Examining Structural Racism and its Impact on Mental Health Outcomes and Services for Black Americans: A Review

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INTRODUCTION

Racism is defined as a system that implements structures, policies, and practices which provides or prevents opportunity for individuals and groups of people based on the way they look or the color of their skin (Centers for Disease Control and Prevention, 2021). The Tripartite theory of racism introduced by Dr. Jones (2000) describes three levels of racism: internalized, personally mediated, and institutionalized. Internalized racism is defined as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth", and personally mediated racism is defined as "prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race." Institutionalized racism is defined as "differential access to the goods, services, and opportunities of society by race." This level of racism is often legalized and engrained in the many systems and institutions of a society. It can prevent individuals from having the same access and opportunities to education, housing and healthcare, among many others (Jones, 2000). For the remainder of this review, the term "structural racism" will include the three components of the Tripartite theory to ensure consistency in definition, as well as the consideration that all three levels contribute towards the complex system of racism we currently see in the United States.

Mental Health

Structural racism interferes with people's ability to utilize or access certain services, often creating social, political, economic, and health disparities. These disparities put people of color at a disproportionate risk for adverse conditions and experiences and can ultimately impact health outcomes and quality of life. For example, black Americans face a greater risk of

developing conditions such as diabetes, heart disease, asthma, and obesity and have a lower life expectancy than white Americans (Centers for Disease Control and Prevention, 2021). In addition to physical health, black Americans experience mental illness at similar rates compared to white Americans, however they are less likely to address these symptoms as anything more than "stress" or "being tired", partly because of the stigma surrounding mental health (Harvard Medical School, 2022).

When observing the relationship between structural racism and mental health outcomes, socioeconomic status (SES) is an important factor to consider because it can often aid or prevent an individual from utilizing necessary resources that can improve health status. According to the American Psychological Association, SES is dependent upon income, education, occupation, place of residence, and race (American Psychological Association, 2022). Americans with lower income are less likely to have health insurance (Khullar & Chokshi, 2018). Health insurance coverage is often expensive and difficult to obtain for many Americans, however, black Americans are more likely to be uninsured (U.S. Department of Health and Human Services, 2022), and this likelihood increases if they are not provided coverage through an employer (Artiga et al., 2021). Lack of access to insurance coverage can greatly impact whether individuals receive mental health care, which can ultimately exacerbate negative mental health symptoms. These adverse physical and mental health outcomes are just a portion of the disparities that black Americans face, most of which are persisted through racist and discriminatory laws and practices that have been established and adapted over time to continue the cycle of oppression (Williams et al., 2019).

Historical Significance

Racism has historically been engrained in the functioning of our society and institutions, which is apparent when observing laws, policies, and regulations that have been passed. The Hill-Burton law, passed in 1946, provided construction grants and loans for hospitals to be built wherever they were needed. The purpose of this law was to provide more access to healthcare for citizens by providing more hospitals and beds available. However, with Jim Crow laws still in effect, the hospitals that were built were often racially segregated, perpetuating discriminatory practices in medical settings and prohibiting equal opportunity to necessary health care services (Yearby et al., 2022). Occupational discrimination also had a significant impact on health for black Americans. The National Labor Relations Act of 1935 allowed union rights, increased wages, and provided more health insurance coverage for employees. This act did not apply to other industries that were more likely to employ people of color, causing wage and health insurance coverage inequalities to increase (Yearby et al., 2022).

The Affordable Care Act (ACA), passed in 2010, expanded coverage and access for Americans, especially those experiencing low-income (U.S. Centers for Medicare and Medicaid Services, n.d.). Not only did more people gain insurance coverage after the ACA expansion (Sommers et al., 2016), but this act also prohibited discrimination based on race, ethnicity, age, disability, and sex in healthcare settings (U.S. Department of Health and Human Services, n.d.).

Current Issue

Health disparities in black Americans has been widely researched for decades, and often points to determinants of health, such as: access and quality of healthcare, social and economic factors, environmental factors, and community safety and resources (Vance, 2019). What is less widely acknowledged is the generational trauma and chronic stress that has been inflicted as a result of structural racism. Since the murder of George Floyd in March of 2020, rates of

depression and anxiety in the black community have significantly increased, proving it to be a traumatizing experience for black Americans (Eichstaedt et al., 2021). Police violence continues to be a threat to life and equality in the United States. In 2022, 1,001 people have died at the hands of the police, 24% of them being black despite only accounting for 13% of the U.S. population (Mapping Police Violence, 2022). Current events, such as COVID-19, police violence, and discrimination in our political system is only beginning to scratch the surface of the many ways that structural racism can become threatening to the physical and mental health of black Americans. Identifying the prevalence of mental illness, how structural racism impacts these adverse outcomes, and the barriers to accessing mental health care may aid in understanding what needs to be done to improve equality in mental health and mental health care.

