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Facing our Fears:
Examining Barriers to Seeking Mental Health Services within BIPOC Communities

By Parris J. Baker
and Adrienne Dixon
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"Pain that is not transformed gets transmitted."[1] Untreated trauma is transformed, transferred, and transmitted. There have been many institutional and individual barriers constructed to prevent members of BIPOC communities from accessing and utilizing existing mental health services. The Human Genome Project[2] recently completed its comprehensive research begun in 2003 and confirmed what the medical and social science associations have known for far too long: Humans are 99.9 percent identical at the genetic level. Therefore, there is no genetic explanation for the utilization of race as a criterion for the determination of health, illness, and medical intervention. Race is a social convention created to rationalize and defend the racist ideologies of segregation, oppression, and the enslavement of African people.

Before antebellum America (1812-1861), medical and scientific racism and the inhumane and unethical treatment of people of color with mental illness was present but wasn't well documented. The medical histories of enslaved people, immigrants from southeastern Europe, and other BIPOC groups were purposely excluded from medical journals, not validated by medical practitioners, and not believed by the white public.

Historic explanations why disparities in mental health care may still exist

John Galt, M.D., was director of the Eastern Lunatic Asylum from 1841 to 1862. He hypothesized and promoted the theory that enslaved Black people were immune to mental illness because they didn't own property, engage in commerce, or participate in civic activities such as voting, attending school, or holding a public office. The threat of mental illness could be mitigated in Black people by limiting their exposure to affluent white men and the stress associated with economic prosperity – or so it was argued.

Samuel Cartwright, a pro-slavery physician, practiced medicine in Mississippi and Louisiana from 1851 to 1863. Dr. Cartwright made up two mental maladies known as drapetomania and dysaesthesia aethiopica (rascality), both attributed exclusively to Black people. He also used scriptures to support his absurd position that the Negro was born to be enslaved. Considered an expert, Dr. Cartwright's work helped cement the association between slave rebellion and mental illness. He was referred to as the Professor of Diseases of the Negro. Drapetomania was defined as a mental illness that caused enslaved Blacks to flee captivity. Dysaesthesia was a mental illness used to explain laziness, lesions on the skin, and intellectual dullness. The cure for both conditions was whipping.

The Tuskegee Study of Untreated Syphilis in the Negro Male[3] operated from 1932 to 1972. Six hundred Black men (399 diagnosed with syphilis and 201 did not have syphilis) were recruited to participate in a medical treatment program for "bad blood (syphilis)." The primary objective of the study was to observe the history of untreated syphilis until treatment or death. In 1947, penicillin was discovered to cure syphilis, yet the vaccine was withheld from both groups. The men were never told the name of the study, its purpose and they received no proper informed consent.

Psychologist Richard Herrnstein and politcal scientist Charles Murray wrote the controversial book "The Bell Curve: Intelligence and Class Structure in American Life." The authors erroneously concluded a strong correlation exists between intelligence quotient and social class, that racial differences in IQ are due partially to genetic environmental factors, and subsequently submitted policy recommendations, such as the elimination of welfare programs that they believed encouraged pregnancy.

In 2006, the U.S. Congress dedicated July as National Minority Mental Health Awareness Month[4] to bring national attention to the mental health experiences within the Black, Indigenous, People of Color, and BIPOC communities. Two years later in 2008, September was declared National Suicide Prevention Awareness Month. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, act, relate to others, and make choices.

Focusing on mental health in various BIPOC communities can be a slippery proposition. The fear and threats of personal harm, discrimination and the promotion of misinformation have led to negative perceptions of mental health issues and foster feelings of shame, guilt, and isolation. The historical and many times horrific lived experiences of BIPOC groups at the hands of trusted white physicians and psychiatrists have been characterized by trauma, unethical treatment, and violence.[5]

According to the Health and Human Services Office of Minority Health, African Americans are 20 percent more likely to experience serious mental health problems than the general population and 1 in 5 adults live with a chronic mental illness. These issues are treatable and often preventable. However, resources and access may be limited. Black individuals are more likely to be uninsured and less likely to seek and receive treatment for their mental health conditions.

