Alleviating the Mental Health Burden of Structural Discrimination and Hate Crimes: The Role of Psychiatrists

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What are clinicians practicing when they carefully attend to the individual stories of patients?

A. Cultural humility.
B. Structural competency.
C. Narrative humility.
D. Cultural safety.

Case 1: Post-Orlando Trauma

An African American psychiatrist has been working with a middle-aged gay black man over 2 years to treat depression and anxiety after a severe traumatic brain injury for which he receives Social Security Disability Insurance payments. Over the past 4 months, the patient's mood and anxiety have worsened, and the patient feels that his life lacks value as he watches videos of the deaths of Mike Brown and Alton Sterling at the hands of police officers. He fears that his sexual preference puts him in danger as he watches interviews in the aftermath of the Orlando gay nightclub shooting. Recent increases in violence against ethnic, racial, and sexual minorities seem to validate his fears that this experience will not end. He feels unsafe outside his home, feeling more vulnerable to hate speech and hate crimes than at any time in memory. As his anxiety and mood worsen, the psychiatrist wonders how to help, because he shares many of his patient's concerns and feels helpless because he cannot shelter his patient from the trauma that comes with being both a black person and gay male in a marginalizing national climate.

Case 2: Immigrants' Anxieties

A Colombian-born Spanish-speaking psychiatrist notices heightened uncertainty and anxiety among both patients and staff in the urban public mental health clinic in which she works. The clinic serves primarily first-generation non-English-speaking patients, many of them undocumented immigrants. Patients who had been psychiatrically stable for years are decompensating, yet they are avoiding hospitalization because they do not feel safe in public institutions because of news reports of changes in immigration law. Colleagues at other public clinics serving immigrants are reporting steep declines in their census, and staff members in her clinic are receiving questions from their patients every day about the legal complexities of their immigration cases, which they are unable to answer. They find, too, that some patients are being taken advantage of by con artists claiming to be immigration lawyers, and others are desperately preparing wills and custody arrangements for their children who were born in the United States, fearing that they will be deported without warning, based on sensationalist local Spanish and Chinese television shows that provide inaccurate information. The psychiatrist attempts to garner accurate information about immigration law enforcement and a list of legal resources in the neighborhood but is told by a senior psychiatrist colleague "not to get mixed up in those issues" and to "just take care of your clinical work."

Case 3: Marked for Religious Violence

A Sikh psychiatrist gets reports that suicides among Sikhs have increased over the past year, related to anti-Muslim violence directed at (non-Muslim) Sikhs wearing turbans. In her clinic, Muslim and African American patients report escalating religious and racial profiling in public spaces. In her Gurdwara (Sikh house of worship), she hears of families that are disintegrating as a result of anxiety among parents, sales of family businesses in neighborhoods that have become unbearably hostile, and back-migration of elder members to India. Sikh community members draw comparisons between current

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religious violence in the United States and the long history of oppression and beheadings of Sikhs in India. Fearing violence against her elementary school–age son, the psychiatrist wonders if she should cut his hair so that he will not be bullied by classmates, but she hesitates given that his uncut hair is a valued link to his heritage and his community's beliefs. She and her husband talk about leaving the United States, even though she was born here and is a U.S. citizen. She laments, "I feel it's not my own country."

Recently in the United States we have seen a string of widely publicized deaths of young African Americans at the hands of police, as well as increasing reports of public harassment and violence on the basis of race, gender, religion, sexual orientation, and immigration status. In the month following the 2016 U.S. presidential election, the Southern Poverty Law Center reported over 1,000 bias-related incidents, including over 300 anti-immigrant hate incidents, over 200 anti-black hate incidents, over 100 anti-Muslim hate incidents, and over 100 anti-LGBT (lesbian, gay, bisexual, transgender) hate incidents (1). At national meetings and on online forums, members of professional groups dedicated to promoting mental health equity, including the American Psychiatric Association's Council on Minority Affairs and the American Association for Community Psychiatry, report heightened fear among patients from targeted groups, including young children who worry about the safety of their parents and caretakers. The relationship between systemic discrimination and mental health outcomes has been established by research findings of elevated cortisol and blunted stress response in targeted populations, as well as elevated rates of emotional dysregulation, anxiety and depression, sleep disturbance, and substance use (2, 3).

It is timely to reflect on how we as psychiatrists should respond to the influence of targeted violence on our patients and on our communities.

This atmosphere of anxiety and mistrust is harmful to mental health in our communities. Publicized incidents of violence, discrimination, and deportation within hospitals, social service agencies, schools, and the justice system threaten our capacity to develop a therapeutic alliance with people in need of support and threaten our ability to advocate for people in emotional and mental distress. We need to bring our expertise to bear in a time of insecurity about civil rights and protections to help ameliorate the community and institutional dynamics that foster insecurity and its detrimental effects on mental health.

