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Racism as a Unique Social Determinant of Mental Health: Development of a Didactic Curriculum for Psychiatry Residents

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Abstract

Introduction—Mental health disparities based on minority racial status are well characterized, including inequities in access, symptom severity, diagnosis, and treatment. For African Americans, racism may affect mental health through factors such as poverty and segregation, which have operated since slavery. While the need to address racism in medical training has been recognized,

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there are few examples of formal didactic curricula in the psychiatric literature. Antiracism didactics during psychiatry residency provide a unique opportunity to equip physicians to address bias and racism in mental health care.

Methods—With advocacy by residents in the Massachusetts General Hospital/McLean Psychiatry residency program, the Division of Public and Community Psychiatry developed a curriculum addressing racial inequities in mental health, particularly those experienced by African Americans. Four 50-minute interactive didactic lectures were integrated into the required didactic curriculum (one lecture per postgraduate training class) during the 2015–2016 academic year.

Results—Of residents who attended lectures and provided anonymous feedback, 97% agreed that discussing racism in formal didactics was at least "somewhat" positive, and 92% agreed that it should "probably" or "definitely" remain in the curriculum. Qualitative feedback centered on a need for more time to discuss racism as well as a desire to learn more about minority mental health advocacy in general.

Discussion—Teaching about racism as part of required training conveys the explicit message that this is core curricular material and critical knowledge for all physicians. These lectures can serve as a springboard for dissemination and provide scaffolding for similar curriculum development in medical residency programs.

Keywords

Racism; Bias; Mental Health; Advocacy; Race; Psychiatry; Health Policy; Disparities

Introduction

Health inequities have been identified among individuals with minority racial status for whom discrimination is a common experience.[1–4] Within psychiatry, it has been shown that racial minorities are less likely to achieve symptom remission and are more likely to be chronically impaired given a mental health diagnosis.[5,6] Bias and racism have been identified as key factors contributing to these inequities. [7,8]

The legacy of slavery and racism, as well as the current realities of racial oppression and violence, has uniquely impacted the mental health of African Americans. For African Americans, mental health inequities began during the time of colonialism and slavery, when myths of racism were being integrated into the developing field of psychiatry. By the end of the 19th century, many psychologists accepted an idea that African Americans were biologically inferior, with smaller brains and a natural instinct for labor.[9] African Americans who participated in the Abolitionist and Civil Rights movements were met with prejudice by mental health practitioners, who labeled them schizophrenic due to their supposed pathologic desire for equality.[9]

This unique history warrants specific focus during residency training. The overdiagnosis of schizophrenia among African Americans persists today,[7,10–12] and they are more likely to be treated with antipsychotic medications that can have lasting, negative side effects.[13–15] Additionally, African Americans have higher rates of severe depression yet lower rates of treatment compared to white populations.[16] African Americans are less likely to receive

office-based counseling for psychological stressors[17] and are more likely to be seen in emergency rooms.[18] Among whites, there is a persistence of negative racial stereotypes of African Americans as unintelligent, lazy, preferring to live off welfare, and prone to violence.[19]

Health care disparities have been taught at the medical school level primarily through the lens of cultural competence.[20–22] Limitations to this approach, however, include assertions that we must go "beyond notions of 'cultural competency' to consider issues of power and privilege, difference, and identity in fostering a professional self committed to fairness and justice."[23,24] In addition, concerns that cultural competency washes out the specific effects of race are supported by Flores, Gee, and Kastner.[25] When racism is directly addressed in medical training, positive change in implicit racial attitudes has been shown.[26,27]

At Massachusetts General Hospital (MGH), leaders of the Division of Public and Community Psychiatry have taken concrete steps toward addressing racism within residency training. Clinical rotations have been designed to shed light on the African American experience. One such 6-week rotation takes place at a homeless shelter, where 50% of clients are African American, a departure from clinical rotations involving majority white patients. Residents also rotate at a local jail, where they must grapple with providing care predominantly to inmates of color, despite being in a predominantly white city. The roles of poverty, physical environment, housing, and policing are explored in this context, underscoring racism as a unique social determinant of mental health for African Americans.

In 2015, in the context of the repeated televised deaths of unarmed African American men, which sparked a national conversation on racism in America, MGH psychiatry residents felt an impetus to develop a more direct conversation on racism within the formal didactic curriculum. As an organizing framework, Dr. Camara P. Jones' schema[28] of racism as a three-tiered entity that includes institutional, interpersonal, and internal factors was utilized. A strength of this approach is that it acknowledges the structural factors of racism while also providing a lens for understanding its internal effects (i.e., how accepted racial stereotypes can lead to demoralization and poor functioning).

