# Invoking History and Structural Competency to Minimize Racial Bias

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> For history, as nearly no one seems to know, is not merely something to be read. And it does not refer merely, or even principally, to the past. On the contrary, the great force of history comes from the fact that we carry it within us, are unconsciously controlled by it in many ways, and history is literally present in all that we do. It could scarcely be otherwise, since it is to history that we owe our frames of reference, our identities and our aspirations.
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> —James Baldwin (Ref. 1, p 94)

While the principle of objectivity in forensic psychiatry is a well-accepted goal, so too is the understanding that the psychiatric expert witness cannot be completely safeguarded from the influence of bias.[2] An emerging body of literature strives to explore individual bias detection and prevention for forensic psychiatrists, as well as to incorporate the cultural formulation into the practice of psychiatry and the law.[3,4] This paradigm shift has underscored the ways in which bias and a culturally blind lens serve as potential obstacles to achieving objectivity while providing strategies for their mitigation. Although these suggested approaches are crucial, they tend to focus on the individual (either individual bias of the evaluator or individual culture of the evaluee) without recognition of broader patterns of societal stigma, structural bias, or the history of how these systems have been developed and reinforced over time.

In the broader field of general psychiatry, a push is being made beyond cultural competency, which is anchored in the study of individual clinician bias, toward structural competency, which encourages physicians ". . . to recognize how social, economic, and political conditions produce health inequalities in the first place" (Ref. 5, p 115). Despite this larger impetus, forensic literature dedicated to mediating prejudice still places the onus on individual evaluators to identify their own biases.[6] Little consideration is given to the role of history in the making of our shared mental health paradigms, shared frames of reference and, specifically, shared perceptions of racial identities, conscious or otherwise.

During the early 1700s, in the context of global capitalist incentives to justify slavery, Carl Linnaeus published *Systema Naturae* wherein he characterized "the taxonomy of the Races," describing black people, "*Homo Afer*," as "cunning, lazy, lustful, careless, and governed by caprice" (Ref. 7, p 43). The ramifications of these and other pseudoscientific claims about race bolstered practice and legislation that stripped black civil rights, enabled mass chattel slavery, and diminished guilt and cognitive dissonance in the collective white conscience.[7] Although the formal institution of slavery ended in the United States, its vast influence on the nation's psyche remains prevalent. We often minimize this history and its implications in our practice of mental health. We adopt the false notion that the field of psychiatry has been immune from the effects of institutionalized racism and biased societal values, and further, we fail to acknowledge the ways in which many leading psychiatrists were complicit in pathologizing blackness and legitimizing systemic racism within a mental health paradigm.[8]

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Griffith underscores the limitations of an ethics framework for forensic psychiatry, wherein the cultural and historical context is gutted from the debate, or in which the inherent fairness of the justice system for all people is taken for granted. He stresses the importance of considering historical context: "I adhere to the precepts [of truth telling and respect for persons] but argue that they must be cast in a framework that is illuminated by the political reality of the dominant/nondominant group interaction in the United States"(Ref. 9, p 181).

In this article we employ a historic lens to examine psychiatry's early role in the creation of scientific racism and the ways in which societal context informs diagnostic and assessment frameworks. Finally, we explore examples of persistent parallels in racial disparities within modern forensic psychiatry. In this process, we move beyond myopic paradigms of interpersonal and explicit racism to exemplify how racism has become embedded in habits, policies, and practices in forensic psychiatry. In turn, we suggest that individual attempts by evaluators to understand and mitigate their own biases and racialized tendencies will be to little avail unless contextualized within a broader historical framework. This approach, we argue, is in alignment with the promotion of structural competency within our field.

## Early Psychiatry and the Making of Race

Dr. Benjamin Rush, the "father of American Psychiatry" (1745–1813) and author of the first printed psychiatric textbook in the United States,[10] created the diagnosis "Negritude," a "disorder" that he described as much like leprosy (Ref. 11, pp 4–8). The reported cure of "Negritude" was to become white.[11] Dr. Samuel Cartwright described the illness "Drapetomania," a disorder that caused enslaved peoples to want to run away.[12] Additionally, Cartwright depicted "Dysaethesia aethiopica," a form of mental illness peculiar to black people causing "rascality" (having traits of a "rascal" or an unprincipled, dishonest person), thought to be remedied by whipping or with internment in "work camps."[11] Instead of regarding the wish of enslaved peoples to be free as a normal and adaptive response to an oppressive and pathological system, Cartwright's assessment allows the institution of slavery to efface accountability. By pathologizing both black identity and the black will for freedom, Cartwright and Rush buttress these racist systems of domination. They develop terminology that legitimizes slavery as scientifically sound, morally justified, and part of the natural order. As late as the turn of the twentieth century, leading psychiatrists followed suit and perpetuated these characterizations under the guise of authoritative mental health assessment, asserting that, "Negroes were 'psychologically unfit' for freedom" (Ref. 8, p ix).

