

HISTORICAL & ETHICAL  
CONSIDERATIONS  
FOR  
EARLY IDENTIFICATION OF  
PSYCHOSIS  
IN URBAN AFRICAN AMERICAN  
YOUTH



VIRTUAL WORKSHOP

THURSDAY, OCTOBER 6, 2022

9:00 AM - 4:30 PM EST

THE MORGAN STATE UNIVERSITY CENTER FOR CONTINUING & PROFESSIONAL STUDIES IS APPROVED BY THE MARYLAND BOARD OF SOCIAL WORK EXAMINERS TO PROVIDE CONTINUING EDUCATION TRAINING

# AGENDA

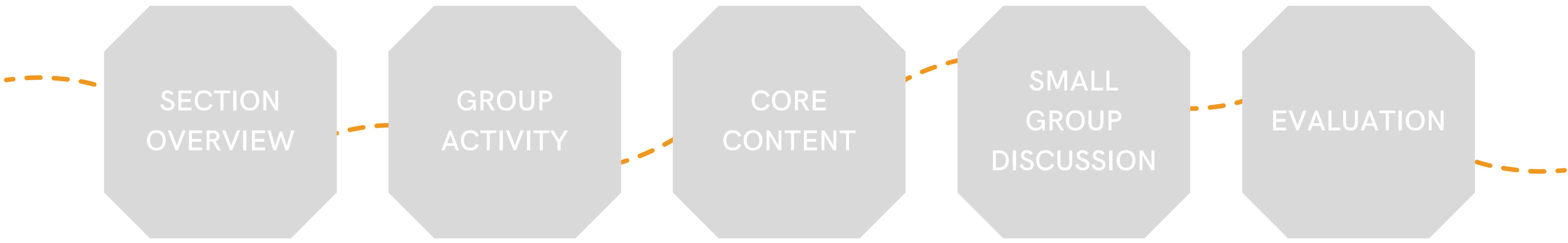
MSU/UMSOM  
CEU WORKSHOP

OCTOBER 6, 2022  
9:00 AM - 4:30 PM



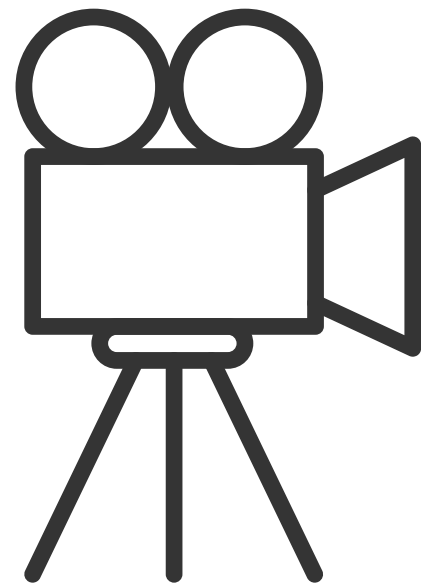
TIME	CONTENT
9:00 - 10:00	HISTORICAL CONSIDERATIONS & CULTURAL RESPONSIVENESS IN MENTAL HEALTH
10:00 - 10:05	BREAK
10:05 - 11:05	PSYCHOSIS & CULTURAL RESPONSIVENESS
11:05 - 11:20	BREAK
11:20 - 12:20	PSYCHOSIS & CULTURAL RESPONSIVENESS
12:20 - 1:00	LUNCH
1:00 - 2:00	ACCESS & TREATMENT CONSIDERATIONS IN PSYCHOSIS FROM AN ETHICAL LENS
2:00 - 2:05	BREAK
2:05 - 3:05	ACCESS & TREATMENT CONSIDERATIONS IN PSYCHOSIS FROM AN ETHICAL LENS
3:05 - 3:20	BREAK
3:20 - 4:20	ACCESS & TREATMENT CONSIDERATIONS IN PSYCHOSIS FROM AN ETHICAL LENS
4:20 - 4:30	CONCLUSION & EVALUATION

# TRAINING PROCESS & METHODS

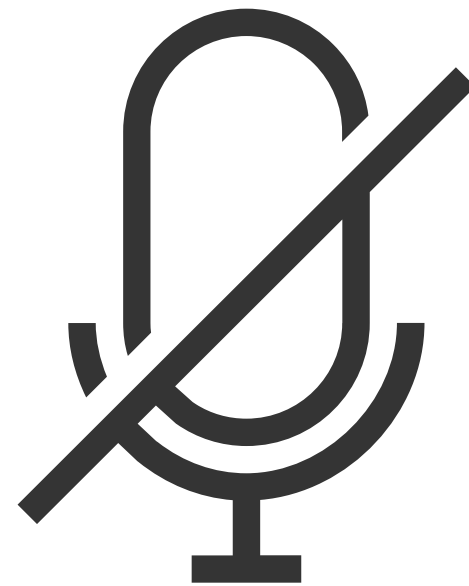


# TECHNOLOGY CONSIDERATIONS

PLEASE KEEP YOUR VIDEO ON



REMAIN MUTED UNLESS SPEAKING



PARTICIPATE IN CHAT BOX



# CEU PROCESS



## SIGN IN

- Zoom name must match registration name
- Please use the provided link to sign in



## COMPLETE EVALUATION

- A link will be emailed to registration email address (where you received registration confirmation)



## CERTIFICATE OF 6 CEU CREDITS

- Provided within 8 weeks
- Questions?

DOHA CHIBANI, LCSW-C

*Clinical Coordinator (She/her/They/them)*



DR. TOVAH COWAN

*Psychology Intern (She/Her)*



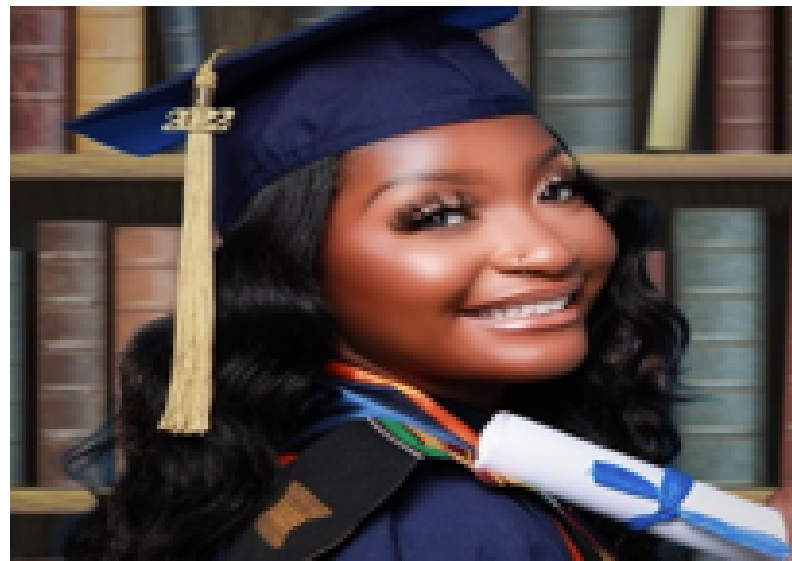
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*Associate Professor (She/Her)*



RANIYA HOLMES

*Graduate Research Assistant*



DR. NANCY LEVER

*Associate Professor (She/Her)*



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*Clinical Research Assistant (She/Her)*



