VIEWPOINT

Addressing Structural Racism and Inequities in Depression Care

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Racial disparities in depression treatment are well documented, with Black adults experiencing greater illness burden and more severe symptoms yet lower treatment rates compared with White adults.[1] We posit racism is a fundamental driver of these disparities. Indeed, the American Psychiatric Association recently issued a formal apology for its support of structural racism.[2] Despite increased awareness of racial injustice, theoretically informed recommendations to curtail racism's effect on depression are limited.

In her seminal work, Camara Jones, MD, MPH, PhD, provides a theoretical framework that describes 3 levels of racism[3]: (1) institutionalized (structural) racism represents differential access to goods, services (including health care), and opportunities of society by race; (2) individual or personally mediated racism is prejudice and discrimination based on race; and (3) internalized racism is negative emotional sequalae among stigmatized racial groups associated with acceptance of negative messages about their intrinsic worth and abilities.[3]

Guided by Jones's framework, this Viewpoint proposes actionable, multilevel recommendations to address racism and promote mental health equity. We present a clinical vignette based on a real patient to illustrate how these 3 levels of racism affect depressive symptomatology and treatment engagement. Our recommendations are rooted in empirical research and informed by our multiple identities as physicians (internist and psychiatrist), investigators, and African American individuals.

Clinical Vignette

Ms Smith is a 65-year-old, single, employed, college-educated Black woman with a history of diabetes, hypertension, and depression. She grew up in a northeastern US city in a 2-parent household. Her neighborhood had few homeowners, limited green spaces, dilapidated infrastructure, rising rents, and housing insecurity. These created constant stresses for her mother, who experienced recurring, debilitating depression.

Ms Smith's first depressive episode occurred after college and was linked to feelings of diminished self-worth after transitioning from a stellar academic career with strong social ties (including a Black sorority) to difficulty finding employment, which she attributed to a television industry dominated by White men. Eventually, Ms Smith found employment in television production. While working full time, she developed recurrent depressive episodes that she partially linked to discriminatory interactions with White colleagues and doubts about her own productivity. She found support from church members and prayer. It was not until her best friend, someone receiving treatment for depression himself, referred her to a counselor that she received a diagnosis of major depressive disorder and engaged in effective psychotherapy, for which she paid out of pocket.

Decades later, Ms Smith lost her job following industry changes. Her depressive symptoms returned in the context of financial strains. She enrolled in Medicaid and recalled going to clinical settings that she described as "a crumbling hole in the wall." She experienced psychiatrists as "just focusing on medications and not getting to know me as a person," which created mistrust in mental health treatment. She avoided antidepressants for more than a decade because of stigma of medication, lack of information about adverse effects, and perceived discrimination from clinicians.

In summer 2020, Ms Smith was emotionally triggered by widespread coverage of racial injustices (eg, the murder of George Floyd) and the disproportionate toll COVID-19 inflicted on Black individuals in the US. Her primary care clinician screened her for depression, and for the first time, she endorsed suicidal ideation. After scoring 24 on the Patient Health Questionnaire-9, she received a "warm handoff" introduction to a social worker counselor onsite for problem-solving therapy who connected her to rent assistance programs. Despite longstanding wariness, she started taking an antidepressant. She also resumed engagement with her church community by attending services virtually. She participated in get out the vote campaigns focused on counteracting voter suppression. At 4 months, her depressive symptoms had reduced significantly.

This vignette highlights the 3 levels of racism: institutionalized (ie, underresourced neighborhood), individual (eg, racial discrimination at work and by health care professionals), and internalized (ie, low self-worth). Below, we make recommendations to address these 3 levels of racism in the context of depression treatment.

Addressing Institutionalized (Structural) Racism

Ms Smith's case highlights mental health stressors from the racist federal policy of redlining, introduced in the 1930s by the Home Owners' Loan Corporation color-coded maps[4] that encouraged housing mortgage lending in predominantly White areas and discouraged lending in mostly Black areas,[4] contributing to structural neglect, lack of green spaces, and limited access to quality education and health care for Black families. These environmental factors have all been linked to depressive symptoms[5] and were depression risk factors for Ms Smith's mother. COVID-19 widened disparities in financial insecurity and housing instability (eg, difficulty paying rent).

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Structural racism may be daunting for practitioners to address, yet ignoring it means ignoring central aspects of so many Black clients' daily lives. First, clinicians, policy makers, and researchers should collaborate to advocate for policies related to fair housing practices, criminal justice reform, and income equality (eg, increased minimum wage) and assess their effect on depression outcomes. Second, routine screening for social determinants of health in clinical settings, while necessary, is insufficient. We encourage health care settings to relentlessly engage organizations embedded in Black communities (eg, barbershops, churches, civic organizations) as partners in depression case finding and engagement. Such strengths-based approaches leverage trusted local settings and can promote collective recovery through organizational mobilization.[6,7] Third, clinicians should also support implementation of integrated interventions, such as collaborative care,[8] in their own health care settings. Collaborative care provides patients from minoritized racial and ethnic groups greater improvements in depressive symptoms, daily functioning, receipt of preferred treatment, and reduced perception of racial discrimination.[8]

Addressing Individual or Personally Mediated Racism

We must acknowledge that physicians can commit racist acts and may be experienced at committing racist acts. Examining one's own implicit biases and racial privilege is crucial to addressing personally mediated racism. The vignette highlights ways in which perceived discrimination can contribute to depression among Black individuals. We recommend assessing discrimination with validated screening instruments, such as the Everyday Discrimination Scale. These measures may provide clinically helpful insights for both patients and clinicians.

We urge clinicians to apply an antiracist lens to depression services that involves identifying aspects of their own racial background and assumptions while learning how racism's legacy can affect clinical management. Our research group recently disseminated antiracist mental health principles[9] centered on (1) building awareness of racial issues, (2) adapting assessments to Black individuals, (3) having a humanistic approach to medication, and (4) using treatment approaches that address real issues related to racism experienced by Black individuals. Clinicians should strive to create spaces that build trust and allow examination of the role of racial discrimination on patients' depressive symptoms.

Addressing Internalized Racism

Finally, the vignette highlights how diminished self-worth due to racism contributes to depression. As health care professionals, we need to identify and explore internalized racism in patients' presentations. Evidence supports use of racial socialization, described as communication between families and youth about how to cope with racialized experiences to protect against persistent and deleterious effects of racial discrimination.[10] Increased frequency of such socialization improves self-esteem, identity, academic performance, and psychosocial well-being among Black youth.[10] More research is needed to identify how clinicians can integrate principles and practices of racial socialization into current evidence-based practices for depression.

Conclusions

Racism is fundamental to depression disparities. Mental health professionals need to recognize the effect of structural, individual, and internalized racism on individuals with depression symptoms.

ARTICLE INFORMATION

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