Psychiatry residency provides a unique opportunity to address the specific health needs of African Americans. The proposed curriculum contributes to the development of psychiatrists who are competent in patient care through training on how individual and systemic racism can lead to treatment disparities and poor outcomes for African Americans. It is hoped that through participation in this curriculum, learners are confronted with their own biases and feel more capable of addressing them. Additionally, the curriculum was designed to instigate specific action on behalf of vulnerable populations by challenging learners to think beyond individual treatment to the necessary policy and structural interventions that are needed to improve health on a broader scale.

Methods

This resource, originally presented as a lecture series entitled "Racism, Justice, and Community Mental Health," was developed by a team of community psychiatry faculty and

residents, utilizing a case-based approach to teaching the three levels of racism (PGY1-PGY3 lectures) and then culminating in a health policy lecture by a community leader in minority health advocacy (PGY4 lecture). This curriculum was implemented during the 2015–2016 academic year, with 4 hours of instruction (one lecture per residency class) integrated into the 31 hours of total required didactic training in community psychiatry. While it would have been ideal to teach all four lectures to psychiatric interns, one lecture per residency class was initially implemented as a step toward exposing all current residents to material on racism and mental health. Lecture topics were designed to meet the anticipated needs of residents at different levels of training. For example, the PGY1 lecture on the racial history of Boston was designed for interns newly arrived in the city and settling into clinical roles, while the more advanced topic of minority health policy and advocacy was shared with senior residents in their final year of training. The target audience for this curriculum was psychiatric trainees who had begun clinical work. The earliest lecture was given 3 months after the start of the academic year.

Pairs of resident-teachers were utilized for the PGY1, PGY2, and PGY3 lectures, as residents expressed a desire to collaborate on developing lecture content both to share the workload of lecture development and to have support in discussing a topic that felt quite new and intimidating. It was also felt that having residents as teachers and champions of this curriculum would increase the receptivity of coresidents to listening and learning, possibly avoiding the more common power dynamic of a faculty expert who might inhibit conversation or be perceived as insisting on a particular point of view.

Each lecture was 50 minutes in length, designed for 10–12 learners (there are 16 residents per class, with a typical didactic attendance rate of 60%–70%). Prior to each lecture, presession readings and assessments were emailed to learners. Lectures were taught using group exercises and case-based discussions. A lecture room with a computer and projector was required for the lectures.

Lecture titles were as follows:

- PGY1: Structural Racism and Neighborhoods: Impact on Mental Health Access and Outcomes.
- PGY2: Racial Bias in the Diagnosis and Treatment of Psychosis.
- PGY3: Personally Mediated Bias: Does It Affect Psychiatric Treatment?
- PGY4: Going Upstream: Addressing Structures and Policies Needing Fundamental Remedy.

PGY1 Lecture

For first-year residents, many new to Boston, instruction focused on place, reviewing the history of residential segregation and subsequent busing and its consequences. Boston was one of the last cities to racially desegregate, and its busing decision created a widespread crisis, which many still consider Boston’s most important event.[29] The lecture highlighted the de facto segregation that has persisted in Boston, as African Americans (23.4% of the population) continue to be geographically concentrated in poor neighborhoods with the

highest rates of foreclosure.[30] Presenting the historical background for patients' experiences provided the residents with previously unknown context, and using a clinical vignette of an African American patient who grew up during the busing period was effective in demonstrating the experiences of institutional, interpersonal, and internal racism that contributed to the patient's psychiatric symptoms, experiences of discrimination, and life course. This lecture can be tailored to fit local geographic histories because it acknowledges patterns of segregation, poverty, and aggressive policing as common neighborhood factors that impact the mental health of African Americans in cities nationwide. The lecture concluded with a call for learners to reflect on what constitutes treatment and to expand their individual formulations to include interventions at a community level. The PGY1 Lecture Plan (Appendix A), which includes presession readings, was distributed to learners prior to the lecture. The PGY1 Presentation (Appendix B) contains the core didactic content that was shared during the session.