**DR. BRITTANY PATTERSON**

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**NIKITA A. PARSON, LCSW-C**

*Assistant Director/Lead Clinician (She/Her)*



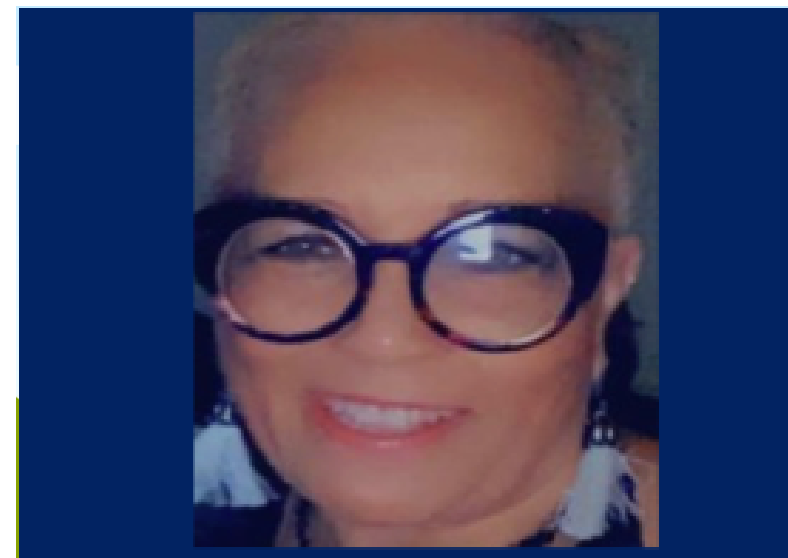
**DR. PAMELA RAKHSHAN ROUHAKHTAR**

*Assistant Research Scientist (She/Her)*



**MS. DIANE SIMMS**

*Administrative Coordinator (She/Her)*



**DR. MICHAEL SINCLAIR**

*Associate Professor (He/Him/His)*



# MORGAN STATE UNIVERSITY

1. Morgan State University's mission statement includes an "urban" focus.
2. Acknowledgement of funding and EIP contributions.
  - Part of a larger initiative related to psychosis with goals of enhancing the work.
3. What changes have happened over the last 10 years re: treatment and appropriate care in urban communities?



# UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

UNIVERSITY OF MARYLAND  
BALTIMORE COUNTY



The Maryland Early Intervention Program is a collaborative effort among several centers that includes four primary components:

1. Outreach and Education Services
2. Clinical Services
3. Consultation Services
4. Training and Implementation Support



UNIVERSITY *of* MARYLAND  
SCHOOL OF MEDICINE



UMBC

# PURPOSEFUL COLLABORATION

The COVID-19 pandemic has highlighted and exacerbated pre-existing disparities and equity gaps in mental health care outcomes, particularly for those belonging to marginalized racial groups, indicating the need for both intensified and novel outreach and education effort.

IN COLLABORATION WITH MORGAN STATE UNIVERSITY, THE MD EIP WILL:

.....

Increase reach and cultural sensitivity of MD EIP training resources

.....

Develop best practice considerations for preservice training

.....

Integrate educational materials into current graduate level courses at MSU

.....

Assess developed training to improve content for implementation for Year 2

.....

Develop a sustainability model for continuation of outreach and education efforts



# ACKNOWLEDGEMENT



**Natalee Solomon**  
**BHA Project Officer**

THIS PROJECT IS AFFILIATED WITH THE MARYLAND EARLY INTERVENTION PROGRAM: A COLLABORATIVE FOR THE EARLY IDENTIFICATION AND TREATMENT OF MENTAL ILLNESS WITH PSYCHOSIS.

FUNDING FOR THE MARYLAND EIP AND THIS COLLABORATIVE IS IN PART THROUGH THE MARYLAND DEPARTMENT OF HEALTH, BEHAVIORAL HEALTH ADMINISTRATION (BHA)

# TRAINING GOALS & OBJECTIVES

*INCREASE UNDERSTANDING OF BEST PRACTICES FOR SERVING ADOLESCENTS AND YOUNG ADULTS WITH POTENTIAL PSYCHOSIS FROM A CULTURALLY RESPONSIVE, STRENGTH-BASED, HOLISTIC AND NON-STIGMATIZING PERSPECTIVE.*

## OBJECTIVES

1

Increase knowledge and skills for applying a historically & contextually informed clinical lens by fostering cultural humility through self-reflection.

2

Learn the importance of ethical standards related to cultural competence for the early identification and intervention of mental health concerns, including psychosis.

3

Understand the impact of sociocultural, systemic, risk, and resiliency factors on young adults' lived experience of psychosis symptoms.

# INVITATION TO LEARNING



"THIRD RAIL" &  
"UNPACKING THE INVISIBLE  
KNAPSACK"  
(PEGGY MCINTOSH)



DIVERSE LEARNING  
COMMUNITY



INTEGRATION OF LITERATURE  
FOR A DIVERSE PROVIDER AND  
SERVICE USER POPULATION

# SHARED AGREEMENTS



- PARTICIPATE FULLY
- HAVE A BEGINNER'S MIND
- LISTEN FOR UNDERSTANDING
- ASSUME POSITIVE INTENT/OWN NEGATIVE IMPACT
- MAINTAIN EQUITY OF VOICE
- RESPECT CONFIDENTIALITY



# CONNECTOR ACTIVITY

AS YOU ENGAGE IN THIS  
IMPORTANT AND  
CHALLENGING WORK,  
WHAT IS **ONE STRATEGY**  
YOU USE TO FOSTER YOUR  
OWN WELL-BEING AND  
MENTAL HEALTH?



