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Slavery's Legacy In Health and Medicine

State of Minority Mental Health

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Slavery and Its Afterlives in US Psychiatry

Èlodie Edwards-Grossi, PhD, and Christopher D. E. Willoughby, PhD

Antecedents of racist treatments of Black patients by the psychiatric profession in the United States affect the way they view treatment today. Specifically, in this essay, we explore the enduring consequences of racial science on various treatment practices.

We examined a range of primary sources on the history of racial theories about the mind, medical and psychiatric publications, and hospitals. We contextualize this analysis by examining the secondary literature in the history and sociology of psychiatry. Through analyzing racial thinking from the antebellum through the Jim Crow periods, we show how US medicine and psychiatry have roots in antebellum racial science and how carceral logics underpinned the past and present politics of Black mental health.

Changing this trajectory requires practitioners to interrogate the historical foundations of racist psychiatric concepts. This essay urges them to reject biological racial realism, which bears reminiscences to 19th-century racial science, and embrace the variable of race as a social construct to study social inequalities in health as a first step toward moving away from the legacies of past injustices in medicine. (*Am J Public Health*. 2024;114(S3):S250–S257. https://doi.org/10.2105/AJPH.2023.307554)

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In the early afternoon of May 1, 2023, Jordan Neely, a 30-year-old Black man, was strangled by a White ex-Marine in a subway train in New York City. As documented in the press, Neely suffered from mental illness and was unhoused for years. In New York City, mentally ill people can be forcibly remanded to hospitals, as was done to Neely on several occasions. During the winter before his death, Neely disappeared from an inpatient treatment center. Three months later, he was killed. This last stop in a psychiatric facility reveals enduring connections between incarceration and mental health care, as Neely's admission was part of a plea deal. Likewise, the deluge of police-involved killings of mentally ill Black people such as Daniel Prude in 2020 shows the cumulative effect of racial marginalization and mental illness on the likelihood of being subjected to law enforcement officers' use of force.[1] It also exposes the porous boundaries between mental health and racialized carceral logics in the United States (i.e., the systematic and disproportional selection of racialized individuals for punishment). Following the definition previously given by social scientists who study racialized discipline, we also define carceral logics as having an impact on representations and practices broadly in society, beyond state institutions.[2]

Neely's killing is not a singular, disconnected episode of violence. Indeed, examining the intersection between mental health and racialized carceral logics unveils a structural continuum of subjugation evidenced by a long history of oppressive treatment toward Black patients in US psychiatric care. This historical review requires returning to 19th-century medical theories and practices to show how physicians systematically "naturalized" Black persons as an intellectually inferior laboring class during the antebellum era. Along these lines, we ask how 19th-century racial science connected carceral logics to Black mental health and how this symbiosis still underpins the psychiatric stereotypes and contemporary treatments of Black patients.

Through an examination of the antecedents of racist treatments of Black patients by the psychiatric profession, we support four statements with specific historical or contemporary evidence. Analyzing discourses on undeservingness, inferiority, and labor, we offer

evidence that the long-term connections between carceral logics and Black mental health solidified because of (1) the historically chronic underfunding of Black mental health services from the 19th century onward based on the underlying stereotype of Black patients as "undeserving poor," (2) the dissemination of theories in craniometry about Black people's inferior intelligence, (3) the institutional use of racialized forced labor to treat and "cure" Black people's mental health in public hospitals from the 19th century onward, and (4) the reactivation today of beliefs in biological racial realism and genetic racial differentialism in expert and lay circles.

HISTORICAL CONTINUITIES OF INCARCERATION AND AUSTERITY

In the media, Neely's case has been analyzed as a system failure. As *New Yorker* journalist Adam Iscoe argued, "police and corrections officers became de-facto mental-health-care providers, one 911 call at a time." As noted, Neely had been forcibly hospitalized on several occasions. Indeed, as Neely was unhoused and not being treated at the time of his death, his social and medical trajectory exemplified institutional neglect and systemic racism at a microsocial scale. This dynamic can be interpreted as the direct result of the systemic underfunding of New York's mental health services since the 1950s, despite lawmakers' repeated but never-fulfilled promises to provide community-based outpatient care to those most in need.[3]

Neely's case also highlights another deeply connected dynamic: the systemic reciprocity between the underfunding of public psychiatric services across the United States and the rise of the carceral state—namely, the alarming growth of the prison population and criminal justice offenses targeting Black individuals.[4] Sociologists such as Loïc Wacquant have addressed the rapid growth of the prison population in tandem with the racialization of the carceral system. This trend parallels the chronic lack of public assistance for disinherited, Black, mentally ill patients who, instead of being cured in hospitals, end up in the criminal justice system.[5]

Racialized populations live in communities subject to chronic disinvestment and lack access to outpatient care, which stands as the majority setting for most mental illness treatments in the United States.[6] Through the emergence of a new "government of social insecurity," Wacquant shows how racialized populations in the United States were seen as not "playing by the rules of white, middle-class society" and labeled as not deserving of assistance, the "undeserving poor."[7] This chronic lack of public assistance contributes to the overcriminalization of "undeserving" Black Americans, as the lack of access to curative institutions often forced them into punitive ones. Wherever public assistance was denied to Black patients, they entered punitive institutions. They were moved from the "left hand" to the "right hand" of the state, their behavior being criminalized and deemed uncurable.[8]

The rise of carceral logics parallels the demographic trend of deinstitutionalization that many historians of psychiatry have analyzed since the 1960s.[9] Deinstitutionalization happened for various reasons, including assumptions that community mental health would replace state hospitals with a more humane approach. However, deinstitutionalization has had the reverse effect, withdrawing public assistance for vulnerable populations.[10] Yet, this history of chronic lack of public assistance for Black patients and labeling them as "undeserving" has roots in the 19th century. Indeed, in the antebellum era, enslaved people suffering from mental illness received little care, and their institutionalization was determined by enslavers' willingness to pay hospital fees.

In antebellum society, enslaved people were forced into a state of "social death" (i.e., not considered as fully human). Their social and mental status were not regarded as worthy of care, and, therefore, they were seen as "undeserving." Enslavers only considered enslaved people's mental condition when it impeded the amount of unpaid labor they could perform.[11] As a consequence, in the antebellum era, mentally ill enslaved people were forced to continue working or, if perceived as dangerous for others, were locked away in local jails, as documented by historian Peter McCandless.[12] This dynamic shows the symbiosis between carceral logics and Black mental health well before 20th-century trends in mass incarceration.