Without intervention, we may encounter increased mistrust among patients on the basis of race, gender, ethnicity, religion, sexual orientation, and migration status. For example, African Americans and recent immigrants report that they hesitate to seek health care, given their historical experience with substandard care, unethical human experimentation, and disproportionate reporting of patients to agencies such as Child Protective Services and Immigration and Customs Enforcement (4, 5). African Americans, Latinos, and Native Americans may experience mental health services as entwined with law enforcement, given that the nation's largest provider of mental health care is now the jail and prison system, and that members of these groups are two to six times as likely to be incarcerated (6).

Our patients and members of our communities may also be traumatized and retraumatized by the graphic media coverage of police shootings, hate crimes, white supremacist groups, and aggression toward women. Such imagery affects viewers of all ages, including young people who are learning to navigate schools, clinics, and systems of public safety. In this atmosphere of anxiety and mistrust, what can we do as psychiatrists?

We can first educate ourselves and our colleagues about the mental health impact of targeted violence and discrimination and the ways that our actions are implicated in alleviating or exacerbating their impact. Targeted violence and discrimination further compound the marginalization of groups that already have histories of interpersonal and institutional violence (such as unethical clinical experimentation, forced sterilization, disproportionate law enforcement) as well as mental health stigma and limited access to mental health care. Reviews of the literature on the impact of discrimination on health have identified significant mental health effects of at least three types of racism: internalized racism (the incorporation of racist attitudes, beliefs, or ideologies into one's worldview), interpersonal racism (interactions between individuals), and systemic, institutional, or structural racism (for example, exercised through control of and access to labor, material, and symbolic resources within a society) (7).

Approaches that help health care providers recognize and counter internalized and interpersonal discrimination in their clinical practice include *cultural safety,* developed in the context of health services for indigenous people (Maori) in New Zealand, in which practitioners examine their own cultural identities and attitudes in order to create an environment that is spiritually, socially, emotionally, and physically safe for people from other cultural backgrounds and affirms their identity and their needs. In New Zealand, this also required increasing Maori community control of clinical institutions (8). In addition, *cultural humility* encourages practitioners' self-reflection, co-learning with patients, and collaboration with community organizations in order to enhance patient and community participation in care (9); and

narrative humility encourages practitioners to attend carefully to their patients' stories, to evaluate their own role in those stories—their expectations of, responsibilities to, and identifications with patients' stories (10, 11). These approaches help clinical practitioners consider the social and historical context of systemic discrimination in marginalized communities and address power imbalances between health practitioners and patients in clinical practice.

The second is to provide *trauma-informed care* (12). Trauma-informed care recognizes that a high percentage of patients in mental health and addiction treatment settings have experienced interpersonal trauma, and it responds with the conscious provision of safe environments (13). Practitioners and clinics that are unaware of patients' histories of trauma risk retraumatizing patients by inadvertently reenacting abuses of power based on the race, ethnicity, gender, sexual orientation, religious background, and socioeconomic status of the patient. Many systems of care regularly screen patients for depression using validated instruments (14). We suggest expansion of this model to add trauma and posttraumatic stress disorder screening instruments (such as the PTSD Checklist–Civilian Version [15]), especially for systems of care that primarily serve racial/ethnic, sexual, or religious minority populations, and that such screening be followed by appropriate mental health support.

The third is to address the *systemic and institutional nature of racism and other biases* that have a negative impact on health (16). *Institutional discrimination*, caused by systemic practices, regulations, and policies rather than individual bias, such as disproportionate law enforcement in nonwhite neighborhoods and targeted deployment of Immigration and Customs Enforcement agents in poor neighborhoods, requires intervention above the level of individual patient care. One way to counteract the negative effects of institutional discrimination is to build trust and foster collaboration between mental health clinics and communities. This requires that mental health professionals learn about the neighborhoods from which their patients come and to partner with community leaders and organizations, including those in non-health sectors (e.g., schools, housing agencies, and faith-based organizations), to plan local events (17). For example, after the September 11, 2001, terrorist attacks, successful mental health interventions in New York City brought neighborhood residents, the staff of local schools, and community-based organizations together for group discussions and creative arts events that promoted *collective recovery* (18). Other forms of community engagement involve the employment of community health workers, such as peers—people with lived experience with psychiatric diagnoses from cultural/racial/ethnic backgrounds and neighborhoods similar to those of patients (19).

The fourth way that psychiatrists can counteract institutional discrimination is through collaboration with relevant non-health sector agencies, such as housing agencies, schools, and law enforcement, and with policy makers. One example is medical-legal partnerships between clinical and legal professionals (20) that use legal means to prevent unlawful eviction of decompensating psychiatric patients or to enforce landlord compliance with health codes, such as those governing lead removal. Another example is From Punishment to Public Health, a multidisciplinary group in New York City that includes clinical practitioners and public health researchers who work with New York City police to redirect symptomatic people in subways from arrest to mental health care, and which prepares physicians to testify to policy makers regarding the health impact of laws such as mandatory minimum drug sentences (21).