- *Please respond in the chat*

# ETHICAL RESPONSIBILITY

TO PROVIDE CULTURALLY RESPONSIVE  
CARE



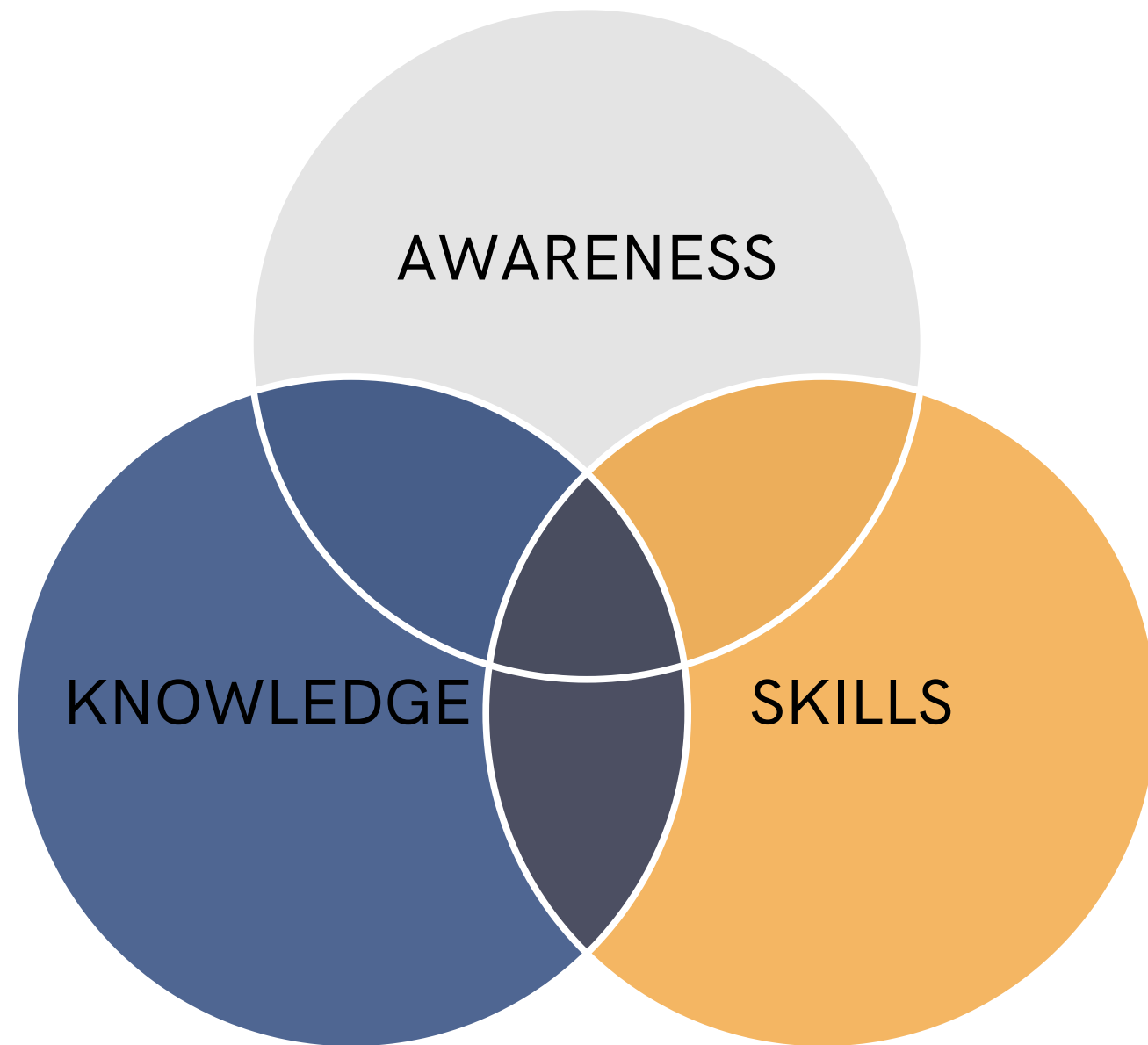
# ETHICAL PRINCIPLES



NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW)

# ETHICAL RESPONSIBILITIES TO CLIENTS

## 1.05 CULTURAL COMPETENCE



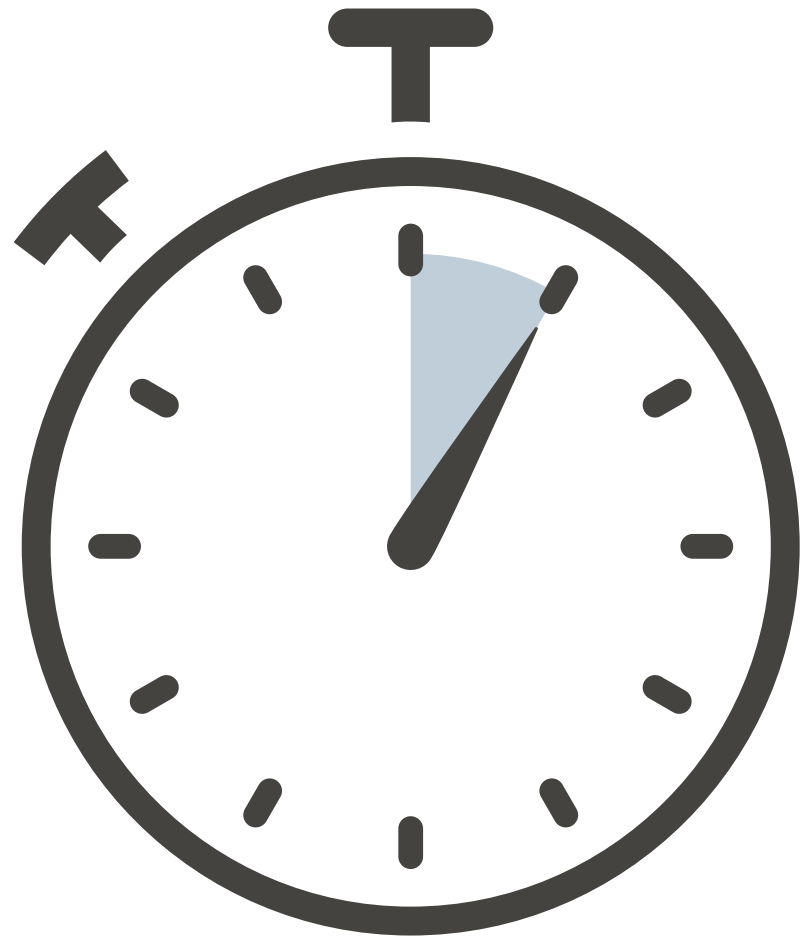
- Understand culture and strengths within each
- Knowledge guiding practice, skills to serve marginalized groups, and ability to act against social injustices
- Awareness and cultural humility
- Obtain and demonstrate knowledge of social diversity and oppression
- Identify and address barriers to equitable access

NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW)

# DESCRIBE ONE WAY YOU CURRENTLY DEMONSTRATE COMMITMENT TO CULTURAL COMPETENCE.

- Please provide your responses in the chat





# BACKGROUND

RACISM & MENTAL HEALTH



# BLACK FOLK MENTAL HEALTH: GENERATIONAL TRAUMA, TRADITIONS & TRUTH



# KEY DEFINITIONS

OPERATIONALIZING OUR TERMS



# WHAT DO WE MEAN BY "URBAN"



There are often stark contradictions within the urban environment.

While there may be exhibitions of opulence and wealth, and great political seats of power that often coexists with oppression, high unemployment rates among the underclass, violence and abject poverty.

The subculture can be both *gemeinschaft* and *gesellschaft*.

WE WILL FOCUS OUR ATTENTION ON THE MARGINALIZED  
GROUPS WITHIN THE URBAN ENVIRONMENT WHICH ARE OFTEN  
POOR, AFRICAN AMERICAN POPULATIONS.



