HHS Public Access

Author manuscript

JAMA Psychiatry. Author manuscript; available in PMC 2023 September 25.

Published in final edited form as:

JAMA Psychiatry. 2022 February 01; 79(2): 93–94. doi:10.1001/jamapsychiatry.2021.2877.

Race as a Social Construct in Psychiatry Research and Practice

Brittany E. Bryant, DSW, LISW-CP[1], **Ayana Jordan, MD, PhD**[2], **Uraina S. Clark, PhD**[3,4]

[1]Medical University of South Carolina, Department of Psychiatry and Behavioral Sciences, Charleston, SC 29425 USA,

[2]Yale University School of Medicine, New Haven, CT 06511 USA,

[3]Department of Neurology, Icahn School of Medicine at Mount Sinai, New York, NY 10029 USA

[4]Center for Scientific Diversity, Icahn School of Medicine at Mount Sinai, New York, NY 10029 USA

In scientific studies, the social construct of race is often conceptualized as a biological variable, supported by the false historical narrative that there are inherent biological differences between racial groups. This scientific error has led to decades of flawed practices in the medical setting,[1] contributed to ongoing health disparities,[2] and reinforced racial biases in diagnosis and treatment rationale.[3] The notion of race as a biological determinant in research has contributed to the perpetuation of negative stereotypes and further stigmatization of minoritized racial and ethnic groups. Due to the reciprocal interdependence of research and clinical practice, these false notions extend into the clinical realm, impacting patient outcomes. Additionally, results from these studies are frequently used to determine policies, practices, and resource allocations throughout medicine and society more broadly. We must therefore consider fully how misinterpretation of research findings contributes to the ongoing oppression of minoritized racial and ethnic groups and perpetuates racism by obscuring the underlying causes of racial disparities. Below, we focus on race as a biological factor and its contribution to misdiagnosis and health disparities in the area of mental health for Black individuals. We also discuss the appropriate use of race in mental health research and provide recommendations on how clinicians can aptly use race to inform practice.

The current concept of race, a social construct, stems from the 18th century when it flourished, in part, due to attempts to rationalize the enslavement of African people in Western societies. This construct has been used to delineate differences between humans, assigning “whiteness” as the standard, and promoting the narrative that Black and other marginalized people are inherently and genetically inferior.[4] In mental health, as in biomedicine, race continues to be used inaccurately—a practice rooted in the historical racialized belief that race can act as a causal factor across the entire spectrum of disease—thereby influencing data interpretation, treatment decisions, and clinical practices.[5] Despite evidence that the variable race is often not genetically discrete, reliably measured, nor biologically relevant,[2] researchers and clinicians continue to use the basis of race to

Corresponding Author: Brittany E. Bryant, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 67 President Street, MSC 861, Charleston, SC 29425, goldsmib@musc.edu, 843-973-0867.

incorrectly explain differences in health outcomes as a consequence of biological properties presumed to be associated with race.[6] This error not only contributes to the fallacy that a person's skin color determines risk profiles for specific mental health conditions but also negates the influence of factors that can contribute to wide variabilities in health and are differentially expressed across diverse global populations (e.g., environmental conditions, cultural practices). Hence, racial determinism obscures the effects of social determinants and contributes to misinterpretation.

Racial determinism also contributes to false diagnostic conclusions, whereby Black people experiencing mental health conditions can be misdiagnosed, even when measures of psychopathology are inconsistent with the given diagnosis.[3] Such examples highlight the need for a greater examination of the ways in which bias influences our diagnostic practices. Similarly, there is a critical need for greater inclusion of Black and other minoritized racial and ethnic groups in research studies to better inform objective diagnostic measures.5 Research that relies on clinical measures that demonstrate disparate validity across racial and ethnic groups produces findings and promotes practices that have low ecological validity and effectiveness, further perpetuating racial and ethnic health inequities.

To adequately address the misuse of race in mental health research and practice, changes must be made on individual, institutional, and societal levels. As the US grapples with the extensive impacts of racism, it is essential that we dismantle the notion of race as a biological determinant in mental health and simultaneously enhance our understanding of how the social phenotype known as race functions in society to preferentially advantage and value White lives, cultural ideals, and norms over those of other racial and ethnic groups. Individually, it becomes the work of every researcher and clinician to acknowledge the existence of structural racism and its historical and current role in producing inequities that contribute to poor mental health outcomes among minoritized populations. This work also requires us to evaluate mental health measures, screening tools, and diagnostic practices to ensure racial and ethnic equity in the validity of these measures.[7] Additionally, research that investigates social determinants (e.g., environmental racism, resource allocation inequities, social discrimination) and the mechanisms through which they confer risk will undoubtedly transform our understanding of mental health and disease. It may also lead to improvements in diagnosis, treatment, and clinician-patient rapport, as findings from this research will foster a more holistic and accurate understanding of pathogenesis. With this deeper appreciation of etiology, we will be better able to reduce the burden of mental health disorders among all members of our society.

