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Racial Bias in Diagnosis:

Practical Implications for Psychotherapists

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Key Words: racial bias, diagnosis, objectivity, interventions

Abstract

Empirical research has consistently shown that persons of color are routinely diagnosed with more severe mental disorders than European Americans. One possible reason for this phenomenon is racial diagnostic bias. This article summarizes research on diagnosis and race, provides an overview of clinician bias during the diagnostic process, and describes implications for psychotherapy practice.

Accurate diagnosis is difficult but extremely important in the clinical decision-making process. On some occasions, psychotherapists may not diagnose mental health disorders accurately (Bell & Mehta, 1980). The *DSM-IV-TR* is a classification system of mental health disorders that was developed for use in clinical, educational, and research settings (American Psychiatric Association [APA], 2000). The diagnostic criteria included in the *DSM-IV-TR* are meant to serve as a guide or a framework to be informed by clinical judgment on behalf of the psychotherapist. However, clinical judgment is involved in the clinical decision-making process and takes clinical experience and expertise. Therefore, incorrect diagnoses can lead to negative consequences for clients, the professional image of psychotherapy, and society in general. One potential pitfall of misdiagnosis is client stigma. Recent research shows that one of the main areas of misdiagnosis may be among persons of color, perhaps because of diagnostic bias.

Racial and ethnic differences in the clinical treatment of clients in the United States have been well documented (Adebimpe, Chu, Klein, & Lange, 1982; Fried, 1975). Such differences affect clients from certain minority groups (i.e., African Americans) more than others. According to the U.S. Surgeon General (*U.S. Surgeon General Report,* 2003), pertinent issues about availability, quality, and access to mental health services for racial minority clients have not been fully addressed in the United States, and there are higher incidences of severe pathology in minority groups compared to European Americans (U.S. Department of Health and Human Services [DHHS], 2001). In particular, minority groups with mental health needs are less likely to receive adequate treatment than the mainstream population and are less likely to receive care when they actually need it. Thus, availability, accessibility, and use of mental health services for racial minority groups have been lacking (*U.S. Surgeon General Report*). In particular, the availability of mental health services depends on several factors, including access to racial minority clinicians, geographical location (i.e., more mental health professionals reside in urban areas compared to rural areas), and the unequal distribution of services. Moreover, lack of health insurance is an obstacle for many racial minority groups, which limits access to mental health services for these clients more than for European Americans.

A review of the literature suggests that racial diagnostic bias may be one of the primary reasons for treatment disparities among persons of color. For example, previous research has shown disproportionately higher rates of impairing diagnoses for African Americans compared to European Americans. It should be noted that this article delimits the context to potential diagnostic bias according to race. The authors acknowledge that other forms of diagnostic bias may exist (e.g., related to gender, age, sexual orientation, and other factors) and other forms of (non-diagnostic) racial bias exist as well. However, given the importance of racial diagnostic bias in psychotherapy and the large scope of other potential forms of client-related bias, these other topics were deemed to fall outside the scope of this article. Therefore, the

purpose of this article is to investigate the potential for diagnostic bias in the psychotherapeutic treatment of persons of color and to highlight clinical implications for psychotherapists.

Summary of Research on Differential Diagnosis and Race

Empirical research has consistently shown disproportionate rates of certain clinical diagnoses among persons of color. These racial differences are likely to be driven by bias in the clinical decision-making process (Sohler & Bromet, 2003). For example, research shows that African Americans are likely to receive more severe clinical diagnoses than European Americans. Schwartz and Feisthamel (in press) echo the notion that one of the primary reasons for admission and treatment differences among European Americans and African Americans could be disproportionately high frequencies of more severe mental disorder diagnoses (e.g., schizophrenia) among African American clients. A misdiagnosis of schizophrenia in African Americans compared to European Americans could reflect clinical prejudice related to a misinterpretation of presenting symptoms (Baker & Bell, 1999). That is, clinicians may either not be adequately trained in the use of the *DSM-IV-TR* (APA, 2000), or stereotyped judgments may hinder diagnostic objectivity; therefore, clinical judgment and accurate diagnosis may be lacking. Snowden and Cheung (1990) reported that African Americans are more likely to be diagnosed with schizophrenia than European Americans and are less likely to be diagnosed with a mood disorder. Usually a mood disorder requires less invasive treatment and has better prognosis than a psychotic disorder, which is why a mood disorder diagnosis may be considered by some as a more cautious diagnosis. Additional studies have found that European Americans and Asians more often receive a mood disorder diagnosis than African Americans or Hispanics and that African Americans and Asians receive psychotic disorder diagnoses more often than European Americans (Foulks, 2004). In the most recent study found to date on diagnosis and race, Schwartz and Feisthamel found that counselors disproportionately diagnose certain mental disorders in African Americans compared to European Americans. In particular, schizophrenia and childhood disorders (e.g., conduct disorder, oppositional defiant disorder, and attention-deficit hyperactivity disorder) were diagnosed more often in African Americans than European Americans. However, European Americans were diagnosed more often with a mood disorder. Thus, one potential cause of the disproportionate diagnosis of African American clients versus European American clients could be diagnostic bias (Sohler & Bromet). Eton, Regier, Locke, and Taub (1981) conducted one of the largest surveys focused on differential diagnoses among racial groups. The study included five broad catchment areas across the country, including cities in California, North Carolina, Missouri, Maryland, and Connecticut. Results showed that African Americans were less likely than European Americans to be diagnosed with major depressive disorder, dysthymic disorder, and obsessive-compulsive disorder. Furthermore, no significant differences were found between African Americans, Asians, Hispanics, and Caucasians regarding rates of bipolar disorder (Zhang & Snowden, 1999). As a result, Zhang and Snowden suggest that higher rates of schizophrenia among African Americans have resulted from misdiagnosing mood disorders as schizophrenia.