METHODS

A literature search was conducted to identify previous research on structural racism and its impacts on mental health outcomes, service use, and access in black Americans. Six databases were chosen, including CINHL, Psych Info, Medline, PubMed, Web of Science, and Public Health Database. All journal articles were peer-reviewed and published between the years 2012 and 2022. Additionally, the searches were limited to articles that had abstracts available to provide a quick overview of the contents of the research. In order to address the components of the research question, the search terms “structural racism”, “mental health”, and “black” were used in all databases except for PubMed, where the search terms included “racism” and “mental health”. Excluding the PubMed search, all databases included the Boolean term “or” to include terms that were similar so that a greater pool of articles were available to choose from.

Once searches were narrowed down to less than 350 results, an initial review of the abstracts were examined to determine if the articles answered the research question. Some databases did not allow an exclusion of review articles, so identifying these types of publications after the search was necessary to exclude article types that could not be used for this research. After excluding articles that were reviews or did not pertain to the research question, a total of 15 peer-reviewed articles were chosen from six different databases. The search terms and process are detailed below in *Figure 1*.

Figure 1: First Article Search

Database	**Terms**	**# of Results**	**Exclusion Criteria**	**# of Results After Exclusion**	**Articles Used**
CINHL	Structural Racism OR systemic racism OR institutionalized racism AND mental health OR mental illness OR mental disorder OR psychiatric illness AND black OR African American	71	Excluded subjects relating to COVID-19, child or adolescent health, racial/ethnic groups that are not African American, and infectious diseases	61	2
Psych Info	structural racism AND access AND mental health AND black OR African American	17,171	Selected subjects of black and racial/ethnic differences	193	3
Medline	structural racism OR systemic racism OR institutionalized racism AND mental health OR mental illness OR mental disorder OR psychiatric illness AND black OR African American OR African-American OR black American	124	No additional exclusions	124	3
PubMed	Racism AND mental health	513	Limited to non-review publications	16	3
Web of Science	structural racism AND access AND mental health AND black OR African American	60	Limited to non-review and open access publications	27	1
Public Health Database	structural racism AND mental health OR mental health care AND access to care AND African American OR black	1,744	Excluded subjects relating to COVID-19, child or adolescent health, racial/ethnic groups that are not African American, and infectious diseases	332	3

After the initial search process, a second search was conducted to find the five remaining articles that filled in any missing information necessary to answer the research question. This search was conducted on the PubMed database. Inclusion criteria were articles that were peer-reviewed, full text, were published between the years of 2012 and 2022, and had an abstract available.

Figure 2: Second Article Search

	Database	**Terms**	**Number of Results**	**Articles Used**
Search #1	PubMed	Racism OR structural racism AND mental health AND African American OR black	262	4
Search #1 Extension				Found article from reference section of (D. R. Williams et al., 2019)

RESULTS

Study Sampling & Design

The studies within this literature review consisted mostly of cross-sectional designs, with two cohort studies, one experimental and one mixed-methods study. The sample sizes of the studies reviewed ranged from 144 to 2,576,952. Most of the studies used secondary data in the form of state- or national-level surveys.

Because of the nature of this topic, experimental designs are difficult to conduct and may not be representative of populations that experience structural racism, making observational studies the most common study design when researching this topic.

Socioeconomic Factors as an Indicator of Mental Health Outcomes

Socioeconomic factors, such as income, education, occupation, place of residence, and race were found to be indicators of mental health outcomes for black Americans.

Black Americans are more likely than white Americans to reside in high poverty areas, and neighborhoods that have higher poverty rates are more segregated with a higher proportion of black residents (Do et al., 2019). Additionally, psychological distress is more prevalent in neighborhoods that have higher rates of poverty and are more racially segregated (Do et al., 2019). Black Americans with less than 12 years of formal education are more likely to report engaging in suicide ideation or attempting suicide than black Americans that have more than 12 years of education (Joe et al., 2014). Cultural competency was also found to be important for people who have low-income. Respondents who had higher rates of poverty were more likely to report wanting to see providers who were more culturally competent (Eken et al., 2021).