~~RACISM~~

**RACISM ISN'T A BINARY.**  
IT'S A SPECTRUM THAT WE ALL  
EXIST ON. WHEN WE SPEND  
ENERGY DEFENDING OURSELVES,  
IT ROBS US OF THE CAPACITY TO  
LISTEN WITH OPENNESS TO POC  
VOICES, EXAMINE OUR BIASES AND  
THINK CRITICALLY ABOUT THE  
SYSTEMS WE ARE A PART OF.  
@LINDSAYBRAMAN

GENOCIDE

The act or intent to deliberately and systemically annihilate an entire people

BIAS MOTIVATED VIOLENCE

Murder, rape, assault, arson, terrorism, vandalism, desecration, threats

DISCRIMINATION

Economic, political, educational, employment, and housing discrimination; segregation, criminal justice disparities

ACTS OF BIAS

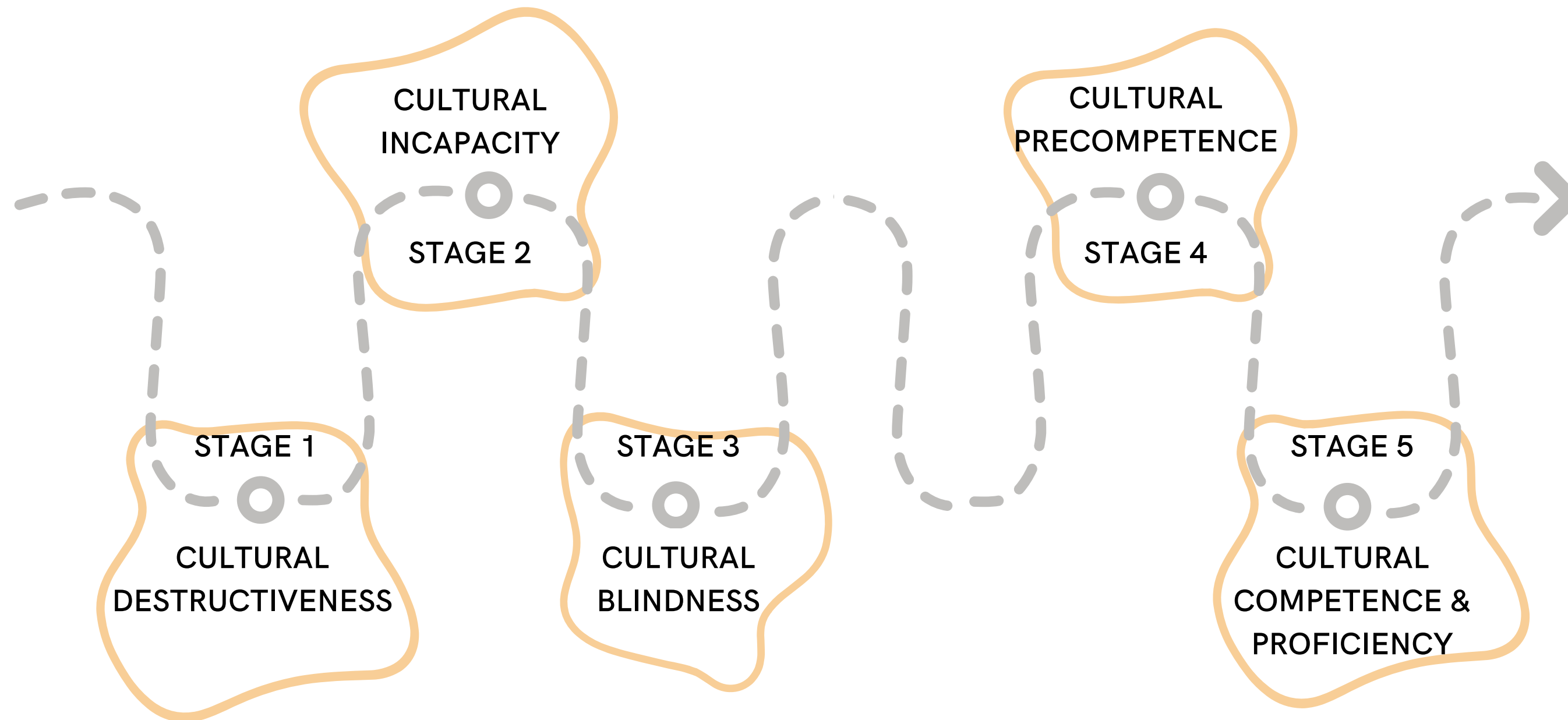
Bullying, ridicule, name-calling, slurs/epithets, social avoidance, dehumanization, biased/belittling jokes

BIASED ATTITUDES

Stereotyping, insensitive remarks, fear of differences, non-inclusive language, microaggressions, justifying biases by seeking out like-minded people, accepting negative or misinformation/screening out positive information



# THE CONTINUUM OF CULTURAL COMPETENCE



SAMHSA TIPS

# CULTURAL HUMILITY

- OWN YOUR CULTURE
- OPENNESS TO LEARN ABOUT OTHER CULTURES/PREFERENCES
- VALUE, RESPECT, APPRECIATE OTHERS' CULTURES/PREFERENCES
- INTEGRATE AND PRIORITIZE CULTURAL/PREFERENCES
- ALTERNATIVE LANGUAGE FOR CULTURES/PREFERENCES:  
"CULTURAL ASSETS AND NEEDS"

“  
COMMITTING TO AN ONGOING  
RELATIONSHIP WITH PATIENTS,  
COMMUNITIES, AND COLLEAGUES  
THAT REQUIRES HUMILITY AS  
INDIVIDUALS CONTINUALLY  
ENGAGE IN SELF-REFLECTION AND  
SELF-CRITIQUE

*(P. 118). TERVALON & MURRAY-GARCÍA (1998)*



BP

NP

# FOSTERING CULTURAL HUMILITY THROUGH REFLECTION

How would you describe  
your social or cultural  
identity(ies)?

How do your social or  
cultural identities show up  
in your work?

# EXPLORING IDENTITY USING THE ADDRESSING FRAMEWORK

*WHAT  
IDENTITIES ARE  
NOT COVERED  
BY ADDRESSING?*

- A AGE & GENERATIONAL INFLUENCES
- D DEVELOPMENTAL DISABILITIES
- D DISABILITIES ACQUIRED LATER IN LIFE
- R RELIGION & SPIRITUAL ORIENTATION
- E ETHNICITY
- S SOCIO-ECONOMIC STATUS
- S SEXUAL ORIENTATION
- I INDIGENOUS HERITAGE
- N NATIONAL ORIGIN
- G GENDER IDENTITY

## POWER

- A** • Adult
- D** • People without a disability
- D** • Persons without a mental health disorder
- R** • Christian
- E** • White/Caucasian
- S** • Owning and Middle Class
- S** • Straight/Heterosexual
- I** • Non-Native/Settler
- N** • US Born
- G** • Cisgender Male

## LESS POWER OR OPPRESSED

- Child and Senior
- Person with disabilities
- Person with a mental health disorder
- Anything else
- Anything else
- Lower- and working-class
- Anything else
- Native or Indigenous
- Non-US Born
- Anything else

BP

*KEY TAKEAWAY:*

*SOCIAL AND CULTURAL IDENTITIES INFLUENCE OUR PERSPECTIVES AND HOW WE INTERACT WITH OTHERS PERSONALLY AND PROFESSIONALLY*

# BLACK MENTAL HEALTH MATTERS





What is your felt reaction to this video?

What is this video challenging you to do?

How would you want to take up that challenge?

# REACTIONS & DISCUSSION

# RACISM IN MENTAL HEALTH: A BRIEF HISTORY

- Cartwright published a report inventing two “psychiatric” disorders, draeptomania and dysaesthesia aethiopica to explain tendencies of enslaved people to run away or resist hard work as mental illness.
- **These beliefs were used to justify lack of therapeutic treatments for Black patients.**
- Many hospitals had dual systems that kept Black patients in separate, substandard facilities and put to work doing laundry, kitchen, and field work.
- These conditions were not seriously challenged until the 1960s.
- In 1967, the Office of Equal Health Opportunity within the Department of Health, Education and Welfare found psychiatric hospitals in the south operating in breach of the Civil Rights Act.
- Inspector Marilyn Rose wrote, “the general wards were horrid.”

