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Defining suffering : African American young men and conduct disorder

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ABSTRACT

This paper will discuss the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder. Existing research attributes this disproportionality to a variety of factors but does not incorporate historical or social analysis. This project will endeavor to consider how the historical and enduring stereotype of black men as "criminal" impacts this diagnosing pattern, and explores alternate ways to define and treat behavioral symptomology among young black men. This paper will discuss how stereotypes as well as the fear of being stereotyped impact both client and clinician and affect their interaction, thereby influencing psychological assessment and diagnosis. This paper will also argue that in general clinicians may not adequately account for the environment with which African American young men contend, and that historical and ongoing oppression must be considered in the assessing and diagnosing process. The way in which a client's problem is defined leads to specific treatment, and thus it is necessary to explore varying ways to define the problem that manifests in behavioral symptoms for African American young men. This analysis will aim to examine the ways in which slavery and its legacy impact psychological assessment and diagnosis today, and how diagnosing clinicians may inadvertently contribute to the criminalization of young African American men when assigning Conduct Disorder diagnoses. The purpose of this project is to encourage social workers to critically consider the ways in which they define the healing and suffering of their clients.

DEFINING SUFFERING: AFRICAN AMERICAN YOUNG MEN AND CONDUCT

DISORDER

A project based upon an investigation, submitted in
partial fulfillment of the requirements for the degree
of Master of Social Work.

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2014

ACKNOWLEDGEMENTS

So many people made this project possible. First, I would like to express my deep appreciation for Robin, my thesis advisor, for her consistent support and encouragement throughout this process. Her unwavering trust in me was invaluable, and her antiracist analysis added significantly to this paper. My great gratitude also goes to Heather Macdonald, PhD, who volunteered her time to help guide this project. Her passion fueled my own, and her extensive research and knowledge gave me academic grounding for my interests and ideas. I could not have completed this project without the support and guidance of these wise teachers. Thank you.

I am so grateful for the many people who have supported me in body, mind and spirit. I would like to thank my supervisor, Susan, for teaching me more than I even know and for believing in me. I am grateful for past supervisors who have greatly shaped my thinking: Richie and James. And to Jerry, who has showed me that it is possible to make real change in the world. A huge thanks to the many people who gave me the strength to finish this project: to my family and to so many supportive friends.

Finally, I am profoundly grateful for the many people I have worked with, the clients who have meant so much to me, who have touched me deeply, who I will never forget. You inspire me.

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CHAPTER I

Introduction

On a bright Tuesday morning, sitting on a tall stool in a local café where I completed the majority of the research and writing for this paper, I looked out of the window onto the streets of a gentrifying neighborhood in Oakland, California. Tuning out the world, I immersed myself in Michelle Alexander's (2012) critical analysis of Jim Crow and mass incarceration, and in my own thoughts about African American young men with behavioral symptoms and the treatment (or lack thereof) that they are able to access. On this particular morning, as I typed a note onto the screen of my computer, I vaguely registered somebody standing behind me. Thinking it was likely a friend-- as he stood close enough that I could feel the heat from his body-- I turned around slowly, unconcerned. Time slowed to a dreamlike crawl as I watched the unknown young man reach around me, grab my computer, and dash out the door. Before he ran I saw his face for just an instant: he looked young, perhaps fifteen or sixteen, black, and male. In the disoriented moments that followed I ran after him, thinking only of the writing I had done and my need to save it, while four other men from the café (all white like myself) joined the chase. I began to wonder what I would do when I caught up, for although young, the man with my computer was considerably larger than me, and I was not interested in a physical fight. As I slowed, the other white men from the café sped up, gaining on him. A quick tussle, and the young man with my computer dropped it on the ground and continued to run, bee-lining for a car that screeched to a halt in the middle of the street, the passenger door open wide. As he dove

into the car, one of the men from the café grabbed his arm, attempting to hold him back. From half a block away I watched this sequence, cradling my computer in my arms, heart pounding, relieved that I had not lost the day's writing. I could see the scene as one of the three young, black men involved in the robbery pulled out a gun and pointed it in the direction of their pursuers. I watched as the white men stepped back and as the three young black men sped off, no shots fired.

Once back at the café, adrenaline pumping and body buzzing, I thanked the white men who had helped me recover my computer. I sat back down in my chair, breathed, and watched as the police arrived within minutes (unusual for Oakland) and began to take statements. One of the white men eventually approached me.

"They want to talk to you," he said, pointing to the two policemen outside. Thoughts filled my head about the impact of a juvenile or criminal record on the lives of the young men who just attempted to steal my computer, and, feeling confused and overwhelmed, I gathered my things and left the café without speaking to the police.

In the weeks that followed I went over this experience in my head repeatedly, wondering if my decision not to involve the police would have a positive or negative impact. Although my statement was ultimately irrelevant-- as the young men stole a computer from someone else as well and several other people in the café made statements-- I questioned my choice. I considered the severity of what happened and the real potential that someone could have been hurt or even killed, given the presence of the gun. I continually wrestled with several challenging and interrelated issues: while the options for treatment for young African American youth with behavioral symptoms may be limited and the consequences of a juvenile or criminal record are great, teenagers running around with guns is a recipe for continuous suffering, injury, and death.

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There must be a way, I thought, for the health, education, and justice systems to improve the current method of intervention and treatment in a way that would support the healing and safety of all members of the community. There must also be a way to prevent such desperate actions before they occur, with the help of structural change that would allow for more equal access to opportunity and resources. The answer to this problem could not be to simply do nothing, as then nothing changes. However, I was not satisfied with the existing options for intervention, which was the basis for my hesitance to involve the police.

My experience that morning, occurring in the midst of this project, eerily and perfectly highlighted one of the central questions of this paper: which factors contribute to the behavioral issues (and/or the perception of behavioral issues by those in power) of African American young men, and what can be done to ameliorate those factors? As a Social Work student, this thesis is my attempt to answer this question in a realm in which my profession has significant power: that of the assessment and diagnosis of young, African American men with behavioral symptoms.

African American young men are currently disproportionately overrepresented among those diagnosed with Conduct Disorder. Conduct Disorder is a DSM-IV-TR (2000) diagnosis that describes a pattern of disturbance in behavior that causes clinically significant impairment in social, academic or occupational functioning. This diagnosis is associated with clinical stigma, and is one of the most frequent diagnoses given within the juvenile justice system (Drerup, Croysdale, & Hoffman, 2008; Mizock & Harkins, 2011; Teplin et al., 2002).   The revisions to the criteria for Conduct Disorder in the DSM-5 are minimal, and will be addressed briefly in Chapter 6. As the DSM-5 was only recently released in May of 2013, the research reviewed in this paper is limited to the Conduct Disorder criteria as listed in the DSM-IV-TR (2000).

Existing research, to be presented in Chapter 2, clearly establishes that African American young men are disproportionately overrepresented among those given this diagnosis. The researchers present various hypotheses about the causes of this phenomenon and propose potential solutions; I aim to expand upon both in this paper. In sum, I argue that the high rate of Conduct Disorder diagnoses among African American young men may be the result of the impact of stereotyping, of clinicians' implicit bias, and of clinicians' lack of adequate accounting for historical and environmental factors during psychological assessment and diagnosis.

Gaps in the Literature

While research on the disproportionate overrepresentation of African American young men diagnosed with Conduct Disorder is extensive, analysis related to the social and historical context of African Americans in the United States is missing. Furthermore, a majority of the reviewed research does not define terms specifically, making results less meaningful and generalizable. For example, populations are poorly defined in the reviewed literature (with two exceptions), as researchers do not state how they determine the race of participants or whom they count as "African American," or "black." At times the terms "African American" and "people of color" are used interchangeably, further compromising analysis. This paper aims to elucidate important definitions around populations and subjectivity, and outline conceptual frameworks. This paper also intends to expand upon existing thought about possible causes of this phenomenon and provide a missing perspective by combining clinical theory with historical and social context.

Connection to the Field of Social Work

Social workers are frequently in the position of diagnosing young African American men, and thus the phenomenon of disproportionate overrepresentation of African American young

men diagnosed with Conduct Disorder can be seen as a direct result of our work. This paper explores our responsibility to critically reflect upon the way in which we engage with clients and communities and how we conceptualize their suffering and healing. Furthermore, the Social Work profession is based upon the concept of the "person-in-environment," in which social workers aim to improve the lives of individuals and society, as well as the relationship between them (Buchbinder, Eisikovits, & Karnieli-Miller, 2004). The "environment" does not occur in isolation; rather, it is a product of history and oppression, as well as current laws, policies, and practices that are essential to understand when assessing and diagnosing. Thus Social Work, with its Person-In-Environment approach, offers an ideal framework to incorporate historical and social analysis into the consideration of psychological assessment and diagnosis.

Why does it matter?

First, the fact that research demonstrates that African American young men are continually disproportionately overrepresented among those diagnosed with Conduct Disorder immediately demands further investigation into the causes of this phenomenon, and an expansion of existing analysis. A Conduct Disorder diagnosis can have concrete and potentially serious impact in the life of an African American young man. Chapter 3 will discuss in more detail the varying social consequences of this diagnosis, ranging from lack of needed access to treatment to more punitive outcomes within the court system (Mizock & Harkins, 2011; Petrila & Skeem, 2003). Furthermore, as will be discussed in Chapter 6, the way in which a problem is defined (e.g. the diagnosis) directly impacts treatment (or lack thereof), and thus the process of defining the suffering of others-- as is the work of clinicians-- warrants thorough and thoughtful consideration. Additionally, it is a worthwhile enterprise to consider the overall philosophy that social workers hold towards defining the suffering and healing of their clients. The DSM-IV-TR

(2000) and DSM-5 (2013) represent one specific window into understanding a person's suffering, oriented towards the individual. While sometimes useful, this approach does not provide much room to consider the suffering of a community in historical context. This paper thus considers the validity and utility of a Conduct Disorder diagnosis for many African American young men, and critically evaluates the ways in which clinicians diagnose and engage with clients and community.

Stereotype Threat and Historical Analysis

In order to expand upon existing research and theory about the reasons for the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder, I borrow from the thoughts of three researchers: Claude Steele (2010), Michelle Alexander (2012), and Dr. Joy DeGruy (2005). Claude Steele's (2010) theory of Stereotype Threat holds that an individual's performance is altered and impaired when one feels under threat of being stereotyped. I use this theory in order to explore how stereotypes and prejudice may affect young African American male clients during psychological assessments, and how this likely impacts diagnosis. I then look at the history of the creation and maintenance of the stereotype of black men as "criminal," using Michelle Alexander's (2012) *The New Jim Crow*. I discuss how the stereotype of black men as "criminal" may impact Stereotype Threat, implicit bias, and current diagnosing patterns. I also examine environmental and political factors that affect many young African American men, such as intergenerational trauma and lack of access to opportunity, and argue that these issues warrant great consideration in the assessment process. Finally, I use Dr. Joy DeGruy's (2005) book, *Post Traumatic Slave Syndrome,* to explore alternative explanations for behavioral symptoms in African American young men.

In the following chapter I will define key terms and outline the theoretical orientation and methodological approach to this paper. Chapter 3 will provide a summary of past and current research and literature relating to the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder. Chapter 4 will discuss Claude Steele's (2010) theory of Stereotype Threat in more depth and look at the history of the theory, its principles, and empirical studies that support it. I will also begin to apply this theory to African American young men in the context of psychological assessment. Chapter 5 will look at the social and historical context of African American people in the United States through the lens of Michelle Alexander (2012) and specifically focus on the creation and maintenance of the stereotype of African American men as "criminal." Here I will also discuss Joy DeGruy's (2005) concept of "Post Traumatic Slave Syndrome" and consider how these two approaches apply to the psychological assessment of African American young men. Finally, in Chapter 6 I will synthesize the three perspectives in order to present how they may help us to better understand the reasons for the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder. I will also discuss limitations to this paper, and consider the implications of this analysis for future social work practice, theory, and research.

CHAPTER II

Methodology

Clinicians are trained to conduct psychological assessments and to assign DSM-IV-TR (2000) diagnoses to clients in order to define the problem (the suffering), and then often to also identify treatment that will support the client's healing. As the NASW Code of Ethics states:

> The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.
>
> (NASW, 2008)

In order to abide by the code of ethics, social workers are thus strongly encouraged to incorporate analysis of the environment and its impact on the client into assessment and treatment. The disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder, however, could be seen to indicate that clinicians (of all professional affiliations) are not adequately accounting for the social and historical environment during the assessment and diagnosing process. This study discusses the theory of Stereotype Threat (Steele, 2010) in order to expand analysis about the impact of stereotypes on assessment and diagnosis. It also utilizes Alexander's (2012) and DeGruy's (2005) perspectives on the

impact and legacy of slavery on African American young men in order to trace the trajectory of history into the present moment and in so doing broaden the factors that should be included when considering a client's current environment.

Definition of Terms

In a theoretical exploration of a phenomenon that is based upon demographic markers related to race and gender, it is essential to acknowledge the subjective nature of these descriptors and to present operational definitions. To write about an African American young man without defining terms is to make a number of implicit and unjustified assumptions about a common understanding of ambiguous and context-specific concepts. Yet the majority of the researchers of the reviewed literature fail to define who counts as "African American" or "white" in their studies, thereby compromising the utility of their results as well as reifying unscientific and non-specific definitions of race. For the purposes of this paper and due to lack of alternatives, I will still use this research despite this limitation. I will attempt to use the language that the researchers use in their own work when presenting their findings. However, to avoid the repetition of imprecise methodology, I will now discuss in more detail an operational definition of "African American" or "black" in the United States as used in my analysis.

"African American," "Black," and the One-Drop Rule

The concepts of "African American" or "black" have unique meaning in the United States, although this is often unacknowledged (Davis, 1991). Davis (1991) outlines the history of how blackness has been defined in the United States, beginning with the "one-drop rule": the South's assertion during slavery and Jim Crow that "one drop" of black blood makes a person black (p. 5). The one-drop rule has been repeatedly upheld in U.S. courts of law, including the case of *Plessy v. Ferguson* (163 U.S. 537) in 1896. In this case, Homer Plessy argued that

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because he was only one-eighth "Negro" and could pass as white, he should be able to ride in the train seats reserved for whites. The Supreme Court threw out this claim based on "… 'judicial notice' of what it assumed to be common knowledge: that a Negro or black person is any person with any black ancestry" (Davis, 1991, p. 8). Courts of law have repeated this finding over the past century, and in 1970 Louisiana created a statute defining a black person as someone whose ancestry was more than one thirty-second black (Davis, 1991). Importantly, a Louisiana state Fourth Circuit Court of Appeals noted during a case that "…'individual race designations are purely social and cultural perceptions…' (479 So. 2d 372)" (as cited in Davis, 1991).

The ongoing judicial confirmation that the one-drop rule still stands and that racial categories are not based on science leads to vague and sloppy definitions of race in varying contexts in the United States, including within academic research. Davis (1991) argues that because the category of "black" has a specific status position in society, "…it has become a self-conscious social group with an ethnic identity" (p. 15). While some have tried to apply the one-drop rule to other racial or ethnic categories, these attempts have mostly failed (Davis, 1991). Davis (1991) points out that research estimations demonstrate that at least 20 percent of the genes within the "black" population in the United States come from European ancestry, indicating that many "black" people are actually of mixed racial background. A salient example of this is the ongoing media references to President Barack Obama as the nation's "First Black President," despite Obama's known and accepted mixed racial heritage (Wilson, 2013). As Davis (1991) writes,

> The black population in the United States is a socially constructed category backed by
> law, not a grouping established by physical anthropologists or biologists. Both the

definition and the treatment of the group are based on publicly held beliefs about race and

racial mixing, not on scientific conclusions. (p. 30)

Additionally, Michelle Alexander (2012) discusses how Jim Crow laws and practices came to

symbolically define what it means to be black: to hold the status of a second-class citizen. She

notes that today mass incarceration plays the role of a "race-making institution," (p. 200) and

that for many youth "…the experience of being 'made black' often begins with the first police

stop, interrogation, search, or arrest" (Alexander, 2012, p. 199).

As belief or perception is the defining factor in racial categorization, I will use the terms

"black" or "African American" to refer to someone who is or may be perceived as such, and

therefore is likely subject to the associated prejudice and treatment. While this label may most

often be applied as the result of skin pigmentation and/or facial features, it is acknowledged that

other factors may come into play, such as form of dress, accent or dialect, as well as other

cultural elements often connected to socioeconomic status. At the risk of reifying an

unscientifically founded notion of race, I will assume for the purposes of this paper that if one is

perceived to be black, then one is potentially impacted by stereotypes and discrimination, and

therefore this racial label holds both meaning and utility.   Finally, I use "black" and "African

American" somewhat interchangeably throughout this paper, although I specifically use "black"

if the person's nationality (from the Americas or elsewhere) is unclear or irrelevant.

Scope

In an attempt to make a meaningful contribution to the Social Work Field, I had to

significantly limit the scope of this project. While discussion of race in the United States is

likely compromised without incorporated analysis of socioeconomic status (class), it is also a

reality that African American people in the United States have a unique history as a result of

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slavery and its legacy. Therefore, it seems that race-based analysis merits its own exploration.

Thus, I limited this project to African American history and people, focusing on the overarching

question of how slavery and continued race-based oppression may currently impact the

psychological assessment process.

I also limited the focus of this paper to male-identified individuals, referred to henceforth

as "young men" for the sake of simplicity. While gender is a spectrum, and a discussion of the

experience of female-identified, transgender, and gender queer young people is needed, it is

beyond the scope of this paper. In order to acknowledge a non-binary conceptualization of

gender, I use the pronoun "they" throughout this paper whenever gender is unknown or

irrelevant.

The unqualified use of both "man" and "African American" in this paper runs the risk of

reifying these fluid and subjective concepts. In an attempt to avoid confusing and unwieldy

descriptions throughout this paper, however, I use "African American young men" as if it is both

a quantifiable and qualifiable group. It is my hope that the analysis stemming from these

generalizations is still meaningful and relevant, despite the limitations this compromise presents.