On an institutional level, universities, federally funded health organizations, and private institutions should work to eliminate the misuse of race and other forms of racial bias in mental health research and practice. As an initial step, institutional leaders must not only reflect the populations being served but also promote practices that allow their organizational members to regularly incorporate antiracism principles into their work and develop systems that leverage resources to promote equity.[8] Institutions have an ethical responsibility to go beyond antiracism, where the focus is not solely on the absence of discrimination and inequities but rather on the presence of deliberate systems and supports that achieve and sustain racial justice through proactive and preventive measures. Examples

include ensuring that people from minoritized groups receive equitable compensation, promotion opportunities, and leadership opportunities; ensuring equity in health care access for all patients; and ensuring institutions regularly examine the impact of policies and practices on marginalized groups, applying corrections as needed to achieve equity.[9] Institutions also have an ethical responsibility to commit to racial justice in action by educating all organizational members about the historical racial context that has contributed to inequities, poor access to care, and poor mental health outcomes in the US, as well as by providing instruction on how to create structures that can reallocate power to those most marginalized.

Societally, major structural reforms and systems that support racial justice must be enacted. We must invest in public health infrastructure, ensuring minoritized individuals have equitable access to critical resources, such as desegregated health care systems, well-funded educational systems, fair employment opportunities, safe and well-maintained housing, and technological advances (e.g., reliable high-speed Wi-Fi). In addition, we must examine and correct dysfunctional institutional practices, such as the utilization of police in responses to acute mental health crises and as a regulatory presence in schools. These are just some of the key societal interventions that could begin to address elements of structural racism and other social determinants of health to improve mental health outcomes for all communities.

Research supports what we know intuitively—racism is associated with grave individual, societal, and economic costs.[10] It is imperative that we address all levels of racism in our society, as doing so will substantially improve the mental health of our citizens and our nation. Academia and those associated therein have the opportunity to hold research agencies, organizations, and individuals accountable to protect Black and other minoritized people from the perpetuation of structural racism (e.g., by requiring regular monitoring of equity metrics and outcomes and by linking these outcomes to institutional resource allocations).[8] It is beyond time that these systems and practices transform into those that prioritize, reward, and promote equity.

References

1. Ioannidis JPA, Powe NR, Yancy C. Recalibrating the use of race in medical research. JAMA. 2021;325(7):623–624. [PubMed: 33492329]
2. Smedley A, Smedley BD. Race as biology is fiction, racism as a social problem is real: anthropological and historical perspectives on the social construction of race. Am Psychol. 2005;60(1):16–26. [PubMed: 15641918]
3. Schwartz RC, Blankenship DM. Racial disparities in psychotic disorder diagnosis: a review of empirical literature. World J Psychiatry. 2014;4(4):133–140. [PubMed: 25540728]
4. Corbie-Smith G, Henderson G, Blumenthal C, Dorrance J, Estroff S. Conceptualizing race in research. J Natl Med Assoc. 2008;100(10):1235–1243. [PubMed: 18942287]
5. Cooper RS. Race in biological and biomedical research. Cold Spring Harb Perspect Med. 2013;3(11):a008573. [PubMed: 24186487]
6. Paradies Y A systematic review of empirical research on self-reported racism and health. Int J Epidemiol. 2006;35(4):888–901. [PubMed: 16585055]
7. Byrd DA, Rivera Mindt MM, Clark US, et al. Creating an antiracist psychology by addressing professional complicity in psychological assessment. Psychol Assess. 2021;33(3):279–285. [PubMed: 33779204]

8. Clark US, Hurd YL. Addressing racism and disparities in the biomedical sciences. Nat Hum Behav. 2020;4(8):774–777. [PubMed: 32651473]

9. National Education Association. Racial justice in education: resource guide. Accessed May 5, 2021. https://www.nea.org/professional-excellence/student-engagement/tools-tips/racial-justice-education-resource-guide

10. Bor J, Venkataramani AS, Williams DR, Tsai AC. Police killings and their spillover effects on the mental health of Black Americans: a population-based, quasi-experimental study. Lancet. 2018;392(10144):302–310. [PubMed: 29937193]