Race was found to be a significant predictor of mental health outcomes. A study observing women in college found that black students had higher levels of perceived stress, as well as higher levels of depression, compared to white students (Longmire-Avital & Robinson, 2018). Considering the recent COVID-19 pandemic, black healthcare workers (HCWs) may also experience an increase in occupational stress levels. A cross-sectional study that examined the relationship between racial and ethnic differences and depression/anxiety during the COVID-19 pandemic found that black HCWs had higher levels of depressive symptoms than white HCWs (Nguyen et al., 2022).

Structural Racism and Mental Health Outcomes

Structural racism is deeply embedded in institutions and social systems and can impact the ways in which individuals view their own race, producing internalized racism. In a study conducted by Mouzon and McLean (2017), U.S.-born black individuals and Caribbean-born black individuals were surveyed to observe the relationship between racism and mental health. They found that U.S. born participants were more likely to report their racial group as being lazy, giving up easily, being violent, and being less-hard working than Caribbean-born individuals (Mouzon & McLean, 2017). Additionally, it was found that these measures of internalized racism were associated with higher levels of depression (Mouzon & McLean, 2017). Similarly, a study conducted in predominantly black neighborhoods in New York City found that participants who did not think about their race reported lower levels of perceived racism yet had the highest levels of negative mental health outcomes (Kwate & Goodman, 2015). Chronic discrimination can alter personality traits, such as increased neuroticism and decreased conscientiousness, compared to no changes in these traits for individuals that did not experience chronic discrimination (Sutin et al., 2016). Experiencing chronic discrimination for long periods can also lead to adverse mental health outcomes. Black women in their 20s and 30s were at a higher risk for depressive symptoms if they experienced chronic racism from their childhood into adulthood (Quist et al., 2022).

Disenfranchisement is an additional product of structural racism when considering incarceration in the United States. A study examining the association between felony disenfranchisement and health among different racial groups found that black Americans were disproportionately disenfranchised in every state, and higher levels of disenfranchisement were associated with higher levels of depressive symptoms (Homan & Brown, 2022).

Nadal et al. (2014) utilized a racial and ethnic microaggression scale (REMS), consisting of six subscales, to determine if experiencing racial microaggressions is associated with mental health. These subscales included assumptions of inferiority, second-class citizen and assumptions of criminality, microinvalidations, exoticization and assumptions of similarity, environmental microaggressions, and workplace and school microaggressions. Black participants had higher average REMS scores than white participants, and these scores were found to significantly predict depression scores (Nadal et al., 2014).

While microaggressions may be commonly experienced by black Americans, major discrimination can be more overt instances of structural racism. A study conducted by Jeffers et al. (2021) in Nashville, Tennessee aimed to evaluate the relationship between experiences of major discrimination, depressive symptoms, and chronic conditions. Black participants reported common experiences of major discrimination and higher levels of depression compared to white participants (Jeffers et al., 2021).

Since the death of Georgy Floyd in 2020, police violence has been at the forefront of conversations involving racial discrimination. Law enforcement in the United States kills civilians more than three times as often as other wealthy countries (Jones & Sawyer, 2020). To assess the relationship between police violence and mental health symptoms, Devylder et al. (2018) surveyed residents in Northeastern states and found that communities of color had higher rates of police violence, as well as higher psychological distress, suicidal ideation, suicidal attempts, and psychotic experiences (DeVylder et al., 2018).

Racial Disparities in Mental Health Service Access & Utilization

Many studies within this review examine the association between structural racism and mental health outcomes, however it is also crucial to assess the availability and access to mental health services for people of color to help mitigate these adverse mental health outcomes.

Seeking mental health care may act as a barrier on its own. Alang et al. (2019) examined how racism impacts unmet mental health care needs for black Americans and found that participants reported experiencing a double barrier: both being black and having mental illness. These participants also reported not receiving mental health care because of institutional mistrust, racial microaggressions, and experiencing accessibility barriers (Alang, 2019).