Additionally, when I do not qualify the term "clinician" with identifying markers, this is

intentional and is meant to imply that the surrounding statement refers to clinicians of any

professional affiliation within the mental health field, as well as of any race/ethnicity, age,

gender, sexual orientation, and any other demographic feature.

I chose to focus on Conduct Disorder and not Oppositional Defiant Disorder (ODD)

primarily as this helped to focus the research and thus hopefully to lead to more meaningful

results. ODD is often associated with younger children, and can be an antecedent to Conduct

Disorder (DSM-IV-TR, 2000). I decided to focus on Conduct Disorder because it is one of the

most common diagnoses in the Juvenile Justice System, and is often diagnosed during

adolescence. This is a crucial time period, as decisions made at this juncture can have lifelong

impact, and thus diagnoses given during this time may be especially significant.

It is necessary to note that there is likely a subset of people for whom the DSM-IV-TR

(2000) and DSM-5 (2013) Conduct Disorder diagnosis is an accurate and useful way to describe

their symptomology. This paper is intended to address a different group of people, however. It

is my belief that there is a separate, large subset of African American young men who receive

Conduct Disorder diagnoses for whom this diagnosis is neither accurate nor useful. It is beyond

the scope of this paper to evaluate the utility of the Conduct Disorder diagnosis as a whole.

Instead, I simply hope to raise critical questions about the criteria and process used to assess and

diagnose African American young men with behavioral symptoms.

Stereotype Threat

Stereotype Threat is a useful perspective for analysis of the disproportionate

overrepresentation of African American young men among those diagnosed with Conduct

Disorder as it provides a window into the impact of stereotypes on both clinician and client.

Steele (2010) and colleagues have demonstrated through numerous empirical studies that when a

person feels that they are under the threat of being stereotyped in an academic or test-related

setting, their performance is impacted and impaired. There are several identified criteria that are

needed to initiate Stereotype Threat, outlined in detail in Chapter 3, and I argue that African

American male clients undergoing psychological assessment satisfy all needed requirements. As

research demonstrates that there are significant changes in test results when Stereotype Threat is

active, it is likely that this also in some way impacts psychological assessment and diagnosis.

Stereotype Threat brings up the concept of identity contingencies, or those conditions in a setting

that one must deal with in order to function, specific to a person based on their identity (Steele, 2010). Steele (2010) also discusses the difference between an actor's (the person experiencing a situation) and observer's (the person observing the actor) perspectives, and how each angle provides different information. These concepts will be discussed in more detail in Chapter 3, and are used in analysis of the psychological assessment of young African American men.

Social and Historical Context

The state of affairs for African Americans in the United States with regards to education, health, and freedom remains strikingly and disproportionately dire, as compared with other races and ethnicities, and particularly as compared with those who are labeled as white or Caucasian. A quick Internet search generates statistics demonstrating this disproportionality. For example, in 2009, the U.S. Department of Health and Human Services Office of Minority Health reported that African Americans have 2.3 times the infant mortality rate as non-Hispanic whites. The Center for Disease Control (CDC) reported that from 2009 to 2012 57.6% of African American or black non-Hispanic women over 20 in the United States and 37.9% of African American or black non-Hispanic men over 20 qualified as obese (CDC, 2012). Additionally, during the same time period, 39.9% of African American or black non-Hispanic men over 20 were reported to have Hypertension (CDC, 2012). Furthermore, Alexander (2012) notes that the United States currently imprisons a larger percentage of its black population than did South Africa during Apartheid (Alexander, 2012). Finally, the New York Times published an article in 2012 noting that in a study conducted by the Department of Education, although African Americans made up only 18 percent of the total school population sampled, they represented 39 percent of all expulsions (Lewin, 2012).

Without historical context, there would be no useful or accurate way to understand these statistics, as they relate to centuries of oppression, trauma, and lack of access to resources. It is similarly essential to consider social and historical factors when looking at the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder. Michelle Alexander's (2012) analysis of slavery, Jim Crow, and mass incarceration allows for a window into the creation and maintenance of the stereotype of black men as "criminal," which likely contributes to Stereotype Threat for African American male clients, and to implicit bias for clinicians. Dr. Joy DeGruy's (2005) concept of Post Traumatic Slave Syndrome provides a useful alternative framework through which to consider behavioral symptoms of African American young men, taking into account the history of slavery and its legacy. I will use the thoughts and theories of each researcher both independently and complementarily in order to illuminate new elements of the phenomenon and its causes.

Biases, Strengths, and Limitations

As do all researchers, I enter this work with several preexisting biases that likely impact my conclusions. First, in general I believe in assigning the least stigmatizing diagnosis that will still allow a client to access services, as some diagnoses can have lasting and damaging impact if they become part of a client's permanent record. Furthermore, I came into this work already believing that Conduct Disorder is a particularly damaging diagnosis for many African American male adolescents, and that it is often an inaccurate and unhelpful way to define their suffering. I am also biased in my belief that historical and social factors are infrequently adequately considered throughout the psychological assessment and diagnosing process, and that the DSM does not provide a useful template for incorporating these elements into analysis.

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Strengths of this paper and approach include the incorporation of perspectives (social/ historical analysis and Stereotype Threat) that are often unaccounted for in existing research on this topic, and the inclusion of both macro- (history) and micro- (clinical theories) level analysis. My hope is that that this discussion will encourage clinicians to take a more critical and reflective stance when engaging, diagnosing, and conceptualizing suffering and healing with African American young men with behavioral symptoms. An additional hope is that this analysis will inspire clinicians to consider both the individual and the community, and to take seriously the way in which a client defines their own suffering.

As with all theoretical endeavors, a major limitation of this paper is that it does not offer new research, but instead works within an existing and contained set of information. Additionally, my biases could blind me to alternative possibilities that would help to explain the causes of this phenomenon. As mentioned previously, my use of "African American young men" as a central defining term may reify subjective racial and gender categories. I also do not address the possibility that the Conduct Disorder diagnosis itself may be problematic, which may reproduce Conduct Disorder as an objective and "real" category. Important perspectives missing from this paper include an analysis of socioeconomic status (class), as well as of the DSM as a cultural, Eurocentric document that may not be helpful in larger ways in the defining of suffering and healing for African Americans in the United States. Finally, this paper does not address many other possible reasons for the behavioral symptomology of African American young men. It is likely and possible that some behaviors function as a form of resistance to the oppression that an African American young man may experience. While important, this discussion is outside the scope of this paper.

In order to explore the possible causes of this phenomenon, and imagine alternative forms of treatment, we must first establish its existence. The next chapter will outline the existing research and literature demonstrating the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder.

CHAPTER III

Conduct Disorder and African American Young Men

The structural development of the *Diagnostic and Statistical Manual of Mental Disorders*

(DSM IV-TR, 2000) by the American Psychological Association occurred partially as a result of

widespread acceptance that the 5-axis system in combination with behaviorally focused criteria

generated diagnostic consistency and avoided clinician bias across theoretical orientations and

professional disciplines (Pottick, Kirk, Hsieh, & Tian, 2007). Yet, despite this acceptance, years

of research demonstrate that a client's race and ethnicity are commonly correlated with specific

diagnoses (DelBello, Lopez-Larson, Soutullo, & Strakowski, 2001; Feisthamel & Schwartz,

2009; Kilgus, Pumariega, & Cuffe, 1995; Neighbors, Trierweiler, Ford, & Muroff, 2003; Pottick

et al., 2007). For example, research shows that African American men are disproportionately

overrepresented among those diagnosed with Schizophrenia and Conduct Disorder, and

disproportionately underrepresented among those diagnosed with affective disorders, such as

Major Depressive Disorder (Adebimpe, 1981; Cameron & Guterman, 2007; DelBello et al.,

2001; Feisthamel & Schwartz, 2009; Kilgus et al., 1995; Mandell, Ittenbach, Levy, & Pinto-

Martin, 2006; Neighbors et al., 2003; Wu et al., 1999). Researchers have hypothesized about the

variables that contribute to these race-based outcomes, ranging from the misinterpretation of

symptoms due to clinician bias to the suggestion that people of particular ethnic backgrounds

genuinely experience higher rates of certain conditions (Adebimpe, 1981; Cuffe, Waller,

Cuccaro, & Pumariega., 1995; DelBello et al., 2001; Mizock & Harkins, 2011; Feisthamel &

Schwartz, 2009; Kilgus et al., 1995). This study will focus on Conduct Disorder and its disproportionate overrepresentation among African American young men.

In the following pages I will summarize the diagnostic criteria for Conduct Disorder and discuss the impact of this diagnosis on African American young men within institutional settings. I will then review some of the previous studies that highlight the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder, and address some of the studies that produce contrasting results. I will then summarize the researchers' hypotheses about possible causes of this phenomenon as well as their suggestions for future research. Finally, I will point to some of the gaps in the existing research and outline how this paper will address them.

Conduct Disorder Criteria

Conduct Disorder is a behavioral disorder that is associated with Oppositional Defiant Disorder (ODD) in younger children and Antisocial Personality Disorder (APD) in adults (Salekin, 2002). According to the DSM IV-TR (APA, 2000), the essential feature of Conduct Disorder is "…a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (p. 93). In order to be diagnosed with Conduct Disorder an individual must display three or more of the following traits within the past twelve months, with at least one criterion present in the past six months: aggression towards people and animals, destruction of property, deceitfulness or theft, and/or serious rule violations. The disturbance in behavior must cause clinically significant impairment in social, academic or occupational functioning (DSM IV-TR, 2000, p. 99).

In order to illuminate the clinical stigma that is often attached to a Conduct Disorder diagnosis, it may be helpful to highlight its connection to psychopathy or sociopathy, concepts

that are more generally understood in nonclinical or criminal settings (Murrie, Boccaccini, & McCoy, 2007). Oppositional Defiant Disorder, Conduct Disorder, and Antisocial Personality Disorder are behaviorally based descriptions of what was once labeled "psychopathy" (Salekin, 2002). One of the "associated features" of Conduct Disorder is that of Callous-Unemotional traits, which are more closely associated with psychopathy (DSM-IV-TR, 2000, p. 96). The first published research that attempted to extend the concept of psychopathy to children was published in 1994, the same year as the DSM-IV came out (Moffitt et al., 2008). Several different research measures are used to assess children for Callous-Unemotional traits, including the Psychopathy Checklist: Youth Version (PCL-YV; Forth, Kosson, & Hare, 2003). Currently, however, clinicians do not routinely assess for Callous-Unemotional traits when making a Conduct Disorder diagnosis, although this assessment may be included (Moffitt et al., 2008). Historically, Antisocial Personality Disorder and Psychopathy were considered intractable and resistant to treatment, and this belief lingers within both the clinical and nonclinical domains (Salekin, 2002). As Conduct Disorder is a necessary prerequisite for an Antisocial Personality Disorder diagnosis, this may further increase the stigma associated with Conduct Disorder.

Significantly, the DSM IV-TR (2000) description of Conduct Disorder includes a caveat regarding the etiology and possible environmental factors contributing to the behavioral problems:

Concerns have been raised that the Conduct Disorder diagnosis may at times be misapplied to individuals in settings where patterns of undesirable behavior are sometimes viewed as protective (e.g., threatening, impoverished, high crime). Consistent with the DSM-IV definition of mental disorder, the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying

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dysfunction within the individual and not simply a reaction to the immediate social

context (p. 96).

This formally mandated focus on environmental factors is of central concern when exploring the

disproportionate overrepresentation of African American young men among those diagnosed

with Conduct Disorder, as African Americans, and particularly young men, are also

disproportionately more likely to be the victims of violent crime (Harrell, 2007). For example, in

2005, although African Americans made up only 13% of the population, they were victims in

15% of all nonfatal violent crimes, and almost 50% of all homicides (Harrell, 2007).

The Social Impact of a Conduct Disorder Diagnosis

A Conduct Disorder diagnosis impacts outcomes for African American young men

within both the Mental Health System and the Juvenile Justice System. Within the Mental

Health System, the stigma that is connected to a Conduct Disorder diagnosis and its association

with psychopathy may influence mental health providers to make more pessimistic predictions

about the chances of recovery, which may lead to less effective treatment (Mizock & Harkins,

2011; Salekin, 2002). Furthermore, African Americans have limited access to mental health care

in general, and thus will likely receive poorer mental health services following diagnosis as

compared with whites (Mizock & Harkins, 2011). Perhaps most importantly, if Conduct

Disorder is misdiagnosed, as some researchers suggest may be the case, this will impede

detection of more accurate etiology of symptoms and will thus prevent access to necessary and

appropriate treatment (Alegria et al., 2008; Kilgus et al., 1995; Mandell et al., 2006; Mizock &

Harkins, 2011).

Repeated studies have shown that white youth with serious mental health needs access

hospitalization and treatment far more easily than do African American youth, as African

American youth are instead steered towards the Juvenile Justice System (Atkins et al., 1999; Cohen et al., 1990; Lewis et al., 1980). Significantly, Conduct Disorder is one of the most frequent diagnoses given to youth within the Juvenile Justice System (Drerup, Croysdale, & Hoffman, 2008; Mizock & Harkins, 2011; Teplin et al., 2002). For example, in a study of 597 court-involved youth, Conduct Disorder was the most common diagnosis (Drerup et al., 2008). Teplin et al. (2002) found that Conduct Disorder and Oppositional Defiant Disorder diagnosis rates within the Juvenile Justice System were as high as 40 percent. Further, it has been shown that labels such as Conduct Disorder or Psychopathy can have a significant impact in legal proceedings, can influence decision-making in a punitive direction, and can result in youth being transferred to adult courts or ordered to serve longer sentences (Mizock & Harkins, 2011; Petrila & Skeem, 2003).

Mental health clinicians working within the juvenile justice system can influence sentencing decisions through their suggestions to the judge, and thus it is particularly important to consider their responses and opinions in this setting (Rockett, Murrie, & Boccaccini, 2007). Rockett et al. (2007) demonstrated in a study with 109 state-employed mental health clinicians working in Juvenile Justice facilities in Texas, Virginia and Wisconsin that clinicians are most affected by clinical labels like Conduct Disorder, as compared with nonclinical staff. This study asked clinicians to read a vignette of a mock psychological evaluation and then complete a survey (Rockett et al., 2007). The results showed that clinicians were more likely to anticipate future violence and criminality when psychopathological personality features were present, as defined by the Youth Version of the Psychopathy Checklist (Rockett et al., 2007). These personality features included the following: charming but manipulative, poor empathy and remorse, and denial of responsibility (Rockett et al., 2007). This anticipation of future

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criminality could feasibly impact the way in which clinicians present the case to the judge, which could in turn influence sentencing. It also seems plausible that therapeutic pessimism based on labels could influence engagement, treatment planning, therapeutic alliance, and outcome. Furthermore, while studies have shown that the Conduct Disorder label is less influential on nonclinical staff, it appears that judges and probation officers base decisions on conduct-related behaviors (Murrie et al., 2007). This highlights the importance of an accurate diagnosis that can account for behavioral issues. For example, if a clinician believes that a youth's behaviors stem from an affective disorder that is treatable, such as clinical depression (instead of from Conduct Disorder), it seems reasonable to assume that this perspective could impact a Judge's decision about whether to direct this youth towards treatment or punishment.

Previous research about the prevalence of mental health issues among youth involved in the Juvenile Justice System has led to the creation of mental health courts around the country (Gardner, 2011). These courts provide intensive case management and mental health support for youth with mental health diagnoses in order to facilitate sustainable linkage to community-based services such as mental health treatment, to support their exit from the Juvenile Justice System, and to prevent future recidivism (Gardner, 2011). Some of these courts, however, do not accept Conduct Disorder as an eligible diagnosis for entry into the program (Gardner, 2011). Furthermore, Teplin et al. (2002) argued that due to the influence of managed care within both private insurance and public benefits, youth diagnosed with Conduct Disorder often do not have access to mental health services, especially once within the Juvenile Justice System. Thus youth who carry the Conduct Disorder diagnosis within the Juvenile Justice System may have significantly less ability to receive needed support and treatment that could facilitate healing and perhaps prevent recidivism.

While the impact of a Conduct Disorder diagnosis may often be detrimental, it is important to note that this is not likely to be the diagnosing clinician's desired outcome. It is the assumption of this paper that most clinicians are well intended, and may even see the Conduct Disorder diagnosis as a useful tool for a client to access services and to guide treatment planning and healing. While noteworthy, good intentions do not explain or justify actual impact. In light of the history of racism within the United States and in Psychiatry in particular, and considering the potential harm caused by a Conduct Disorder Diagnosis, this paper endeavors to further investigate the causes of inaccurate diagnoses and to offer suggestions to shift this pattern.

Review of the Literature

Decades of research indicate that African American men have been disproportionately overrepresented among those diagnosed with Schizophrenia and Conduct Disorder, and disproportionately underrepresented among those diagnosed with affective disorders (Adebimpe, 1981; Alegria et al., 2008; Cameron & Guterman, 2007; DelBello et al., 2001; Fabrega et al., 1993; Feisthamel & Schwartz, 2009; Kilgus et al., 1995; Mandell et al., 2006; Neighbors et al., 2003; Wu et al., 1999). For example, in 2003, Neighbors et al. directed a study in which an ethnically diverse group of psychiatric residents conducted interviews of 665 African American and white patients at a state psychiatric facility in Detroit, Michigan. This study found that African Americans were disproportionately overrepresented among those diagnosed with Schizophrenia even when using a semi-structured diagnostic instrument to determine diagnosis, suggesting that it may be more than clinician bias that contributes to this pattern (Neighbors et al., 2003). Neighbors et al. (2003) argue that one possible explanation may relate to the lack of education for clinicians about cultural variations in the clinical presentation of disorders. Jones and Gray (1986) argue that inaccurate Schizophrenia diagnoses often occur as the result of errors

on the part of white clinicians who have little experience with African American people, and that it can be difficult for these clinicians to distinguish the difference between the symptoms of Schizophrenia and the symptoms of an affective disorder with their African American clients. Adebimpe (1981) similarly argues that clinicians often make more severe diagnostic errors when working with African Americans as compared to those of other racial or ethnic backgrounds.