Overview of Racial Bias in Diagnosis

Results of empirical studies clearly point to differential diagnoses of racial minority clients compared to European American clients. As stated previously, disproportionately high rates of more severe diagnoses in persons of color (e.g., psychotic disorders) are likely to at least in part be due to clinician bias. Whaley (2004) suggests that clinician diagnostic bias usually falls into two categories: cultural bias, which represents factual racial disparities in symptomatology being ignored or misinterpreted by diagnosticians, and clinician bias, which refers to a lack of adherence to diagnostic criteria during the clinical decision-making process. Interestingly, Neighbors et al. (1999) found that racial differences in diagnostic outcomes remain after controlling for clinicians' lack of adherence to *DSM* criteria when making diagnoses.

Cultural bias (or cultural differences) is one potential hypothesis for the disproportionate diagnosis of persons of color found in the research cited above. Johnson, Saha, Arbelaez, Beach, and Cooper (2004) report on racial and ethnic differences in client perceptions of bias and cultural competence. Their results suggest that racial and ethnic minority clients are more likely than European Americans to perceive bias and a lack of cultural competence when seeking clinical treatment in the health care system. Moreover, Whaley (1998) reported that mild forms of suspiciousness toward the mental health system are more prevalent in African Americans than in European Americans, suggesting that African Americans' culturally based mistrust of a European American-dominated mental health care system may impact clinicians' diagnostic decisions (e.g., cultural suspiciousness may be misinterpreted as psychotic symptoms). Cultural differences in paranoid symptom expression may play a role in the misdiagnosis of schizophrenia in African Americans. Therefore, a lack of clinicians' awareness of mistrust, which is culturally based, is more likely to conceal an underlying diagnosis of depression in African Americans if there is a mental health concern at all (Whaley, 2004). In particular, cultural bias suggests that cultural norms related to suspiciousness in African Americans are different than other cultural groups because of historical and contemporary racism and tyranny. So, African Americans' articulation of mistrust, irritability, or defensiveness during a clinical interview may not reflect psychopathology (Whaley, 2004; Maultsby, 1982; Newhill, 1990). Ridley (1984) reported that suspiciousness serves a self-protective function against racially based risks to self-worth for African Americans, but it may be misinterpreted as more severe pathology by psychotherapists, leading to a misdiagnosis of schizophrenia.

Clinician bias is another potential reason for disproportionate diagnoses of more severe mental disorders in persons of color. Psychotherapists must operate

with some degree of clinical uncertainty because clinical diagnoses rely heavily on client self-reports (Fauman, 1994). This uncertainty may open the door to possible bias or stereotypes that psychotherapists or clinicians link to observable differences in race (Smedley, Stith, & Nelson, 2002). Sohler and Bromet (2004) reported that racial bias can lead to errors in the clinical stage of treatment decisions, and such errors can lead to the misdiagnoses assigned to racial minority groups. These errors may indicate that psychotherapists do not rely on prescribed diagnostic criteria and that diagnoses assigned in the treatment setting remain racially tainted. Eriksen and Kress (2005) report that psychotherapists are not "value-free," and cultural value differences may bias clinicians and hinder the diagnostic process. Therefore, psychotherapists need to be aware of and acknowledge their own cultural biases before prescribing treatment to persons from another culture.

Practical Implications for Psychotherapists

Given that cultural diagnostic bias and clinician diagnostic bias may both be common in psychotherapy, it is important that psychotherapists be conscious of how they are diagnosing persons of color. Given that diagnoses depend in large part on clinical judgment (APA, 2000), use of objective assessment strategies is vital if psychotherapists are to be less biased. Psychotherapists should also heed the advice of multicultural counseling experts—patience and special attention should be devoted to interviewing persons of different cultural backgrounds.