# IMPACT OF RACISM ON MENTAL HEALTH

- BIPOC youth more likely to receive referral to juvenile justice system than mental health as compared to white peers
- Racism, bias, and prejudice in MH settings does harm, contributes to racial trauma
- Increased experiences with racism, subtle and overt, associated with increased depression rates in BIPOC populations.



# IMPACT OF RACISM ON MENTAL HEALTH

- **MISDIAGNOSIS**
  - IN BLACK BOYS
    - OVER DIAGNOSE EXTERNALIZING DX
    - UNDER DIAGNOSE INTERNALIZING DX
- **IRRELEVANT TREATMENT**
  - RELIGIOUS MINORITIES
- **DISPARATE OUTCOMES**
  - LESS POSITIVE IMPACT OF TX
- **MISDIAGNOSIS OF SCHIZOPHRENIA**
  - BLACK CLIENTS 4X MORE LIKELY TO BE DIAGNOSED WITH SCHIZOPHRENIA
    - OVERLOOK MAJOR DEPRESSION

## MENTAL HEALTH AMERICA

- “One study found that physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with Black patients than with white patients.”
- “Compared with white people with the same symptoms, Black people are more frequently diagnosed with schizophrenia and less frequently diagnosed with mood disorders.”
- “Native and Indigenous American adults have the highest reported rate of [diagnosed] mental illnesses of any single race identifying group.”

# IMPACT OF RACISM ON MENTAL HEALTH

“

CULTURAL INCOMPETENCE OF HEALTH CARE PROVIDERS LIKELY CONTRIBUTES TO UNDERDIAGNOSIS AND/OR MISDIAGNOSIS OF MENTAL ILLNESS IN BIPOC.

LANGUAGE DIFFERENCES BETWEEN PATIENT AND PROVIDER, STIGMA OF MENTAL ILLNESS AMONG BIPOC, AND CULTURAL PRESENTATION OF SYMPTOMS ARE SOME OF THE MANY BARRIERS TO CARE THAT EXPLAIN THESE ERRORS IN THE DIAGNOSTIC PROCESS.

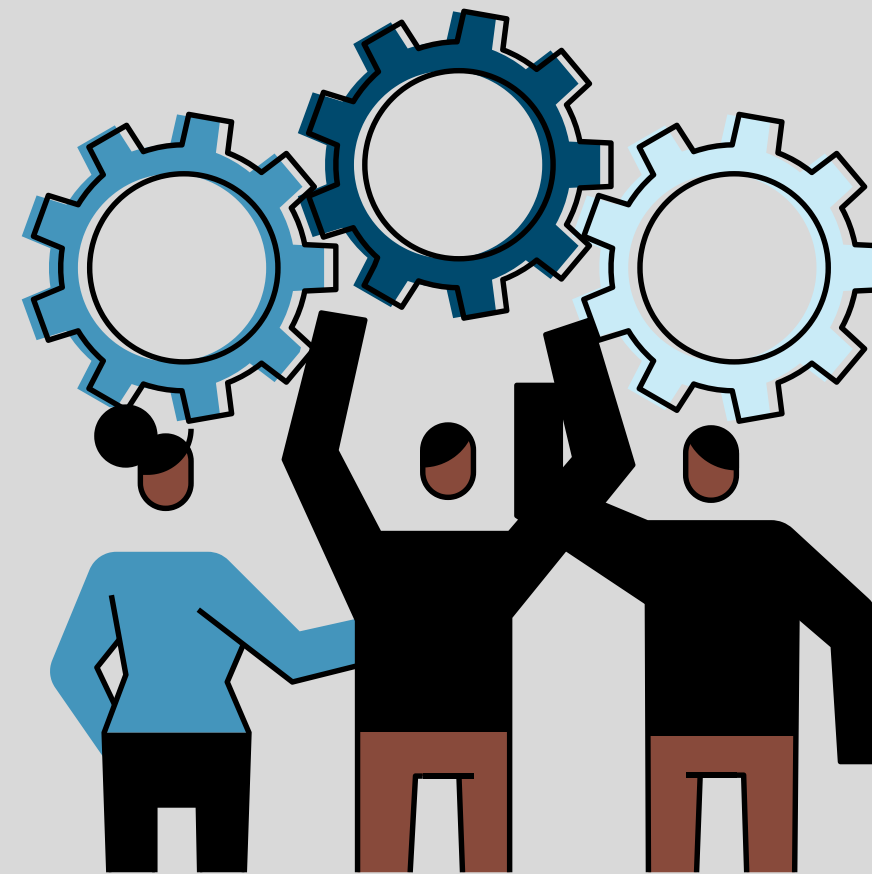
[HTTPS://WWW.MHANATIONAL.ORG/RACISM-AND-MENTAL-HEALTH](https://www.mhanational.org/racism-and-mental-health)

IN YOUR EXPERIENCE, HOW HAVE YOU SEEN RACISM  
IMPACT MENTAL HEALTH SERVICES AND/OR  
SUPPORTS?

WHAT STRATEGIES/TOOLS/RESOURCES WERE USED TO  
ADDRESS THESE CONCERN?

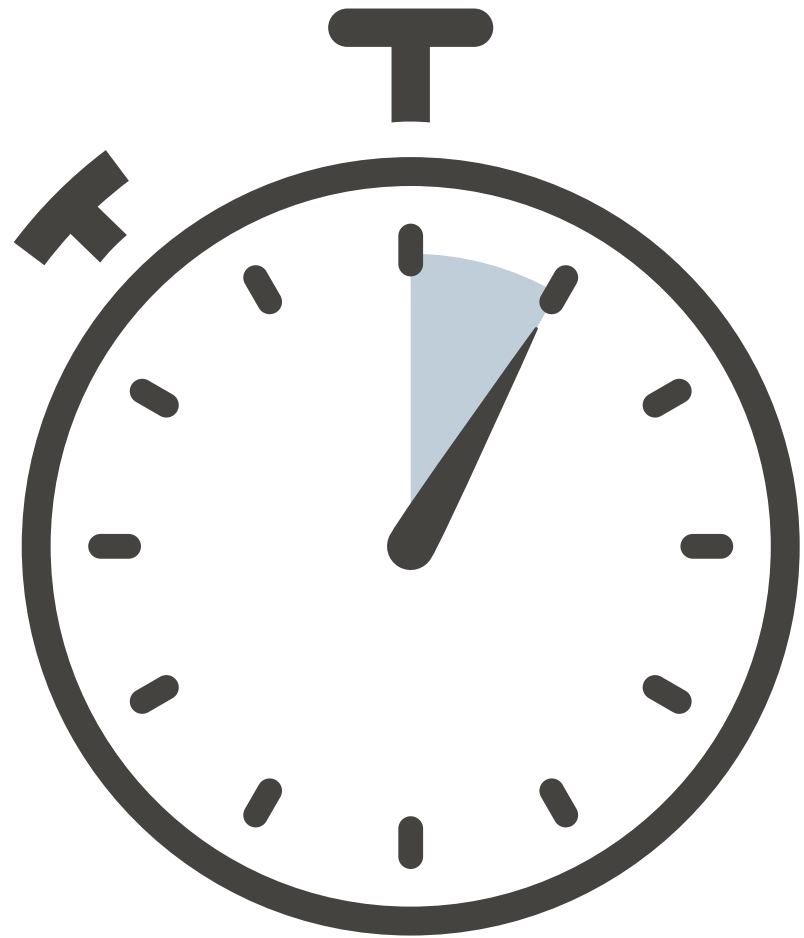
# BREAK OUT DISCUSSION

- 4-5 people per room
- 1 facilitator
- Script on maintaining safety
- Webcam on
- Everyone has a chance to speak



# DISCUSSION DEBRIEF





reconnecting  
after the  
break...