Structural competency integrates the approaches listed above by training clinical practitioners to engage with community organizations, non-health sectors, and policy makers (22). It involves 1) recognizing and naming the institutional forces that shape clinical interactions; 2) rearticulating "cultural" presentations in structural terms (e.g., nutritional choices as limited by "food deserts" in poor neighborhoods rather than by cultural tradition); 3) observing and practicing structural interventions as clinicians (such as collaborating to form mental health support groups in churches and community organizations and advocating for mental health–promoting policies); and 4) developing structural humility—the ability to collaborate with community members and members of other disciplines who have complementary expertise, while recognizing that institutional change is incremental and requires patience. Structural competency responds to the call that clinical trainees are making for intervention against institutional discrimination, as reflected in the medical student–initiated group White Coats for Black Lives (23).

Despite its utility to clinical practitioners, however, the concepts of structural racism and institutional discrimination, which have origins in social science and legal scholarship, rarely enter into the broader clinical mental health discourse. In our own review of clinical journals indexed in PubMed over the past 40 years, we found just over two dozen articles about the impact of structural racism on mental health (24–50), the majority (67%) of which were published in the past decade (see the online supplement). Almost 30% of these articles were published by investigators outside the United States, predominantly in Germany and the United Kingdom (26, 32–34, 37, 44–46). Only five of the articles offer systemic solutions to overcoming structural racism (24, 29, 35, 47, 48). The proposed systemic solutions emphasize having members of these minority populations provide mental health care to their community and the need to empower providers with the responsibility of identifying and dismantling discriminatory practices (24, 29, 35). To introduce the concept of institutional discrimination to practitioners, it is critical that papers on this topic be published in leading clinical journals.

DISCUSSION

To return to the case vignettes, we found that the psychiatrists involved in each of the cases ultimately found ways to intervene at structural levels. The psychiatrist caring for the black gay man whose symptoms of anxiety and depression steadily worsened as he saw televised violence in Orlando and elsewhere connected the patient to the National Black Justice Coalition, an organization dedicated to empowering and protecting the rights of black lesbian, gay, bisexual, transgender, queer (LGBTQ) community members. This motivated the patient to look for ways to demonstrate, which led to his participation in a protest. At the local level, the psychiatrist helped the patient find support groups at The Center, an LGBTQ community center in the patient's city that had groups specifically addressing the needs and concerns of members of color. To better identify, understand, and support the problems unique to the patient, the psychiatrist familiarized himself with the Association of LGBTQ Psychiatrists, which provides resources and information relevant to the care of LGBTQ members. Other resources and advocacy groups include the Trevor Project, which operates a suicide prevention hotline for LGBTQ youth, the Human Rights Campaign of the Historically Black Colleges and Universities Program, which develops LGBTQ students of color to become agents of change on their respective campuses, and Lighthouse (www.lighthouse.lgbt) which aids in finding LGBTQ health providers for patients.

The psychiatrist working in the clinic with undocumented patients partnered with a legal defense group to host informational sessions on immigration law and legal aid, as well as guidelines for clinical staff to refer patients with immigration questions to local legal aid offices. She and colleagues organized a series of stress-reduction workshops for patients, called "Todos Somos Bienvenidos/All Welcome Here," featuring yoga, nutrition information, and discussion groups. In addition, her clinic is now offering a therapy group in Spanish specifically for undocumented immigrants that not only provides psychosocial support but also offers information about social and legal resources for undocumented immigrants and solicits feedback from participants about additional offerings that the clinic should have for those without documentation.

The psychiatrist who experienced the impact of anti-Sikh and anti-Muslim violence on her community convinced her local Sikh Coalition to participate in interfaith marches against religious violence, women's discussion forums on religion, and educational outreach to local elementary schools involving a turban coloring activity, teaching students to play Sikh music, and offering lessons on the history of Sikhs in India and the United States. Using personal experiences of discrimination to fuel local activism and foster inclusion could be encouraged as a healthy defense mechanism for minority and immigrant psychiatrists (51).

Additional resources for psychiatrists who strive to ameliorate the impact of institutional discrimination and violence on their patients include the Substance Abuse and Mental Health Services Administration's guide to trauma-informed care (www.samhsa.gov/nctic/trauma-interventions), and the American Psychiatric Association is preparing a tool kit for mental health practitioners that provides tailored guides for addressing distress in members of specific targeted groups, including black, Latino, Native American, Asian, LGBTQ, Muslim, Jewish, and women patients. In addition, articles written by and for psychiatrists on structural competency provide approaches for and examples of interventions to reduce institutional discrimination (52–54). These resources are designed to help psychiatrists promote collective recovery among their patients and in their communities in an era of major structural challenges to our nation's mental health.

C. Narrative humility.

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