Bias in Mental Health Assessment and Intervention: Theory and Evidence

A recent surgeon general's report and various studies document racial and ethnic disparities in mental health care, including gaps in access, questionable diagnostic practices, and limited provision of optimal treatments. Bias is a little studied but viable explanation for these disparities.

It is important to isolate bias from other barriers to high-quality mental health care and to understand bias at several levels (practitioner, practice network or program, and community). More research is needed that directly evaluates the contribution of particular forms of bias to disparities in the area of mental health care. (Am J Public Health. 2003;93:239–243)

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RACIAL AND ETHNIC disparities are as widespread in the diagnosis and treatment of mental illness as they are in other areas of health. In 2001, then-Surgeon General David Satcher issued the report Race, Culture, and Ethnicity and Mental Health,1 in which he convincingly documented disparities in access and treatment that leave too many minority individuals untreated or improperly treated.

One possible reason for disparities is that practitioners and mental health program administrators make unwarranted judgments about people on the basis of race or ethnicity. Their inappropriate expectations lead to inappropriate decisions and actions. In a strict sense, it is these unwarranted views, reactions to a person “on the basis of perceived membership in a single human category, ignoring other category memberships and other personal attributes,”2 that constitute bias. Biased views can be held knowingly or unknowingly and can result in action or a failure to act.

Taking account of racial and ethnic differences does not in itself constitute bias. Indeed, some critics argue that responding to racial and ethnic differences is essential, that mental health interventions must be varied to allow for differences in race, culture, and ethnicity.3 They claim that appropriate treatment necessitates awareness of critical differences between minority individuals and others in beliefs and sensitivities related to mental health, in expression of symptoms, and in treatment preferences. From this perspective, to ignore racial and ethnic differences reflects a kind of bias.

There may be greater reason for concern about bias in mental health than in other areas of health. Some continue to doubt the very existence of mental illness, believing that difficulties labeled as such, however troublesome, are no more than universal problems in everyday living.

Consensus has increased about appropriate methods of diagnosis and treatment, but a large role remains for discretion. There is great variation in practice norms, and the advent of well-founded protocols is recent. These protocols are far from achieving full acceptance.

Decisionmakers other than mental health professionals, including business owners, neighbors, and the public at large, as well as police and courts, play an important role in assessing mental illness and in deciding whether troublesome behavior warrants treatment or punishment.4 Mentally ill persons can be detained by the police and required to undergo treatment against their will, a practice with few counterparts elsewhere in health. Institutional and community decisionmakers also enjoy considerable discretion, and there is great opportunity for bias to intrude.

It is useful as a starting point to consider disparities, examining the research literature for clues about bias. What is the evidence on disparities in mental health? What does it tell us about bias?

DISPARITIES IN ACCESS AND QUALITY

As noted by Surgeon General Satcher, epidemiological research consistently reveals that African, Asian, Native, and Latino Americans needing outpatient care are unlikely to receive it.5 Disparities persist after differences in socioeconomic status, region of residence, and other sociodemographic factors are controlled. They have been shown to occur among Mexican Americans, despite lower levels of need,6 as well as among children, adolescents, and the elderly.6

Some regional studies point to a lessening of differences between racial/ethnic groups in regard to treatment rates.7 Specialized programs, including those operated by the Department of Veterans Affairs, have reported encouraging results.8 At the same time, recently published national data suggest that, in the nation as a whole, access disparities persist.9

When sought, assistance for mental health problems is especially likely to come from providers in the general medical sector.10,11 For example, one study showed that, among individuals treated by the Indian Health Service, mental health and social problems were associated with one third of requests for services and that “[m]ental health was identified as the top health problem by 10 of 12 IHS areas and...
the Urban Indian Health Programs in [fiscal year] 2001.22

There are disparities as well among members of minority
groups who do seek mental
health specialty treatment. African
Americans, Latinos, Asian Americans,
and Native Americans have been
shown to be more likely than Whites to leave treatment
prematurely.23 The “dropout prob-
lem” includes large numbers of
individuals who attend only one
treatment session and are unlikely
to have received any benefit.

African American populations
have received the greatest atten-
ton from researchers, and African American–White disparities have
been revealed. A persistent find-
ing has been that, along with Na-
tive Americans, African Americans are greatly overrepresented
in inpatient settings.24 African
Americans are overrepresented
too in psychiatric emergency
rooms. Dramatic changes in the
mental health care system, includ-
ing the advent of managed care, have had little impact on the
overrepresentation of African
Americans and Native Americans
in emergency care settings.