In a national survey, black participants who reported suicidal ideation or suicide attempts had lower percentages of receiving mental health services and a higher likelihood of not knowing where to go to receive mental health services (Bommersbach et al., 2022). Traumatic events, such as the murder of George Floyd and the COVID-19 pandemic, may also exacerbate mental health service disparities. In a cross-sectional study conducted by Thomeer et al. (2022), researchers found that black respondents were the only racial/ethnic group to report an increase in depression and anxiety around the time of the death of George Floyd. Black participants also reported an increase in depression and anxiety after the pandemic, and they experienced more unmet care needs and receiving less mental health care than white respondents (Thomeer et al., 2022).

Having access to mental health services does not always indicate proper treatment. In a clinical trial, researchers examined differences in clinician's diagnosis of mental health disorders based on race and expression of symptoms. Within this study, there were four video presentations of mood disorders and culturally expressed depressive symptoms. Each clinician

was shown a video of a black actor exhibiting symptoms of a mood disorder and symptoms of culturally expressed depression, as well as white actor with a nearly identical script. 97% of clinicians accurately identified a mood disorder for the video with a black patient, but only 63% accurately identified culturally expressed depression for the same patient, indicating that race and symptom expression can lead to misdiagnosis of mental health disorders (Payne, 2012).

Experiencing racism in a healthcare setting can also impact the consistency of mental health care treatment. Black patients that reported experiencing discrimination during a mental health care visit were 13 times more likely to stop treatment early compared to white patients (Mays et al., 2017). Race can also impact patient mistreatment in clinical settings. Black patients who presented with psychiatric disorders in an emergency setting were found to receive chemical sedation more often than white patients. This was significant for black patients admitted to emergency departments that had a high proportion of other black patients (Khatri et al., 2022). Additionally, a retrospective cohort study found that the length of stay for black patients with mental illness was significantly higher than white patients, regardless of mental illness being perceived as serious or not (Adepoju et al., 2022)

DISCUSSION

Understanding structural racism and its influence on populations is a difficult task, however analyzing experiences of racism and connecting it to the prevalence of mental health issues can provide insight on how this system can create a burden of mental health disparities. This literature review examined how structural racism can impact the mental health, as well as the utilization and access of mental health services, for black Americans.

The first overarching finding was that there were similarities in socioeconomic factors and that these factors were often indicators of mental health outcomes. These factors include

race, income, occupation, education, and place of residence. Doe et al. (2019) found that black Americans are more likely to reside in lower income and more racially segregated neighborhoods, and that these factors were associated with higher levels of psychological distress. One explanation of these distressing outcomes may be that violent crime rates are often higher in less privileged neighborhoods (Schleimer et al., 2022), and these crime rates can increase the risk of insufficient sleep and psychological distress (Kim et al., 2022)

Longmire-Avital & Robinson (2018) found that black students have higher levels of stress and depression compared to white students (Longmire-Avital & Robinson, 2018). Similar observations have found that black students who experience occupational stress have an increased risk for anxiety, and students who have higher levels of financial stress often have more experiences of individual racism (Lee et al., 2016). These findings indicate that income may act as a mediator for racism and mental health outcomes among black students.

The second overarching finding was that structural racism impacts mental health outcomes for black Americans. Experiencing racial discrimination and microaggressions is associated with a significant increase in depressive symptoms (Jeffers et al., 2021; Nadal et al., 2014). This may be explained because black Americans are more likely to have higher levels of heightened vigilance–a state of psychological arousal–than white Americans, which is often a result of experiencing racism (LaVeist et al., 2014). Additionally, vigilance increases the risk for depressive symptoms (LaVeist et al., 2014), describing how this heightened arousal, due to experiences of racism, can lead to depression.

Mental health disparities are more prevalent among black Americans who exhibit characteristics of internalized racism (Kwate & Goodman, 2015; Mouzon & McLean, 2017). A similar study found that individuals who agree with negative stereotypes about their own race

report higher levels of anxiety (Sosoo et al., 2020). Validating negative beliefs and stereotypes about one's own race may indicate individual vulnerability, and therefore the acceptance of these stereotypes upon oneself, which can be a result of experiencing racism on a structural and institutional level (Sosoo et al., 2020).