Numerous studies also indicate a historical and ongoing trend in which African American young men are disproportionately overrepresented among those diagnosed with Conduct Disorder (Cameron & Guterman, 2007; DelBello et al., 2001; Feisthamel & Schwartz, 2009; Kilgus et al., 1995; Mandell et al., 2006; Wu et al., 1999). The following studies include a variety of research designs such as providing vignettes of cases to clinicians and asking them to fill out a questionnaire, retrospectively reviewing charts and diagnoses within institutions, and conducting interviews that utilize structured and semi-structured assessment procedures and instruments. The samples include clinicians, Juvenile Justice System professionals, parents of youth, and youth within the health care system (hospital), correctional system (jail), and within community mental health clinic settings. The larger sample sizes of some of the studies potentially add strength to the generalizability of the results. The results of the studies vary, although they overwhelmingly indicate that African American young men are consistently disproportionately overrepresented among those diagnosed with Conduct Disorder.

Numerous studies conducted across the nation over the past twenty years point to this consistent pattern of diagnosis (Cameron & Guterman, 2007; DelBello et al., 2001; Feisthamel & Schwartz, 2009; Kilgus et al., 1995; Mandell et al., 2006; Wu et al., 1999). Fabrega et al. (1993) evaluated 2,190 youth ages 13-18 at the Western Psychiatric Institute of Pittsburgh, and found that African American youth were significantly more likely to be diagnosed with a Conduct

Disorder as compared with white youth. DelBello et al. (2001) retrospectively examined 1,001

charts of all adolescents aged 12-18 years admitted to an adolescent psychiatry unit at Cincinnati

Children's Hospital Medical Center between July 1995 and June 1998, with similar results.

More recently, Mandell et al. (2006) studied the demographics and diagnoses collected from

Medicaid of 406 youth who were eventually diagnosed with Autism. This study found that

African Americans youth were 2.4 times more likely to receive a diagnosis of Conduct Disorder

instead of ADD, as compared with white youth (Mandell et al., 2006). Boys of all racial

backgrounds were 3.5 times more likely to receive a Conduct Disorder diagnosis as compared

with girls (Mandell et al., 2006). Significantly, it took 8 months longer for African American

youth in treatment to be diagnosed with Autism, as compared with white youth (Mandell et al.,

2006). If the Autism diagnosis can be assumed to be accurate, this points to a significant barrier

getting in the way of African American clients accessing appropriate and helpful diagnoses.

Cameron and Guterman (2007) conducted a study in which they compared the diagnoses of

1,173 boys and girls receiving care in residential settings (group homes, group care, and

therapeutic foster care) in various regions across the country. This study found that African

American boys were significantly more likely to be diagnosed with Conduct Disorder as

compared with white boys, despite the fact that white boys were found to be proportionally more

clinically aggressive (Cameron & Guterman, 2007). Cameron and Guterman (2007) highlight

that in many of the cases in their study the African American male youth did not present with

externalizing behaviors, and thus the Conduct Disorder diagnoses may not have been warranted.

Finally, Feisthamel and Schwartz (2009) studied intake diagnoses for 899 African American and

white clients at a community mental health agency in a Southeastern state. They found that

white clients were significantly more likely to be diagnosed with less stigmatizing Adjustment

Disorder diagnoses, while African Americans were significantly more likely to receive Conduct Disorder, Oppositional Defiant Disorder, or ADHD diagnoses (Feisthamel & Schwartz, 2009).

It is worth noting one study that presented contrasting results (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Teplin et al. (2002) interviewed 1,829 youth ages 10-18 (1,002 African Americans, 296 white Americans, 524 Hispanic Americans) incarcerated in a Juvenile Detention Center in Cook County, Illinois. This county encompasses Chicago and the surrounding area, and the study used a highly structured instrument, the Diagnostic Interview Schedule for Children (DISC 2.3). The study found that *white* youth had the highest rate of Conduct Disorder diagnoses, based on an in depth interview conducted within two days of intake, and that *African American* youth had a higher rate of Affective Disorders as compared with white youth (Teplin et al., 2002). The contrasting results of this study as compared to the previously cited studies could relate to the proportionally smaller number of white youth in the sample, differences related to the specific geographic region, or subconscious or conscious bias on the part of the researchers, implicit in all studies. It is outside the scope of this paper to determine the reasons behind these varying and anomalous results. It seems clear that based on the overwhelming supportive evidence, in general African American young men are disproportionately overrepresented among those diagnosed with Conduct Disorder.

Another important aspect to the history of diagnoses with African American males has been their disproportionate underrepresentation among those diagnosed with affective disorders (Adebimpe, 1981; Alegria et al., 2008; DelBello et al., 2001; Fabrega et al., 1993; Kilgus et al., 1995). Adebimpe (1981) discusses various stereotypes of African Americans that contribute to this phenomenon. He describes how African Americans have been considered hostile, without motivation for treatment, primitive in character structure, not psychologically minded, impulse-

ridden, and "…too jovial to be depressed or too impoverished to experience object losses,"
(Adebimpe, 1981, p. 281). Lewis et al. (1980) discusses how the resistance of white
psychiatrists to diagnose psychopathology in African American clients partially results from
archaic beliefs held by White psychiatry that African American people are fundamentally
different from white people, and therefore the same criteria for mental health disorders do not
apply. Studies indicate that if an African American person presents with an affective system
(such as lethargy due to depression), it is less likely to be recorded in the medical record
(DelBello et al., 2001; Kilgus et al., 1995). Furthermore, without considering the impact of
racism and historical oppression, white clinicians may view African Americans' healthy distrust
and suspicion of institutions as pathological symptoms, leading to inaccurate diagnoses of
Schizophrenia (Adebimpe, 1981; Mizock & Harkins, 2011; Neighbors et al., 2003). In addition,
research has demonstrated a link between conduct-related symptoms and clinical depression
(Mizock & Harkins, 2011). There may thus be a link between the disproportionate
underrepresentation of African Americans among those diagnosed with affective disorders and
the high rates of Conduct Disorder and Schizophrenia diagnoses (Adebimpe, 1983; Jones &
Gray, 1986). It is also possible that the disproportionate overrepresentation of African American
people within correctional facilities similarly relates to the failure of mental health professionals
to accurately assess, diagnose and treat psychopathology in African American adolescents
(Lewis et al., 1980).

Possible Causes of Conduct Disorder Diagnoses for African American Young Men

Previous researchers hypothesize that there are a myriad of potential explanations for the
disproportionate overrepresentation of African American young men among those diagnosed
with Conduct Disorder (Cameron & Guterman, 2007; DelBello et al., 2001; Feisthamel &

Schwartz, 2009; Kilgus et al., 1995; Mandell et al., 2006; Wu et al., 1999). Some consider the possibility that this phenomenon reflects actual racial differences in the rates of psychiatric disorder (DelBello et al., 2001; Feisthamel & Schwartz, 2009). For example, Feisthamel and Schwartz (2009) hypothesize that due to the high rate of sociocultural stressors experienced by African Americans and/or due to the lack of early, preventative treatment, it is possible that clinicians are accurately diagnosing a trend of Conduct Disorder among African American young men. However, this conclusion does not acknowledge the impact of institutional, clinician or referral bias, and considering the extensive history of racial bias within psychiatry, these possibilities demand exploration (Thomas & Sillen, 1991). Furthermore, the very notion of "racial difference" is problematic, and says more about racial stereotypes and conditioning of the clinician than it does about accurate rates of disorder. It is also questionable whether these researchers have adequately explored whether environmental conditions may account for the behavioral symptomology present among those diagnosed with Conduct Disorder, as mandated by the DSM-IV-TR (2000).

Based on the research, it is most likely that the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder is related in part to bias on the part of the clinician. Studies show that when more strict diagnostic criteria are followed the differences in diagnoses between races are fewer (Adebimpe, 1981; DelBello et al., 2001). Hypotheses presented in the literature about the misdiagnosis of Conduct Disorder include the misinterpretation of symptoms by clinicians, diagnostic bias, and referral bias (Atkins et al., 1999; DelBello et al., 2001; Feisthamel & Schwartz, 2009; Mizock & Harkins, 2011). It is important to explore the range of possibilities leading to misdiagnosis in order to better

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understand the etiology of the high rates of Conduct Disorder diagnoses for African American young men.

Misinterpretation of Symptoms by Clinicians and Diagnostic Bias

It is possible that African American young men's behavioral issues may actually be symptoms of untreated affective disorders, Post Traumatic Stress Disorder (PTSD), or substance abuse (Atkins et al., 1999; Mizock & Harkins, 2011; DelBello et al., 2001; Feisthamel & Schwartz, 2009). Studies point to the high rates of comorbidity of Conduct Disorder and affective disorders (Atkins et al., 1999). Atkins et al. (1999) found in a comparative study with youth in juvenile justice, community and hospital settings that there was a significant comorbidity rate among incarcerated youth diagnosed with Conduct Disorder. Forty percent of incarcerated youth within their study were diagnosed with Conduct Disorder, and among this group 96% also carried another Axis I diagnosis (Atkins et al., 1999). This could indicate that the conduct-related behaviors are symptoms of other untreated mental health issues, such as an affective disorder (Atkins et al., 1999; Mizock & Harkins, 2011). DelBello et al. (2001) and Feisthamel and Schwartz (2009) hypothesize that African Americans are less likely to seek out treatment for an affective disorder, substance abuse issue, or PTSD due to mistrust of the mental health system as well as due to lack of access to services. Mizock and Harkins (2011) also argue that youth may use substances as a way to cope with anxiety, depression, and PTSD, and that substance use can also lead to conduct issues.

It is also possible that misdiagnoses occur due to cultural differences between clinician and client (DelBello et al., 2001; Fabrega, et al., 1993; Jones & Gray, 1986). Fabrega et al. (1993) suggest the possibility that white clinicians are generally better able to connect with and understand white clients, which could lead to a more complex and nuanced picture of white

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psychopathology, and a lack of comparable understanding within other cultural groups. They

argue that it is possible that one ethnic group may be more or less prone to manifest symptoms of

a particular disorder such as depression, or may manifest them in a qualitatively different manner

than do other ethnic groups, due to socioculturally learned modes for expressing distress

(Fabrega et al., 1993). Some clinicians may incorrectly assume that the clinical presentation of a

particular disorder should look the same across all ethnic/cultural groups (Kilgus et al., 1995).

While it is essential for clinicians to learn about and consider general differences between ethnic

groups, it is important to note that this suggestion runs the risk of reifying the notion of static

"cultures" that can be read about, learned, and fully understood.

Finally, diagnostic bias also relates to statistical assumptions and availability heuristics

on the part of clinicians about African American clients, based on behavioral stereotypes and

beliefs about the rates of diagnosis (Mizock & Harkins, 2011). Simply put, clinicians may assign

diagnoses based on inaccurate assumptions about higher rates of specific disorders among

particular ethnic groups, such as Conduct Disorder for African American young men, creating a

self-fulfilling loop.

Referral Bias

There is a strong, documented pattern of referral of African American youth away from

treatment (hospitalization or outpatient mental health services) and towards the juvenile justice

system (Atkins et al., 1999; DelBello et al., 2001; Kilgus et al., 1995; Lewis, Shanok, Cohen,

Kligfeld, & Frisone, 1980). Lewis et al. (1980) compared adolescents from an urban area in

Connecticut who were referred to a correctional facility with those who were referred to a state

hospital. Both groups came from families with low socioeconomic status and were referred in

the same year. They found that violent, disturbed African American male adolescents were sent

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to the correctional facility, and comparably violent, disturbed white male adolescents were hospitalized (Lewis et al., 1980). Some studies show that African Americans are disproportionately underrepresented in the hospital setting, and that a higher level of symptoms must be present for African Americans to access treatment, as otherwise they will be filtered into the Justice System (DelBello et al., 2001; Kilgus et al., 1995). Atkins et al. (1999) hypothesize that referral bias may be partially explained due to the lack of access to mental health treatment in the earlier stages of affective disorders for African American youth. These youth may then develop conduct behaviors, which brings them to the attention of the juvenile justice system rather than the mental health system, thereby preventing African American youth from accessing needed and appropriate services.

Fabrega et al. (1993) highlight the influence and impact of gatekeepers' biases as they manifest in referral patterns. Fabrega et al. (1993) found that African American adolescents exhibited a lower level of symptoms as compared with white adolescents, and that there was a weak but significant trend for African Americans to show a higher level of social aggression. The researchers suggest that this may particularly alarm adult gatekeepers, and could help to explain the high number of Conduct Disorder diagnoses (Fabrega et al., 1993). Fabrega et al. (1993) hypothesize that as care for adolescents is often mandated by systems, this trend indicates a lower level of tolerance of symptoms exhibited by African American youth by adult gatekeepers. Cohen et al. (1990) conducted a study that supports this hypothesis. This study compared 32 youth from a hospital setting and 36 youth from a correctional facility in the Richmond, Virginia metropolitan area. Using the Child Behavior Checklist (CBCL) and a brief demographic questionnaire filled out by the parents of the youth, Cohen et al. (1990) found that African American youth in the correctional setting had similar scores on the CBCL and similar

law breaking behaviors as did the white youth in the hospital, indicating that the African American youth perhaps should have been served by the Hospital system instead of by the Correctional system (Cohen et al., 1990).

Previous Suggestions for Research

The researchers of the reviewed studies present a myriad of suggestions for future research and policy changes that should be made as a result of their findings. Some call for epidemiological studies of genetics (DelBello et al., 2001; Kilgus et al., 1995). Research on the influence of genes on Conduct Disorder is underway, but results are not conclusive enough to warrant entry into the DSM-5 (Moffitt et al., 2008). Researchers also make a repeated call for an investigation into implicit clinical bias based on racial and cultural differences between clinician and client, and how this impacts Conduct Disorder diagnoses, treatment, and outcomes (Feisthamel & Schwartz, 2009; Mizock & Harkins, 2011; Murrie et al., 2007; Pottick et al., 2007). Others focus on the need for research about the many causes of conduct related behaviors such as exposure to community violence, as well as about the long-term impact of a Conduct Disorder Diagnosis (Cameron & Guterman, 2007; Mandell et al., 2007; Mizock & Harkins, 2011). Finally, others point to the need to look at the impact of cultural sensitivity training on diagnostic practices, and to expand culturally sensitive evaluation and treatment of youth from varying ethnic and cultural backgrounds (Kilgus et al., 1995; Mizock & Harkins, 2011).

In addition to studies, Kilgus et al. (1995) and Mizock and Harkins (2011) both call immediately for more cultural sensitivity training and education for clinicians. It seems that there may be a lack of consideration of the environmental factors that differentially impact African American young men, despite the formal mandate listed in the DSM IV-TR (2000) to

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include this in the diagnosing process (Mizock & Harkins, 2011). It is possible that if clinicians accounted for environmental conditions when diagnosing African American young men, including institutional racism, the disproportionate rate of diagnosis would diminish (Mizock & Harkins, 2011). Mizock and Harkins (2011) point to the number of environmental stressors in the lives of many low-income, African American youth, and argue that these need to be factored into clinicians' assessments and diagnoses. As the DSM IV-TR (2000) suggests, in order to determine if an individual's behaviors meet criteria for Conduct Disorder, "It may be helpful for the clinician to consider the social and economic context in which the undesirable behavior occurred" (p. 97). Mizock and Harkins (2011) point to the researched link between behavioral issues and lower socioeconomic status, witnessing or experiencing community or domestic violence, and the experience of racial and academic discrimination. They argue that it is essential to consider these factors when diagnosing (Mizock and Harkins, 2011).

Finally, some researchers call for new programs and changes to policy. Teplin et al. (2002) argue that mental health and juvenile justice policies should be directly based on mental health research that has explored patterns of diagnosis and treatment. They point to the consequences of welfare reform, in which some youth now have less access to medical care, and the impact of managed care, which often does not cover services for diagnoses such as Conduct Disorder (Teplin et al., 2002). These are gaps that could be altered with policy changes. Atkins et al. (1999) argue for diversionary programs to prevent the incarceration of youth at risk for mental illness or emotional disturbance. They also point to the utility of mental health courts, in which treatment services are provided to youth within correctional facilities, and follow up and case management services are provided upon release (Atkins et al., 1999; Gardner, 2011).

Gaps and Bias in the Research

There are several central assumptions and biases evident in the reviewed literature. With the notable exceptions of Fabrega et al. (1993) and Neighbors et al. (2003), none of the previously mentioned studies define race or describe how the researchers determined which participants they counted as "African American" or "white," as discussed previously. This lack of definition and transparency in the studies may make it more difficult to draw meaningful conclusions from the results. Furthermore, a primary assumption within the reviewed literature is that Conduct Disorder is a meaningful and useful diagnosis. The reviewed studies focus on whether or not Conduct Disorder is accurately assigned, but do not challenge the basis of the diagnosis itself. It is beyond my expertise and the scope of this paper to determine whether Conduct Disorder is a valid diagnosis, but this topic deserves further discussion.

The plethora of research that confirms the ongoing disproportionate overrepresentation of African American male adolescents among those diagnosed with Conduct Disorder supports the need for further investigation into the causes of this phenomenon (DelBello et al., 2001; Fabrega et al., 1993; Feisthamel & Schwartz, 2009). Previous research and aforementioned suggestions for future research focus primarily on implicit bias on the part of the clinician or professional, and on current organic or environmental factors that lead to behavioral issues among African American young men (Feisthamel & Schwartz, 2009; Mizock & Harkins, 2011; Murrie et al., 2007; Pottick et al., 2007). Steele and Aronson (1995) provide a useful additional lens through their theory of stereotype threat, in which an individual performs differently and worse when they feel under threat of confirming a negative stereotype about their group. Also missing from the reviewed literature is an analysis of institutional and historical oppression of African Americans in the United States. The next chapter will outline Steele's and Aronson's (1995)

theory of Stereotype Threat and discuss the ways in which this theory can help to explain the

high rates of Conduct Disorder diagnoses for African American young men.