Similarly, these racialized carceral logics found new life after the Civil War. As most Black freedmen and freedwomen resided in Southern counties and parishes, new financial debates arose concerning the mental care and public assistance made available to them. Some institutions such as the Central Lunatic Asylum for Colored Insane in Virginia were funded by Reconstruction Era (1865–1877) state legislatures. Newly elected Black legislators fought to provide public assistance to this vulnerable population. Opening in 1869, this institution became the first in the country to host Black patients only.[13] However, as Southern states

gradually implemented the segregationist Jim Crow regime after 1877, opening public institutions for Black citizens caused public controversy. White legislators in Virginia and North Carolina opposed the funding of institutions that provided public assistance for Black people, lamenting the costs inflicted upon White taxpayers.[14]

Antitaxation ideologies and the racialization of public support have long-lasting legacies in the US South. As historian Romain Huret argues, in the immediate wake of the Civil War, the North Carolina legislature hotly debated African Americans' citizenship status and sought to refuse them public assistance.[15] Public discourse among Whites reflected this further. Local newspaper editorialists reacted furiously to the collection of newly established federal taxes by Radical Republicans, who aimed to protect African Americans' emancipation and provide basic services through the Freedmen's Bureau.[16] Furthermore, antitax rhetoric proves how carceral logics and racialized discourses on the "undeserving" poor was tied to the politics of mental health care in the 19th century.

THE CONTEMPORARY INFLUENCE OF 19TH-CENTURY THEORIES

The symbiosis between carceral logics and Black mental health is also connected to the history of racism in psychiatry and medicine throughout the 19th century. While medical and scientific theories of race extend back to at least the 17th century, prominent antebellum physicians disseminated novel theories about Black people's intelligence and psychological traits as a justification for enslavement in the 1850s. These theories also supported distinctive carceral logics, confining Black people to agricultural labor in the US South.

While originating in a different social and political context, these theories can be interpreted as historical antecedents for the politics of neglect and coercion central to Jordan Neely's death. In his popular science blog, psychiatrist Awais Aftab contended that Neely's death could be analyzed as "illustrative of sanism," which can be defined as "an irrational prejudice against people with mental illness," who are defined by psychiatrists and lay circles as "erratic, deviant, sexually uncontrollable, emotionally unstable, superstitious, lazy, and ignorant" and demonstrating "a primitive morality" in mainstream society.[17] As a matter of fact, these stereotypes coincide with negative representations of Black hypermasculinity as featured in newspapers such as *The American Conservative*, targeting Neely specifically.[18] Calling Neely a "bothersome street performer," senior editor Declan Leary argued that Neely "behaved irrationally, even viciously." Leary's stance provides an almost perfect application of sanism and the stereotypes of innate dangerousness associated with Black males in modern society.

These arguments also strikingly resemble racial science and the carceral logics propelled by polygenesis in 19th-century medical circles. Polygenists theorized that each "race" was created for and in different climates, constituting separate species. In tandem, craniometry was the influential anatomical science of the intellect that anatomists saw as proving polygenesis. Craniologists, like the influential anatomy professor Samuel George Morton, collected skulls, organized them by race, measured their cranial capacity, and created an average of the measurements. Morton drew upon many antebellum medical advancements. It was anatomical in nature. It relied on specialized instrumentation and medical statistics. Thus, craniologists created a science influenced by many defining features of antebellum medical progress.[19]

Craniologists also influenced medical education.[20] For example, in 1861, University of Pennsylvania anatomy professor Joseph Leidy published his influential anatomy textbook, *An Elementary Treatise on Human Anatomy*. In this and later editions, Leidy discussed supposed cranial differences dictated by race. He asserted that White people had the largest cranium. Elsewhere, he claimed that Whites possessed the heaviest brains, supposedly proving their superior intelligence. This was also a sexist science. Leidy claimed that the lighter average weight of women's brains in comparison with men's proved women's inferior intelligence.[21]

Other anatomy faculty also taught their students about craniometry and polygenesis at Harvard University and Columbia University. These schools each trained thousands of antebellum doctors. Thus, polygenists shaped theories of race and intelligence in antebellum medicine and politics.[22]

Polygenesis also upheld larger carceral logics. For some Northerners, Southern slavery represented a mass carceral project, protecting them from cohabitation with Black people. Daniel Drake, professor of pathology and the practice of medicine at the Louisville Medical Institute, illustrated this dynamic in a series of articles in 1851 for *The National Intelligencer*, a leading US newspaper. Theoretically, Drake opposed slavery. As a colonizationist, he believed that Black people in the United States should voluntarily

"return" to Africa. Drake, however, acknowledged that this process would be slow. He opposed emancipation, because Black people were supposedly temperamentally and constitutionally unsuited for freedom. Thus, he insisted that Black people must be confined to the South, where most would remain enslaved.[23]

Thus, antebellum medical doctors' theories about Black people's bodies and minds aligned with the political and social debates contemporary to their production. Moreover, medical educators reproduced these ideas, and their students implemented racialized systems of labor in the United States' first asylums.[24]

Carceral logics of racial science could also be seen in some Southern medical discourse pathologizing mentally ill enslaved individuals. Published in 1851, Samuel Cartwright's invented diagnosis of drapetomania illustrated the carceral logics of antebellum racial science and theories of the mind. Like Drake's argument that fleeing slavery for the North was unhealthy, Cartwright claimed that fleeing the plantation was a mental illness called drapetomania. While drapetomania was hardly universally accepted, Cartwright influenced US politics and medicine. His peers in the North even recognized his expertise. In 1826, one of his articles received an award from the Medical Committee of Harvard University.[25]

Cartwright's diagnosis of drapetomania mirrored his proslavery political beliefs. He theorized drapetomania in the immediate context of the Compromise of 1850, which comprised five laws dealing with the issue of slavery and territorial expansion. Among other controversial policies, the Compromise of 1850 amended the Fugitive Slave Act, requiring Northerners to help capture self-liberated individuals. The 1850 act gained much support from Southern White elites, because it drastically expanded their influence over Northern states and the enslaved population. Cartwright's theorization of drapetomania extended the logic of the Fugitive Slave Act of 1850 to the medical sphere. He pathologized self-emancipated individuals, restoring the social and moral order that reigned over Southern plantations. A frequent correspondent with prominent Southern politicians, Cartwright was well aware of the political potential that his medical theories represented.[26]

This dynamic relationship between medicine and politics also mirrored Drake's position in the early 1850s, writing that Black people must be confined to Southern slavery until they emigrated back to Africa. In an 1851 letter to John Collins Warren, retired professor of anatomy at Harvard Medical School, Drake explicitly invoked the Fugitive Slave Act as context for his advocacy for Black colonization. Specifically, he hoped to "terminate the colonizing of free Black people within the limits of the United States."[27]

After the Civil War, physicians continued to pathologize Blackness in mental health care. This continuity existed in the circulation of the category of "political excitement," listed as a cause of insanity and applied to Black patients in the annual reports of Southern asylums and hospitals such as the Central Lunatic Asylum for Colored Insane in Virginia.[28] One of the theoreticians of "political excitement" was medical professor Joseph Jones at the University of Louisiana and former Confederate officer who studied under Joseph Leidy at the University of Pennsyvania. In his 1889 medical lecture at the 11th annual session of the Louisiana State Medical Society in New Orleans, he defined the cause of his Black patients' mental afflictions as "certain political and race changes, such as those wrought by the great American civil war of 1861–1865."[29] Jones participated in the Redeemers' ideology, which intended to restore a moral, social, and political order based on White supremacy. Jones accused the 1863 Emancipation Proclamation of harming the health and moral character of African Americans, who should not have been freed.

