Bias in Mental Health Assessment and Intervention: Theory and Evidence

Lonnie R. Snowden, PhD

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, Surgeon General David Satcher issued the report Race, Culture, and Ethnicity and Mental Health, 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,” 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. 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. 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. 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, as well as among children, adolescents, and the elderly.

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

When sought, assistance for mental health problems is especially likely to come from providers in the general medical sector. 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

February 2003, Vol 93, No. 2 | American Journal of Public Health

Snowden | Peer Reviewed | Racial/Ethnic Bias and Health | 239
the Urban Indian Health Programs in [fiscal year] 2001.12

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.13 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-
tion from researchers, and African
American–White disparities have
been revealed. A persistent find-
ing has been that, along with Na-
tive Americans, African American-
s are greatly overrepresented in
inpatient settings.14 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.15 re-
ported 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.16
found that African Americans were
less likely than Whites to obtain treatment meeting a Health Plan Em-
ployer Data and Information Set
guideline calling for a follow-up
visit within 30 days after psychi-
atric hospitalization. Wang et al.18
found that African Americans were
overrepresented among per-
sons suffering from serious mental
illness who failed to receive “mini-
mally adequate” treatment.

Investigators have studied Afri-
can Americans19 and Latinos25
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 commu-
nity residents as well, African
Americans have been found to be
relatively unlikely to receive anti-
depressant medications.20

Studying Medicaid recipients,
Melfi et al.21 found that African
Americans were less likely than
Whites to receive an antidepres-
sant 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 Rothbard22 re-
ported that African Americans were
less likely than Whites to re-
ceive newer atypical antipsychotic
medications that have fewer side
effects and more likely to receive
injectable antipsychotics. Other re-
searchers as well have demon-
strated greater receipt of inject-
able antipsychotic medications
among African Americans.23

In addition, when they are pre-
scribed 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-
vice 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 misidentifying
the problem and misdirecting
attempts at finding solutions, we
must consider explanations other
than bias.

Socioeconomic differences are
typically proposed at the outset.
Often, researchers control for so-
cioeconomic differences; after
doing so, they typically continue
to find evidence of disparities.1

Critics next turn to insurance cov-

erage as a possible explanation.
Minority individuals lack private
health insurance in disproporti-
ate numbers, a gap that is not
eliminated by coverage obtained
from public sources.1

Health insurance coverage fac-

tilates treatment seeking, and
widening the scope of coverage
would benefit members of minor-
y 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 alterna-
tives. Chief among them is lack
of familiarity with mental
illness—related concepts, prefer-
ences for interpreting mental
health problems in spiritual or
other culturally sanctioned terms,

In addition, when they are pre-
scribed 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-
vice 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 misidentifying
the problem and misdirecting
attempts at finding solutions, we
must consider explanations other
than bias.

Socioeconomic differences are
typically proposed at the outset.
Often, researchers control for so-
cioeconomic differences; after
doing so, they typically continue
to find evidence of disparities.1

Critics next turn to insurance cov-

erage as a possible explanation.
Minority individuals lack private
health insurance in disproporti-
ate numbers, a gap that is not
eliminated by coverage obtained
from public sources.1

Health insurance coverage fac-

tilates treatment seeking, and
widening the scope of coverage
would benefit members of minor-
y 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 alterna-
tives. Chief among them is lack
of familiarity with mental
illness—related concepts, prefer-
ences for interpreting mental
health problems in spiritual or
other culturally sanctioned terms,
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 sensivity, 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. 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.

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. 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.

Bias might intrude in the formation of clinical relationships. The therapeutic alliance 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 compounded by cultural misunderstanding.

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 interorganizational differences in culture: quality emphasis, performance goals, coordination of care, communication, and conflict resolution.

Shared understandings might include biases about the mental health status of or treatment expectations for ethnic minority clients. That clients from certain backgrounds are un receptive 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.

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. 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. 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. 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, 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. Catalano, 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 be-
yond that of the individual practi-
tioner: in the practice network, treatment organization, and com-
munity.

Nevertheless, whether intentional or inadvertent, whether by
decision-making or by default, it is reasonable to believe that bias partially explains dispari-
ties. Social scientists have established that bias need not be bla-
tant but rather can be “automatic, cool, indirect, ambiguous, ambiva-
 lent.” 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 operates in mental health de-
cisionmaking 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, ulti-
ately, efforts to effectively address them.

About the Author
The author is with the School of Social Welfare, University of California, Berkeley.
References
2. Fiske ST. What we know about decision-making or by default, it is reasonable to believe that bias partially explains dispari-
ties. Social scientists have established that bias need not be bla-
tant but rather can be “automatic, cool, indirect, ambiguous, ambiva-
 lent.” 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 operates in mental health de-
cisionmaking 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, ulti-
ately, efforts to effectively address them.

About the Author
The author is with the School of Social Welfare, University of California, Berkeley.

Requests for reprints should be sent to Lonnie R. Snowden, PhD, University of California, 120 Harvard Hall, Berkeley, CA 94720-7400 (e-mail: snowden@wcl-law.berkeley.edu).

This article was accepted October 21, 2002.