CHAPTER IV

Stereotype Threat

Claude M. Steele's (2010) theory of Stereotype Threat provides a useful lens to view the disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder. Stereotype Threat holds that when a person feels that they are under threat of being stereotyped, both unconscious and conscious anxiety are produced, creating an addtional cognitive load that tends to impair performance. For example, Aronson et al. (1999) conducted a study in which they gathered a group of white, male students from Stanford who had historically done well on math tests. The researchers instructed this group that they would be taking a math test in which "Asians tend to do better than whites" (p. 90). Using a control group of white, male students in which no such statement was made, they found that participants in the control group performed a three full points better (out of an 18 point test) than the participants for whom a stereotype was introduced (in this case the stereotype was that Asian people are better than white people at math) (Aronson et al., 1999).

Over the past fifteen years, Steele and his colleagues have shown through numerous empirical studies that Stereotype Threat can affect anyone who may be targeted, and that it has dramatic impact on the overall performance and outcomes of marginalized groups of people, such as African Americans or females within an academic setting. This may be because Stereotype Threat is not an isolated incidence for these groups, but rather is a dynamic they must navigate continually due to negative stereotypes that constantly circulate in the culture and

institutions at large. The following pages will summarize the historical evolution of the theory of

Stereotype Threat, outline key concepts, features, and principles, provide examples of studies

that demonstrate its existence and impact, and begin a discussion about how this theory enriches

our understanding of the social factors that contribute to the high rate of Conduct Disorder

diagnoses for young African American men. To be clear, the central thesis of this chapter is to

explore how Stereotype Threat may impact the process of diagnosis between clinician and client,

but not to specifically determine which exact behaviors are a reaction to the threat and which

may be truly pathological or clinical. The goal here is to suggest that there are much larger

forces at work that may increase the likelihood of young African American men receiving certain

diagnoses over others.

History of Stereotype Threat

Steele first began thinking about the concept of Stereotype Threat in 1986, when he

visited Ann Arbor, Michigan to determine whether he would accept a job as part time director of

an academic support program for minority students at the University of Michigan. During this

visit, Steele was struck by the academic underperformance of African American students at the

University. He focused particularly on the lack of correlation between predicted grades based on

these students' high school SAT scores and their actual performance once in school. Despite the

fact that the SAT is designed to predict college grades, African Americans consistently

performed below the expected level once at the University of Michigan. This disconcerting

phenomenon inspired Steele to look for a trend nationwide and he quickly found it: African

Americans, Latinos, Native Americans, and women in advanced math classes, law schools,

medical schools and business schools all underperformed in university settings, as measured by

their grades. The existing explanations at the time for this phenomenon focused on internal

deficits of the students: lack of motivation, lack of cultural knowledge, lack of skills to succeed with difficult coursework, and low self-expectations or low self esteem generated by society, family or local communities. Struck by the undeniable disparity between measured intelligence and performance in school among African American students, and unconvinced by the existing theories about the etiology of this phenomenon, Steele began to hypothesize and conduct his own research with other interested colleagues.

Steele (2010) hypothesized that there was something "in the air" on campuses nationwide that was contributing to the underperformance of minority groups, and he eventually named this concept "Stereotype Threat" (p.23). Steele (2010) believed that the underperformance of these students could be linked to external factors relating to their environment. In 1999, Spencer, Steele and Quinn conducted a study looking at women's performance in math and assessing for Stereotype Threat. This study demonstrated that women underperformed on a math test given in the laboratory as compared with men when a gender stereotype was raised, despite the fact that they had roughly equivalent SAT math scores and grades in math classes. When the researchers informed participants before taking the test that this particular test had never shown gender differences in the past, however, women's underperformance was completely eliminated, thereby indicating that the threat of stereotype likely contributed to their previous scores. Energized by their findings, Steele and others continued to research, conducting numerous studies over the next decade that would refine and validate the theory of Stereotype Threat.

Key Concepts

Identity contingencies. The theory of Stereotype Threat is based on a number of key concepts. Steele borrows from behaviorism in his use of "contingencies…those conditions in a setting that reward some behaviors and punish others, and thereby determine how we respond in

a setting and what we learn" (Steele, 2010, p. 68). Steele further modifies this idea by including identity, creating the concept of "identity contingencies." Identity contingencies are those conditions in a setting that you must deal with in order to function, that are special to you because of your perceived social identity. They are local, may be positive or negative, and change with the setting (Steele, 2010). Historically this would include segregated drinking fountains: if you were perceived as an African American person in 1950 in the south of the United States, a contingency of your identity would be that you may only use the water fountain designated for black people. Identity contingencies did not disappear with Jim Crow, however; rather, they simply shifted form (Steele, 2010). Many studies show the current impact of negative identity contingencies: one recent study demonstrated that job applicants with names that "sound black" were less likely to get a job, despite equivalent (and even higher) qualifications to their white counterparts (Francis, 2003). Identity contingencies can also be "social psychological," such as the pressure an African American student may feel in a college course to defy stereotypes by not appearing overly emotional or angry (Steele, 2010). The studies around stereotype threat demonstrate that the effort an African American student may put into avoiding this stereotype takes a heavy toll with regards to health and school performance (Steele, 2010). Negative identity contingencies, whether they are concrete or social psychological, have significant impact.

Positive identity contingencies, on the other hand, go largely unnoticed. This concept is another way of describing privilege: those aspects of one's identity that do not disrupt the norm are easy to take for granted. For example, when a white, educated woman interviews for housing with her white, educated landlords, and after a friendly and easy conversation is invited to rent an apartment, she might not notice the ways in which her whiteness, gender, and educational

privileges contributed to her positive experience because nothing was disrupted in the interaction. For a person who holds a particular identity that does disrupt the norm, however, the disruptive identity often becomes most prominent for that individual (Steele, 2010). Steele (2010) looks to French Lebanese essayist and novelist Amin Maalouf when he describes how those identity contingencies that are most capable of influence (and are most noticed) are those that restrict or threaten, or those that are under attack. For example, the queer, male-bodied, Buddhist African American musician may feel his African American identity most strongly in his primarily white college classes, where he might worry that he will be stereotyped as an unintelligent, angry black man. This example also demonstrates the ways in which identity contingencies are local: when this same person attends a conservative, black church service in which the preacher labels homosexuality as a sin, he may suddenly experience his queer identity as primary, as now this is the identity under attack. Furthermore, the very threat of the attack is enough to create vigilance and preoccupation: the possibility of something bad happening (such as receiving judgment, or not getting a job or an apartment) is that which makes that specific identity primary. Simply put, while positive identity contingencies are often difficult for the owner to notice, negative identity contingencies are magnified by the threat of attack and can be powerfully influential with regards to an individual's self-perception.

Additionally, studies show that it does not take much for people to affiliate with a specific group identity, as well as to discriminate against others based on that identity. An important study conducted by Henri Tafjel in England in 1969 demonstrated what is now called "minimal group effect": the tendency for humans to discriminate and favor members of our own group, even if there is an extremely minimal connection between members (Tafjel & Turner,

1979). In sum, it does not take much to create an identity contingency, and these contingencies

can have tremendous impact.

The concept of identity contingency is useful when considering the types of experiences

that young African American men may have within the United States. Continuous police

brutality, public violence, and media exploitation against this population, including the more

publicized examples of Trayvon Martin and Oscar Grant, create numerous contingencies. One

contingency of this perceived identity is that African American young men will be assumed to be

criminals until proven otherwise. Objectively benign actions such as wearing a black hoodie

sweatshirt or walking down the street alone at night may quickly confirm the "criminal"

stereotype. This public perception can be seen in action through New York's "Stop and Frisk"

law, in which the majority of people stopped by the New York police were racial minorities, and

more than half were African American (Baker and Vasquez, 2007). In response to public

protest, "Stop and Frisk" was studied, and the first results concluded that African Americans

were stopped six times more frequently than whites, and that guns were found in only 2.5 percent

of all stops, despite NYPD's assertion that the stops were designed to remove guns from the

streets (New York State Attorney General, 1999). As Conduct Disorder is the most common

diagnosis within the Juvenile Justice system, it is important to consider the connection between

the "criminal" identity contingency for African American young men and how this may affect

clinicians who conduct psychological assessments or intakes and assign diagnoses (Drerup,

Croysdale, & Hoffman, 2008; Mizock & Harkins, 2011; Teplin et al., 2002).

Downwardly constituted and the psychic damage of racism. In order to bridge the

concepts of Stereotype Threat and racism, it is important to outline another idea that Steele

(2010) discusses: philosopher Charles Mill's concept in which the creation and maintenance of

large African American ghettos has functioned to "…'downwardly constitute' people living in ghettos, to so disadvantage them as to make them less effective agents on their own behalf" (p. 25). Steele (2010) expands this concept to include African American students in elite universities, and discusses how a "concentration of factors" function to downwardly constitute this group, leading to academic underperformance (p. 26). A psychological assessment that results in a Conduct Disorder diagnosis for an African American young man can be seen as a downwardly constituting force, especially if he is involved in the Juvenile Justice System. Once diagnosed with Conduct Disorder, this young person is labeled with a mental health disorder that ultimately traces the source of his problematic behavior to his own internal deficits, and does not focus on the current environment (if the problem appears to stem from the immediate environment the DSM-IV-TR instructs the clinician to avoid this diagnosis) (DSM IV-TR, 2000, p. 96). This young person may also be unable to access mental health treatment, as Conduct Disorder is often not considered an eligible diagnosis for entry into treatment programs, especially within Juvenile Justice facilities (Gardner, 2011). Once officially labeled as a criminal by a judge in juvenile court (and even more so within adult criminal court), this young man has become an even less effective agent on his own behalf, now potentially unable to access employment, Section 8 housing, food stamps, financial aid for school, and possibly even the right to vote (Alexander, M., 2012).

Steele (2010) also discusses one of the more common explanations for underachievement by minorities through a term coined by Daryl Scott, an intellectual historian: that of "psychic damage," caused by negative images of the group projected into mainstream society through film, television, news, and politics, as well as by historical oppression (p. 46). This concept holds that this internalized self-perception leads to low self-esteem, low motivation, self-doubt,

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and low-achievement. While a likely factor in overall outcomes, Steele (2010) argues that this

theory is missing a key perspective: that of the person experiencing the oppression. Steele

(2010) outlines this critique in his discussion of the difference between the perspective of the

actor versus that of the observer.

Observer vs. actor perspective. Steele (2012) looks to two social psychologists,

Edward Jones and Richard Nisbett (1972), to highlight the difference between the observer's

perspective, that of the person *observing* the behavior, and the actor's perspective, that of the

person *doing* the behavior. According to Steele (2010), Jones and Nisbett argue that from the

observer's perspective, "…the actor dominates our literal and mental visual field, which makes

the circumstances to which he is responding less visible to us" (p. 18). Thus, explanations of

behavior focus mainly on internal characteristics of the actor, such as explaining African

American academic underperformance as the result of psychic damage from racism and

oppression. While the observer's perspective may provide some useful insight, the actor's

perspective, on the other hand, may bring to light other essential contributing factors. Before the

introduction of Stereotype Threat theory to the field, the majority of the explanations for African

American academic underperformance were based on an observer's perspective. Stereotype

Threat, on the other hand, shifts the focus to look at environmental cues that are "in the air"

(Steele, 2010, p. 23). These are the cues in a setting that the actor responds to, and which impact

their ability to perform.

While the DSM-IV-TR (2000) links the initial etiology of Conduct Disorder to a variety

of previous experiences including physical or sexual abuse, frequent change of caregivers, early

institutional living, and lack of parental supervision, among others, a Conduct Disorder diagnosis

implies that the primary problem is now located within the diagnosed individual, unrelated to

environmental, social, or political forces. Without an accompanying mood or anxiety related

diagnosis, this diagnosis attributes the source of the problem to the individual's character,

including a possible lack of ability to empathize. When considering an individual's behavior

through the lens of a Conduct Disorder diagnosis, an observer's perspective prevails. If the

actor's perspective were included, it is possible that the individual's behavior would be

understood in the context of traumatic experiences, and might lead the clinician to a different

clinical conceptualization and diagnosis.

When considering traumatic experience as central, diagnoses such as Depression, Post

Traumatic Stress Disorder, or Adjustment Disorder with Disturbance of Conduct may come to

the forefront (DSM-IV-TR, 2000). These diagnoses could all manifest in conduct-related,

behavioral symptomology that could be misinterpreted as Conduct Disorder if the environment is

not properly considered. Post Traumatic Stress Disorder (PTSD), for example, includes

symptoms such as "self destructive and impulsive behavior" and "irritability or outbursts of

anger" (DSM-IV-TR, 2000, p. 465, 468). Furthermore, the DSM-IV-TR (2000) describes some

of the features of a major depressive episode: "Many individuals report or exhibit increased

irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or

blaming others, or an exaggerated sense of frustration over minor matters)" (p. 349).

Furthermore, an Adjustment Disorder with Disturbance of Conduct is:

> A psychological response to an identifiable stressor or stressors that result in the
>
> development of clinically significant emotional or behavioral symptoms…the
>
> predominant manifestation is a disturbance of conduct in which there is violation of the
>
> rights of others or of major age-appropriate societal norms and rules. (DSM-IV-TR,
>
> 2000, pp. 679-680)

An Adjustment Disorder diagnosis is a milder, less stigmatized diagnosis, and the fact that it includes the word "adjustment" implies that there was a difficult external event to which the individual was exposed. The actor's perspective may thus be crucial to a more accurate assessment and diagnosis of an African American young man who is exhibiting behavioral symptomology. However, it is important to understand that a diagnosis of PTSD, Depression, or Adjustment Disorder may not resolve the Stereotype Threat, nor does it take into account the social and political forces of oppression that may also contribute to a person's identity as well as behavior. In other words, the identity contingencies and "downward" constituting forces play a role in the evaluation of a diagnosis, and this needs to be explored further theoretically and in terms of actual clinical practice.

Stereotype Threat: How it Works

Stereotype Threat, described simply, is the feeling that "one false move" could lead someone to be misunderstood and reduced to a shallow stereotype image (Steele, 2010, p. 7). This threat is distracting enough to impair performance, as well as a wide range of human processing, ranging from allocation of mental resources to brain activation. Steele (2010) describes Stereotype Threat as "…a situational predicament as a contingency of…group identity, a real threat of judgment or treatment in the person's environment that [goes] beyond any limitations within" (pp. 59-60).

For example, social psychologists at Princeton University brought two groups of white students at Princeton University into the lab and had them complete a miniature golf course. The first group was instructed that they were taking a test that measured "natural athletic ability," while the second group was told nothing (Stone, Lynch, Sjomeling, & Darley, 1999). The first group played golf significantly worse than the second, on average taking three more strokes to

complete the course. In this case, Stereotype Threat functioned so that when white students felt frustrated in the course of the test, this could be seen to confirm the stereotype that, at least compared with black people, white people have less natural athletic ability. When the same study was conducted with two groups of black students at Princeton, there was no difference in the scores between the two groups. As there is no stereotype about lack of natural athletic ability among African Americans, there was likely nothing to distract black students and impair their performance, thereby confirming the possibility that Stereotype Threat impacted the white students. A final confirmation came when the same study was conducted with black and white students respectively, but this time one group of white students and one group of black students were told that this study tested "strategic sports intelligence," thereby putting the black students under threat of stereotype as less intelligent, an existing stereotype about black people. This time, the group of black students under Stereotype Threat played golf significantly worse than the white students, and worse than they had before, confirming the researchers' hypothesis that Stereotype Threat impairs performance (Stone et al., 1999).

As can be seen by this study, it is not necessary to explicitly state a stereotype in order for Stereotype Threat to function. People are already aware of and working to ward off the stereotypes about their perceived social identity, and therefore it is enough to simply say the word "intelligence" to initiate Stereotype Threat for black students, and "natural athletic ability" for white students (Stone et al., 1999). In fact, it is not necessary that the person who is operating under Stereotype Threat is actually encountering a prejudiced person. It is enough that the stereotype exists in the cultural fabric (e.g. language, social gestures, media images) of our society and the person under threat is aware of it. Furthermore, similar to the way in which an identity becomes primary, it is the simple *threat* of stereotype that is enough to require extra

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vigilance, to distract, and to impair performance. Rather than individual prejudice, it is more importantly cues in a setting that will implicate a specific group's marginality, and lead to Stereotype Threat. For example, Steele (2010) lists the cues that he has found to be instrumental in generating identity and Stereotype threat: few people in a setting share that identity, a lack of powerful people in that setting that have the identity, the setting is organized by identity (e.g. is the school cafeteria organized by race), the setting's inclusiveness (does the setting explicitly value diversity), and prejudice in the setting (is expression of prejudice common and accepted).

Stereotype Threat and Psychological Assessments

When considering psychological assessments, especially evaluative diagnostic assessments (e.g. clinical interviews, intelligence test, achievement tests, Rorschach, and so on) with young African American men, it is likely that there are many cues that would initiate stereotype threat. According to the 2010 Statistics on Social Work Education, conducted by the Council on Social Work Education, 52.1% of social work graduates identified as white, while 13.6% identified as African American/other Black (p. 13). Thus it is statistically more likely that a white clinician will assess an African American young man, and this alone could initiate stereotype threat. If the young man is in trouble either at school or with the law due to behavioral issues, and this is the context in which the psychological assessment is taking place, this could further contribute to the young man's experience of Stereotype Threat. Furthermore, if the assessment takes place within a school or juvenile justice milieu, it is possible that this setting will be organized by race (as seen by de facto segregation in the school cafeteria, or the large number of black and brown people incarcerated in the juvenile justice facility). Finally, it is relevant to consider whether expression of prejudice is normalized and accepted in the setting.