The third overarching finding was that there are many racial disparities in accessing and utilizing mental health services. Stigma around receiving mental health care in black communities is important to consider. Alang et al. (2019) found that black participants reported having mental illness as a barrier to receiving mental health care (Alang, 2019). This may be explained in part because of a lack of trust in receiving adequate care. Emergency settings that treat more black patients than white patients are more likely to chemically sedate black patients presenting with psychiatric disorders (Khatri et al., 2022), and hospital length-of-stay was longer for black patients, regardless of the severity of mental health presentation (Adepoju et al., 2022). Mistrust in medical professionals is not without merit; Black Americans are more likely to be misdiagnosed for mental illness (Bell et al., 2015), and have historically been exploited through experimental medical practices such as eugenics (Ko, 2016).

An additional explanation for black Americans not receiving mental health care is their use of alternative treatment options. One-third of survey respondents who reported attempting suicide also reported going to religious or spiritual advisors rather than mental health specialists (Joe et al., 2014). Black Americans are one of the most religious racial/ethnic groups in the United States, with 87% identifying with a specific religious affiliation (Sahgal & Smith, 2009), so many black Americans may rely on their faith and spirituality to treat mental health. Black Americans are also less likely than white Americans to perceive a need to seek mental health

care (Villatoro et al., 2018), which may result in a delay to treatment until symptoms are severe and require more intensive care.

Black Americans may also face difficulties in accessing care due to lack of health insurance coverage. Despite the implementation of the Affordable Care Act (ACA) in 2010, which provided more health insurance coverage for Americans, black Americans continue to face disparities in insurance coverage and are less likely to be insured than white Americans (U.S. Department of Health and Human Services, 2022).

Limitations

There are several limitations within this study that must be addressed. The most prominent limitation is that the search process of this review may be subject to selection bias. Each search was filtered by subject, which excluded many articles that may have contributed towards the conclusions. This review also utilized 20 research articles from six online databases, which limits the findings on this topic. Research on alternative databases may have contributed to or altered the findings of this review.

Much of the research used was observational in nature, which prevents the establishment of causative relationships. Additionally, 19 of the 20 studies used survey data, which is subject to recall bias and response bias, especially when considering the nature of questions surrounding mental health and mental illness.

Another limitation is the sample sizes and demographics within the research being reviewed. Research on populations that may be experiencing poor mental health due to structural racism, such as the incarcerated population, were not included in this study, which may cause results to lack generalizability and external validity.

Additionally, structural racism is complex and can be presented in different ways and through different institutions, making it difficult to identify and control factors that contribute towards racism and its impact on mental health and healthcare services. The use of observational data results in a lack of consistent definitions and measures across research, which can affect the reliability of the results observed.

Finally, this review mainly focused on depression and anxiety as mental health outcomes, so it is unknown whether structural racism may impact mental health outcomes other than depression and anxiety. Further research is needed to determine the relationship between mental health outcomes that were not included in this review.

Implications of Research

There are several implications after reviewing research. Racial minorities are overrepresented in the incarceration system (Bommersbach et al., 2022), so future research should include the incarcerated population in study samples to see the impact of structural racism on mental health for the entirety of the U.S. population. Additionally, policies that allow racism to survive in our institutions, such as redlining and disenfranchisement, should be considered as topics for future research to assess how structural racism can prevent black Americans from accessing services, especially ones that may impact mental health or are necessary to improve mental health.

Quasi-experimental studies are needed to demonstrate causality between structural racism, mental health outcomes, and access to and use of mental health services for black Americans. Additionally, longitudinal studies would be useful in evaluating the onset and long-term effects of structural racism and how it may impact mental health outcomes and treatment.

Conclusions

This literature review examined structural racism and its impact on mental health and mental health services and access for black Americans. The research within this review found that structural racism impacted negative mental health outcomes and decreased accessibility and utilization of mental health services. It was also found that SES and environmental factors contributed towards mental health.

Addressing the impact of structural racism on mental health in black Americans is necessary to reduce disparities and increase access and use of mental health services. Policy change is a potentially effective way to reduce discriminatory practices that perpetuate economic, political, and social inequalities. Additionally, increasing insurance coverage and lowering the cost of care can aid in providing better access to mental health treatment. Lastly, cultural competency training in occupational and healthcare environments may reduce experiences of discrimination and institutional mistrust, which can decrease the prevalence of mental health disparities as well as increase utilization of mental health services.

Changing the history of racial discrimination and oppression is not a feasible solution, however, identifying ways in which the impacts of structural racism can be alleviated may potentially improve the mental health of black Americans.

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