Along with problems involving
access, researchers have paid in-
creasing attention in recent years
to the quality of mental health
care provided to members of mi-
nority groups. Young et al.25
reported that African Americans
and Latinos were less likely than
Whites to receive guideline-ad-
herent treatment when suffering
from anxiety disorders and de-
pression. Similarly, Wang et al.26
found that African Americans
were relatively unlikely to receive
guideline-based care.

Gaps in quality extend to el-
derly and seriously mentally ill
African Americans. Schneider et
al.27 investigating enrollees in
Medicare health plans, discovered
that African Americans were less
likely than Whites to obtain treat-
ment meeting a Health Plan Em-
ployer Data and Information Set
guideline calling for a follow-up
visit within 30 days after psychi-
atriac hospitalization. Wang et al.28
found that African Americans
were overrepresented among
persons suffering from serious mental
illness who failed to receive “mini-
mally adequate” treatment.

Investigators have studied Afri-
can Americans29 and Latinos30
visiting primary care physicians
with mental health–related com-
plaints. African Americans and
Latinos have proved to be less
likely than Whites to receive a
prescription for psychotropic med-
ication. Among elderly com-
nunity residents as well, African
Americans have been found to be
relatively unlikely to receive anti-
 depressant medications.20

Studying Medicaid recipients,
Melfi et al.31 found that African
Americans were less likely than
Whites to receive an antidepressant
medication and less likely, if
they were in fact prescribed such
a medication, to receive selective
serotonin reuptake inhibitors. In
another study of Medicaid recipi-
ents, Kuno and Rothbard32 re-
ported that African Americans
were less likely than Whites to re-
cieve newer atypical antipsychotic
medications that have fewer side
effects and more likely to receive
injectable antipsychotics. Other
researchers as well have demon-
strated greater receipt of inject-
able antipsychotic medications
among African Americans.33

However, in addition, when they are
prescribed psychotropic medications,
minority individuals sometimes
receive suspiciously high doses.
Segal et al.24 and Chung et al.25
reported that African Americans
seen in psychiatric emergency ser-
VICES and inpatient settings were
prescribed higher doses than oth-
ers of anti-psychotic medications.
Other researchers have reported
similar results.26,27

DISPARITIES AND BIAS

Although disparities in access,
continuity, and quality are well es-
tablished, it is hazardous to infer
bias solely from the presence of
disparities. To avoid missidenti-
fyng the problem and misdirect-
ng attempts at finding solutions, we
must consider explanations other
than bias.

Sociocultural differences are
typically proposed at the outset.
Often, researchers control for so-
ciocultural differences; after
doing so, they typically continue
to find evidence of disparities.3
 Critics next turn to insurance cov-
erage as a possible explanation.
Minority individuals lack private
health insurance in disproportionate
terms, a gap that is not
eliminated by coverage obtained
from public sources.3

Health insurance coverage fa-
lidates treatment seeking, and
widening the scope of coverage
would benefit members of minor-
ity groups disproportionately. In-
vestigators have found, however,
that despite having lower in-
comes, minority individuals ex-
hibit a less active response than
Whites to reductions in the cost
of mental health treatment.28

Thus, it appears that even after
financial barriers have been re-
moved, other factors continue to
prevent minority individuals from
seeking treatment. Bias is an im-
portant hypothesis, but it must be
considered in a context of alter-
avatives. Chief among them are lack
of familiarity with mental
illness–related concepts, prefer-
ences for interpreting mental
health problems in spiritual or
other culturally sanctioned terms,
stigma, and coping habits that
stress self-reliance and family re-
liance. Among Asian Americans,
for example, researchers have
identified cultural barriers to
treatment seeking such as coping
strategies that favor willpower
and avoidance of morbidity
thoughts and kinship and family
orientations that allow for recog-
nizing mental illness only if it re-
disrupts social harmony.29

Evidence is sparse, however,
and suggests a complicated pic-
ture. Diala et al.30,31 analyzing the
National Comorbidity Survey,
found that African Americans had
more favorable attitudes than
Whites toward mental health ser-
VICES before using them but less
favorable attitudes after using
them. Another study33 indicated
that African American women
were more likely than White
women to affirm religious or su-
nernatural causes of mental ill-
ness. Latinas were less likely than
members of other groups to
indicate stigma and less likely to sub-
scribe to medical causation. On
the other hand, an analysis of the
General Social Survey revealed
few differences between African
Americans, Latinos, and Whites
in terms of beliefs about causes of
and appropriate treatment for
mental illness.32