Stereotype Threat seems to only come alive when an individual cares about the task at hand. In one study conducted in an inner city school in Los Angeles, researchers Joseph Brown and Mikel Jollet found that for students who self-identified that they did not care about school, the addition or subtraction of Stereotype Threat into the study made no difference on their test results (as cited in Steele, 2010). This may point to a lack of skills among those who stated that they did not care about school, but over the past fifteen years of research, it has been confirmed that the one prerequisite to Stereotype Threat is that the person must care about the performance in question (Steele, 2010). This concern is what makes the threat of stereotype distracting enough to impair performance. Furthermore, the more you care, the more Stereotype Threat impacts you, and if you continue to care and to work against this stereotype over time, it has been shown that the risk grows for resulting health problems, such as hypertension (James, 1994). Steele (2010) cites Sherman James, an epidemiologist and public health researcher, who hypothesized and found that those " "…who would persist with effortful active coping under difficult conditions'" would experience higher levels of stress, and consequently higher blood pressure (p.130). Several subsequent studies have confirmed this phenomenon among working and middle-class blacks: those who care greatly about succeeding in an area in which their group is negatively stereotyped, and who continue to persist despite the barriers, experience higher levels of hypertension (James, 1994).

It is reasonable to assume that an African American youth will care about the result of a psychological assessment or mental health intake. First, we can imagine that he will want to be respected by the clinician, and he will care that he is not labeled negatively and seen as "stupid" or "crazy." If the assessment takes place in the context of a school disciplinary procedure or within the Juvenile Justice System, the diagnosis can have real impact on court proceedings or

access to services, and the young man may be aware of this (Gardner, 2011; Mizock & Harkins, 2011). Whether it relates to a concrete outcome related to court, or to self-esteem and desire to be regarded as a competent, respectable person, it likely that African American young men are invested in the outcome of a psychological assessment, thereby satisfying the sole key prerequisite for Stereotype Threat.

Stereotype Threat functions most strongly when someone is challenged at the edge of certain skill sets, as this is the place where they will encounter the most frustration (Steele, 2010). If there is no threat of stereotype, the person may use all of their mental resources to focus on the problem at hand. It the person feels threatened by a stereotype associated with the task, they will be distracted by this concern, and, in directing mental resources towards this anxiety instead of towards the work itself, they may underperform. If, on the other hand, an individual is particularly skilled at a specific task, even if it is one in which their group is negatively stereotyped, research has shown that Stereotype Threat actually *improves* performance (Steele, 2010). Steele (2010) argues that when the task feels manageable, the ability to disprove a stereotype can act as a motivator, and can boost performance. However, when a person completes the process of a psychological assessment we can imagine that most people are unfamiliar with the task or questions that will be presented to them. Therefore, whatever stereotype threat may be at play will not improve performance. In addition, many of the questions and tasks a person is asked to complete may trigger the threat of stereotype that is related to larger historical prejudices.

For example, intelligence tests are a standard part of a psychological assessment battery, and have historically been used to promote a false Eurocentric intellectual superiority in order to discriminate against minority groups. In his classic text published in 1976, *Even the Rat Was*

White: A Historical View of Psychology, Robert Guthrie (2003) thoroughly outlines how IQ tests, especially in the early 1900's, were used to promote the intellectual superiority of Europeans and also used to prove the genetic inheritance of lower intelligence of nonwhites. This test in particular, as part of the Psychological assessment, may initiate Stereotype Threat for African American young men and others who may feel they have been unfairly targeted for inferior intelligence.

Stereotype Threat impairs performance in many realms, not simply in the one that is under threat of stereotype. For example, Talia Ben-Zeev (2005) and her students at San Francisco State University conducted a study in which they brought a group of women into the lab and told them they would be taking a very difficult math test, thereby putting them under the threat of the stereotype that women are not good at math (Ben-Zeev, Fein, & Inzlicht, 2005). While waiting to take the math test, the researchers had the women write their names backwards, in order to see how the anxiety created about the test would impair their abilities in other realms. This group of researchers found that the women struggled significantly with this handwriting task, showing that Stereotype Threat impairs performance outside of the one specific area in which there is threat of stereotype (Ben-Zeev et al., 2005). Thus, if during a psychological assessment an African American young man experiences Stereotype Threat due to the intelligence test, this would impact his abilities in other realms as well, thereby affecting the overall assessment.

Some studies have shown the physiological and neurological impact of Stereotype Threat. Steele (2010) cites a study conducted by French social psychologist Jean-Claude Croizet and his colleagues, in which they measured the stability of heartbeat interval when psychology majors and science majors were taking a test. There is a pre-established direct connection

between stability of heartbeat interval and "cognitive load": the higher the cognitive load, the more stable the interval (Croizet, Despres, Gauzins, Huguet, & Leyens, 2003). This study found that with the group under Stereotype Threat, the harder they thought, the worse they did. For the group that was not under Stereotype Threat, on the other hand, the harder that they thought, the better they did (Croizet et al., 2003). This indicated that when someone is under threat of stereotype, they are not focused entirely on the task at hand, and the racing mind may include preoccupation with the risk of stereotype (Steele, 2010). In another study psychologist Tony Schmader and Michael Johns (2003) showed that the racing mind interferes with working memory, " 'the type of memory used to retain and manipulate information for immediate or near immediate use'" (as cited in Steele, 2010, p. 123). This is the type of memory that would be used for academic tests, conversations, and could impact perceived intelligence (Steele, 2010).

If an African American young man experiences Stereotype Threat during a psychological assessment, it is possible that this would lead to a great deal of physiological arousal with racing thoughts, which would impact his memory and his "performance" during the assessment. Neuropsychological tests are generally viewed as objective measures by many clinicians, and thus the results are often taken seriously in school or court contexts (AERA, APA, & NCME, 1999; Cushman, 1995). However, the actual relationship between assessor and client may also impact the results of the tests, and impact how the person's identity is characterized in the final written psychological report. These relational contexts are often not taken into account by the legal, school, or mental health systems (H. Macdonald, personal communication, March 17, 2014).

Another important factor to consider is how Stereotype Threat may impact a white clinician who is assessing an African American young man. Steele (2010) describes a study in

which researchers measured the blood pressure of white students asked to approach a black or white fellow student that they didn't know and speak to them (p. 119). The researchers found that white students who approached a black student had substantially higher blood pressure, potentially indicating that the white student felt under threat of stereotype when talking to the black student (Blascovich, Mendes, Hunter, Lickel, & Kowai-Bell, 2001). The researchers hypothesized that the white student may feel under threat of seeming racially insensitive, which is an existing stereotype about white students (Blascovich et al., 2001). As Stereotype Threat is often an unconscious process, as elaborated below, it is likely that white clinicians may not be aware of the impact of Stereotype Threat upon themselves or upon the person they have evaluated. Perhaps the white clinician feels under threat of stereotype of being seen as racist by the client, and this in some way impacts the process of the assessment. Or, maybe the clinician is a social worker, who feels under threat of stereotype of being seen as too "soft" or as unqualified by her Psychologist peers. This may also impact the way in which the clinician conducts the assessment, as well as the diagnosis she assigns the client. Alternatively, it is possible that over time a white clinician who often works with African American youth may come to believe that she is not prejudiced, as she believes herself to be an expert due to her experience. This belief could feasibly lead to exacerbated expression of unconscious prejudice.

People under the threat of stereotype are often not aware that they are feeling distracted or concerned, and in a number of studies, reported explicitly that they were not anxious (Steele, 2010). In one study, Blascovich, Spencer, Quinn, and Steele (2001) looked at Mean Arterial blood Pressure (MAP), a direct physiological measure of stress and anxiety. Black participants taking a test they believed measured intelligence reported that they did not feel any anxiety while taking the test. The MAP, however, showed otherwise: while the MAP dropped over the course

of the test for white participants, it raised significantly for black participants, those under threat of stereotype (Blascovich et al, 2001). Therefore it is likely that Stereotype Threat is an unconscious process, impairing performance outside of the impacted individual's awareness. Furthermore, it is not necessary that a person had a previous self-doubt about a specific attribute or skill in order to activate Stereotype Threat. This can be seen through the aforementioned study in which white males underperformed on a math test when told that on this particular test Asians tend to do better than whites, as there is not a general stereotype that white people are bad at math (Aronson et al., 1999). As mentioned previously, stereotypes already exist about African American young men as "unintelligent" and "criminal." This simply amplifies the likelihood that Stereotype Threat will impact them during the psychological assessment or mental intake process (Steele, 2010).

Combating Stereotype Threat

The good news, according to Steele (2010), is that Stereotype Threat can be countered and removed relatively easily. Steele (2010) argues that social identities are simply adaptations to specific circumstances in our lives, and if those circumstances are shifted, so will the responses utilized by those who hold the associated identity. Steele (2010) thus advocates for focusing on changing the circumstances that function to downwardly constitute a group of people, rather than on changing the internal adaptations of those who hold that specific identity. For example, if test-takers are reminded of identities that counter a relevant stereotype, studies show that this works to eliminate Stereotype Threat and improve academic performance (Steele, 2010). For example, McIntyre, Paulson, and Lord (2002) found that if they reminded women of positive female role models just before taking a math test, this significantly improved their test scores (McIntyre et al., 2002). As a working rule, Steele (2010) writes, "…if cues in a setting

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that point in an unsettling direction mount up, a sense of identity threat is likely to emerge. But

if such cues are sparse in a setting and/or point in a benign direction, then a sense of identity

threat should not arise or should subside" (p. 140). In addition to reducing identity threat, Steele

(2010) argues that there must also be a sustained opportunity for access to quality education.

With regard to psychological assessments with young African American men, there are

several measures that could be taken to combat Stereotype Threat. In order to minimize the cues

in the setting that indicate a marginal identity, it will be important to consider where the

assessment takes place. If the assessment takes place in an institution that the African American

young man experiences as racist (such as an educational or Juvenile Justice facility) this could

impact the assessment. If the assessment takes place in a mental health clinic or other

community facility, it is important to consider the demographics of the staff, the race of the

person conducting the assessment, the pictures hanging on the wall, and so on. Perhaps it would

help to start the assessment with the areas of strength and competence of the young man, so as to

remind him of identities he holds that may counter stereotypes. A useful first step would be to

conduct studies of Stereotype Threat within the arena of psychological assessment and diagnosis.

It would be helpful to look at the impact of Stereotype Threat in a variety of settings (schools,

Juvenile Justice facilities, mental health clinics, hospitals, community-based home visits) in

order to explore the ways in which Stereotype Threat affects both the assessor and the assessed.

Stereotype Threat may offer a window into a potential cause of inaccurate diagnosis for

African American Young men. As Steele (2010) writes,

In addition to learning new skills, knowledge, and ways of thinking…you are also trying

to slay a ghost in the room, the negative stereotype and its allegation about you and your

group. You are multitasking, and because the stakes involved are high... this multitasking

is stressful and distracting. (pp. 110-111)

Stereotype Threat may thus impact the quality of the information gathered about an African

American young man during a psychological assessment. This brings up important questions

about the accuracy of the clinician's conclusions and final diagnosis, and leads to suggestions for

possible modifications of the psychological assessment that could bring small improvements to

this process. The lens of Stereotype Threat focuses on the interaction between the individuals

involved in the assessment, and perhaps expands to include the particular institution to which the

assessment is linked. Another crucial factor when considering the disproportionate

overrepresentation of African American young men among those diagnosed with Conduct

Disorder, however, relates to historical racism within the United States. It is important to

consider the ways in which the institutions of education, mental health, and justice view certain

behaviors when they come from African American young men, and how this fits into the

historical narrative of African Americans in this country. In the following pages I will discuss

the disproportionate overrepresentation of African American young men among those diagnosed

with Conduct Disorder through Michelle Alexander's (2012) historical analysis of the stereotype

of African American men as "criminals." I will also use Dr. Joy DeGruy's (2005) framework of

Post Traumatic Slave Syndrome in order to consider alternative explanations for some of the

behaviors of African American young men today.

CHAPTER V

An Historical Analysis

In the following pages I continue to examine some of the larger forces that contribute to the disproportionate overrepresentation of young African American men among those diagnosed with Conduct Disorder. In the first section I will discuss the historical roots of stereotypes that may portray African American young men as "criminals" and may negatively impact the diagnostic outcome of a psychological assessment. I argue that this stereotype is rooted in historical policies and practices, both formal and informal, that have served specific political purposes intended to serve the interests of those in power. Using Michelle Alexander's (2012) *The New Jim Crow: Mass Incarceration in the Age of Colorblindness,* I look at the development and maintenance of this stereotype and its impact on the implicit bias of those who have power. I also argue that knowledge of history and of the current system of mass incarceration is essential to understanding behaviors and presentations of African American young men today, and thus historical analysis should be incorporated into the process of psychological assessment, diagnosis, and treatment. I then discuss the impact of the legacy of slavery on the health of young African American men today through the lens of Dr. Joy Degruy's (2005) *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing,* and suggest how this provides an alternative lens through which to view behaviors.

Creating Stereotypes: A History

History is powerfully present in the here-and-now environment. Therefore, clinicians should incorporate historical and social analysis into the assessment and treatment of clients. While social workers are strongly encouraged to include family history into an assessment of a client, I argue that equally important is the history of racism, classism, and any other form of oppression that has impacted the client or his ancestors. Also important is the way in which this history may impact the clinician's perception of the client, based on stereotypes that may operate in the clinician's conscious or subconscious mind. Michelle Alexander (2012) and Dr. Joy DeGruy (2005) each respectively outline a history of the laws and practices that have restricted and controlled African Americans through the times of slavery and Jim Crow, and continue to impact African Americans presently though mass incarceration. This history highlights the creation and maintenance of the stereotype of African American men as "criminal." Upon closer examination, this history is exposed as a series of strategic moves made by the white males in power in order to justify, bolster and ensure their ongoing supremacy. The following historical summary links calculated policy and practice to the origins of this powerful stereotype about African American men that still lingers "in the air" today (Steele, 2010, p. 23).

Black Codes and Convict Leasing

Alexander (2012) outlines the transition from the end of slavery to the Black Codes. Mississippi and South Carolina first enacted the Black Codes in 1865, near the beginning of the Reconstruction era (1863-1877), and directly after the end of the Civil War. The Black Codes included provisions that required all black people to have written proof of employment for the coming year at the beginning of January (History.com staff, 2010). If they left before the end of their contract they were forced to forfeit earlier wages and were subject to arrest. Furthermore,

both states implemented convict and vagrancy laws, which led to heavy fines and forced labor as penalty for those who did not have a job (History.com staff, 2010).

While the Black Codes were struck down in court in 1868, the Southern white backlash against Reconstruction continued to rage fiercely (Alexander, 2012; DeGruy, 2005). Alexander (2012) cites Thomas Blackmon's *Slavery by Another Name,* noting that tens of thousands of African Americans were arbitrarily arrested during this period. The convict leasing system, in which prisoners were contracted out as laborers to plantation owners and private companies, started in 1846 in Alabama and lasted until 1928 (Alexander, 2012; DeGruy, 2005). Conditions were harsh, and in South Carolina half of the individuals subject to this system died within the first 12 months due to hard labor and severe physical punishments (DeGruy, 2005). While this system was not originally designed for African Americans, after the end of slavery it served as a convenient tool to oppress and disempower freed black people and to line the pockets of white plantation and corporation owners (DeGruy, 2005). There was thus a clear monetary incentive to charge and convict black men with crimes so as to expand the free labor force. Furthermore, after the Civil War Southern whites anticipated and dreaded a great uprising by black people, and Alexander (2012) describes how this fear further contributed to the stereotype of black men as aggressive, dangerous predators who might hurt white men or rape white women. Here in these misperceptions was born the image of the black male "criminal."

In 1871, the Virginia Supreme Court made a crucial ruling about the state of affairs for convicted criminals in *Ruffin v. Commonwealth*:

> For a time, during his service in the penitentiary, he is in a state of penal servitude to the
>
> State. He has, as a consequence of his crime, not only forfeited his liberty, but all his

personal rights except those which the law in its humanity accords to him. He is for the

time being a slave of the State.

In no uncertain terms, convicts thus became slaves. By 1898, 75% of Alabama's state revenue

came directly from convict leasing (DeGruy, 2005). By the 1900s, almost all Southern states had

laws that disenfranchised blacks, and politicians of all affiliations competed to be more

conservative in order to win over the (white) public vote (Alexander, 2012).

Jim Crow

Jim Crow was legal apartheid, and the well known "Separate but Equal" doctrine of

Plessy v. Ferguson (1896) resulted in separate but very unequal access for blacks to quality

education, housing, medical treatment, and even places of amusement (e.g. swimming pools,

beaches, museums, and so forth) (DeGruy, 2005). The first Jim Crow Law on the books took

place in Tennessee in 1881 in the form of a law segregating state railroads. Over the next fifteen

years other Southern states passed similar laws (PBS website, 2002). According to Alexander

(2012), Jim Crow began roughly at the end of Reconstruction (1877), and was dismantled as a

cumulative result of the end of WWII (1945), *Brown v. Board of Education* (1954), the Civil

Rights Act of 1964 and the Voting Rights Act of 1965.

In 1866 the Klu Klux Klan (KKK) was established in Tennessee, and began its

terrorizing of blacks and white allies (DeGruy, 2005; PBS, 2002). Among the most salient of

abuses was the use of lynching to intimidate and subordinate blacks. Between the years of 1882

and 1967, 200 bills were presented to congress to outlaw lynching, and 7 different presidents

advised Congress to take action. Congress rejected every one of these proposals, and lynching

continued unpunished (DeGruy, 2005). In 2005, the U.S. Senate finally apologized for

"domestic terrorism" against mostly black people (DeGruy, 2005, p. 93). The delay in

acknowledgment of this legally sanctioned murder highlights the ongoing racism and continued

disempowerment of African Americans. The stereotype of black men as criminals, created and

invoked by white Southern politicians, the KKK, and much of the general white public, did not

die with Jim Crow Segregation. Instead, it continued, veiled within the new rhetoric of

"Colorblindness."