PGY2 Lecture

For second-year residents, who spend much of their clinical time in hospital settings with acutely ill patients, the focus was on racism-related factors contributing to the misdiagnosis of schizophrenia among African Americans, which connected directly with their work of learning the nuances of diagnosis and treatment of serious mental illness. At the beginning of the lecture, learners were asked to complete a quiz covering racial disparities in diagnosis and treatment of psychotic disorders (Appendix D); answers and impressions were discussed. The case (Appendix E) of a 38-year-old African American man who has been brought to the emergency room due to social withdrawal, poor work attendance, and little food intake and who is then treated as psychotic by the inpatient team was reviewed to identify and discuss provider bias and differences in patient presentation that can lead to misdiagnosis of schizophrenia. The point was made that African American patients often present with more severe affective symptoms, including first-rank psychotic symptoms when experiencing a mood episode.[31–33] Yet affective disorders are often missed due to clinician bias of not eliciting affective symptoms or overemphasizing psychotic symptoms.[34–37] How these factors contribute to treatment disparities, including overuse of depot antipsychotics in African Americans,[13] was explored. Learners were asked to evaluate their own biases, and in the concluding remarks, suggestions were given for how to address bias in diagnosis and treatment. The PGY2 Lecture Plan (Appendix C), which includes presession readings, was distributed to learners prior to the lecture. The PGY2 Presentation (Appendix F) contains the core didactic content that was shared during the session.

PGY3 Lecture

For third-year residents, the didactic focus was on interpersonal racism, explored through discussion of implicit bias, which residents tied to their own experiences as well as to its effects on their psychiatric practice. Prior to the lecture, it was strongly recommended that attendees take the Race Implicit Association Test (IAT) at Project Implicit (https://implicit.harvard.edu/implicit/selectatest.html). Developed at Harvard University, the Race IAT is an online self-report measure designed to uncover implicit racial attitudes by analyzing users' emotional reactions to white versus black faces. Core features of this lecture were definitions of the different forms of bias (with an emphasis on

microaggressions), discussion of interpersonal bias and racism that can impact treatment (e.g., why do African American patients frequently drop out of therapy?), and discussion of the principle of affirmation and its potential uses in combating racial bias in treatment. The PGY3 Lecture Plan (Appendix G), which includes presession readings, was distributed to learners prior to the lecture. The PGY3 Presentation (Appendix H) contains the core didactic content that was shared during the session.

PGY4 Lecture

For fourth-year residents, increasingly moving from considerations of individual patient care to broader health policy issues, instruction centered on institutional racism and its intersection with discrimination, access to psychiatric care, and impact on treatment. The PGY4 Lecture Plan (Appendix I), which includes presession readings, was distributed to learners prior to the lecture. The discussion was led by a guest speaker, who worked as an attorney, community health advocate, and policymaker in Boston. His discussion (approximately 40 minutes) centered on exploring strategies for dismantling structural racism, including health reform (through public health interventions focused on African American health crises, such as neighborhood violence), criminal justice reform, education reform (through pipeline development and mentoring, especially in order to grow the number of African Americans entering medicine), and community reinvestment. As this lecture was given by a guest speaker from the local community, an official presentation has not been provided here. However, facilitators may select guest speakers from their local area, provided they can speak to the issues above. Following the presentation, discussion of the lecture content and implications ensued (approximately 10 minutes).

Results

Following the session, residents were asked to complete an anonymous evaluation form (Appendix J) using a series of multiple-choice and open-ended questions. Survey responses were obtained from seven of 16 (44%) PGY1 residents, 13 of 16 (81%) PGY2 residents, eight of 16 (50%) PGY3 residents, and eight of 16 (50%) PGY4 residents. With regard to learners' experiences, the overall positive value placed on the curriculum was reflected in the survey responses. The majority of residents felt that the topic of racism should remain in the didactic curriculum. PGY1 residents were the most strongly oriented toward this topic, with 100% of those completing the evaluation rating the lecture experience as "strongly positive." This response may reflect the unique content of the PGY1 lecture (racism in Boston), which many commented was unfamiliar prior to the session. In addition, 97% of all residents who provided feedback agreed that discussing racism in formal didactics was at least "somewhat" positive, and 92% agreed that it should "probably" or "definitely" remain in the curriculum. Additional detailed survey responses are shown in Appendix K.

Qualitative feedback is reflected in the comments below:

- "I really enjoyed this lecture. The presenters were very polished speakers and provided a historical context for the conversation which was crucial to the topic. The presentation was thoughtfully done and engaging because of the presenters' passion."

- "I am very proud of my classmates for taking this on."
- "I think we should have more sessions on this topic and more opportunities to learn about advocacy within the standard curriculum."
- "I would love to have more time after the lecture itself for discussion."
- "I think this is a hugely important topic. If we don't recognize and acknowledge the impact of racism, we collude with it. Thank you so much for taking this on in our curriculum."