**What is your main  
take-away from  
the last section?**

*Please post your thoughts in the chat*

# ROLE OF THE CULTURALLY RESPONSIVE PROVIDER



# ROLE OF THE CULTURALLY RESPONSIVE PROVIDER

## PROVIDER

- Address your own biases
- Understand client's values and cultural context
- Address potential concerns of client regarding positionality (ADDRESSING intersections)
- Understand/ask/respond to client language
- Help client be heard and understood

## COLLABORATOR

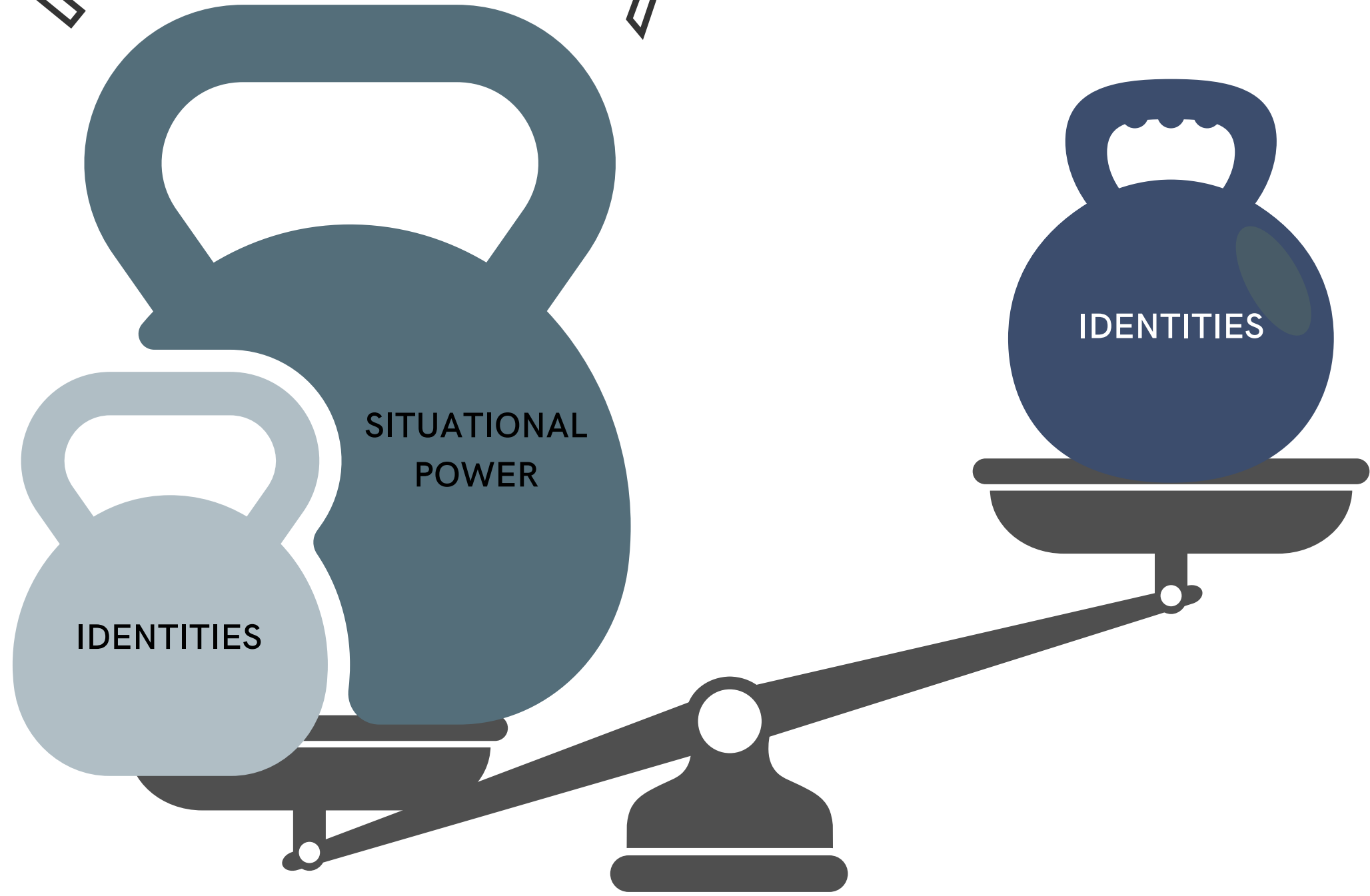
- Working with family, loved ones
- Mindful of language used to discuss client in public/private
- Understand family dynamics

## AMBASSADOR

- Working with diverse stakeholders in community to support client's/clients' holistic needs

