals in the 1920s • NMA lobbied the passage of Medicare and Medicaid to make the health system available to black people, the indigent, and the handicapped	• White Coats for Black Lives (Racial Justice Report Card)

Abbreviations: AMA, American Medical Association; NAACP, National Association for the Advancement of Colored People; NMA, National Medical Association.
Data from Refs.[67,68,72]

political) in justifying slavery and failing to condemn Jim Crow violence. This insight facilitates the slower, more reflective thinking needed to challenge the automatic fast thinking resulting in implicit bias. Key strategies for subsequently translating this knowledge into clinical practice include avoiding coercion and abusive practices, reconsidering diagnosis against this historical landscape, and making every effort to provide treatment to ensure there are no missed care opportunities.

First, Do No Harm: Prevent the Toxic Exposure of Racism in the Clinical Encounter

Because of this historical context and the known health consequences of racism, any act of racism, no matter how small, is a toxic exposure for patients and a sentinel event for the health care system. Inadequate or negligent care of minorities who have weathered or even died of racism across generations, particularly within a caregiving profession that violated its most basic oath, constitutes grave medical error. Accordingly, the risk of racism should always be acknowledged and accounted for by clinicians as if it were a vital sign. This consideration is particularly relevant, given the significant power differentials between clinicians and patients and the risk of the former using power to enact racial subordination of the latter.

Within this framework, good intentions are irrelevant, rather it is the impact of racism (particularly the health consequences) that defines the focus.[69] Clinicians operationalize an antiracist approach to clinical care by reviewing the definitions of racism (see **Table 1**) to see where they might be operating in the patient's experience and by checking for touchpoints and direct links to the historical arcs of racism characterizing medicine and health care more broadly (see **Table 2**). The overarching goal is to protect patients of color against the daily assault of racism embedded in the health care system, and, whenever possible, beyond. The process is deliberate and thoughtful to ensure clinicians do not default to the fast, automatic thinking behind racist implicit biases. The moments when a lead clinician argues that something has nothing to do with race (or racism) or responds with silence if the role of racism is raised are precisely the moments when an antiracist approach to clinical care should be actualized.

Incorporating antiracist dialogue into the clinical encounter traverses the wall of silence characterizing organized medicine's stance on issues of justice and disrupts the legacy of racism in health care. Faculty who benefit from white supremacy bear a greater responsibility for illuminating the invisible forces of racism that shape patients' experiences. Faculty and trainees of color, who face disproportionate professional and personal burdens because of racism and discrimination, should not solely be tasked with improving the system.[70] Case discussions, team treatment planning, grand rounds, didactics, and other treatment and educational opportunities should become the vehicle for these conversations.

LIMITATIONS AND NEXT STEPS

This article describes an antiracist approach to clinical care focused on elucidating the racism shaping providers' and patients' lives and clinical interactions, reversing the historical arc of racial oppression embedded in the health care system, and preventing the toxic exposure to racism in the clinical encounter. Although this approach's ultimate goal is to eliminate health inequities, the authors fully acknowledge their complexity and rooting in structural racism and social determinants of health, which cannot be overcome in a single clinical encounter.[27,29,50] Nonetheless, this approach responds to the burgeoning emphasis on addressing implicit bias and promoting racial justice in health care. It joins other recent antiracist curricular materials developed to challenge racism in health care. Furthermore, it can be implemented immediately by clinicians, can potentially reduce harm experienced by patients, and could facilitate more systemic change in the future by shifting culture and promoting meaningful racial dialogue now.[71]

More data regarding the most common acts of racism taking place in mental health care are needed; however, measuring and tracking (ie, diagnosing) these clinical microaggressions is complex. Family separation has disproportionately affected families of color through slavery, forced relocations, and more recently through mass incarceration. Given these findings, what does it mean when clinicians alienate or antagonize parents of color, are unable or unwilling to partner with them, or disproportionately report them to family services? Are clinicians intervening clinically on the patient's behalf or doing more harm by subscribing to racist ideologies regarding inadequate parenting or pathologic families? Given the legacy of segregating and denying health care services to people of color, what are the implications of fast-tracking out of care a person of color with a documented mental health history seeking shelter but with no acute psychiatric emergency? What does it mean for health care providers to prescribe antipsychotic medications to an agitated child in foster care with an established trauma history whose parents are not available to advocate for the child? How does the overrepresentation of children of color in foster and juvenile justice settings govern antiracist approaches to their care?

Racial disparities permeating the economy, housing, education, and the law raise serious concerns regarding whether certain clinical practices, although potentially justified by a current clinical presentation, do more harm than good to people of color in the long term. Although clarifying answers to these complex questions might take time, initiating dialogue among clinicians, particularly given that the mental health workforce does not mirror the racial diversity of the US population, is an important and immediate next step in leveraging an antiracist approach. Remaining silent or denying the presence of racism in clinical care not only stands in the face of growing demands for antiracist health care but it also perpetuates a legacy of racial injustice that demands to be challenged.

DISCLOSURE

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