WPHP Report

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Double Vulnerability: Identifying and Tackling Disparities in Behavioral Health Among Minority Communities

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Just as policing has been tasked to untangle and dismantle the roots of racism and inequity, so too are other systems being called to face and dismantle these issues within our society. As we watch police forces address the perpetuation of white supremacy, we have a responsibility to critically view our field and where inequity, inequality and bias have flourished. Behavioral health as a discipline has a long history of pathologizing normal behaviors observed in minority groups, including: racial, gender identity, sexual identity, disability, and body size communities. From homosexuality being included in the DSM until 1987, the over diagnosis of psychotic disorders in Black men who may express understandable "paranoia" in relating to white dominant culture, the lack of access to resources and appropriate care among gender and sexual minorities, misdiagnosis of fat bodies, to social workers removing Black and Brown children more often from their families, it is time we explore these issues within the behavioral healthcare field. We must work to dismantle the systemic issues of oppression within ourselves, our workplaces and the larger field to offer appropriate, culturally humble care to all who need support and treatment.

The foundation of behavioral health is inextricably tied to white supremacy, reflecting the larger culture of the US. The reference used to diagnose and treat all individuals, the Diagnostic and Statistics Manual, Fifth Edition (DSM-5) is based on studies primarily conducted on white, affluent individuals living in industrialized, Western societies. Therefore, our conceptualizations of behavioral health issues are largely limited to cis-gender white men. This leads to a lack of effective and culturally appropriate care for individuals of various minority statuses, including racial minorities, sexual and gender minorities, women and fat-bodied individuals. For instance, consider cognitive behavioral therapy (CBT), a well-studied and evidence-based treatment for a multitude of conditions. CBT focuses on changing internal thoughts and associated behaviors for relief from symptoms. But what if your struggle is based on society's view of who you are? Is CBT effective or harmful if the struggle is due to systemic oppression based on race, sexual identity, gender identity or your body? This issue can be termed "therapeutic bypassing" and is very similar to spiritual bypassing. It involves ignoring the larger systemic issues and focusing on an individual changing their internal experience or response, without addressing the external contributing factors. Cognitive "reframing" is not a solution to discrimination and bias. Individuals in a minority group have a high likelihood to discontinue treatment due to the pattern of therapeutic bypassing in traditional behavioral healthcare.

Disparity in behavioral healthcare outcomes are seen for racial minorities. Minority individuals often discontinue therapy, up to 50% after just one session, due to the lack of culturally appropriate care from someone within their community. Over 50% of Black individuals suffering from severe mental illness do not receive treatment or care for their mental health. Black and African American men are less likely than their white counterparts to consume alcohol or suffer from substance-related disorders, yet they face more legal issues and consequences due to their use. Disparities in behavioral healthcare also exist among other ethnic groups. One study examined the utilization of mental health care services across racial and ethnic minority groups in a nationally representative study. Researchers found that ethnic minority groups reporting severe suicidal ideation were less likely to receive treatment. The study went on to explore barriers to accessing mental health services for these groups, including differences in health care coverage, lack of interpreter services, and culturally/linguistically relevant resources. Less than a quarter of graduate-level or higher behavioral healthcare professionals are from a minority community, and 70-90% of those who work in substance use disorder treatment are white.

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Two spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual (2SLGBTQIA+) individuals face discrimination in many areas of life, including their ability to find gainful employment, trans-affirming healthcare, insurance coverage, housing, and other services that offer affirming and inclusive care, including behavioral health care. Individuals in the 2SLGBTQIA+ community have higher rates of mental health and substance use issues than the general public and die at significantly higher rates from suicide. These disparities are directly linked to minority stress and the oppression faced within this community. Such individuals are less likely to stay engaged in therapy and treatment if they are not provided with affirming care that takes into consideration the unique challenges and stressors of their identity.

Eating disorders affect men and women at equal rates, yet it is most often diagnosed among young, thin, upper-middle class white women. Black individuals are at a higher likelihood of suffering from an eating disorder, which is often left undiagnosed or treated, due to systems that uphold white ideals of body type. Stigma and bias about fatness also perpetuate health disparities. People with fat bodies are more likely to be given the diagnosis of binge eating disorder, even in the face of a more predominant restricting pattern. Fat bodied individuals and those with binge-eating disorder are often placed in separate treatment groups from thin-bodied individuals in eating disorder treatment, reinforcing food and diet culture's hierarchy of bodies and, inadvertently, the antecedents of disordered eating. Eating disorder therapists prioritize image over health when they promise fearful clients that they won't get fat, despite evidence that chronic dieting, weight loss and repeated metabolic insults lead to higher weights over time. Finally, over-reliance on body mass index (BMI) to define individual health, despite BMI being a statistical population measure, may reflect anti-fat bias while also potentiating confusing and unrealistic expectations for overall health, which does not equate to weight. It is noteworthy that anorexia nervosa is the only eating disorder that has BMI as part of the diagnostic criteria (and that is to define underweight patients).

Disabilities, physical and cognitive, can also play a role in the accessibility of care as well as the outcomes. One would think these issues are covered by the Americans with Disabilities Act, but that does not guarantee service sensitivity or accessibility. Those who are disabled and seek out needed behavioral health treatment often report dissatisfaction due to lack of training of behavioral healthcare providers, higher rates of over-use of sedating medication, and physical injury to staff and clients. It takes effort to adjust and adapt treatment to be more accessible for a range of disabilities.

It is easy to feel overwhelmed with the prospect of providing affirming and inclusive care within a system that continues to reinforce inequity and the norms of white supremacy. It takes significant self-education, intention, and commitment to provide anti-racist and affirming to care to individuals from all minority-status communities that honors the intersection of those identities. There are frameworks that have been created to help assess the accessibility and equity of behavioral healthcare programs. Social justice theory and feminist theory provide a foundation for bringing understanding and exploration of the larger cultural and systemic biases within which we and our patients exist. Using these intentional frameworks for behavioral healthcare, instead of teaching clients to internally bypass the very real experiences of oppression and marginalization they face, will provide true healing and care.

Above all, ask! Ask people their pronouns, their gender identity, their cultural and racial identities and how you can incorporate those into their treatment and care. We can empower ourselves and each other to bring these topics into healthcare while also recognizing that the dynamics of power, patient to health professional, minority to majority, will often impact the degree of psychological safety a patient feels in discussing these matters. When you ask, do not place the burden of education on the patient, but use the information they provide to self-educate. When incorporating what you have learned, ask if it fits, as no community's experience is an absolute. Patients may not respond much when first asked these questions, but it sets the stage where these conversations are welcomed and considered, which can go an incredible distance in providing culturally humble care. When we create a system that allows disabled, severely mentally ill, addicted Black trans women to thrive, we will have a system that is accessible and equitable to all. If we can create space where the most marginalized community member can get the most skillful, culturally humble and appropriate care, we will all benefit from that system. We who hold the power must create the space and prioritize those we have, until now, either ignored or pushed to the margins of care and society.