2. Fiske ST. What we know about bias and intergroup conflict, the prob-
3. Sue S, Fujino D, Hu L, Takeuchi DT, Zane N. Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypo-
5. Morris A, Bloom JR. Contextual factors affecting job satisfaction and or-
ganizational commitment in community mental health centers undergoing sys-
tem change in the financing of care. Ment Health Serv Res. In press.
6. Akutsu PD, Snowden LR, Organ-
ista KC. Referral patterns to ethnic spe-
cific and mainstream mental health pro-
7. Takeuchi DT, Sue S, Yeh M. Return rates and outcomes from ethnic-specific

Racial/Ethnic Bias and Health

American Journal of Public Health | February 2003, Vol 93, No. 2


This article has been cited by:


5. Nan Sook Park, Yuri Jang, David A. Chiriboga. 2018. Willingness to use mental health counseling and antidepressants in older Korean Americans: the role of beliefs and stigma about depression. *Ethnicity & Health* 23:1, 97-110. [Crossref]


7. Matthew J. Gormley, George J. DuPaul, Lisa L. Weyandt, Arthur D. Anastopoulo los. 2017. First-Year GPA and Academic Service Use Among College Students With and Without ADHD. *Journal of Attention Disorders* 26, 108705471562304. [Crossref]


14. Sherrise Truesdale-Moore. Understanding the Historical Influences on Contemporary Assessment and Counseling Issues of African American Offenders 39-61. [Crossref]


16. William Maurice Redden. Geriatric Psychiatry: Perceptions, Presentations, and Treatments 179-199. [Crossref]

17. Laura E. Agnich, April M. Schueths, Tiffany D. James, Jeffrey Klibert. 2016. The effects of adoption openness and type on the mental health, delinquency, and family relationships of adopted youth. *Sociological Spectrum* 36:5, 321-336. [Crossref]

18. Melissa Thompson, Kimberly Barsamian Kahn, Jean McMahon, Madeline O’Neil. Mental Illness, Race, and Policing 175-196. [Crossref]

19. Elijah P. Ricks, Jennifer Eno Louden. 2016. Slipping Through the Cracks. *Criminal Justice and Behavior* 43:4, 525-538. [Crossref]

20. Emily C. Williams, Shalini Gupta, Anna D. Rubinsky, Rhonda Jones-Webb, Kara M. Bensley, Jessica P. Young, Hildi Hagedorn, Elizabeth Gifford, Alex H. S. Harris. 2016. Racial/Ethnic Differences in the Prevalence of Clinically Recognized Alcohol Use Disorders Among Patients from the U.S. Veterans Health Administration. *Alcoholism: Clinical and Experimental Research* 40:2, 359-366. [Crossref]


22. Kahu McIntock, Roimata Tauroa, Graham Mellsop. 2016. An examination of Child and Adolescent Mental Health Services for Māori rangatahi [youth]. *International Journal of Adolescence and Youth* 21:1, 56-63. [Crossref]


70. Pamela Williamson, Minka E. Koro-Ljungberg, Regina Bussing. 2009. Analysis of Critical Incidents and Shifting Perspectives: Transitions in Illness Careers Among Adolescents With ADHD. *Qualitative Health Research* **19**:3, 352-365. [Crossref]

71. Arthur W. Blume, Laura V. Lovato. 2009. Empowering the disempowered: harm reduction with racial/ethnic minority clients. *Journal of Clinical Psychology* **7**, n/a-n/a. [Crossref]

72. Arthur W. Blume, Michelle R. Resor, Anthony V. Kantin. Addiction Treatment Disparities 311-325. [Crossref]


74. Kevin Feisthamel, Robert Schwartz. 2009. Differences in Mental Health Counselors’ Diagnoses Based on Client Race: An Investigation of Adjustment, Childhood, and Substance-Related Disorders. *Journal of Mental Health Counseling* **31**:1, 47-59. [Crossref]


77. 2008. PDM volume 23 issue 5 Back matter. *Prehospital and Disaster Medicine* **23**:05, b1. [Crossref]

78. Martin La Roche, Michael S. Christopher. 2008. Culture and Empirically Supported Treatments: On the Road to a Collision?. *Culture & Psychology* **14**:3, 333-356. [Crossref]


86. Edilma L. Yearwood, Shaniqqua Crawford, Matthew Kelly, Nina Moreno. 2007. Immigrant Youth at Risk for Disorders of Mood: Recognizing Complex Dynamics. *Archives of Psychiatric Nursing* **21**:3, 162-171. [Crossref]


111. Sevgi O. Aral. 2004. Mental Health: A Powerful Predictor of Sexual Health?. *Sexually Transmitted Diseases* **31**:1, 13-14. [Crossref]


113. Mary B. Adam. 2003. INSURANCE AND NONINVASIVE SCREENING FOR STDS. *American Journal of Public Health* **93**:7, 1033-a-1034. [Citation] [Full Text] [PDF] [PDF Plus]

114. Leopoldo J. Cabassa. 2003. INTEGRATING CROSS-CULTURAL PSYCHIATRY INTO THE STUDY OF MENTAL HEALTH DISPARITIES. *American Journal of Public Health* **93**:7, 1034-1034. [Citation] [Full Text] [PDF] [PDF Plus]

115. Lonnie R. Snowden. 2003. SNOWDEN RESPONDS. *American Journal of Public Health* **93**:7, 1034-a-1035. [Citation] [Full Text] [PDF] [PDF Plus]