PROVIDER

CLIENT



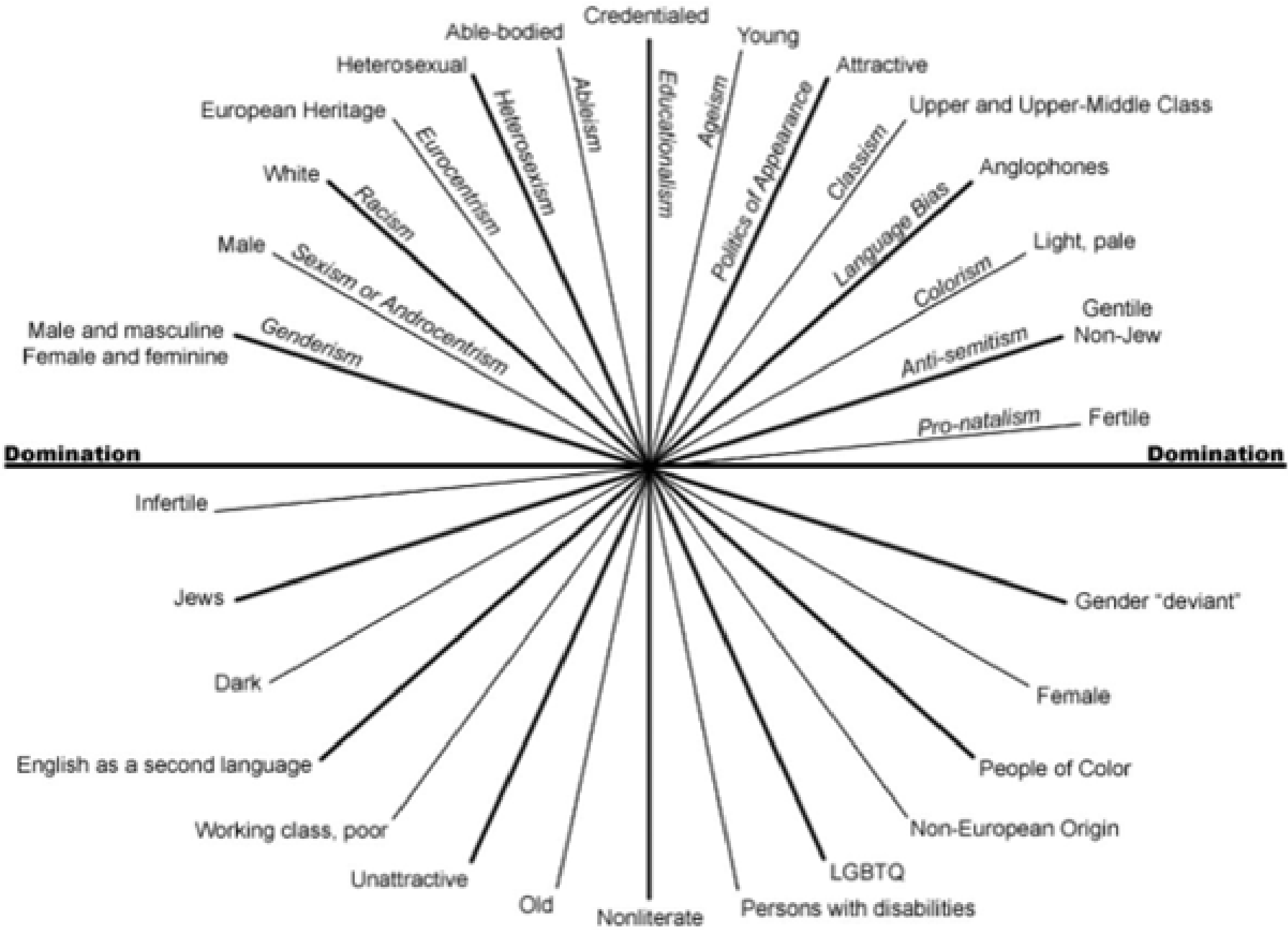
# ROLE OF THE CULTURALLY RESPONSIVE PROVIDER

**INTERSECTIONALITY**

Privilege is seen above the Domination line.

### Intersecting Axes of Privilege, Domination, and Opression

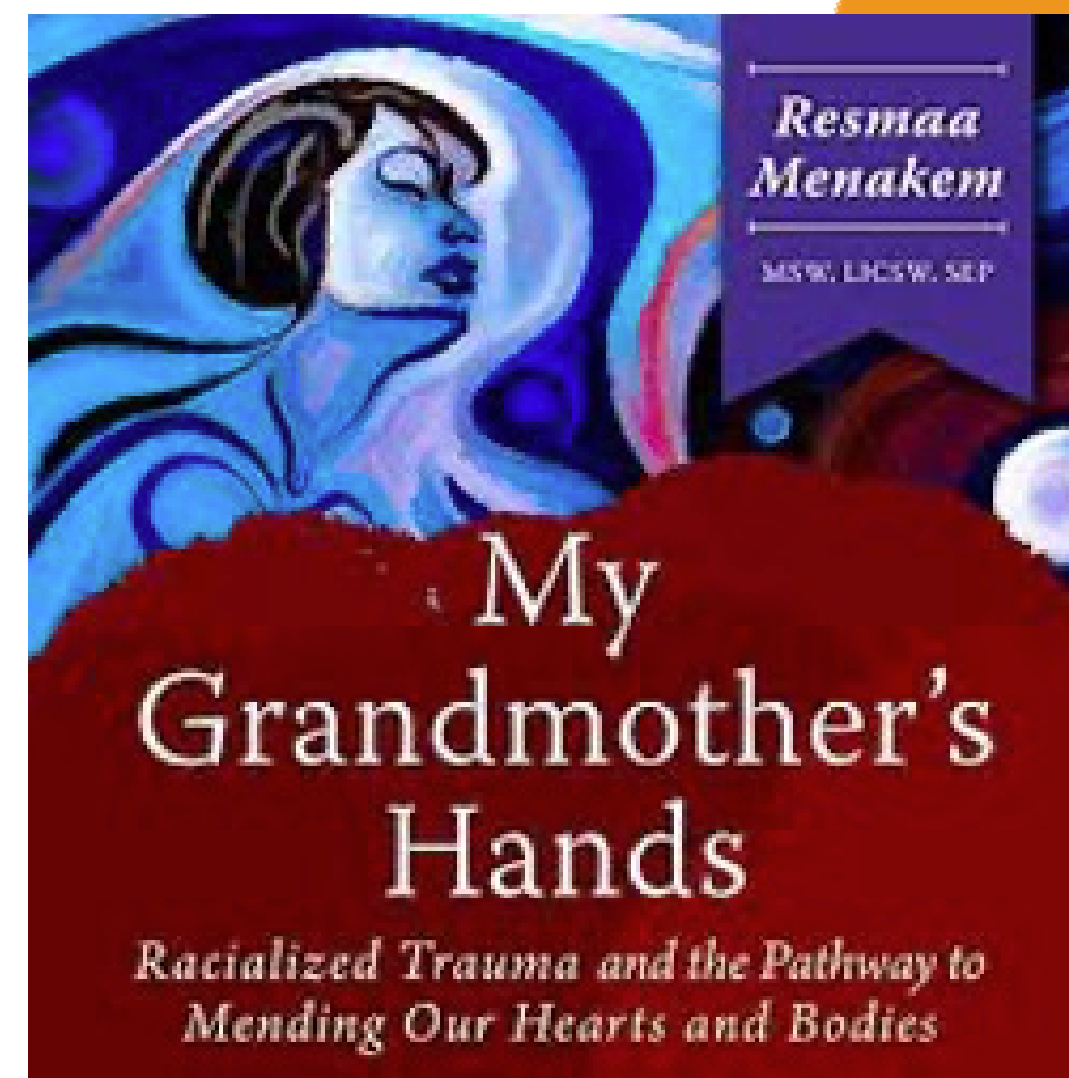
*Adapted from Kathryn Pauly Morgan, "Describing the Emperor's New Clothes: Three Myths of Educational (In)Equality," The Gender Question in Education: Theory, Pedagogy & Politics, Ann Diller et al., Boulder, CO: Westview, 1996.*



# BEING CULTURALLY RESPONSIVE: ACTING AS PROVIDER

## Addressing your own biases

- If you don't proactively do it, they'll show up without you knowing
- Start by listing your values and principles
- Cultivate the mindset of humility
- Recognize your own assumptions
  - "Where did I learn this?"
  - "Does this align with my values?"
  - "Did this protect me from something? Does it still?"
- Learn from as many different people as you can



# EXAMPLES OF IMPACT IN PRACTICE

## RACIAL BIASES IN ATTITUDES & TREATMENT PROVISION

- **Implicit Biases**

- *“The doctor comes in and goes, ‘Hey, do you want us to tie your tubes?’ . . . Yes! But she had been told by other friends to expect that, because apparently it’s kind of common that if you’re a Black woman and you’re on Medicaid, you will be asked if you want to tie your tubes. Which is—that’s fucked up!”*

- **Explicit Biases**

- “We don’t want these people having any more babies than they already do.”
- “(Long pause) Um . . . uh . . . One of my African American clients said that she felt not listened to, but, since I wasn’t there, I can’t comment on what I would have observed.”