Kress, Eriksen, Rayle, and Ford (2005) point out that the *DSM* provides psychotherapists with a general outline for evaluating a client's cultural context, including (1) the client's cultural background, (2) issues related to the client's culture, (3) sociocultural issues related to the client's environment, (4) factors involved in the therapeutic alliance, and (5) the overall cultural evaluation. Understanding this cultural framework may help psychotherapists be more culturally sensitive. Furthermore, according to Kress et al., psychotherapists need to promote cultural sensitivity. In particular, these authors provide concrete information about how to reduce bias in clinical practice, including assessing the client's worldview, the client's cultural identity, and sources of cultural information pertinent to the client; delving into the cultural meaning of a client's problem and the impact on family, work, and community; and understanding culturally based stigma associated with the presenting problem. Assessing the client's worldview includes taking into account the client's own values, beliefs, and assumptions about the world. Grieger and Ponterotto (1995) report that asking about a client's worldview is the most important question for assessment in cross-cultural psychotherapy. The client's identity is assessed by gathering data about the client's language, religious beliefs, and employment so the psychotherapist understands who clients are in relation to their environment. Helpful professional development activities in this regard may include reading relevant books about support systems, cultural history, and spirituality, which help to provide cultural information relevant to the client's life. Thus, before a diagnosis can be made it is important to understand the client in his or her cultural context. Addressing these ongoing issues can help provide psychotherapists with more objective diagnostic awareness.

Eriksen and Kress (2005) explain that psychotherapists should be cautious when making clinical decisions regarding clients from differing cultures. During initial interview sessions psychotherapists must be open to and aware of language, inflection, nonverbal behavior, and expressive communication differences among culturally different clients. Increasing one's knowledge about how culturally different clients may respond to clinical interviews can help a psychotherapist avoid the inherent pitfalls described above. For example, Gibbs (1981) presents a five-stage process through which African Americans interpret their meetings with European American psychotherapists. Stage one is the appraisal stage, in which the client "sizes up" the counselor to help minimize the intensity of the initial interaction. "Sizing up" refers to the client behaving in a reserved manner, not asking many questions, and attempting to "feel out" the clinician and his or her intentions. Stage two involves the client's assertive investigation of who the counselor is. Clients may challenge the psychotherapist to see if he or she will react with empathy and validation. Stage three provides an exchange of information such as background information and biopsychosocial history between psychotherapist and client. If the client does not feel comfortable with the clinician at this stage, he or she may terminate psychotherapy. Stage four represents the client's commitment to the therapeutic alliance. Stage five involves the actual therapeutic process and collaboration on the clinical problem that brought the client into psychotherapy. Stage five enables the client and psychotherapist to work together on the presenting problem that resulted in the client seeking psychotherapy. Clinician or cultural bias may influence any of these stages and, as a consequence, may hinder the therapeutic objectives of the psychotherapist.

In a broader sense, Sue, Arredondo, and McDavis (1992) laid the foundation for multicultural psychotherapy competencies by providing a set of skills that allow psychotherapists to respond more appropriately to particular situations when working with persons of color. These skills include seeking out educational and training experiences to help promote knowledge of working with culturally different populations, understanding one's self as a racial and cultural being, becoming familiar with relevant research regarding the mental health of racial minority groups, being actively involved with racial minority groups outside the psychotherapy setting (e.g., community functions, friendships), gaining training and expertise in the use of culturally compatible assessments, and being aware of the cultural limitations of diagnosis.

Parham (1999) extended his work to focus particularly on African American clientele and divided competencies into three domains: awareness, knowledge, and skills. Examples of awareness include the therapist being knowledgeable of his or her own personal biases about African American people, the therapist's role as a healer, and the therapist's self-knowledge. Some

examples of knowledge include understanding African American psychology and societies, central components of an African American-centered worldview, and assessment instruments appropriate for African Americans. A few examples of skills are establishing rapport in a way that African American clients will accept, setting therapeutic goals in the context of an African American-centered reality, and increasing advocacy efforts for African Americans. Relatedly, Sanders (1999) provides suggestions for working with African American persons that might be effective for psychotherapists: (1) increasing cultural awareness—knowing yourself and your own culture; (2) encouraging self-advocacy to help empower African Americans and promote self-help groups within the community; (3) strengthening multicultural accountability training of colleagues by suggesting multicultural classes and workshops; (4) becoming more active in community resources such as churches and civic centers; (5) being more present in African American communities; (6) raising awareness of bias, prejudice, and discrimination; (7) seeking funds to conduct needed research on the African American lifestyle as it relates to psychotherapy; and (8) encouraging the hiring and promotion of African American clinicians, educators, and support staff.

With a greater understanding of diagnostic bias, a broader knowledge of the *DSM* and its limitations, and additional training and skills in cross-cultural psychotherapy, psychotherapists can help to reduce the impact of this all-too-common phenomenon.

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