Beyond the theoretical claims of academic medicine, these psychiatric and "scientific" race-based assertions strongly influenced discourse, clinical practice, and norms across the nation. In an essay examining clinical records from 1900–1940 at St. Elizabeths Hospital, the first federally operated psychiatric hospital in the United States, these same assumptions about black caprice, violence, and inherent criminality are portrayed.[8] Clinical records demonstrated that, "physicians' and employees' beliefs that blacks lacked self-control sometimes led them to overestimate the dangerousness of the situation. Officials occasionally transferred black men to the highly-secure forensic unit, Howard Hall, merely on the suspicion of threatening behavior, while white patients avoided such reassignment even after becoming destructive or assaultive" (Ref. 13, p 397). Echoing the Linnean pronouncement of inherent black caprice, the hospital system itself conflated blackness with criminality and violence risk, despite the lack of difference in actual rates of patient violence by race. Individual practitioner bias was made invisible as the disparities in dangerousness assessments propagated on the unit were inseparable from the wider hegemonic norm. Thereby, objectivity and evidence-based reasoning were superseded by subjective assessment, and subjective assessment was inevitably influenced by the broader socio-historic context and values.

## Diagnostic Encoding of Social Context

While the aforementioned phenomena of reifying oppression within psychiatric paradigms may seem like archives of the past, more recent patterns very closely parallel these racialized trends. In his book, *The Protest Psychosis: How Schizophrenia Became a Black Disease*,[8] Metzl portrays how public fears about racial difference have shaped modern psychiatric understanding, diagnostic tools, assessment, and treatment. Metzl focuses on the 1960s and 1970s, demonstrating how, in the context of the American Civil Rights Movement and public black protest for freedom and equality, "rhetorics of health and illness

become effective ways of policing the boundaries of civil society, and of keeping these people always outside" (Ref. 8, p xxi).

During this time, the Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II, published in 1968), reflected a shift in diagnostic criteria, transitioning from descriptions of schizophrenia as an illness of calm-natured docility and "the schizophrenogenic housewife" in the prior edition to a disease marked by hostility and aggression.[8] Metzl describes how these criteria and language were imprinted upon black men. In turn, leading psychiatric journals began describing schizophrenia as an illness that afflicted "Negro Men" with "hostile and aggressive feelings" (Ref. 8, p xiv). As the language used in the diagnostic criteria for schizophrenia began to reflect what had already been racially conflated with blackness, a subsequent demographic shift took place in schizophrenia's prevalence from predominantly white middle class women to predominantly men of color. This transition was coupled with an ever-increased (and often subconscious) public misperception of black people's proclivity toward violence and irrationality based on falsely medicalized pretenses and flawed theories. These impressions, along with inherently biased legal and mental health institutions, concretized the groundwork for the disproportionate criminalization and incarceration of black people under the semblance of mental health care.

## Racial Bias in Modern Forensic Psychiatry

Forensic psychiatry is a field theoretically grounded in a number of ethics principles, including, at its foundation, the pursuit of honesty and objectivity.[14] Despite these stated ideals, there exists a vast body of evidence of racial disparity and implicit bias in various domains within the practice of psychiatry and the law, including, but not limited to, violence risk assessments, competency to stand trial evaluations, and clinical triage dispositions.[15] These findings are reported in a plethora of research studies, but they are left unexamined in terms of their etiology, consequence, and remedy. The literature on implicit bias (individual or collective) is not applied. Further, history is rarely referenced to guide our understanding of these patterns and how they may have come to be.

### *Violence Risk Assessments*

Several research studies conducted in civil and forensic facilities find that when inpatients are assessed for violence risk, and these predictions are in turn compared with incidents of actual assaultive behaviors after their inpatient stays, clinicians tend to overpredict violence in black men, despite the fact that there is no significant difference in actual violence related to race. This overprediction of violence persists even when other factors such as diagnosis, past violence, and substance use history are controlled for.[16] In many of these studies, concluding remarks list black race as a risk factor for the overprediction of violence without an in-depth exploration of hypotheses for the mechanism of this trend. This racialized overprediction of violence appears all too familiar when juxtaposed with Cartwright's descriptions of black "rascality,"[11] the DSM-II's account of "hostility and aggression,"[8] and the historical normative practice at St. Elizabeths Hospital,[13] wherein caprice and dangerousness were projected onto black men by clinicians, in turn justifying their preemptive transfer to the secured forensic unit.