Thus, these two medical categories reveal continuities between racial science and White Southern political interests before and after the Civil War. Southern physicians developed these theories, reflecting how supposed expertise on Black bodies often originated in the US South.[30]

Whether before or after the Civil War, many Southern doctors believed that Black people were mentally and physically suited for enslavement and the brutally exploitative sharecropping labor regime that replaced it. Medical educators also reinforced these beliefs, as the idea of temperamental adaptation to enslavement or peonage was taught at Northern and Southern medical schools.[31] Whether in terms of mental or physical health, racial policy routinely bore carceral overtones. As demonstrated by the circulation of the "political excitement" category in Southern state institutions, racial science was not only confined to theoretical endeavors such as Drake's and Cartwright's writings. Medical theories on racial differentiation were disseminated in asylums and hospitals, where scientific theories about Blackness were applied to Black patients' bodies. Each of these theories also shared an overarching logic: that Black people's mental fitness

relied on their confinement to agricultural labor in the South.

RACIAL VIOLENCE AND CARCERAL LOGICS IN INSTITUTIONS

Asylums reproduced—in novel ways—previous carceral logics and the racial violence of slavery. They were originated as primary sites for the installment of social and medical control over bodies and minds to restore docility in the Black population. What had formerly been mere theories on racial inferiority were now being applied directly to Black patients. From the late 19th century to the mid-20th century, therapeutic treatments were often organized in the form of physical labor for Black patients, under the pretext of occupational therapy.[32]

Even though these 19th-century institutions originated in a distinct period, they can be analyzed as the foundations of 20th- and 21st-century psychiatric institutions.[33] Reflecting these continuities when reacting to Neely's killing, Mayor Eric Adams stated that his death proved the need for forced hospitalization of mentally ill people unable to adapt to life in society. This response was heavily criticized by his political allies and New York Civil Liberties Union activists, who saw in Adams's statement a return to "the failed approaches of force and coercion" that have long been systemic of psychiatric institutions.[34] Indeed, many sociologists of psychiatry have highlighted how "total institutions" such as modern psychiatric hospitals were still based on coercive measures including physical restraint and treatment through labor, labeled as "work therapy" even in the 21st century.[35] As a consequence, while many dissimilarities exist between the past and present, 19th-century asylums can be seen as the cornerstones of contemporary psychiatric hospitals, especially their enforcement of treatment regimens based on carceral logics.

In the 19th century, the discourse of cure and recovery was justified according to a broader ideological belief among the medical community that Black patients had a "natural" ability and desire to work, mimicking the antebellum moral order. A prime example of this dynamic was Daniel Burr Conrad, the first superintendent of the Central State Hospital in Virginia. Burr Conrad was a typical Southern asylum director, educated about racial science at the University of Pennsylvania. Graduating in 1853, Burr Conrad would have learned about Black people's supposed intolerance of cold and suitability for labor in the South from Professor George Bacon Wood and about craniometry from anatomists such as Leidy and his predecessor William Horner. It is unsurprising, then, that Burr Conrad underlined the importance of labor in one of his first reports for the institution. He explained that "from our experience during the past two years . . . , we are inclined to think that this manual labor is the chief, if not the only, means of cure we possess for this class of our insane, coming as they all do from the totally uneducated former slave class."[36] Emphasizing labor as "the chief" curative, Burr Conrad established a clear link between moral treatment in the form of labor and the supposed specificities of previously enslaved Black people.

In the mid-to-late 19th century, physicians such as Burr Conrad naturalized Black people as an intellectually inferior laboring class, directly applying racialized carceral logics to Black asylum patients from the postbellum period through the 1940s. Indeed, the naturalization of labor infused therapeutic practices in Southern states up to the 20th century. In a newly emancipated society, Black men represented a potential threat to White society by disrupting work regimes, or by refusing the social roles to which a segregationist society confined them. At public psychiatric hospitals in Louisiana between the 1900s and 1940s, Black patients worked long hours in agricultural fields.[37] Briefly put, for administrative officials, Black patients provided unpaid labor for the operation of the asylum.[38]

Therefore, in their writings, administrators advertised values such as the curative, the transformative, and the restoration of good health and sanity.[39] Physicians depicted how well White patients behaved together, presenting their integration into rituals of social interaction as the promise of rapid reintegration into the White social order outside of the asylum. They coded recovery for Black people around norms of docility, labor productivity, and, consequently, the suppression of newly acquired civil rights.[40] While the White patients also worked, thus showing that occupational therapy was not only applied to Black patients, the labor they performed was less physically demanding and outside the realm of these racialized carceral logics.[41] In contrast, the asylum for Black patients was designed as a workhouse that established physical labor as transformative treatment. These asylums' most clear departure from carceral institutions was that medical officers sought to attain the final goal of curability.

LEGACIES OF 19TH-CENTURY RACIAL SCIENCE

As highlighted throughout this essay, theories and medical practices interweaving

discussions on labor, punishment, and undeservingness were not restricted to the 19th-century US South. Indeed, in many ways, 19th-century and 20th-century racial science helps us understand broader aspects of contemporary society. For example, Neely's killing is a contemporary case that highlights powerful connections between mental health and carceral logics in the United States. It serves as a pivotal example that reveals, flagrantly and shockingly, how discourses on undeservingness, Blackness, and criminality remain intertwined.

Racial differentiation in the treatment of mentally ill patients is also tied to the recent revitalization of biological racial realism (i.e., theories supporting so-called innate racial differences), which reflects the long-term development of racial science.[42] Paradoxically, this revitalization has been taking place despite a consensus among social scientists condemning biological racial realism. In article after article, social anthropologists and sociologists have stressed how the variable of race should be considered in the medical field as a social construct and a social determinant rather than a genetic, biological essence.[43] As scholars Merlin Chowkwanyun and Adolph Reed Jr have recently cautioned regarding the COVID-19 pandemic, discussion of racial disparities must be contextualized within broader socioeconomic factors. Otherwise, scholars risk reinforcing biodeterminist explanations for disparities rather than highlighting social causes.

This same risk exists in mental health practice.[44] Despite acquiring negative connotations after the eugenics movement, biological racial realism still looms as a threat. In lay circles, White nationalists have recently attempted to revive racial science—a development largely overlooked by the general public. For instance, sociologists Aaron Panofsky, Kushan Dasgupta, and Nicole Iturriaga have shown how White nationalists have attempted to promote racial realism and hereditarian explanations for behavioral differences by publishing amateur papers on the OpenPsych platform, at the margins of academic research.[45] Relying on writings by controversial psychologists such as Arthur Jensen, these papers argue that a correlation exists among race, intelligence, and IQ. These authors even argue that their work is rooted in antebellum racial science. On several occasions, Jensen and his regular coauthor J. Philippe Rushton have cited the work of the influential antebellum polygenists Josiah Nott and George Gliddon, establishing a deep lineage beginning with craniometry.[46] Racial realists are often adept at mimicking academic language and gain wide followings through wearing the mantle of scientific legitimacy. These contemporary political and social misuses of disproven theories are one of the enduring legacies of 19th-century racial science developed in the United States.