Colorblindness and the Culture of Poverty

With the end of Jim Crow in 1965, Alexander (2012) argues that political conservatives

sought new methods and linguistic strategies to undermine the coalition between poor whites

with blacks, as this unification directly threatened wealthy white interests. Some of these

methods included the phenomena of colorblindness combined with the reconstruction of

meanings, links, and causes between poverty and race. Seizing on one aspect of Dr. Martin

Luther King Jr.'s "I have a Dream" speech, conservatives coopted the concept of

"Colorblindness" to conceal their divide and conquer cause for the continued subordination of

African Americans. They accomplished this through the seemingly "race neutral" language of

"law and order" (Alexander, 2012, pp. 40, 42). For example, after *Brown v. Board of Education,*

civil rights activists used direct-action tactics to attempt to desegregate schools in resistant

Southern states, and conservative Southern politicians began to use the media to associate the

opposition to civil rights legislation with "Law and Order" (Alexander, 2012, pp. 40-41).

Conservatives proclaimed the need to "[crack] down on crime," but did not distinguish between

different types of crimes, such as civil rights actions, violent rebellions, and more traditional

crimes (Alexander, 2012, p. 43).

Simultaneously, some groups of African Americans and allies, such as the Black Panther

Party, moved away from the nonviolent tactics of the Civil Rights movement. Additionally, riots

broke out in urban centers across the United States, including Detroit and Los Angeles (The

Learning Network, 2011). Perhaps due to white fear resulting from the violence and the media,

the conservative rhetoric took hold, and by 1968, 81% of those who responded to the Gallup Poll

in the U.S. confirmed that they believed that "law and order has broken down in this country,"

and blamed "Negroes who start riots," and "Communists" (Alexander, 2012, p. 46). Colorblind

ideology and language further enabled the continued stereotyping of black men as criminals,

only now through implicitly (rather than explicitly) racial legal terminology.

Simultaneously, in the late 1960s and early 1970s, fueled by the 1965 Moynihan report,

conservatives argued that poverty was caused by "culture." This report also introduced the

concept of a "welfare cheat," and discussion of the "deserving" versus the "undeserving" poor

entered public discourse (Alexander, 2012, p. 44). Further, the field of eugenics, which began in

the 1870s, continued full force into the 1960s and 70s (Guthrie, 1998). For instance, in 1969, Dr.

Arthur R. Jensen, a professor of educational psychology at the University of California at

Berkeley, published a paper in the respected *Harvard Educational Review*, arguing that "genetic

factors are strongly implicated" in average group differences between blacks and whites in

intelligence testing (as cited in Thomas & Sillen, 1991, p. 30). This assertion highlighted the

continued prevalence in this line of thinking, despite the countless studies that demonstrated the

fallacy of this assertion (Thomas & Sillen, 1991). The Moynihan Report, the concept of the

culture of poverty, and racist eugenics contributed to the creation and maintenance of the

stereotype of black people as unintelligent, as this ideology held that their poverty was a direct

result of their own deficiencies, rather than of 350 years of oppression, lack of opportunity,

disenfranchisement, and continuous traumatic experience. These claims served to further justify

white supremacy and the ongoing subordination of African Americans, and paved the way for

the next iteration of the subordination of African Americans: mass incarceration and its source, the War on Drugs.

The War on Drugs and Mass Incarceration

In 1982, when President Ronald Wilson Reagan declared the "War on Drugs," drug use was actually in decline (Alexander, 2012). Crack hit the streets of the United States shortly thereafter, and the Reagan Administration took this opportunity to introduce and implement racially biased policy (harsh drug laws) using race-neutral language ("tough on crime," a continuation of the language of "Law and Order") (Alexander, 2012, p. 53). In 1984, Congress amended the Comprehensive Drug Abuse Prevention and Control Act in order to permit "…federal law enforcement agencies to retain and use any and all proceeds from asset forfeitures, and to allow state and local police agencies to retain up to 80% of the asset's value…" (Alexander, 2012, pp. 78-79). Law enforcement thus made significant money off of the Drug War and therefore had a concrete investment in its continuance. This stake in the material rewards of the Drug War was obscured by "tough on crime" rhetoric, and even Democrats jumped on board in order to win public approval (Alexander, 2012, p. 55). In 1996, President Bill Clinton passed the "Personal Responsibility and Work Reconciliation Act," which included a lifetime ban from "entitlements" such as welfare if convicted of a drug offense (Alexander, 2012). This legislation had a dramatic impact, as those with drug offenses suddenly found themselves with increasingly fewer opportunities to make changes in their lives.

Courts of law implicitly and explicitly condoned the use of racial profiling for "stop and searches" conducted by the police (Alexander, 2012). This established precedence for enactments of implicit bias on the part of law enforcement officers, based on racial stereotypes of those whom they believed looked like a "criminal." This immediately put black men a risk of

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profiling, due to the pre-existing and powerful stereotype of African American men as dangerous predators.

Explicit and Implicit Bias in the Courts

Various court cases have been brought forth arguing that racial bias is used in decision making by law enforcement, lawyers, and judges (Alexander, 2012). Each case thus far has been dismissed, and few cases make arguments related to racial profiling at this point, as it has proven too difficult to win (Alexander, 2012). A striking example is the case of McCleskey v. Kemp (1987), in which lawyers used the Baldus study to show that black men in Georgia who killed white victims received the death penalty four times more often than their white peers, when accounting for confounding factors (Alexander, 2012). The Supreme Court upheld the death penalty sentencing of McCleskey and stated: "evidence of conscious, racial bias in McCleskey's individual case was necessary to prove unlawful discrimination," (as cited in Alexander, 2012, p. 110). Alexander (2012) discusses how this type of evidence is virtually impossible to obtain or to submit in court, and thus far all attempts to do so have failed.

In 1996, in the case of Whren v. United States, the lawyers petitioning for Whren argued that law enforcement officers should not be able to use traffic violations as a pretext to pull over someone as part of a drug investigation, as this would enable police to utilize "snap judgments," which "…would likely be influenced by prevailing racial stereotypes and bias" (Alexander, 2012, p. 108). The Supreme Court of the United States ruled that claims of racial bias could not be brought under the Fourth Amendment, and thus law enforcement officers were free to continue profiling during traffic stops and searches (Alexander, 2012). Alexander (2012) argues that as a result of the wording of the equal protection clause of the Fourteenth Amendment and of other Supreme Court rulings, only intentional discrimination is now considered viable in

court, thereby defining racism as solely that which is explicit.   It is extraordinarily difficult to prove intentional, conscious discrimination within the context of Colorblindness (Alexander, 2012).

Mass Incarceration: Where we are Today

Today, the US has the highest rate of incarceration in the world: 750 out of every 100,000 adults are behind bars within our borders (PEW Center on the States, 2008). Furthermore, the United States incarcerates a higher percentage of its black population than South Africa did during Apartheid, and in 2001 one in six black men in the United States had been incarcerated in his lifetime (Alexander, 2012; NAACP, 2009). The impact of racial profiling in drug related convictions is undeniable: the NAACP (2009) reports that five times as many whites use drugs as African Americans, yet African Americans are sent to prison for drug offenses at ten times the rates of whites. Furthermore, African Americans represent just 12% of the population of drug users, but 38% of those arrested for drug offenses, and 59% of those in state prison for a drug offense (NAACP, 2009). In order to understand the causes of these dramatic disparities, it is important to consider aforementioned historical precedent, and to understand how the criminal justice system works today.

Mass Incarceration: How it Works

Michelle Alexander (2012) outlines how mass incarceration functions today as the newest iteration of the United States' "caste system," and argues that the majority of the public does not recognize it as such (p. 13). She discusses the way in which this system functions to continue to disempower and disenfranchise African American men in the United States. First, she argues that defendants who are accused of drug offenses often plead guilty even if they are innocent due to lack of legal counsel (as a result of indigence, age, English language issues,

mental illness, or general lack of understanding), or as a way to avoid very harsh penalties if they were to go to trial and lose (Alexander, 2012). She notes how police continue to have free reign to use biases to determine whom they stop and search, which leads to an overrepresentation of black and brown people among those searched, as evidenced by the previously discussed Stop-And-Frisk study in New York (New York State Attorney General, 1999). Furthermore, prosecutors can load up charges and are effectively immune from accusations of racial bias, due to previous court rulings. Once the defendant has served his time, he returns to society to find himself blocked from access to education, housing, jobs, and public benefits, thus leading to recidivism (Alexander, 2012). Alexander (2012) argues that an important element of this system is that it appears to be voluntary, thus obscuring the existence of systematic discrimination.

Furthermore, Alexander (2012) discusses how black exceptionalism is necessary for the maintenance of this caste system: those black individuals who have been able to be successful in U.S. society allow for conservatives to argue that it is individual choices that lead to incarceration (or, alternatively, to success). Finally, Alexander (2012) argues that the issue of mass incarceration has transitioned from a people' movement to a lawyer's movement, and thus has remained outside of the public eye. Lawyers tend to take on issues that can be won through legislation, which excludes the issue of mass incarceration, according to Alexander (2012). Mass incarceration continues, and a majority of the public remains unaware and quiet. It is essential for clinicians to understand this concealed reality in order to be able to account for the environment with which an African American man is likely contending.

Alexander (2012) makes a convincing argument that mass incarceration bears remarkable similarities to previous forms of an institutionalized caste system. Mass incarceration allows for legalized discrimination in terms of employment, housing, education, public benefits, and jury

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service. Black men have been prohibited from voting during the times of slavery, by the KKK during Jim Crow, and currently if they have a felony on their records (Alexander, 2012). Alexander (2012) argues that a newly released prisoner has few more rights than did a newly freed slave in 1853, and she notes that there are more African American adults under correctional control today than were enslaved in 1850. Finally, she discusses how both Jim Crow and mass incarceration use seemingly race-neutral policies in a racially discriminatory manner (Alexander, 2012).

Impact of Mass Incarceration

In order to better understand the environment in which many young African American men live today, it is important to discuss the concrete impact of a criminal record. The following limitations relate mainly to adults involved in the criminal justice system, but these restrictions still impact many young men whose fathers, mothers, grandparents, brothers, sisters, cousins and friends have been or are currently incarcerated. When considering the actor's perspective, it is essential to include the many facets of the environment that may impact the actor (Steele, 2010).

An African American man with a criminal record leaves prison or jail with severely limited opportunities. The following is a summary of the restrictions that impact an adult with a felony drug offense. While this may appear to be a specific group of people, due to the War on Drugs these restrictions impact the families of many African American young men, and some of these restrictions also impact adults with other varying classifications of felonies.

An adult with a felony drug offense cannot apply for Section 8, and landlords are permitted to bar applicants whom they believe uses alcohol or drugs (Alexander, 2012). Furthermore, the "no fault" clause in public housing leases allows tenants to be evicted if a visiting guest or family member uses drugs, even if the tenant was unaware. The impact of this

clause is to strongly discourage family members from allowing relatives to stay with them after their release from jail or prison (Alexander, 2012, p. 146). Additionally, an adult with any felony is required to check a box on many job applications indicating that they have a record, thereby dramatically reducing their ability to find employment (Alexander, 2012). Notably, some cities and organizations, including the city of San Francisco, have eliminated this box due to community organizing efforts, but these examples are still the exception (Lagos, 2014). Some argue that the absence of the box on job applications may lead to *more* discrimination because of the continuing stereotype of black men as "criminals," and implicit bias on the part of employers (Alexander, 2012).

Furthermore, some people who have been convicted of any offense are required to pay fines associated with their imprisonment, and if they do get a job, up to 100% of their paychecks may be garnished (Alexander, 2012). Unsurprisingly, this makes the prospect of employment less desirable, and rings a similar note to the plight of African Americans impacted by convict leasing directly after the Civil War, in which they were forced to work to pay off fines associated with various "violations" with which they were charged (Alexander, 2012, p. 156). Adults with felony drug offenses are not eligible for food stamps and for the most part they cannot vote. In 2000, Human Rights Watch reported that 13% of black men had lost the right to vote as a result of felony disenfranchisement. Some may be eligible to vote, but are barred by high fines and bureaucracy, reminiscent of the poll taxes and literacy tests of the past (Alexander, 2012). Finally, Alexander (2012) discusses one of the greatest impacts of a criminal record: that of the shame and social stigma stemming from family, community, and society at large.

These severe restrictions make up the social environment for many young African American men who may be directly or indirectly impacted by these laws and practices. This

environment may shape (and restrict) the imagination of a child through linguistic and visual symbolic registers, who comes to see the limitations of the options available to those in his family or to those who look like him. An African American young man may be directly denied access to resources as a result of a parent who has a felony drug offense, or due to implicit (or explicit) bias on the part of landlords, police, community members, or a clinician. As clinicians, it is essential to consider the legal and structural restrictions and limited options available to those with criminal records so as to consider the actor's perspective when assessing a young African American man and his environment.

Implicit Bias

Although the legal definition of racism is now primarily limited to explicit bias, Alexander (2012) and others point to numerous studies in which implicit bias is shown to have significant impact. In 1989, Watson and Jones conducted a study of 400 people in Washington D.C., asking them to "envision a drug user, and describe them" (as cited in Burston, Jones, & Roberson-Saunders, 1995, p. 20). 95% of respondents described someone of African descent, in sharp contrast with the fact that the majority of drug users then, and today, are white Americans (Burston et al., 1995). This inaccurate belief manifests in dramatic racial disparities among those incarcerated: Alexander (2012) indicates that 75 percent of those incarcerated for drug offenses are African American or Latino.

Furthermore, Alexander (2012) notes that cognitive bias research indicates that both implicit and explicit bias lead to discriminatory action, regardless of an individual's intention. For example, Bridges and Steen (1998) conducted a study based on 223 narrative reports written by probation officers in three counties in a western state between 1990 and 1991. The researchers found that attribution for crime was directly linked with race: probation officers

made more internal attributions (personality traits) for black youth, and external attributions (environmental influences) for white youth (Bridges & Steen, 1998). Furthermore, a recent study conducted by the U.S. Department of Education Office for Civil Rights (2014) found that while black children represent 18 percent of pre-school enrollment, they make up 48% of children who receive more than one out-of-school suspension. Another recent study conducted by Goff and colleagues (2014) included 123 mostly white, female college students, and asked them questions designed to assess for perceived innocence of children of various races. This study found that participants perceived black children of ten years of age and older as significantly less innocent than their white peers (Goff, Jackson, Culotta, Di Leone, & DiTomasso, 2014).

Thus, there is no doubt that implicit bias concretely impacts treatment and outcomes of African American young men by law enforcement, probation officers, teachers, and the general (mostly non-black) public (Alexander, 2012). These studies illuminate the power of the existing association of African American men with criminality and guilt. This stereotype has maintained with substantial help from the media through local news shows that highlight black male "criminals." Dr. Joy DeGruy (2005) points out a notable example of this inaccurate portrayal: she writes that after the death of Rodney King over half of the people rioting were Hispanic, and the rest were a mixture of African Americans, whites, and Asians, but that this is far from the public perception as the result of the media's focus on black rioters. Therefore, as clinicians of all backgrounds breathe air contaminated by the stereotype of black men as "criminal," it is crucial to consider the impact of clinicians' implicit bias within the clinical assessment process.

The Lasting Impact of Slavery on Mental Health: Post Traumatic Slave Syndrome

Slavery and its legacy have had significant impact on African American families and individuals throughout history, likely leading to patterns of behavior and outcome for African Americans today. Dr. Joy DeGruy (2005) looks at the current state of affairs for African American people in the United States in her book *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing.* She outlines how African Americans have a life expectancy that is five to seven years younger than that of whites, that the infant mortality rate is twice that of whites, and how African Americans per capita have the highest number of deaths as a result of heart disease, diabetes, HIV/AIDS, hypertension, homicide, influenza and pneumonia (DeGruy, 2005). She links these outcomes to the impact of ongoing trauma for African Americans in the United States, starting with the 180 years of the Middle Passage between various countries in Africa and the Americas, 246 years of slavery, and one hundred years of "illusory freedom" (DeGruy, 2005, p. 107). She describes the trauma of the Black Codes, convict leasing, Jim Crow, lynching, medical experimentation (e.g. Tuskegee), redlining, disenfranchisement, brutality by police, and unequal treatment of African Americans at many levels of society (DeGruy, 2005). She cites James P. Comer, professor of child psychiatry at the Yale School of Medicine, in order to discuss the ways in which African American families adapted in order to survive slavery:

> The slave family existed only to serve the master and in order to survive physically, psychologically and socially the slave family had to develop a system which made survival possible under degrading conditions. The slave society prepared the young to accept exploitation and abuse, to ignore the absence of dignity and respect for themselves

as blacks. The social, emotional and psychological price of this adjustment is well

known. (DeGruy, 2005, p. 118)

 DeGruy (2005) argues that the impact of these adaptations, as well as the systematic denial of

opportunity for African American men to be fathers during slavery, have had far reaches, and

help to explain some behaviors presenting in some African American people today.

Based on this history and what she observes today, DeGruy (2005) proposes a new

diagnosis: "Post Traumatic Slave Syndrome" (PTSS) (p. 13). Unlike the diagnosis of Conduct

Disorder (DSM-IV-TR, 2000), PTSS names the source of the problem within its definition.

DeGruy (2005) defines Post Traumatic Slave Syndrome as: "Multigenerational trauma together

with continued oppression and absence of opportunity to access the benefits available in the

society [real or imagined]," and "A syndrome is a pattern of behaviors that is brought about by

specific circumstances" (p. 121). She goes on to describe a number of the patterns of behavior

that she believes to be direct results of slavery and its legacy: vacant esteem, ever present anger,

and racist socialization. DeGruy (2005) uses an actor's perspective in her analysis, as she

heavily considers the impact of the environment.

Vacant Esteem

The first pattern of behavior associated with PTSS is that of "vacant esteem" (DeGruy,

2005, pp. 123-128). DeGruy (2005) defines "healthy esteem" as the accurate, honest assessment

of one's worth, with worth being the degree to which one contributes to friends, family, and

society at large (p. 123). She describes how individuals come to have unhealthy or healthy self-

esteem first as the result of appraisals by significant others, then later by the appropriate

recognition of their contributions, and finally as the result of the experienced meaningfulness of

their lives (DeGruy, 2005).