Though addressing mental health in BIPOC communities is a touchy subject, it is critical that we get beyond the stigma and maximize strength-based resources and interventions such as those more readily engaging the faith-based community. Protective factors and strengths among African Americans include strong extended family and community connections, religious and spiritual grounding, resourcefulness, and social and familial support resilience to deal with societal issues and positive ethnic identity (Caldwell-Colbert et al., 2009).

Some of the barriers that prevent or inhibit help-seeking behaviors in BIPOC communities are remnants from the past practices and perceptions of medical communities. Other barriers are protective strategies employed by BIPOC communities to prevent further harm and unethical treatment. Below are some of the coping strategies, adaptative and maladaptive, that are utilized by members of BIPOC groups:

It's Just 'the Blues.' This Too Shall Pass

African Americans may not identify symptoms of mental health and are more likely to shrug it off as having "the blues" as noted by the Alliance for Minority Mental Health. This may reflect the ongoing stigmatization of identifying with a

mental health disorder and may dismiss the seriousness of the signs out of fear, denial, alienation, and shame.

Pray! Your Faith Will Make You Whole

Religiosity and spirituality are protective factors and a great source of strength for BIPOC communities (Diamant, 2021). Additionally, spirituality serves as a particularly protective factor for LGBT African Americans; it is related to lower depression and increased social support (Lassiter et al., 2019). While help-seeking behaviors are affected by mistrust of the medical system, they can be positively mitigated with faith-based outreach. Thus, understanding the spiritual worldview of BIPOC clients can present as a challenge for helping professionals who do not share the lived reality of culturally diverse clients (Muran, Eurbanks, & Samtag, 2020; Smith & Trimble, 2016).

Faith coupled with prayer and professional support is a powerful resource. No one says, “Oh, this cancer will pass on its own!” Mental health concerns are treatable and need just as much concern and care as our physical health. Jesus plus therapy is a good mental health intervention.

BIPOC Women: They Don’t Get Depressed. They Keep it Pushing

Sadly, BIPOC women have been socialized that it’s the expectation of women to just grin and endure. Black women experience unique forms of racism and related challenges because of their multiply oppressed identities, two of which are gendered racial microaggressions and adherence to the perception of the strong Black woman or “Black superwoman.” BIPOC women are hailed for their strength and ability to withstand tremendous adversity.

The Black super woman stereotype portrays Black women as unaffected by life's troubles and these expectations can be at the cost of their mental health (Sue, D. W. et al., 2022). BIPOC women who subscribe to this feel as though they must appear strong, suppress their emotions, resist being vulnerable, and place others’ needs before their own (Woods-Giscombe, 2010). While this narrative may have been needed to help BIPOC women cope with stressors, embracing these stereotypes can undermine their psychological and physical health.

Black and Brown Folks Don’t Commit Suicide

According to the Center for Disease Control and Prevention (CDC)[6] there were 49,449 suicides reported in 2022. For individuals ages 10 to 24 suicide is the second-leading cause of death. Suicide rates were higher for males than females, though a precipitous increase in the incidence of suicide with females has been observed. The highest rates of suicide are reported among non-Hispanic American Indians and Alaska Natives (28.1 per 100,000, age-adjusted) followed by African Americans (19.2).

In 2021, of the reported 45,222 gun-related deaths in America, approximately 54% (24,292) were suicides.[7] The Center for Disease Control and Prevention reports that rates of suicide caused by the use of firearms have reached record levels. African Americans are more likely to have feelings of sadness, hopelessness, and worthlessness than their white counterparts, and Black teenagers are more likely to attempt suicide than white teenagers. Many who survived past attempts include celebrities such as Halle Berry, Fantasia, and Oprah Winfrey and all found the courage to share their stories with the hope of breaking the stigma cycle.

Therapy Is for the Other Folks

We were carefully taught to keep what goes on in our home in the home and that it's nobody's business outside the family. Often the BIPOC community deals with a range of issues such as trauma, grief, anxiety, depression and the fear that others will see them as weak and unable to handle their own problems. However, silence creates greater vulnerability and compounds the struggle. There should not be shame in needing or asking for help.