Beyond race realists, many geneticists, biologists, and physicians still use the notion of race as a biological or genetic variable in peer-reviewed research. Let us consider explanations given for the consistent high rate of psychotic disorder diagnoses among African Americans. In the absence of "genetic evidence" to support the overdiagnosis of schizophrenia among Black people, some psychiatrists and historians argue that clinicians' racial bias should be considered as a potential explanation.[47] Yet, others still contend that genetic predispositions underlie this trend, despite this lack of positive evidence.[48] When genetics are not mentioned, cultural differences are described as accounting for disparities, denoting cultural essentialism—a belief in innate, fixed, and essential cultural characteristics.[49]

CONCLUSION

By linking economic structure, racial science theories, and therapeutic practices, this essay has shown how carceral logics have underpinned politics of Black mental health from the 19th century onward. Instead of focusing solely on the development of theories that advance carceral logics, namely 19th-century racial science and 21st-century biological racial realism, we have shown how the spread of carceral logics relied on economic decisions regarding public assistance given to Black mentally ill patients and on racialized therapies for Black patients that link Blackness and labor. Overall, these examples should act as powerful reminders that social scientists, physicians, and biologists as well as the general public should remain vigilant toward the political and social uses of science and the framing of race as a potential "biological" variable, especially in light of technological advancements made toward personalized medicine today and in the near future. The disentanglement of carceral logics and Black mental health will only come at the price of a careful assessment and acknowledgment of past and present injustices in psychiatry and medicine. AJPH

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Growing Up With an Undocumented Parent in America: Psychosocial Adversity in Domestically Residing Immigrant Children

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Enrique is a 6-year-old male child presenting for an evaluation at the request of his school. Both he and his undocumented mother appear tense and worried. He was born in the United States after his parents migrated from El Salvador due to safety concerns, and the police arrested his father in a workplace raid 2 months prior to this visit. Since then Enrique and his mother have been living in cramped quarters without access to a washing machine. Enrique's mother has been looking for work and money is tight. Despite being a United States citizen, Enrique does not have access to health insurance, housing support, school programming, or other services for which he qualifies. He did not attend preschool, and as a first-year kindergarten student, he is now struggling academically with English. Other students are bullying him because of his speech and appearance. He and his mother do not know where to turn, and the school is concerned about developmental and learning disabilities. Enrique's mother states, "He has not been the same boy since his father got arrested. Before he used to go outside and play with the neighborhood kids, and he used to laugh a lot at home. Now he mostly stays in his room, barely talks, and barely eats. I'm really worried about him." Enrique's mother also relays that she herself has been struggling to adjust to the loss of her spouse, which has resulted in her having far less support. She has been feeling depressed herself, and is worried about her ability to care adequately for her children in her current predicament. On examination, Enrique has his head down throughout most of the interview, defers questions to his mother, and becomes briefly tearful when talking about his father.

According to Pew Research Center, 6 to 7 million children are residing in the United States with at least one undocumented parent. The vast majority of these children were born in the United States themselves, and a small minority were born outside America. Even more noteworthy is the longitudinal data that 7% to 9% of all children born in the United States between 2003 and 2014 have at least one undocumented parent. Given the numbers, it is highly likely that all child health care providers will encounter this population clinically. In this Clinical Perspectives article, we start by reviewing general and specific vulnerabilities in this population, and then discuss how child and adolescent psychiatrists can effectively help these children and their families. The majority of data presented herein refers to the US-born children of undocumented immigrants, but some may include foreign-born children of undocumented immigrants residing in America.

The children of undocumented parents in America are at risk for several general vulnerabilities. Like the children of many minority groups, they are more likely to suffer from poverty than their peers.[1,2] Poverty translates to cramped living conditions,[1,2] decreased access to washers and dryers,[1] food insecurity and malnourishment,[1,2] difficulties with academic achievement and increased risk for learning disabilities,[1] behavioral issues,[1] community violence,[3] parental depression and stress,[4] and a whole host of adverse childhood experiences.

Yet, the children of undocumented parents are at risk for a number of specific and unique vulnerabilities as well. Unexpected parental arrest and deportation can cause drastic transitions for these families, with little to no notice. Parental arrest and deportation worsen the existing problems of economic hardship, housing and food instability, loss of childcare, reluctance to go to agencies for assistance, and difficulty obtaining basic needs.[2,3] Caregivers who remain after a parent is detained report difficulties in emotional adjustment, their ability to support their children financially, emotionally, and educationally.[2,4,5] Remaining caregivers also report increased social isolation, depression, and suicidal ideation following the arrest of a spouse. These sudden and specific traumas also increase the rates of posttraumatic stress disorder, depression, and anxiety in children born to undocumented parents.[2,5]

Other vulnerabilities that are specific to this population include eligibility for services, academic difficulties, and acculturation stress. The fact that undocumented parents are ineligible for services such as housing and health insurance increase the risk that their children will not get these services even if they qualify.[1,2,6] For example, the children of undocumented Mexican parents report lower reading and mathematics skills, and lower rates of preschool enrollment than other ethnic groups matched for poverty, immigrant, and minority status.[1] Finally, the children of undocumented immigrants report acculturation stress in the form of difficulty communicating with friends, negative perceptions of their home country, a lack of supportive school networks, and difficulty in their relationships with their parents.[3]

Health care providers who work with the children of undocumented immigrants must be aware of the aforementioned vulnerabilities to provide holistic, comprehensive, compassionate, and effective care. There are several clinical considerations when working with this patient population. First, child and adolescent psychiatrists may inquire about immigration status, but should only do so in a careful and thoughtful way, and only if the child and family feel comfortable sharing this information. Providers can explain their rationale in asking this information so that additional referrals for services can be made for the family. Forcing the issue could cause undocumented parents and their children to become even more fearful and reluctant to return. Child and adolescent psychiatrists should explain that immigration status is protected information under the Health Insurance Portability and Accountability Act (HIPAA), and that child and adolescent psychiatrists do not have any legal mandate to report this information. Many child and adolescent psychiatrists who are experienced in this work will not document immigration status, even if disclosed by the patient or family, for fear that this information could be used against the family if subpoenaed by a court.