In considering these trends through an ahistorical lens, well-intended clinicians and forensic psychiatrists alike may presume their own objectivity and subconsciously adopt the notion that, as stated, black race on the part of the patient is the risk factor. They may unknowingly infer that these patterns are attributable to the individual patients and their race, rather than grasp the active and purposeful ways in which these biased perceptions were encoded in the making of race in our country and in the diagnostic frameworks we routinely use within psychiatry. They may miss the ways in which history is carried within us.

### *Competency to Stand Trial Evaluations*

In competency to stand trial evaluations, studies repeatedly demonstrate the overrepresentation of black men in categories linked with incompetence.[17] Mental health clinicians and attorneys alike more often deem black men "irrational," their opinions and treatment wishes discounted.[17] Many of these studies in turn report black race as an unmodifiable risk factor for incompetence with little further discussion. Consequently, forensic psychiatrists reading this literature, while taking their own objectivity for granted, unconsciously equate blackness with irrationality and simultaneously evade all responsibility for perpetuating this disparity. If, however, this were un-

derstood within a historic and structural competency paradigm, the parallels between these trends and the diagnosis of Drapetomania (the supposed disorder by which enslaved people wished to be free) become apparent. Through applied history, we can better understand the longstanding propensity of our field to disregard the wish and will of black people as illogical and crazed, making them "psychologically unfit for freedom"[8] and in turn justifying their incarceration. What is crucial to understand here is that the individual propagation of racial bias on the part of the forensic psychiatrist conducting an assessment does not require ill intent or animus. In fact, these patterns thrive when we fail to acknowledge the relationship between structurally embedded bias and our own judgment, when we presuppose our own immunity to bias, and when we fail to recognize such tendencies as a threat to the very principles of psychiatry and the law.

### *Clinical Triage Dispositions*

As it pertains to clinical triage dispositions, a number of recent studies have demonstrated a trend similar to that described at St. Elizabeths hospital in the early 1900s, namely the propensity to disproportionately refer black evaluees to higher-security settings than their white counterparts. In a study reviewing all referrals to a Massachusetts court clinic (for competency or criminal responsibility evaluation) from 1994 to 2001, it was found that black defendants were significantly more likely than white defendants to be referred for an inpatient evaluation after their outpatient screening.[18]In addition, regardless of their diagnosis or the severity of their criminal charge, black defendants were more likely than their white counterparts to be referred for evaluation in a strict-security facility. These patterns hold true even in the evaluation of adolescents; black youth with behavioral disturbances are far more likely to be discharged to the carceral system over treatment centers than white adolescents, despite having the same degree of behavioral disturbance and diagnoses.[19] In this way we can perceive the propensity for clinicians, presumably striving to uphold ideals of honesty and objectivity, to mirror historic patterns of facilitating the criminalization of blackness. In turn, this process contributes to the disproportionate incarceration of black Americans, and particularly those with serious mental illness.[20] In these clinical and assessment scenarios, it is not sufficient to ask oneself whether one is perpetuating bias. Rather, it is essential to broaden the scope of vision to include structural patterns of the past and comprehend the inevitability that this history and process of socialization has impacted our individual frames of reference and tools of discernment.

## Conclusion

In the examples of research findings listed above, repeated racial disparities in modern forensic psychiatry are demonstrated; however, bias is rarely called upon to explain these disparate outcomes by race. Rather than scrutinize the objectivity of the evaluators, the race of the evaluee is frequently listed as a risk factor, with the mechanism left unquestioned. Even in literature that addresses implicit bias directly in forensic psychiatry, the discourse is limited by paradigms of individual and interpersonal bias, preference, personality, and fund of knowledge.[3] Forensic psychiatrists are called upon to take ownership of addressing and announcing their own bias, which requires both awareness and the overcoming of powerful guilt and denial. What we have demonstrated here, however, is that racial bias in forensic psychiatry is not a personal, individual, or new phenomenon. Racism has been embedded in the roots of our field; its legacy, therefore, is insidious and far-reaching. Recognizing our own biases within a broader context of history, structural racism, and pseudoscientific claims about race allows us to comprehend the inevitability that we will carry these points of reference within us. Learning widespread patterns of the past aids us in overcoming the inertia of individual guilt and arms us with the will to deconstruct systems that support the status quo, if and when that status quo is perpetuating disparity.

Beyond moral and ethics-based arguments for the promotion of racial justice within psychiatry and the law, it behooves us to promote structural competency within our field. This framework strengthens our ability to strive for objectivity and truth-telling by practice, and not by presumption. Furthermore, it is only when we comprehend the powerful historical legacy of racialized assessments in forensic psychiatry that we can deconstruct their etiology and devise their antidote, pushing us to recognize that where disparity in outcome exists it is usually racism, not race, that is the risk factor.

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