Establishing disparities by eli-
minating alternative competing al-
terative reflects an indirect ap-
proach based on circumstantial
evidence. Direct evidence estab-
lishing bias, however limited, is
important to consider. More than
a decade ago, Lopez34 carefully
weighed studies evaluating
whether mental health decision-
making, as conducted by practic-
ing clinicians, was tainted by bias.
He began by enlarging the defini-
tion of bias, noting 2 kinds of
distortion: overpathologizing bias
and minimization bias. The for-
mer occurs when unfamiliar behavior of minority individuals is interpreted as a manifestation of mental illness. The latter occurs when practitioners ignore genuine manifestations of mental illness. Lopez noted that, perhaps operating from a sense of misguided cultural sensitivity, practitioners could dismiss real mental illness, attributing genuine symptoms to variations in cultural beliefs and practices.

Lopez’s review was restricted to African Americans and Latinos, groups on whom data were available, and in fact few of the available studies addressed Latinos. Lopez found mixed evidence for most kinds of bias but stronger evidence of bias when clinicians diagnosed mental illness among African Americans.

The evidence of bias in diagnosis underscored a robust phenomenon in African American mental health. For more than 2 decades, researchers have documented that African Americans have higher than expected rates of diagnosed schizophrenia and lower rates of diagnosed affective disorders.24 These differences have aroused suspicion that clinicians indeed are biased in the course of routine practice. However, recent research suggests a complex picture, and differences between African Americans and Whites in how they present symptoms of mental illness to clinicians play a crucial role.35

There are indeed reasons to believe that clinicians misinterpret problems of minority individuals in making diagnoses and in formulating overall assessments of mental health problems. Translation, which is often necessary, leaves room for confusion. In some instances, important mental health-related concepts lack true equivalents in languages other than English, opening the way to misunderstanding of complaints.32 When faced with standardized assessment procedures, for example, some Asian Americans approach the very task of responding with tendencies different from those assumed by developers of the procedures.30

Bias might intrude in the formation of clinical relationships. The therapeutic alliance36 through which practitioner and client engage each other can be adversely affected by bias. The therapeutic alliance is compromised not only by outright rejection but also by lack of commitment to overcoming estrangement. The result can be alienation and lack of trust,37–38 compounded by cultural misunderstanding.39,60

**BIAS IN MENTAL HEALTH TREATMENT**

Bias occurs in the beliefs and actions of individual clinicians, and it is at this level that it has received the greatest amount of attention. Bias also occurs when unfounded assumptions become normative beliefs shared by members of practitioner networks or treatment organizations. Bias occurs too when authorities and community members become particularly intolerant of minority individuals with mental illnesses and differentially enforce conformity norms of acceptable behavior.

Practice styles are local norms governing diagnosis and intervention. They reflect shared understandings of how clinical decisions should be made over the wide range of discretionary action open to clinicians. Practice styles come about because, in the course of informal interactions, people develop common understandings about how uncertainty should be handled.

Organizational culture also refers to shared, often unspoken understandings about procedures and goals. Researchers have measured dimensions of organizational differences in culture: quality emphasis, performance goals, coordination of care, communication, and conflict resolution.42

Shared understandings might include biases about the mental health status of or treatment expectations for ethnic minority clients. That clients from certain backgrounds are unreceptive to treatment, hostile, naive, superstitious, or otherwise unpromising might represent a prevailing view in a practitioner network or organization.

Shared understandings also can express themselves in neglect. Among minority communities as well as individuals, engagement can require overcoming reluctance and mistrust. Positive steps toward community engagement reflect necessary norms of commitment.43–46

Behaviors defining mental illness violate societal expectations of acceptable behavior; mental illness is a kind of deviance. Mental illness can elicit forces of social control.

Police and courts, as well as employers, merchants, neighbors, and family and friends, determine whether boundaries of acceptable behavior have been transgressed. When inconvenient or threatened, community agents decide whether to respond and whether an appropriate response is personal, legal, or medical. Bias can be found in differential degrees of tolerance.

Researchers have documented notable differences between African Americans and Whites in rates of involuntary civil commitment.47 These differences are associated with differences in how mentally ill individuals are presented to the emergency room; African Americans are more likely to be brought in by police.48 African Americans and Latinos are overrepresented in jails and prisons, institutions with substantial representations of individuals who are mentally ill. The question of why differences occur in rates of civil commitment and in rates of incarceration associated with mental illness remains to be answered, and the role of bias in decision-making is yet to be determined.

In related research on the “visibility hypothesis,” investigators have found evidence that mentally ill individuals are more likely to be challenged when, as members of minority groups, they are visibly different from other community residents.49 They stand out as more worthy of attention than others—more visible—and deviant behavior is recognized more readily.