DeGruy (2005) describes "vacant esteem" as the state in which an individual believes that they have little or no worth. This state comes about as the result of family, friends, community, and society. Family can influence esteem through the ways in which an individual is raised and groomed to take a specific place in society and in community; community can influence esteem by establishing norms and encouraging (or not) conformity to society at large; and society can influence esteem through institutions, laws, policies, and media (DeGruy, 2005). DeGruy (2005) describes how vacant esteem arises when these influences all promote a disparaging or limiting identity. Vacant esteem, she argues, is transmitted generation to generation and leads to the following behavioral expressions: taking on negative stereotypes as self-identity, low expectations for selves, families and communities, assuming failure in most attempted endeavors, loss of respect and love for self and others, undermining the achievements of other African Americans, focus on material possessions, lack of trying to succeed in school, and suicidal ideation and attempts (DeGruy, 2005). Those with vacant esteem, she argues, believe they have "little worth, little power, and little self-efficacy" and will go to great lengths to amass any amount of power, even if it means fulfilling negative stereotypes. Often this takes the form of inspiring fear in others, as this may be only space in which an individual feels that they can be powerful (DeGruy, 2005).

Furthermore, DeGruy (2005) conducted research on violence and the conditions present that lead to anger and violent behavior among African American male youth. Participants in the study included 200 African American young men, ages, 14-18, half of whom were incarcerated, and half who were not. DeGruy (2005) found that the antecedent most likely to produce anger or violence in African American young men was an experience of disrespect. She postulates that because African Americans experience disrespect so frequently in their lifetimes, as well as

throughout the collective consciousness of history, they are more sensitive to it, and internalize it more deeply than others. She writes, "What stands between a disrespected African American and the source of the disrespect is almost four hundred years of history, four centuries of being the targets of humiliation and abuse" (DeGruy, 2005, p. 168). Thus, if a clinician does not account for the historical environment, an African American young man who gets into physical fights frequently could be diagnosed with Conduct Disorder (DSM-IV-TR, 2000). When considering the impact of history on the current environment, this same young man could be more accurately diagnosed with "Post Traumatic Slave Syndrome," as evidenced by vacant esteem (DeGruy, 2005). In order to address vacant esteem, DeGruy (2005) advocates for increasing the ability of African American individuals to recognize their own true value.

Ever Present Anger

The second pattern of behavior associated with PTSS is that of "ever present anger." DeGruy (2005) cites Dr. James R. Samuels in defining anger:

> In its simplest form anger is the normal emotional response to a blocked goal. Often, if a person's goal remains blocked over time, they will begin to consider the possibility of failure and so experience fear, and when we are fearful we also lash out in anger. (p. 130)

DeGruy (2005) goes on to discuss the many ways in which African Americans historically and currently experience blocked goals, including lack of opportunities for education and economic self-sufficiency as a result of redlining, gentrification, and bank lending practices. She notes the long history of lies about fair and equal access to opportunities and resources for African Americans, and discusses how this logically leads to anger, both past and present. This type of anger can lead to many behaviors that are listed under the criteria for Conduct Disorder (DSM-IV-TR, 2000). Again, it is important to consider whether the behavior is simply a "…reaction to

the immediate social context," which would rule out a Conduct Disorder diagnosis (DSM-IV-TR, 2000).

Racist Socialization

The final pattern of behavior associated with PTSS is that of racist socialization (DeGruy, 2005). This refers to "adoption of the slave master's value system," and includes the internalization of the white ideal of beauty (leading to the privileging of straight hair, lighter skin, and Aryan facial features) (DeGruy, 2005, p. 135). DeGruy (2005) notes that it is not uncommon for people to take on the views and attitudes of their captors, and this can occur relatively quickly. Slave owners utilized anger and violence frequently as a way to maintain control, and DeGruy (2005) argues that African Americans may also have taken on these attributes. Further, she argues that African Americans may feel threatened by the accomplishments of others as a result of divide and conquer strategies utilized by slave owners, and continuing throughout history (DeGruy, 2005). DeGruy (2005) advocates for positive *racial* socialization in lieu of *racist* socialization, and outlines how this could include education about institutional racism, history, past struggles and successes, and the teaching of coping mechanisms and skills needed in order to survive in the current environment. She cites existing strengths in African American communities that could support this change, including the faith-based community (DeGruy, 2005).

Defining the Problem

Alexander (2012) and DeGruy (2005) both offer alternative lenses through which to view the behavior and diagnosing of African American young men. Alexander (2012) helps to illuminate the implicit bias that may be at work for clinicians during assessment, and also to better understand the environment of African American young men today. DeGruy (2005)

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provides a differing perspective from that of the DSM-IV-TR (2000) on conduct-related

symptoms by connecting the historical and current impact of trauma with the behavior of African

American young men today. The definition of the presenting problem is crucial, as differing

definitions lead to differing treatments. The final chapter will connect Stereotype Threat

(Steele, 2010) with Alexander (2012) and DeGruy (2005), and will look at the concrete and

practical impact of how the problem is defined.

CHAPTER VI

Discussion

We have now considered several perspectives intended to illuminate some of the factors

that contribute to the disproportionate overrepresentation of young African American men

among those diagnosed with Conduct Disorder. To review, the criteria for Conduct Disorder

includes a disturbance in behavior that causes clinically significant impairment in social,

academic, or occupational functioning, and is associated with Oppositional Defiant Disorder

(ODD) in younger children, and Antisocial Personality Disorder (APD) in adults (DSM-IV-TR,

2000). All three diagnoses are behavioral descriptions of what was once simply labeled

"Psychopathy," and an assessment for Psychopathy can still be included when a Conduct

Disorder or APD diagnosis is given (Salekin, 2002). Significantly, the DSM-IV-TR (2000)

includes a caveat that encourages clinicians to consider the environment in which the behavior

takes place: "…the Conduct Disorder diagnosis should be applied only when the behavior in

question is symptomatic of an underlying dysfunction within the individual and not simply a

reaction to the immediate social context" (p. 96).

It is well established that African American young men are disproportionately

overrepresented among those diagnosed with Conduct Disorder (Cameron & Guterman, 2007;

DelBello et al., 2001; Feisthamel & Schwartz, 2009; Kilgus et al., 1995; Mandell et al., 2006;

Wu et al., 1999). Furthermore, this diagnosis can negatively impact treatment and outcomes for

African American young men. For example, studies show that a Conduct Disorder diagnosis

may generate therapeutic pessimism in clinicians which likely impacts quality of treatment, may block access to mental health services and/or lead to lack of treatment for undiagnosed conditions, and may drive court proceedings in a more punitive direction (Alegria et al., 2008; Gardner, 2011; Kilgus et al., 1995; Mandell et al., 2006; Mizock & Harkins, 2011; Salekin, 2002). In order to expand the current analysis about the causes of this racially disproportionate diagnosis phenomenon, I looked at Claude Steele's theory of Stereotype Threat (2010), Michelle Alexander's historical analysis (2012), and Dr. Joy DeGruy's discussion of Post Traumatic Slave Syndrome (2005).

First, I outlined Claude Steele's (2010) theory of Stereotype Threat, which holds that when a person feels that they are under threat of being stereotyped, conscious and unconscious anxiety are produced, which distracts from the task at hand and thereby impairs performance. While most of Steele's (2010) studies thus far have taken place in academic settings, I discussed that it is reasonable to assume that this theory similarly applies to the clinical assessment process. For a young African American male client, the clinical assessment situation likely satisfies the criteria needed to initiate Stereotype Threat. This may be due to the setting (school and/or juvenile hall could contribute to the experience of a young African American man feeling under threat of stereotype), to the high probability that the young man cares about the task at hand (the outcome of the assessment), and that he may be challenged on the edge of a skill set within the assessment.

Next, I discussed the creation and maintenance of the stereotype of black men as "criminals" using Michelle Alexander's (2012) historical analysis of slavery, Jim Crow, and mass incarceration. I also looked at the many restrictions and lack of access to opportunity for anyone convicted of a felony level drug offense, and discussed how this may affect many

African American young men today who may be directly or indirectly impacted by these laws and policies. I argued that it is essential that a diagnosing clinician take into account both the current environmental conditions as well as a more general historical analysis as part of the clinical assessment process. I then turned to Dr. Joy DeGruy's (2005) discussion of Post Traumatic Slave Syndrome (PTSS), which holds that slavery and its legacy have led to several patterns of behavior that directly link to this historical trauma. I outline her concepts of vacant esteem, ever present anger, and racist socialization, and in the following pages I will discuss her proposals for treatment and how they may be used by clinicians working with young African American men with behavioral symptoms.

DSM-5

The criteria for Conduct Disorder in the DSM-5 (2013) are largely unchanged from those of the DSM-IV-TR (2000). Modifications are limited to an additional specifier that is to be used for individuals who meet full criteria for Conduct Disorder, but who also "…show a callous and unemotional interpersonal style across multiple settings and relationships" (APA, 2013, p. 15). The APA (2013) states that they have added this specifier "…based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response" (p. 15). As the criteria for the Conduct Disorder diagnosis is relatively unchanged, the arguments made in this paper similarly do not require modification in order to be applicable to the DSM-5. It is possible, however, that the additional specifier may apply to those individuals for whom a Conduct Disorder diagnosis is a more useful definition of the presenting problem. It is recommended that studies be conducted regarding this added specifier and accounting for race, and exploring how it applies to African American youth specifically.

Black "Criminals," Stereotype Threat and Psychological Assessment

As discussed previously, one of the lasting identity contingencies of African American men is that they are often assumed to be criminals unless proven otherwise. The creation of the stereotype of the black "criminal" was partially born out of white Southerners' fear of an uprising of freed black slaves after the Civil War. Additionally, this stereotype was strengthened by the criminalizing of black men so as to access their free labor as part of the convict leasing system (Alexander, 2012). Furthermore, the KKK and others used the stereotype of black men as "criminal" as justification for lynching African Americans throughout the duration of Jim Crow (Alexander, 2012; DeGruy, 2005). With the end of Jim Crow, explicit calls for segregation were no longer socially or politically acceptable. In the subsequent shift towards "Colorblindness," conservatives capitalized on the stereotype of black men as "criminal" in their cries for "law and order," and were thus able to push for racially biased policy using racially neutral language (Alexander, 2012). The media added fuel through their depiction of urban riots around the country, fanning the flames of white fear of a black uprising (The Learning Network, 2011). Finally, propaganda from Reagan's "Drug War" furthered this stereotype both in print and on the radio, in which shows depicting crime featured mostly black faces in the role of criminal and used terms such as "crack whores," "crack babies," and "gangbangers" (Alexander, 2012, p. 52).

Due to the combination of harsh, discriminatory drug policies and racial profiling on the part of police departments, the majority of those incarcerated for drug related offenses then and now were black and brown, creating today's mass incarceration (Alexander, 2012; NAACP, 2009). Furthermore, ongoing violence against African Americans by police and community members continues. The murders of young men such as Trayvon Martin and Oscar Grant

highlight the continued association between black men and criminality, and the minimal punishment for white perpetrators magnifies the low value today's legal system places on the lives of African American men.

Additionally, as Conduct Disorder relates to behaviors that often include law-breaking, and as this is one of the most common diagnoses within the Juvenile Justice System, it is likely that an African American young men who may be diagnosed with Conduct Disorder has already been labeled as a "criminal" by his school or the court system, or is at risk of this, prior to the psychological assessment (Drerup, Croysdale, & Hoffman, 2008; Mizock & Harkins, 2011; Teplin et al., 2002). Furthermore, as evidenced by the aforementioned history and maintenance of this stereotype, an African American young man may have concern about being stereotyped in this manner regardless of his behavior. Thus, Stereotype Threat related to the "criminal" stereotype will likely impact an African American young man during psychological assessment, thereby altering and impairing performance (Steele, 2014). This stereotype may also contribute to implicit bias of the diagnosing clinician, further impacting the assessment process. It is also probable that other stereotypes will also come into play, such as that of African Americans as unintelligent. Without cues intended to counteract these stereotypes, this could lead to underachievement in the intelligence test, and could also impact the overall interaction between clinician and client.

Stereotype Threat and Race

Despite the convincing evidence that Stereotype Threat affects us, the question may remain about the specific content of an individual's sub- or unconscious when they are under threat of stereotype. Steele (2010) and his colleagues found several ingenious ways to access this information. Steele and Aronson (1995) conducted a study in which black and white Stanford

students were instructed that they were going to take a challenging verbal test. Just before the test began, Steele and Aronson gave participants a few samples of difficult questions from the test. Participants were then asked to complete a list of eighty word fragments, in which each had two letters missing, and to do so as quickly as possible, so as to stimulate free association. Word fragments included examples such as _ _ mb, and _ _ ce, which could be completed as "dumb" and "race," if these concepts were on the minds of the participants. When black students were told that the test would measure ability, they completed the word fragments with far more stereotype related words than when they were told that the test was not a measure of ability. White students made almost no stereotype related word completions in either case (Steele & Aronson, 1995). Furthermore, these students were asked to rate their music and sports preferences before the test. When the black students believed that the test measured ability, they indicated less preference for music or sports with an African American association. When black participants did not believe that the test measured ability, they showed a higher preference for music and sports with an African American association (Steele & Aronson, 1995). This experiment was a window into the unconscious (or, in some cases, perhaps conscious) thoughts of participants, highlighting concerns and preoccupation about racial stereotypes.

Other studies confirmed this conclusion, including a study in which Asian women completed a questionnaire prior to completing a math test (Shih, Pittinsky, & Ambady, 1999). When the questionnaire reminded them of their female identity, participants scored lower on the test. When reminded of their Asian identity, comparable participants scored higher on the same test (Shih et al., 1999). These studies verify that performance on tests is directly impacted by preoccupation about stereotypes, which may be functioning on varying levels of consciousness.

This further validates the high likelihood that Stereotype Threat impacts Intelligence Test results and overall psychological assessments for young African American men.

Availability and Affect Heuristics

Also important to consider are availability and affect heuristics, and how these impact the diagnosing clinician (Pachur, Hertwig, & Steinmann, 2012). Availability heuristics are unconscious mental shortcuts that one makes based on examples that immediately come to mind, those that are most easily *available* (Pachur et al., 2012; Tversky & Kahneman, 1973). Numerous studies have linked judgment and decision making to availability, based on an individual's direct experience (that which occurs to the individual, their family, and/or their close friends), indirect experience (that which they hear about), and the media (Pachur et al., 2012). Affect heuristics are mental shortcuts that are based on the emotional strength of the subject at hand, and these also impact judgment and decision-making (Pachur et al., 2012). For example, when assessing for risk, Slovic, Finucane, Peters, and MacGregor (2002) propose that individuals use their emotional responses to the risk in order to assess for how large is the risk. While availability and affect heuristics may *feel* accurate to the individual, they often do not relate to fact, but instead are based on emotionally charged beliefs stemming from media or experience (Pachur et al., 2012).

For example, an individual may utilize availability and affect heuristics when they overestimate the number of burglaries that occur in their neighborhood, basing their judgment on sensationalized and disproportionate coverage on the local news, and on the fact that they know someone who was robbed on their street. It follows, then, that this same process could impact clinicians during the psychological assessment of a young African American man, and that this would thereby impact the clinician's decision-making (e.g. diagnosis). For example, when

assessing a young African American male client, a clinician might attribute the client's recent involvement in robbery and gang-activity to Conduct Disorder based on the clinician's unconscious association of black men with criminality, and in this case, with those behaviors that violate laws or the rights of others. The availability and affect heuristics impacting this clinician would likely be fueled by the historical precedent for this stereotype, and the ample availability of the connection between black men and criminal behavior, due to the media, and perhaps as a result of direct or indirect experience. It is thus crucial that clinicians learn and consider history as well as the impact of media and personal experience in order to be conscious of their own bias and how it may affect assessment and diagnosis. In order to better understand the impact of the clinician's diagnosis, I will now turn to a broader discussion of diagnosis and treatment.

Diagnosis and Treatment

Diagnosis can be understood as one definition of the presenting problem. If a young woman sleeps all day, has little appetite, and expresses feelings of hopelessness, a clinician may believe that a diagnosis of Depression defines the client's problem, and this diagnosis may lead to a specific treatment that aims to treat this disorder. DSM-IV-TR (2000) and DSM-5 (2013) diagnoses function as a way to identify a client's symptoms and problem, to quickly communicate this information between professionals, and to identify and initiate the most effective treatment. Therefore, as treatment is an outgrowth from diagnosis, the definition of the presenting problem is of central concern, as it leads to differing treatment and intervention. It is thus relevant to consider varying definitions for the presenting symptoms of Conduct Disorder, and to explore the treatments connected with each. First, it is important to put this analysis within the context of today's mental health system, and to discuss the impact of the widespread acceptance of Evidence-Based Treatment.

Evidence-Based Treatment

Evidence-Based Treatment (EBT) has gained significant support within the mental health field, as well as by health insurance (state, federal, and private) that funds mental health services (Haine-Schlagel, Fettes, Garcia, Brookman-Frazee, & Garland, 2014; Henggeler & Sheidow, 2012). EBT is based on manualized interventions that have been repeated and researched in order to prove their efficacy (Haine-Schlagel et al., 2014). Evidence Based Treatments are intended for specific conditions or symptomology, and clinicians' may prescribe them based on what they believe to be the client's presenting problem. For example, Dialectical Behavioral Therapy (DBT) is an Evidence-Based Treatment that has been shown to be particularly successful in treating personality disorders and suicidality, and a clinician may prescribe DBT if they believe that this is the client's primary problem (Stoffers et al., 2013). With the growing preference for Evidence-Based Treatments by funders (health insurance) and within the mental health field as a whole, it seems likely that diagnoses have also become increasingly powerful, as they may determine which services and treatment a client will be able to access. It is thus important to consider the variety of ways to understand and define behavioral symptoms in a young African American man, and the respective associated treatments.