The child and adolescent psychiatrists who provide clinical care to this population are not doing so in a forensic role with immigration authorities, and thus families can be reassured that their information is as safe as possible. Second, the knowledge of a family's immigration status can be incredibly helpful in treatment planning. Child and adolescent psychiatrists can listen empathically and normalize the experiences of the family, while providing psychoeducation on migration stress and trauma. The ease of efficient communication is critical to forming a therapeutic alliance with families, and bilingual mental health providers and/or easy access to high-quality interpreter services can help to facilitate communication with families. Children should not translate for their parents, as this could cause undue stress and could violate confidentiality laws. Undocumented families, especially those with US-born children, may qualify for a number of services. US-born children should be eligible for special school programming where available, health care, and potentially even housing. In such cases, child and adolescent psychiatrists should advocate for the child directly and should avoid situations in which children feel pressured to secure services for their parents. These families may also require assistance in the form of case management, transportation, and language/translation services. Moreover, undocumented families may benefit from connections to nonprofit grassroots organizations, immigrant law centers, and churches, and being tied into their local immigrant communities. Third, a family-centered, trauma-informed, and culturally sensitive approach should be applied to the clinical care of this population.[7] The trauma experienced by the children of undocumented parents is transgenerational and historical in nature. Thus, a family-centered approach, which could include components of family therapy, allows the entire family unit to heal simultaneously while enhancing the family's ability communicate with one another and support one another through difficult transitions. Similarly, trauma-informed systems of care anticipate the potential for trauma in patients and create clinical environments that are safe and healing for patients and families who are suffering. Trauma-informed systems of care include calm, patient, and welcoming staff at the reception desk, a soothing "look and feel" of clinical environments, and efforts to avoid potential re-traumatization and/or triggering of patients. Finally, many children of undocumented parents may have experienced discrimination at school or in the community. Thus, a culturally sensitive approach in which cultural norms are understood and respected, rather than judged and questioned, will likely enhance the quality of the therapeutic relationship and effectiveness in patient engagement. Fourth, it is a great advantage for clinics to be located in areas with high concentrations of undocumented immigrants. This can help to facilitate community relationships between child and adolescent psychiatrists and other local providers, stakeholders, and families. It also improves trust in and visibility of mental health services. Similarly, flyers can be placed in community mental health center offices where there are high concentrations of undocumented patients, informing them that they are safe to receive care. Finally, physicians can play an effective role in advocating for policies that promote the mental health and wellness of children residing with undocumented parents in America.[8] Many undocumented parents and their children may refrain from speaking out for fear of retaliation, and therefore their voices may not be heard at a local and

national level. This may especially be the case in areas where immigration raids, arrests, detention, and deportation are more prevalent. The American Academy of Child and Adolescent Psychiatry released policy statements against immigration executive orders and the separation of immigrant children from their families in 2017 and 2018, respectively. We must continue joining with other medical organizations in this advocacy effort to address the vulnerabilities discussed in this article.

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Dr. Sidhu is with University of New Mexico, Albuquerque. Dr. Song is with George Washington University Medical Center, Washington, DC.

The contents of this article have not been presented by Dr. Sidhu or Dr. Song to date, nor have they been published elsewhere. Both Dr. Sidhu and Dr. Song have given multiple American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting presentations on special immigrant populations, including immigrant youth fleeing torture and persecution as well as domestically residing immigrant youth. Both Dr. Sidhu and Dr. Song have written multiple articles on this topic as well.

Disclosure: Dr. Sidhu has received grant funding from the 2018 AACAP Advocacy and Collaboration Grant. He has received honoraria as the 2018 AACAP Hansen Review Course Co-Chair and from Tulane University Department of Psychiatry Grand Rounds. He has received travel expenses from the University of New Mexico Health Sciences Center and AACAP. Dr. Song has served as consultant to the International Rescue Committee, the Office of Refugee Resettlement, the United Nations High Commissioner for Refugees, and the TriCity Health Center. She has received honoraria from the Penn State Medical Center Department of Psychiatry Spring Symposium and Grand Rounds and the Department of Behavioral Health of Virginia Grand Rounds. She has received book royalties from Springer Nature. She has received travel expenses from the George Washington Medical Center.

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For Black people, the mental effects of police killings linger

nbcnews.com/news/us-news/black-people-mental-effects-police-killings-linger-n1281353

Minyvonne Burke

Michelle Kenney still has nights when she stays up crying over the death of her son, Antwon Rose II, a 17-year-old high school student who was shot three years ago by an East Pittsburgh, Pennsylvania, police officer.

Time has also not healed the pain Zion Carr grapples with after witnessing the shooting death of his aunt, Atatiana Jefferson, by a Fort Worth, Texas, police officer in 2019.

And it has not lifted the weight Darnella Frazier still carries after she filmed a video last year of former Minneapolis Police Officer Derek Chauvin kneeling on George Floyd's neck, killing him.

For victims' relatives, witnesses and those who are subjected to replays of videos of police brutality against Black people, there's no such thing as getting over the trauma it causes, according to experts.

William A. Smith, a professor of ethnic studies and chair of the education, culture and society department at the University of Utah, has done extensive research on how trauma affects marginalized groups, especially Black people. He's coined the term "racial battle fatigue" to describe how continued acts of aggression or discrimination can lead to anxiety, stress and even health issues.

"It's a systemic race-related repetitive stress injury," Smith said. "It's not a post-traumatic

stress disorder or injury because we're not in a post-racist society. It's something we have to deal with every day."

Trauma "doesn't leave you," said Rufus Tony Spann, a licensed professional counselor and a Forbes health adviser.

"So a lot of times we may say PTSD thinking that it's post-trauma, but for many people, it could be continuous trauma," he said. "And a continuous trauma is that I experienced an actual event that either has shocked me, it has changed my thought process or instilled fear in me."

That fear is what prompted Zion's mother, Amber Carr, to file a federal lawsuit in September, saying the now 9-year-old suffers from "anxiety, terror and agony" from witnessing Jefferson's death.

Zion was playing video games with Jefferson, 28, when a neighbor called police for a welfare check because the home's front door was open. According to the suit, the door had been left open to allow a cool breeze to blow inside.

Former Fort Worth Police Officer Aaron Dean responded to the call just before 2:30 a.m. on Oct. 12, 2019, and walked into the backyard of the home. When Jefferson heard a noise outside, she grabbed her legally owned gun for protection and went over to a window to investigate, the lawsuit said. Dean, who was standing outside the window with a flashlight, shot and killed Jefferson.

"At the age of 8, Z.C. was forced to watch the murder of his aunt, Atatiana Jefferson, at the hands of Fort Worth Police," the lawsuit stated. Zion has now been left with "severe and extreme mental and emotional distress," it said.

Carr was not available for an interview. The family said in the suit that the city is responsible for Zion's trauma. It names Dean, Police Chief Ed Kraus, the city of Fort Worth and former Mayor Betsy Price as defendants.

Kraus, an attorney for the city and a representative for Price did not respond to multiple requests for comment about the lawsuit. A lawyer for Dean said he could not comment because of a court-issued gag order.

Dean was arrested shortly after Jefferson's death and charged with murder. The trial for the former officer, who has been out of jail on bail, will start no earlier than late November, according to officials.

On the one-year anniversary of Floyd's death, Frazier described how being a witness to the killing changed how she viewed life and took away part of her childhood.

