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Cognitive Behavioral Therapy and the Implementation of Antiracism

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Despite decades of efforts to promote health equity, racial and ethnic minorities continue to endure health disparities perpetuated by racism.[1] Medical education has historically struggled to address this problem adequately.[2] In recent years, several medical schools have integrated antiracism and structural competency programming into their curricula.[3–5] This promising approach aims to teach trainees to recognize the social structures, including structural racism, that impact patient care. While many trainees may be familiar with the rhetoric of antiracism, we believe that the application of this knowledge is a challenging task. Racism functions on multiple levels and the magnitude of the problem in healthcare may necessitate targeted-multilevel interventions.

Targeted interventions at the provider-level that complement existing structural competency programming may be beneficial due to the shortcomings of medical education and the pervasiveness of implicit racial bias. Medical education prioritizes non-analytic processes in clinical diagnostic reasoning, namely “pattern recognition,” which relies on combinations of signs and symptoms to suggest specific diagnoses.[6] This approach, though useful in many clinical scenarios, also runs the risk of priming learners to revert to mental shortcuts and racial stereotypes when faced with stress, time pressure, test vignettes, or unfamiliar clinical situations.[6,7] Physicians can thus hold implicit racial biases independent of—and often in opposition to—conscious antiracist attitudes. When such cognitive dissonance is not processed or resolved, we believe it supports and enables racist medical practice.

In this Viewpoint, we hypothesize that using psychotherapeutic methods to address provider-level bias may provide an important means to combat racism in medicine. We propose that cognitive-behavioral therapy (CBT) frameworks, already familiar to psychiatrists, may hold promise in the implementation of antiracism in mental health care. Both the scientific literature and professional medical organizations have highlighted that implicit biases and microaggressions play a large role in maintaining structural racism.[8,9] The

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cognitions perpetuating racism thus may require intentional interventions to teach physicians to identify, react to, and correct problematic mental shortcuts that hinder the translation of antiracism into action.

CBT-based frameworks for antiracism have not been commonly developed for medical professionals in training or in healthcare settings. However, dissonance-based approaches have been successfully developed in other fields, such as social psychology, with a notable example being Devine et al.'s Breaking the Prejudice Habit.[10] In this intervention, non-Black students learned cognitive-behavioral strategies (such as stereotype replacement, perspective-taking, and increased contact with outgroup members) to combat implicit racial bias. Devine and colleagues conceptualized that individuals who endorse personal values opposed to prejudice may experience cognitive dissonance when they learn they have acted on their implicit biases.[10] The resulting psychological discomfort motivates them to seek out information or perform behaviors to reduce prejudice expression.

The foundational principles of Breaking the Prejudice Habit support the benefit of well-defined modules that harness evidence-based skills to combat racism in medicine. Table 1 illustrates potential applications of CBT-based frameworks to facilitate the implementation of antiracism in psychiatry. For instance, providers can develop negative automatic thoughts in clinical situations that cloud clinical judgments and predispose patients to structural racism (Table 1: Implicit bias). CBT-based approaches for antiracism may further help clinicians manage defensive responses that arise when they experience cognitive dissonance, e.g., when colleagues verbalize concerns about discrimination (Table 1: Structural Racism). The lack of diversity amongst medical providers presents additional barriers to addressing racial inequality.[2] Black physicians are profoundly underrepresented in medicine, creating an insular community of healthcare leaders prone to defensiveness and passivity when confronted with racial challenges (Table 1: Exclusion). The application of CBT-based approaches to re-examine internal cultures, prejudices, and fears that drive racism may be a promising addition to existing diversity, equity, and inclusion interventions.

We emphasize that this Viewpoint is not intended to be prescriptive, provide objective assessments of feasibility, or serve as a comprehensive review of CBT-based interventions for antiracism. We recognize that practitioners of CBT for antiracism may have their own racist beliefs that challenge their ability to implement our proposed framework effectively. However, CBT offers the advantage of using dissonance as a signal to challenge one's core beliefs or thoughts. Another challenge facing any CBT-based intervention for antiracism is the measurement of downstream effectiveness. The existing literature based on structural competency curricula has focused predominantly on physician-centered metrics of changing knowledge, beliefs, attitudes, and behaviors prone to the biases we aim to reduce.[5] CBT for antiracism may potentially be assessed in terms of its capacity to modify patient-centered metrics such as changes in the patient experience related to race, reductions in against-medical-advice discharges, clinic dropout rates among patients of color, as well as reducing biased word choices in patient-physician encounters and physician electronic medical records. However, rigorous research is needed to further conceptualize and test the framework of CBT for antiracism as it seeks to disconfirm maladaptive cognitions that

maintain racism in healthcare while we concomitantly construct much-needed interventions at the systems level.

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Table 1 -

Applications of CBT based antiracism in mental healthcare

ANTECEDENTS Illustrating Racism in Mental Health Care	BELIEFS/ AUTOMATIC RESPONSES	POTENTIAL CONSEQUENCES	ALTERNATIVE RESPONSES
Domain: Implicit Bias			
A 50-year-old Black patient with schizophrenia presents to the psychiatric emergency department with "altered mental status." Upon noticing that the patient had many past-year encounters in the chart for "malingering," the attending physician, before having seen the patient, states that "we shouldn't waste resources on these people." After hearing this, a Black medical student asks the attending why it was assumed the patient was malingering.	The attending replies: "I am here to help my patients. But I have worked here for 15 years. I know malingerers when I see them."	After discharge to a homeless shelter, the patient became dyspneic and was hospitalized for COVID-19 respiratory failure.	"I am being defensive. My 15 years of work experience does not preclude me from racial bias. Objectively, I am not using the standard of care to evaluate altered mental status in this Black patient. Stigmatizing language in the chart can negatively influence my attitudes towards patients and adversely affect management.[1]
Domain: Structural Racism			
A psychiatry resident receives a phone call about a 30-year-old Black clinic patient with a chart history of antisocial personality disorder (ASPD). The patient was recently released from prison. The patient is allegedly "being threatening at the group home." When asked for input, the resident's supervisor suggests that police be called because "jail is the only treatment for ASPD." In response, the resident expresses concern about police involvement, fearing potential harm to the patient.	The supervisor replies: "Patients with an ASPD diagnosis who have been in prison are a threat. To be safe, the police should be called."	Police were called. The patient later required hospitalization for injuries sustained while restrained by Police.	"I am being defensive. I have negative automatic thoughts about antisocial behavior and legal history in Black patients, which I am not reconciling with the ongoing crisis of mental health criminalization in Black patients.[2] Inappropriate utilization of police can have life-threatening consequences."
Domain: Exclusion			
A 40-year-old Black psychiatrist at an academic medical center has been asked to oversee the psychiatry department's diversity and inclusion programming and mentor Black junior trainees singlehandedly. After being declined a promotion due to a light publication record, the psychiatrist voices concern to a senior faculty member that the department's work environment is discriminatory.	The senior faculty member replies: "Your diversity and inclusion work is great. Senior faculty positions are limited amid the pandemic."	The psychiatrist resigns from the medical center. There are subsequently no psychiatrists of color in the department.	"I am being defensive. I am tepidly praising my colleague's work, without advocating for a tenure and promotion system that acknowledges the vital importance of their work, or acknowledging that health care environments are discriminatory to physicians of color, creating barriers to advancement.[3]"

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