Defining the problem

A Conduct Disorder diagnosis simply describes a pattern of behavior that relates to the breaking of rules, laws, or societal norms (DSM-IV-TR, 2000). When considering an African American young man who is gang-involved and who consistently gets in trouble at school, there are varying ways a clinician can conceptualize his symptomatic behavior. As prejudice and discrimination against African American young men by teachers and school administrators is a frequent occurrence in schools, let us assume for the purposes of this exercise that this is not the

primary explanation for this young man's problems in school and that his behavior is clinically significant (e.g. starting physical fights in class, stealing a cell phone from a teacher or classmate, and so on.) Through the lens of Conduct Disorder, this young man has developed a pathological pattern of rule breaking, may have little regard for the feelings or wellbeing of others, and his behavior is *not* simply a reaction to his immediate social context, but instead is a pathological problem. A Conduct Disorder diagnosis will typically lead to specific treatment that includes increased supervision, discipline, and improved family relationships, outlined in more detail below. While many of these interventions may be helpful, let us consider what we may be missing if we stop here, without considering alternate explanations for his behavior.

DeGruy (2005) discusses how "vacant esteem" can lead African American young men who feel fundamentally powerless to take power in any way that they can, even if it means fulfilling negative stereotypes. She also argues that some young African American men do not believe they will ever go to college, and as a result they do not attempt to behave in school. In both situations, the result may be that a young, African American man may have behavioral symptoms, based on the impact of historical oppression (stemming from slavery) on him and his family, and current limited access to opportunity (whether real or perceived).

Furthermore, it is important to consider this young man's environment. It is possible that due to gang rivalries in the neighborhood, lack of access to housing, higher income, or healthy food as a result of a parent's or caregiver's felony drug offense, this young man have joined the gang so as to secure a source of protection and support, in the service of his physical and/or emotional survival. Furthermore, this young man may have few or no examples of people he knows who have been able to be successful through traditional (legal) forms of employment, and thus this may not seem like a viable option for him. Through the perspective of DeGruy (2005), this

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young man's problem may be defined as "…multigenerational trauma and continued oppression plus a real or imagined lack of access [to the benefits available in the society]" (p. 121).

When considering the client's behavior through an actor's perspective, it is possible that his behavior (joining a gang and getting into trouble in school) is a direct, rational response to his environment, as the gang offers protection and support, and as other opportunities may not be (or may not seem to be) accessible to him. Therefore, based on the caveat listed in the DSM-IV-TR (2000), a Conduct Disorder diagnosis would be inappropriate, as his behavior is a direct response to his current environment.

Evidence-Based Treatment for Conduct Disorder

If this African American young man's problem is defined by the DSM-IV-TR (2000) or DSM-5 (2013) diagnosis of Conduct Disorder, specific treatments emerge as the most widely accepted (and most highly funded) intervention. Henggeler & Sheidow (2012) and Frick (2012) discuss various researched risk factors for Conduct Disorder, including the youth's beliefs (attitudes and cognitions), prenatal complications and en-utero drug exposure, cognitive functioning, temperamental vulnerabilities (impulsivity, poor emotional regulation), biological processes, family parenting practices (e.g. ineffective discipline), drug use and mental health of caregiver, "deviant" peer involvement, lack of positive activities, low academic functioning and involvement, neighborhood (e.g. exposure to community violence), and "community disadvantage" (Henggeler & Sheidow, 2012, p. 33). This well researched list of risk factors may adequately explain the etiology of behavioral symptoms for many youth. Missing from the list, however, is any mention of the impact of historical oppression and trauma. These factors warrant greater exploration. First, let us turn to the existing Evidence-Based Treatments researched to be most effective for youth diagnosed with Conduct Disorder. Henggeler and

Sheidow (2012) discuss three of the more professionally respected treatment models of family- and evidence-based treatments for Conduct Disorder and delinquency in adolescents, including Multisystemic Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy each outlined in more detail below. These researchers note that these treatments are currently used in more than 800 community practice settings (Henggeler & Sheidow, 2012).

According to Henggeler and Sheidow (2012), Multisystemic Therapy (MST) functions on the premise that an adolescent's antisocial behaviors are based on their peers, school, and neighborhood, and that the family is the most important and powerful agent of change. MST thus works to empower caregivers to make change in the youth's environment as it relates to peers (disconnection from those who are deemed to be negative influences), and to support improvement in school performance.

Functional Family Therapy (FFT) is used within over 270 programs worldwide, and 12,000 youth and families are treated annually (Henggeler & Sheidow, 2012). The vast majority of families who have participated in FFT studies were white, however, and therefore it is undetermined whether this intervention works well for African American families. FFT views the problem of Conduct Disorder as directly related to dysfunctional family dynamics and relations (Henggeler & Sheidow, 2012). FFT interventions focus on generating and maintaining new patterns of interaction within the family, and utilize communication, assertiveness and anger management training.

Multidimensional Treatment Foster Care (MTFC) is based on social learning theory, which includes behavioral principles, such as behavior modification using concrete rewards and punishments (Henggeler & Sheidow, 2012). MTFC also looks at the "natural social context," and how this impacts learning, such as how an adolescent may imitate the behaviors of others in

his environment Henggeler & Sheidow, 2012, p. 47). Interventions are based on behavior-management plans and problem-solving skills training.

Additionally, Frick (2012) suggests interventions that promote identity development and increase engagement with prosocial peers, including mentoring and after school programs. Frick (2012) discusses how interventions focusing on anger control or on improving parenting techniques may work for a specific subset of those diagnosed with Conduct Disorder (those for whom the symptoms of Conduct Disorder began in early childhood).

These treatments mainly center on altering family relations and dynamics in order to support change in the youth's behavior, and specifically focus on the importance of the influence of positive peers, and on improving school performance. Interventions include behavior-management training, utilizing systems of rewards and consequences, and improving problem-solving and emotional regulation skills. These treatments have been researched and shown to be effective for many adolescents with behavioral symptomology, and likely address many of the core causes of their presenting problems. Some of the interventions may also address issues pertaining to the historical oppression and trauma (the legacy of slavery) of young African American men, such as Frick's (2012) suggestion to help youth to get involved in activities or groups that support identity development. Because a Conduct Disorder diagnosis defines the problem in such a way that solely addresses the behaviors of the client, however, the interventions logically focus on behavior modification, relying on the family or caregivers as the source of change. If the problem were defined differently, however, varying and expanded interventions would likely follow.

Alternate Definitions, Alternate Treatments

If the young, African American, male, gang-involved youth's presenting problem is defined by DeGruy's (2005) terms, Post Traumatic Slave Syndrome, the interventions would be designed to treat vacant esteem, ever present anger, and/or racist socialization. In order to address vacant esteem, DeGruy (2005) suggests ways to build healthy self-esteem, defined by the accurate appraisal of one's value (that which one contributes). First, she discusses the need for African American people to recognize that which they already contribute as siblings, parents, family members, workers, friends, partners, and community members. She argues that there is not enough direct acknowledgment among African Americans of one other's contribution, and that it is important to use a strength-based, rather than deficit-based, perspective. She also suggests working to alter beliefs about self worth and to expand beliefs about the possibilities available to African Americans (DeGruy, 2005). Clinicians working with young African American youth with behavioral symptoms could use these same interventions directly with the youth, as well as within family therapy, by supporting the family in directly and more frequently acknowledging one another's contributions. In working directly with the youth, clinicians could focus on exploring and changing beliefs about the youth's contributions, as well as the possibilities open to him, utilizing a strengths-based approach.

In order to address ever present anger, DeGruy (2005) first discusses how this anger is rational response to a multitude of blocked goals within the lives of many Africans Americans, as well as that of their ancestors. Although the anger may be understandable, DeGruy (2005) goes on to discuss how stress (linked to the anger) causes many negative health impacts, and thus it is important to find ways to manage anger in a healthy way. She suggests that African Americans learn skills that help with emotional regulation and anger management, a similar

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suggestion to that of some of the Evidence-Based Treatments for Conduct Disorder. She then

discusses the importance of exercise and healthy eating as techniques to reduce anger and stress.

The intervention does not stop here, however. She goes on to outline the importance of assessing

the available options for addressing specific blocked goals, whether this means utilizing outside

advocacy, trying a new approach independently, or letting the issue go (DeGruy, 2005). She also

discusses the impact of poverty, and how this greatly adds to stress. Finally, she suggests that it

is important for African American people to learn financial management skills, and that this will

have lasting impact on stress and anger. These interventions expand greatly beyond anger

management behavior modification, as they acknowledge historical and current oppression and

discrimination (and therefore validate the youth's experience), and teach concrete skills (such as

financial management) that may lead to lasting change within a family.

Clinicians could utilize these interventions with young, African American men with

behavioral symptomology by first acknowledging that their anger is rational (and not

pathological), and then discussing the negative impact anger (and stress) will likely have upon

their health. This approach might allow the young men to feel better understood, and then

potentially more open to considering the reasons why behavioral change might benefit them.

Clinicians could then work with clients to improve anger management skills, as well as other

useful skills, such as financial management. Financial management may traditionally be

considered outside of the scope of the work of a clinician, but DeGruy (2005) makes a

convincing argument that this type of skill may be key to long term healing and health.

Clinicians may not have the resources or abilities to teach such skills, however, and can thus

work to make referrals and support the client in following through.

In order to address racist socialization, DeGruy (2005) advocates for *racial* socialization. She discusses the importance for African American parents to teach their children about the many strengths of their family and culture, as well as about the reality of racism and discrimination that they will likely face, so as to prepare them for coping with the real world. She outlines the importance of young African Americans having adult African American models, and discusses the need for African American elders to share their stories of struggle and success, so that children and adolescents will have a better sense of their own history. Finally, DeGruy (2005) discusses some of the many strengths of African American people in the United States, such as consistent faith and a history of strong community and powerful leaders, both recognized and not. She advocates for working to promote and re-establish strong African American community and leadership.

Clinicians of all backgrounds could work to address racist socialization by incorporating the history of racism and oppression into their analysis and work with young African American men, acknowledging and discussing the many strengths of African Americans within this history, and also by making space to talk about race in therapy. This could be incorporated into both individual as well as family therapy, in which elders within the family could be encouraged to share their history and stories of struggles and successes. Interventions could also include supporting the youth in getting involved in community and leadership development, if appropriate. These interventions may necessitate changes on an institutional level within the field of Social Work, potentially impacting the hiring of faculty in schools of social work, curriculum changes, and ongoing training for social workers.

Finally, in order to address the lack of opportunity available to many young, African American men due to restrictions based on discrimination, or on their own criminal records or

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that of family members, the logical intervention would be to first work to make systemic changes

that would increase access to opportunity and resources for African Americans overall,

especially those with criminal records, and/or those living in poverty. Clinicians could

simultaneously work individually or in groups with young, African American men so that they

may be ready and able to recognize and utilize opportunities. Systemic interventions could

include criminal and juvenile justice reform (e.g. allowing those with felony level drug offenses

to utilize food stamps), welfare reform, increased job opportunities for young African American

men, support for affirmative action programs, increased scholarship opportunities for college,

training for faculty and students in schools of education and social work, and support for policies

aimed to counteract discriminatory lending and access to housing (e.g. redlining).

Limitations

A limitation inherent to any theoretical paper is the dependence upon existing

information and theory, rather than the collecting of new evidence and generation of ideas based

on this information. This paper is no exception, as it relies on the previous research and no new

data was collected. It assumes as fact the disproportionate overrepresentation of African

American young men among those diagnosed with Conduct Disorder, working within existing

evidence. The ample previous research demonstrating the existence of this phenomenon,

however, seemed sufficient to preclude the necessity to replicate a qualitative or quantitative

study, and allowed for the opportunity to instead engage in theoretical analysis.

As a white woman, I am an outsider looking in, relying on accounts, writings, and

theories generated by those more directly impacted by Post Traumatic Slave Syndrome (DeGruy,

2005). My desire to distance myself from the role of oppressor, and my inclination towards

political and historical analysis could contribute to bias away from identifying "true" clinical

pathology in an attempt to avoid participating in the historical trend within psychology of

pathologizing the behavior of African American men (Adebimpe, 1981). As social and historical

analysis appears to be an under-discussed area within psychological assessment and diagnosis,

however, it is my hope that this approach will provide useful perspective.

Additionally, as a white person in the United States I inherently have an investment in

racism. Racism against African Americans and black immigrants can be said to have directly

benefited my family, as they were Jewish immigrants who were able to access significant

opportunity and resources once they were considered "white" (Brodkin, 1998). Prior to WWII

Jews in the United States were *not* considered white in the context of mainstream American

culture. With the help of institutional racism and increased access to opportunities to amass

wealth, Jews were able to become white in relation to blackness (Brodkin, 1998). Thus many of

the privileges I have had access to in my lifetime (education, resources, employment) are a direct

result of racism. While I make consistent and conscious attempts to be aware of my privilege

and to make choices that do not further racist practices, the benefits I receive from this system,

the privilege I have as a white person, and my overall racial socialization within the current

racial hierarchy necessarily impacts my analysis, presenting a potential limitation to my research.

However, in order to account for this limitation, my primary theoretical frameworks are rooted in

the work and perspectives of African American scholars.

Additionally, there are a multitude of potential causes of behavioral symptomology for

young African American men that are not addressed in this paper. Learning differences

("disabilities"), institutional racism, chaotic home lives, and complex (ongoing) trauma are a few

of the possibilities that might contribute to behavioral symptoms, especially within the school

setting. For example, a crucial discussion, beyond the scope of this paper, is that raised by

Herbert Kohl (1994) in his book *"I won't learn from you": And Other Thoughts on Creative Maladjustment.* Kohl (1994) explores the use of "not-learning" as a form of political resistance, used when a student feels that his intelligence, dignity or integrity is compromised by those in power (the teacher, institution, or society at large). This topic warrants lengthy consideration, but is the focus for another paper.

Finally, in order to effectively challenge the current method and criteria for diagnosis for Conduct Disorder, I operated under the assumption that DSM diagnoses are generally accurate and useful measures of disorder. A discussion about the utility of the DSM as an "objective" instrument is beyond the scope of this paper. A needed and missing analysis is that of the DSM as a cultural and historical document that generally may not be able to encapsulate the nature of suffering and healing for African Americans in the United States. Furthermore, another topic outside of the scope of this paper relates to the long history of racism within the field of psychiatry. This further complicates the use of the DSM, Intelligence Testing, and psychological assessment tools, and is worthy of study. In order to make an argument that might hold weight in the context of current accepted thought within the Mental Health Field, I did not challenge the verity and utility of the Conduct Disorder diagnosis, nor of the DSM. I do not mean to reify the scientific accuracy of the DSM through this paper, but this may be an unintended consequence of my limited review. My hope is that the benefits of this analysis might outweigh any repercussions.

Implications

With the help of Steele (2012), Alexander (2012), and DeGruy (2005) we see how the history of oppression of African Americans in the United States plays a large role in the creation of lasting negative stereotypes, as well as in ongoing symptomology for many African American

young men today. Both clinicians and African American male clients are likely impacted by the stereotype of African American men as "criminal," and it is probable that this impacts (and skews) clinical assessment and diagnosis, as a result of Stereotype Threat for the client and implicit bias for the clinician. We then see that there a variety of ways to define the core problem that leads to behavioral symptomology for some young, African American men, and that differing interventions follow these varying definitions. It is possible that if a clinician gives a diagnosis of Conduct Disorder to a young, African American man, this definition of the presenting problem may exclude interventions that perhaps more accurately address the source of the problem.

Implications for social work practice include the need for clinicians to incorporate historical analysis into the assessment and treatment process, in order to address both Stereotype Threat and implicit bias. Social work training, education, and organizations could promote this perspective, and could consistently encourage clinicians to incorporate this into their thinking. While some programs may already do this to some extent, more is needed. Also important is for clinicians to consider the impact of current discriminatory policies, past and current, on the client's environment, so as to accurately assess for whether the client's behavior is pathological or rational.

In terms of social work research, it is recommended that studies be conducted looking at the effect of Stereotype Threat within the psychological assessment process. Based on this research, recommendations could be generated as to how to address and minimize the impact of Stereotype Threat on this process, and perhaps the assessment tools and methods would be altered. Clinicians could also be encouraged to design treatment plans that intervene on varying levels, with the individual, family, community, and with state and federal policy. While many

clinicians likely will not have the resources, skills, or interest in participating in work on such varying levels, incorporating this into the treatment plan could encourage collaboration across discipline, and could thus potentially lead to more lasting and sustainable change for the client.

Conclusion

If clinicians do not consider historical oppression and trauma when conducting psychological assessments with African American young men, they ascribe to the philosophy and logic of "Colorblindness." As discussed previously, Colorblindness was born out of the attempt of political conservatives to continue racial segregation without using explicitly racist language. The purported intent of Colorblindness was to enact Martin Luther King, Jr.'s call to judge people not based on "…the color of their skin, but by the content of their character" (Nobelprize.org, 1964). Instead of combating prejudice, the rhetoric of Colorblindness decontextualized and coopted this call to end discrimination, and used it to invalidate negative racial experiences, dishonor diverse cultural heritage, and silence those voices that acknowledged racism.

Let not clinicians continue this denial of the reality of oppression in our work with African American young men. In a role ideally intended to alleviate suffering and facilitate healing, it is essential that we invite and make room for the expression of the client's full experience. The disproportionate overrepresentation of African American young men among those diagnosed with Conduct Disorder fits seamlessly into a legacy of criminalizing black men in the United States. This alone should be enough to warrant ongoing exploration into the impact of historical oppression on clinicians, on African American young men, and within the psychological assessment process.

Clinicians are granted considerable power to define the suffering of their clients through the language of the DSM. Once defined, the reverberations of assigned labels echo in the far reaches of institutions, within the systems of education, welfare, criminal or juvenile justice, and health. With the great power to define others' suffering comes the obligation to take the work seriously, and to find ways to honor and respect the experience of each individual who comes before us. In turn, we must also know ourselves as well as the forces that shape our perceptions and impact how we hear our clients. Perhaps the analysis presented in this paper leads to a call to clinicians to simply listen differently to the people who sit in front of us: to allow each person to define their own suffering and healing in their language and on their terms.

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