"I am 18 now and I still hold the weight and trauma of what I witnessed a year ago. It's a little easier now, but I'm not who I used to be," she wrote in an emotional Facebook post on May

25. "I used to shake so bad at night my mom had to rock me to sleep. ... Having panic and anxiety attacks every time I seen a police car, not knowing who to trust because a lot of people are evil with bad intentions. I hold that weight."

Frazier was walking to a corner store with her 9-year-old cousin when police attempted to arrest Floyd after receiving a call about a counterfeit bill. Frazier said she happened to be "in the right place at the right time" when she captured footage of his arrest. The video would

later play a key role in Chauvin's conviction.

Frazier, via her representative, declined to be interviewed.

In the Facebook post, she acknowledged the impact her video has had but wrote that she's still "trying to heal from something I am reminded of every day."

'I have to figure out ... how to survive'

Kenney said she has days when the weight of Rose's death is so paralyzing, "I can't get off my couch; I can't stop crying." Her son was fatally shot on June 19, 2018, by former East Pittsburgh Police Officer Michael Rosfeld after a traffic stop.

Rose had fled from a vehicle that was involved in a drive-by shooting earlier that evening. The teen had been sitting in the front passenger seat of an unlicensed taxi when a person in the back seat shot at two men in North Braddock, Pennsylvania.

Rosfeld fired at Rose as he fled, hitting him three times. Video of the incident captured by a bystander and posted online triggered a series of protests in the Pittsburgh area that included a late-night march that shut down a major highway. The former officer was charged with homicide and later acquitted.

"How do you take your mind off of a video that was circulated worldwide of your son being gunned down?" Kenney said. "Everyone thinks that is just a situation where you have to figure out the process of grief. No, I have to figure out day to day how to survive."

Therapy and talking with a pastor have been some of the ways Kenney has been able to keep going, but she said more needs to be done on the local level to assist families affected by police violence.

"I wish that every city had a resource agency where these families could go to get everything they needed, whether it was legal advice or mental health advice," she said.

A 2018 study found that Black people experienced days of poor mental health over a three-month period after a police killing of an unarmed Black person in their state. Law enforcement kill more than 300 Black Americans, at least a quarter of them unarmed, each year, according to the study.

These killings have "adverse effects on mental health among Black American adults in the general population," the study said. "Programs should be implemented to decrease the frequency of police killings and to mitigate adverse mental health effects within communities when such killings do occur.

Following Floyd's death last year, officials in Newark, New Jersey, diverted 5 percent — nearly $12 million — of the city's Public Safety Department budget to create the Office of Violence Prevention and Trauma Recovery.

The office has combined several community-based units under one umbrella to provide resources faster in the wake of a violent event.

"It's taking a public health approach to violence," said Juan Rios, an assistant professor who directs the master of social work program at Seton Hall University in New Jersey. "So if there's a shooting, we're able to not just work with the victim, but also work with those in the community who may be affected."

Rios, who works with the trauma recovery office, said they can set up community members with therapists, provide mental health resources and even assist with possible relocation costs.

"This is innovative," Rios said. "What we're saying is that safety and well-being is not just in the hands of law enforcement; it's also in the hands of folks who are adequately trained to put people first and take a humanistic approach to addressing the whole person."

On the national level, organizations such as the Black Mental Health Coalition, the Association of Black Psychologists and the NAACP provide support, Rufus Tony Spann, the Forbes health adviser, said.

Spann has also started working with a new tech company called Hurdle, which was formed in response to the killings of Black men by law enforcement and provides mental health resources to those in need.

Prominent civil rights attorney Benjamin Crump often deals with grief-stricken loved ones and community members after a police killing. He has represented the families of Floyd, Daunte Wright, Breonna Taylor and many others. The lawyer has established relationships with mental health organizations around the country that he can refer clients to, he said.

"We have to continue to talk about the mental effects on Black people because oftentimes society chooses to disregard it," Crump said. "It's almost as if we have to say Black lives matter, but Black mental health matters, as well."

Mental Health Disparities:
African Americans

AMERICAN PSYCHIATRIC ASSOCIATION

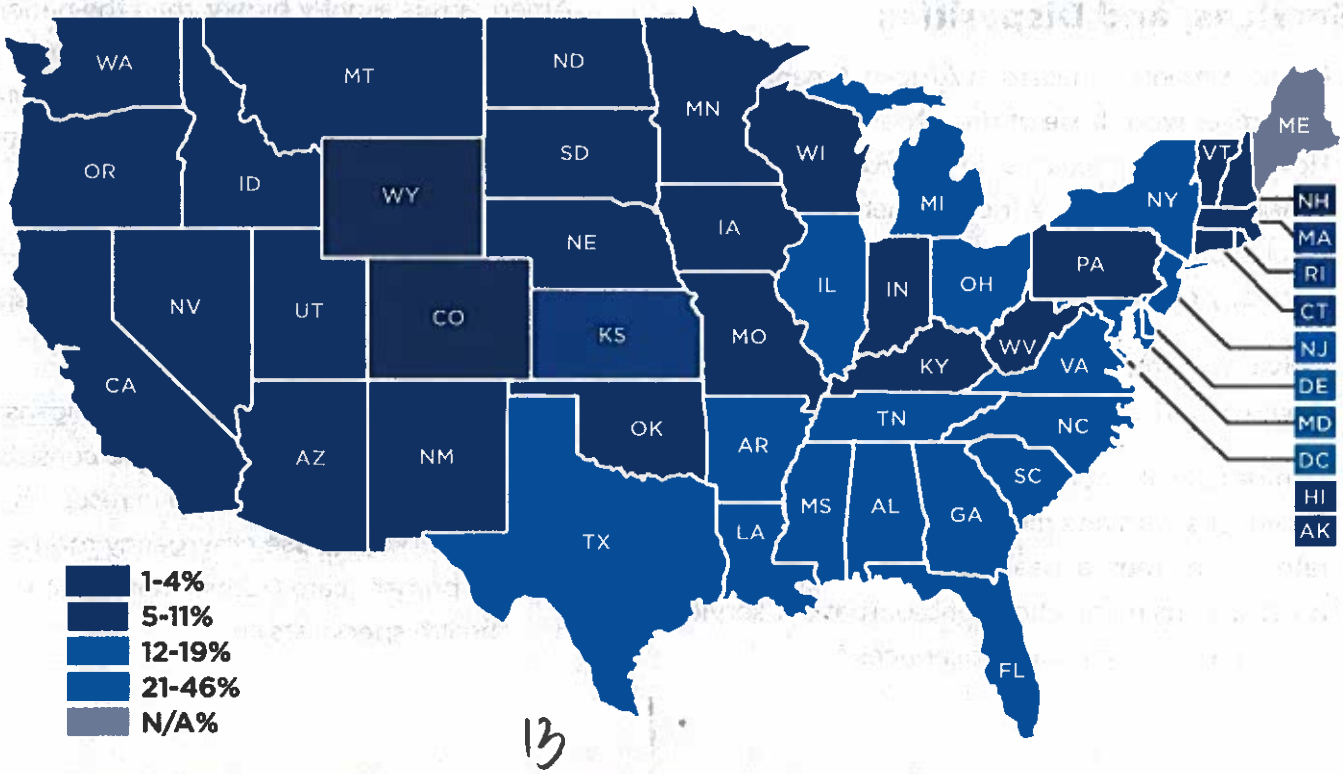
African American Population

- African Americans make up 13.3% of the US population.[1]
- African American communities across the US are culturally diverse, with immigrants from African nations, the Caribbean, Central America, and other countries.
- About 27% of African Americans live below the poverty level compared to about 10.8% of non-Hispanic whites.[2]
- Approximately 30% of African American households are headed by a woman with no husband present, compared with about 9% of white households.[3]