Discussion

Our experience of implementing a racism curriculum in our residency was largely a study of the feasibility and desirability of directly addressing racism in mental health care settings. We found not only that it is possible to implement such a curriculum within a matter of months but that the experience is also valued by residents. The resident-teachers themselves were a racially diverse group (African American, Caucasian, Asian) who reflected upon this experience as being highly formative in their own development and training. Their sensitivity to racism was heightened not only through preparing for the lectures and reflecting on their own experiences but also by interacting with one another and appreciating more of their group's diversity. Developing a formal curriculum that addressed the effects of racism, that was color specific, and that focused on African American history and current events was deeply gratifying for the resident-teachers. They commented that embarking upon this journey together was one of the most enriching experiences of residency.

Racism as a social determinant of health was a recognized concept prior to the lectures; however, the construct of internal racism was relatively unknown. Perhaps this correlates with societal messages about racism that tend to emphasize its external effects, especially violence.[38,39] Internal racism and the experiences of the racially oppressed are less often recognized and discussed. We hope that by raising sensitivity to the internal effects of racism, we may increase the likelihood that residents will develop sensitivity to these issues and perhaps discuss them with patients.

With regard to discussing racism in treatment, most residents rated themselves as at least "likely" to ask patients about their experiences of racism in the future. Notably, while PGY2s felt most strongly about the negative impact of racism, they also saw themselves as least likely to ask patients about their experiences with racism. In contrast, PGY4s were most likely to ask. Overall, most attendees felt that the lectures enhanced their ability to demonstrate empathy, curiosity, and respect for diversity in psychiatric evaluation and treatment and that it would be helpful to understand what factors could influence the direct discussion of racism in treatment (e.g., what makes a physician more or less confident discussing racism in clinical settings?). This could be a focus for future study.

Although limited, there has been some attention to racial bias in formal didactic curricula.[27] Most recently, Brooks, Rougas, and George described an approach to teaching medical students specifically about health disparities and talking about racism.[40] There is surprisingly little, however, that is described at the residency training level of education.

Culhane-Pera, Like, Lebensohn-Chialvo, and Loewe surveyed family medicine residencies and found that the number teaching multicultural issues had increased from 25% overall in 1985 to 58% in 1998 using an informal curriculum and 28% using a formal curriculum.[41] There are also proposals for health care providers at any level to shift away from concepts of cultural competence to those of cultural humility[42] and structural competence.[43,44] We are not aware of literature describing racism-specific curricula in graduate medical education in general or in psychiatric residency training in particular.

We created a curriculum for psychiatry residents to teach about racism as a social determinant of mental health in the absence of other examples to draw from. We chose an accepted framework to guide us and were aware of public discourse about racism, increasing dialogue about the responsibility of academic medicine to teach about racism,[45–47] and anecdotes from our own residents about their experiences in various clinical settings. The limitation of lacking formal baseline data about our residents' knowledge and attitudes was counterbalanced by a sense of urgency regarding the issue and a timing opportunity to move ahead. Accordingly, our effort was a first attempt at providing formal structure and content for an area relevant to psychiatric education through embedding in the formal residency curriculum. Support from the residency director and the department chair facilitated implementing this course, although we are aware that other programs may not have this option. Using our residents as teachers provided them with an opportunity to develop teaching skills and provided us with homegrown content knowledge that obviated the need for outside faculty. As our resident-teachers graduate, we will need to engage junior residents in this endeavor or identify faculty to provide teaching. While the former is an approach that other residencies can consider, the latter is much more dependent on local resources.

Our assessment captures some data about precourse knowledge, demonstrates resident acceptability, and affirms that the majority of residents are likely to ask patients about experiences of racism. It fails, however, to assess mastery of the educational objectives, and this is an area warranting improvement in future years. We are also aware of the pedagogic limitations of a cross-sectional annual lecture rather than a continuous iterative learning process for material of this nature,[48] but the current structure of our residency and demands on residents' time do not permit this approach across the residency. We have created several longitudinal smaller groups for interested residents as a way to facilitate ongoing discussion and integration of the curricular material, increase opportunities for interracial contact, and promote experiential peer learning.

We are early in this work. We are planning more rigorous evaluation and refinement of the current lectures. We believe there is interest in replicating this curriculum at other institutions based upon requests we have received for specific course content, for guidance around implementation, and for developing strategies to address anticipated departmental or administrative resistance to incorporating this content into formal teaching. In spite of the limitations described, we believe this material can be replicated, adapted, and improved.

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Educational Objectives

By the end of this training module, learners will be able to:

1. Define racism and its operant levels (e.g., institutional, interpersonal, internal) as they intersect with mental health access and outcomes for African American patients.
2. Describe five ways racial bias impacts diagnosis and treatment of mental disorders in African American patients.
3. Suggest two strategies for addressing racial bias in mental health care.