Community tolerance varies not only from community to community but also with the passage of time. Coerced treatment has been shown to increase with economic decline.50 The reason being that economic contraction produces greater insecurity, greater frustration, and less tolerance. Tolerance of members of racial and ethnic minorities especially appears to decline. Forces of social control appear aimed more at minority individuals, especially male African Americans, who exhibit symptoms of mental illness (R. F. Catalan, L.R. Snowden, and M. Shumway, unpublished data, 2002).

**CONCLUSIONS**

We know that there are disparities in access, treatment, and quality of mental health care, but we do not yet know the extent to which these disparities are attrib-
utable to bias. We know even less about bias operating at levels beyond that of individual practitioners: in the practice network, treatment organization, and community.

Nevertheless, whether intentional or inadvertent, whether by active decisionmaking or by default, it is reasonable to believe that bias partially explains disparities. Social scientists have established that bias need not be blatant but rather can be "automatic, cool, indirect, ambiguous, ambivalent." The ambiguity surrounding mental illness and appropriate treatment invites bias, including bias of a well-intentioned kind (i.e., minimization bias). Missing is knowledge of where, when, how, and to what extent bias occurs in mental health decisionmaking and treatment. In addition, the contribution of bias relative to that of other factors has not yet been assessed. Determining the role of bias in mental health assessments is important in establishing a comprehensive explanation of disparities and ultimately, efforts to effectively address them.

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Physiological Responses to Racism and Discrimination: An Assessment of the Evidence

A growing body of research explores the impact of encounters with racism or discrimination on physiological activity. Investigators have collected these data in laboratories and in controlled clinical settings. Several but not all of the studies suggest that higher blood pressure levels are associated with the tendency not to recall or report occurrences identified as racist and discriminatory.

Investigators have reported that physiological arousal is associated with laboratory analogues of ethnic discrimination and mistreatment. Evidence from survey and laboratory studies suggests that personality variables and cultural orientation moderate the impact of racial discrimination. The neural pathways that mediate these physiological reactions are not known.

The evidence supports the notion that direct encounters with discriminatory events contribute to negative health outcomes. (Am J Public Health. 2003;93:243–248)


RACISM OPERATES WITHIN objective life conditions, popular culture, and religious and educational institutions. Williams\textsuperscript{2} listed racism among basic causes in a framework that described the relationship between health and race, arguing that racism shapes other important social determinants of health outcomes, including economic resources and the availability and nature of health care. The individual acts of bias and interpersonal discrimination that grow out of racism represent its latter-day, or surface,\textsuperscript{1,28,29,229} manifestations. They are salt in wounds previously inflicted by a host of negative life events whose relationship to racism is often cloaked. Indeed, it is likely that, at the point at which people encounter these individual forms of racism, other racist institutional and cultural forces already have encroached on their lives.\textsuperscript{3}

Here we describe a sample of studies focusing on the impact of various forms of racism on physiological activity. We selected reports from the medical literature and social science literature in which investigators directly measured physiological responses. The racially stressful material in the reports was either recalled or experimentally imposed.

STUDIES OF THE PHYSIOLOGICAL IMPACT OF RACISM

Laboratory experiments dominate investigations of the physiological consequences of racism. However, several important survey research projects have measured physiological activity. The laboratory studies expose individuals to analogues of racist events, whereas the survey studies focus on racism as perceived by the participant. Although the approaches differ substantially, both sets of studies provide evidence that is crucial to our understanding of the relationship between health and racial oppression. They have tested the proposition that analogues of racist events or memories of these encounters result in physiological arousal or negative health sequelae. Complex designs can identify factors that contribute to individual differences in responses to discrimination, determine the uniqueness of patterns of physiological reactions, or uncover the neural pathways that mediate these physiological effects.

Table 1 describes 4 paradigms available to researchers in this area. In self-report correlational studies, participants disclose their perceptions of the number and kinds of experiences they have had with racism or racial discrimination. Such studies seek to determine whether these reports correlate with changes in physiological arousal. Some investigations have revealed that personality and coping processes moderate the relationships between discrimination and physiological variables.

Basic psychophysiological investigations develop laboratory analogues of racially charged encounters and examine their physiological effects. In some instances, these studies compare the physiological activation resulting from discrimination and bias with responses to nonracial stressful events. These experimental studies permit the drawing of cause-and-effect conclusions about the relationships between physiological changes and raciallynoxious events.

A hybrid method combines the correlational and psychophysiological approaches. Studies of this type employ laboratory challenges that are known...