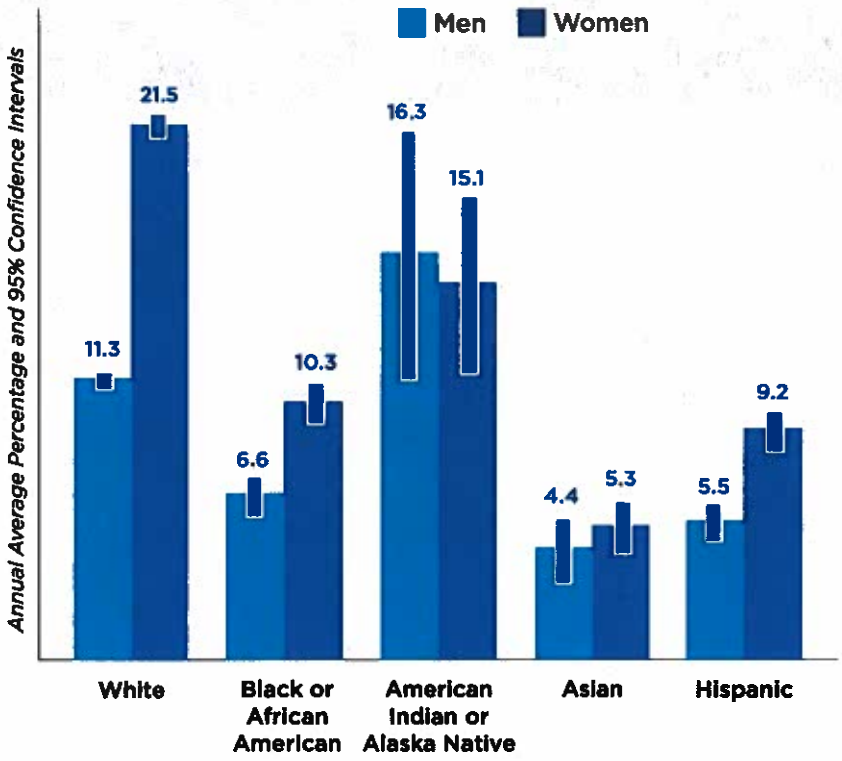
Health Challenges

- Approximately 11% of African Americans are not covered by health insurance, compared with about 7% for non-Hispanic whites.[4]
- Death rate for African Americans is higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.[5]
- CDC estimates that African Americans represented more than one-third (40% or 498,400 persons) of all people living with HIV and almost half (45%) of all persons with newly diagnosed infection in 2015.[6]

Population Distribution of Black Americans in the United States



Mental Health Service Use in the Past Year among Adults



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2012

Mental Health Status, Use of Services, and Disparities

- Rates of mental illnesses in African Americans are similar with those of the general population. However, disparities exist in regard to mental health care services. African Americans often receive poorer quality of care and lack access to culturally competent care.[7]
- Only one-in-three African Americans who need mental health care receives it.[8]
- Compared with non-Hispanic whites, African Americans with any mental illness have lower rates of any mental health service use including prescriptions medications and outpatient services, but higher use of inpatient services.[9]
- The rate of illicit drug use among African Americans is slightly higher than the national average (12.4% vs 10.2%). Rate of alcohol use is slightly lower than the national average (44.2% vs 52.7%) including heavy drinking (4.5% vs 6.2%) and binge drinking (21.6% vs 23%).[10]
- Rate of opioid overdose among African Americans (6.6%) is less than half of that for non-Hispanic whites (13.9%).[11]
- Compared with whites, African Americans are:
  - Less likely to receive guideline-consistent care
  - Less frequently included in research
  - More likely to use emergency rooms or primary care (rather than mental health specialists)[12]

- Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy.[13]
- Compared with whites with the same symptoms, African Americans are more frequently diagnosed with schizophrenia and less frequently diagnosed with mood disorders. Differences in how African Americans express symptoms of emotional distress may contribute to misdiagnosis.[14]
- Physician-patient communication differs for African Americans and whites. One study found that physicians were 23% more verbally dominant, and engaged in 33% less patient-centered communication with African American patients than with white patients.[15]
- Black people with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than people of other races.[16],[17]

Barriers to Care

Despite recent efforts to improve mental health services for African Americans and other minority groups, barriers remain regarding access to and quality of care. The barriers include:

- Stigma associated with mental illness
- Distrust of the health care system
- Lack of providers from diverse racial/ethnic backgrounds
- Lack of culturally competent providers
- Lack of insurance, underinsurance

Other common barriers include: the importance of family privacy, lack of knowledge regarding available treatments, and denial of mental health problems. Concerns about stigma, medications, not receiving appropriate information about services, and dehumanizing services have also been reported to hinder African Americans from accessing mental health services.

To learn about best practices for treating diverse populations and to get answers to your questions by leading psychiatrists, please visit APA's Cultural Competency webpage at https://www.psychiatry.org/psychiatrists/cultural-competency.

Walter Patton's Ghetto Therapy™ supports community wellness

signalcleveland.org/walter-pattons-ghetto-therapy-supports-community-wellness/

April 16, 2024

Activist Walter Patton's weekly Ghetto Therapy™ sessions pack the house at Environmental Health Watch every Wednesday evening. The event brings together licensed therapists and local residents to talk about the impact of trauma passed down through generations.

Patton, of Ward 5, provides all forms of therapy from reiki to sound bowl, traditional healing, art therapy, massage therapy, yoga, meditation and foot detoxing.

Last month, divine feminine energy warmed the room for a special ladies night edition focused on how women are dealing with trauma. Patton gave roses to the first 50 ladies who were present at the event co-hosted with behavioral health coach and founder of @acaciaparkwellness Precious Phillips.

The evening began with a poetic showcase by Nailah "Vision" Mohammed, who read moving pieces that electrified the room with unity, grace and understanding. She is on Instagram as @azulvision.

Poet Dana gave a thrilling presentation of her poem, "Healers Code." She is on IG @queen_dana216

Licensed therapist Billie Gilliam moved the audience with relatable life experiences. Graham discussed ways to let go of suffering and how trauma is passed down and affects generations of interactions in society.

Many residents spoke of wanting to feel safe and building more trust with neighbors and the people who share their space.

The night featured a delicious array of catered food options by "That Brown Girl," giving off nourishing vibes for overcoming common adversity.