There are several innovative initiatives reflective of BIPOC culture that are designed to break through the stigma surrounding mental health and wellness in BIPOC communities. One such effort is The Confess Project, founded in 2016 by Lorenzo Lewis. It is America's first barbershop mental health movement committed to building a culture of mental health by training barbers to be mental health advocates. This framework is not a substitution for the skills of credentialed mental health professionals. However, it can make a meaningful difference by identifying mental distress and connecting clients to professional care. This is one of several creative resources that acknowledge and actively seek to debunk the negative myths about mental health and treatment.

The therapeutic needs in BIPOC communities are numerous and demand increased attention. The onset of Covid-19, partnered with other social determinants of health have heightened the necessity of creating and implementing innovative methods to reach people suffering with mental illness and chronic mental health issues. More public health education, an increased number of BIPOC mental health professionals, and teaching the history of medical malpractice, unethical treatment, and physical and psychological abuse experienced within BIPOC communities regarding mental health and wellness are needed.

Together we can reduce the stigma of seeking psychological help, bringing awareness to the stigmatizing language around mental illness. There remains a need to educate family, friends, and colleagues about the unique challenges of mental illness and mental health care provision within the BIPOC community.

Each one of us can make a difference if we face our fears. The fear of rejection, of making a mistake, of offending another, of making a fool of oneself, of showing apathy are all incredibly powerful inhibitors to meeting our clients, our patients, our family and friends, our brothers and sisters in humanity. While we work diligently at reducing barriers for the BIPOC community, don't forget to work the barriers within ourselves.

[1] Richard Rohr is an author and American Franiscan priest. He was ordained in the Roman Catholic Church in 1970.
[2] National Institute of Health. National Human Genome Research Institute. The Human Genome Project. https://www.genome.gov/human-genome-project
[3] The Tuskegee Study is now referred to as The United States Public Health Service Syphilis Study at Tuskegee. https://www.cdc.gov/tuskegee/timeline.htm
[4] July is Bebe Moore Campbell National Minority Health Awareness Month also known as BIPOC Minority Mental Health Month. https://www.mhanational.org/bipoc/mental-health-month
[5] Mental Health America: Black and African American Communities and Mental Health. https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health. For further information read Baker, P.J., Mock, C., Cuneo, P., Horton, G., Sherrod, J. & Speggen, Be. (2020). Faith, Fear, and Facts: African Americans, Vaccinations and the Fierce Urgency of Now for BIPOC Communities. Jefferson Education Society. Erie, PA. https://www.jeserie.org/uploads/Faith%2C%20Fears%2C%20and%20Facts.pdf
[6] Center for Disease Control and Prevention. Suicide Data and Statistics. https://www.cdc.gov/suicide/suicide-data-statistics.html
[7] Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/firearms/fastfact.html. Gramlich, J. (February 3, 2022). What the data say about gun deaths in the U.S. *The Pew Research Center*. https://www.pewresearch.org/short-reads/2022/02/03/what-the-data-says-about-gun-deaths-in-the-u-s/

ABOUT THE AUTHOR

Dr. Parris J. Baker is an Associate Professor at Gannon University, where he is the Social Work, Mortuary Science and Gerontology Program Director. An alumnus of Gannon, Baker received his graduate degree from Case Western Reserve University, Jack, Joseph, & Morton Mandel School of Applied Social Sciences and his doctorate from the University of Pittsburgh, School of Social Work. Presently, Baker serves as the Senior Pastor of Believers International Worship Center, Inc. He is married and has five children.

Dr. Baker can be reached at: baker002@gannon.edu.

ABOUT THE AUTHOR

Adrienne Dixon is president and chief executive of Sarah A. Reed Children's Center and is on the faculty at PennWest University in the counseling program. Dr. Dixon holds a master's degree in counseling and a Ph.D. in counseling psychology from Gannon University. She has over 35 years of clinical experience as a counselor, educator, and administrator.

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