"Ghetto Therapy™ has become a safe space to share our experiences and build healthy relationships while growing into healthier beings," said one of the ladies who attends these sessions of relief often.

Walter Patton, founder and owner of Ghetto Therapy™, built a partnership with Cleveland Clinic where he holds teen nights at 6 p.m. every second Wednesday at the Cleveland Clinic's Langston Hughes facility, 2390 East 79th St.

Find more information about upcoming sessions and guests by contacting Walter Patton via Instagram @Walterpatton_or @freethinkersince87llc_team.

Ghetto Therapy™ is also held at 6 p.m. on Wednesdays at the Environmental Health Watch headquarters, 4600 Euclid Ave. Find a member of the Central listening team there each week this month and at other community events.

Black women working to dismantle 'strong Black woman' trope, break stigma around mental health

GMA goodmorningamerica.com/wellness/story/black-women-working-dismantle-strong-black-woman-trope-84749892

Kendall Ross, Katie Kindelan, Janai Norman, Brittany Berkowitz, Sabina Ghebremedhin, Kendall Ross, Asher May-Corsini

A growing movement is calling on Black women to do something long held out of their reach as the country faces an ongoing pandemic, racial conflict, and a growing political divide -- to rest.

Tricia Hersey of Atlanta is one woman behind that movement. In 2016, the artist and theologian founded The Nap Ministry, a collective that examines the power of rest through collective nap sessions, lectures and community workshops, prioritizing rest as radical resistance, particularly for Black women.

"This culture has made it so that we are not living in a human way anymore," said Hersey. "We're so disconnected and disembodied from our bodies."

Hersey said the ministry is designed to combat what she describes as the "unsustainable," "machine level pace" required by the world today.

"Everything is go-go-go, be-be-be, keep going, keep going, never stopping," said Hersey. "I think that increases the risk of mental health issues when we don't allow our bodies and minds enough time to just kind of settle into what is right now and to actually make space for a new way."

For Black women in particular, according to Hersey, the pressure to persevere and at least appear OK while suffering can contribute additional stressors to already difficult situations.

Rooted in racist antebellum stereotypes, the trope of the perpetually "strong Black woman" harms Black women's mental health in its inherent dismissal of the effect any hardship may have, according to Hersey.

> 'Strong Black woman,' to me, allows so much time for abuse and manipulation.

"'Strong Black woman,' to me, allows so much time for abuse and manipulation, for not resting, for burning yourself out," she said. "So the 'strong Black woman' has never been anything I've ever related with. I want rest. I want ease. I need help."

Hersey said she sees the trope of the "strong Black woman" as one reason Black women in particular struggle with mental health.

Activist Ianne Fields Stewart and the Nap Ministry founder Tricia Hersey discuss the need to dismantle the "strong Black woman" trope.

Women overall are more likely to experience depression than men, according to the National Institutes of Health (NIH), and for Black women, burnout and stress are also "rampant," according to research analyzed by the American Psychological Association (APA).

Black women, like all Black Americans, are also less likely to have access to mental health care, data shows. Only one-in-three Black Americans who need mental health care receives it, according to the American Psychiatric Association (APA).

MORE: Black American anxiety at all-time high, experts say
In addition to socioeconomic disparities and a lack of inclusive research on mental health, the APA identifies stigma, distrust, and limited access to diverse and culturally competent health providers as barriers to care for Black Americans.

For Mental Health Awareness Month, ABC News' Janai Norman led a "Good Morning America" digital roundtable conversation on what many consider the taboo topic of mental health for Black women, exploring how racial injustice and the "strong Black woman" trope impact mental health.

Black women speaking out to change the conversation

For Ianne Fields Stewart, a New York City-based activist and storyteller, being given the power to rest was a transformative experience.

"Your work has been a massive part of how I've done my own healing," Fields Stewart told Hersey during the conversation.

Fields Stewart, who identifies as transgender and uses the pronouns she/they, said that while growing up in Birmingham, Alabama, the myth of the strong Black woman was the "model of womanhood" she tried to emulate and follow.

Now, she said she no longer believes that "every Black woman must be a strong Black woman," but wonders what spaces are left for Black women to hold.

"The problem is that I don't think we've yet decided what Black women can be in this space that's left behind," said Fields Stewart, adding separately, "Do we have space for soft Black women, for emotional Black women, for Black women who aren't really good at their jobs, but are great as people and human beings ... or even that we don't have to talk about black women in terms of what we can contribute, but as far as we are just being?"

Ianne Fields Stewart is a New York City-based activist and storyteller.
Fields Stewart, an actor and founder of The Okra Project, which works to provide meals to Black trans people, said when the pandemic began two years ago, it forced her to think about the spaces she held.

"I was someone who defined myself by what I did, and suddenly when the pandemic struck, I didn't have an industry anymore," she said of her acting profession. "I didn't have anything to ground me."

The experience, according to Fields Stewart, made her question the weight of the pressure she was under.

For Hersey, the start of the pandemic was a time to embrace what she called the new "slowed down, not normal."

Hersey noted that, pre-pandemic, mental health in the Black community was already in "crisis." The pandemic motivated her to expand her work with The Nap Ministry to reach more people.

"[I] really wanted people to see this as a beautiful opportunity to take space to listen to our bodies, to really take account of what's really happening," she said. "Because we don't have a chance to do that in our lives."

Dr. Teresa Taylor Williams, a New York-based psychotherapist, said she had seen firsthand the ways in which the changes brought about by the pandemic, including, for some, the ability to rest, had impacted her clients, including Black women.

"I've gotten to the point where I've had to turn people away, because I can't physically handle the number of people that are trying to get appointments with me," she said. "The one question that was common amongst most of all of my new clients was, 'Tell me when I'm gonna feel like myself again,' and that's the question that has been so hard to answer."

As a Black woman herself, Taylor Williams said she had seen the downside of the "strong Black woman" stereotype.

What she called the "Superwoman complex" can distract from larger issues that affect self-esteem and mental health overall, she said.

"If we think about what allows us to go beyond, to be able to think and explore and daydream about 'what could I be,' we have to be comfortable right where we are," said Taylor Williams. "We have to be mentally healthy right where we are."

> These are luxuries that should be given to every Black woman.

Fields Stewart said she wants the conversation around mental health and rest to be something all Black women have access to. "These are conversations and these are ideas and these are luxuries that should be given to every Black woman," she said.

"When we talk about mental health ... it does not care what clothes you wear, it does not care about any of that," she said. "Your mental health is your mental health and we have to be able to have that conversation amongst all of us."

MORE: Doctor navigates culture and stigma to address black mental health amid COVID-19
Hersey said she hopes people take away from the conversation a desire to move toward a more mindful, even leisurely, way of life as a way to protect Black women's space.

"The systems of grind culture, of capitalism, of patriarchy, of white supremacy, we can disrupt these systems by just being in these moments of joy and holding ourselves and space to love and care and rest," she said. "And when we do that, collectively, I think things begin to shift."

If you or someone you know is in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting HOME to 741741.