# BEING CULTURALLY RESPONSIVE: ACTING AS PROVIDER

## COMMIT. UNVEIL. RESPOND. EVALUATE. (CURE)

### COMMIT

Commit to ongoing self-reflection, learning, and actively addressing problematic biases

### UNVEIL

#### YOUR BIASES

- Diversity Profile
- Take stock of your friends

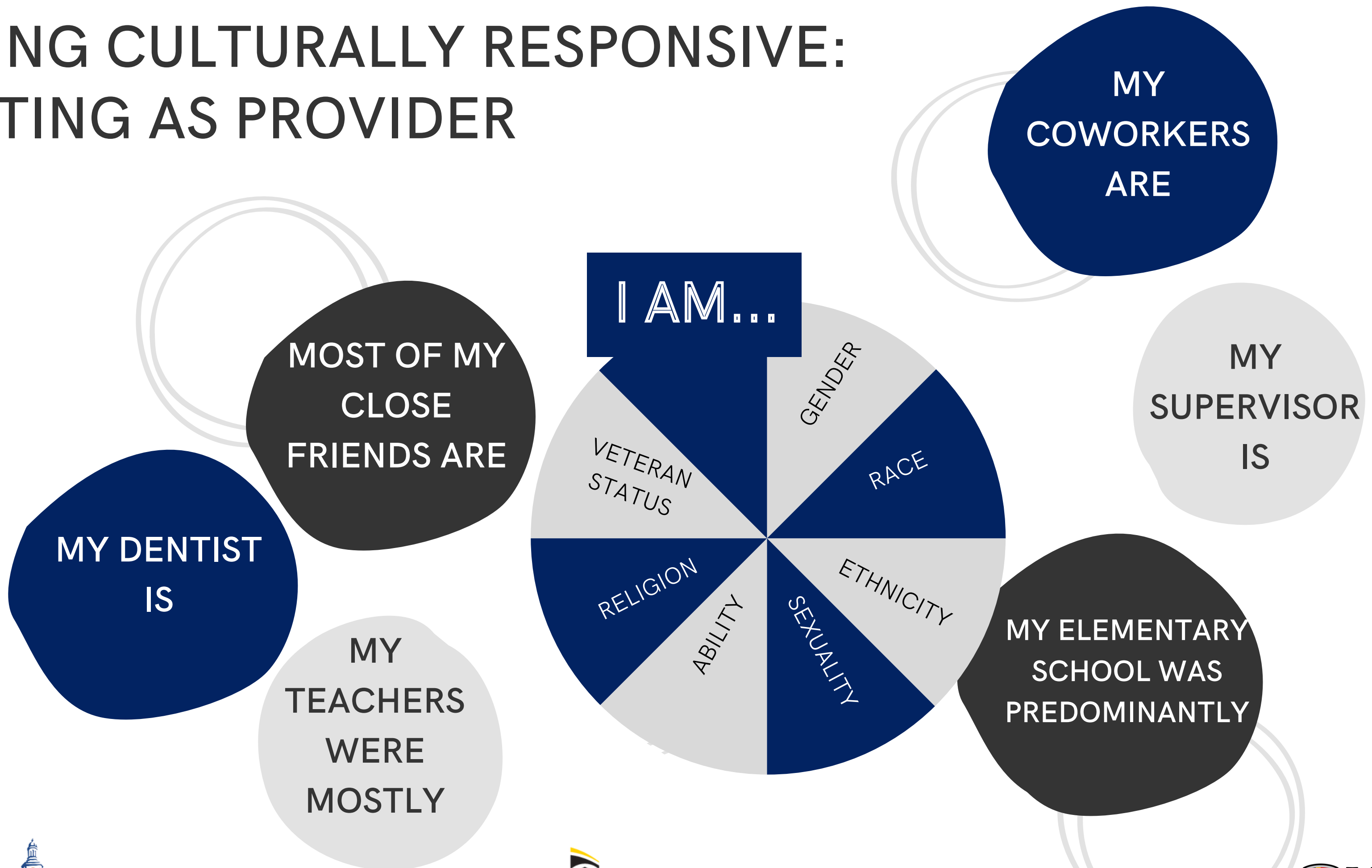
### RESPOND

- Seek out other sources of information, perspectives different than your own
- Cultivate mindful awareness to what happens when you're challenged
- Practice new responses/alternative ways of seeing the world

### EVALUATE

- Solicit and learn from feedback
- Repeat the process 😊

# BEING CULTURALLY RESPONSIVE: ACTING AS PROVIDER



# BEING CULTURALLY RESPONSIVE: ACTING AS PROVIDER

ARE THERE ANY WAYS THAT CULTURE/SPACE/IDENTITY MAKES IT HARDER FOR YOU?

HOW DO YOU IDENTIFY? WHAT IDENTITIES ARE IMPORTANT TO YOU?

WHAT ARE WAYS THAT CULTURE/SPACE/IDENTITY SUPPORTS YOU?

## UNDERSTAND CLIENT'S VALUES AND CULTURAL CONTEXT

- *Open ended questions*

## ANY TWO PEOPLE WITH THE SAME IDENTITIES WILL STILL HAVE DIFFERENT EXPERIENCES

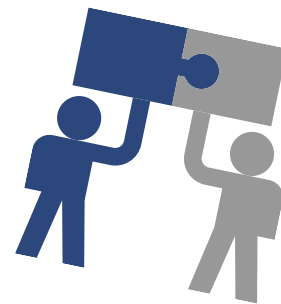
- *But they may have some shared experiences, language, connection*

"YOU HAVE X IDENTITY, AND I HAVE Y IDENTITY - FOR SOME PEOPLE, THAT BRINGS UP CONCERNS. WHAT CONCERNS DO YOU HAVE?"

"YOU AND I BOTH SHARE X IDENTITY; WHAT FEELINGS DO YOU HAVE ABOUT THAT?"

## ADDRESSING CLIENT'S CONCERNS REGARDING SHARED/DIFFERENT IDENTITIES

- *Be clear, inquire what it means for them*
- *If needed, practice before...*



# BEING CULTURALLY RESPONSIVE: ACTING AS PROVIDER

## UNDERSTAND/ASK/RESPOND TO CLIENT LANGUAGE

- Periodically check in about therapeutic relationship
- Help client be heard and understood
- Seek out own voices/academic perspectives in order to support the client feeling heard
- It shouldn't be on them! Look for leaders in those communities and do your own research

LISTEN.  
LISTEN...



# IMPROVING CROSS-CULTURAL COMMUNICATION

HEALTH DISPARITIES HAVE MULTIPLE CAUSES. ONE SPECIFIC INFLUENCE IS CROSS-CULTURAL COMMUNICATION BETWEEN THE COUNSELOR AND THE CLIENT.

WEISS (2007) RECOMMENDS THESE SIX STEPS TO IMPROVE COMMUNICATION WITH CLIENTS:

1. Slow down.
2. Use plain, nonpsychiatric language.
3. Limit the amount of information provided at one time.
4. Use the "teach-back" method. Ask the client, in a nonthreatening way, to explain or show what they have been told.
5. Create a shame-free environment that encourages questions and participation.

# BEING CULTURALLY RESPONSIVE: ACTING AS COLLABORATOR

## WHAT DID THE WIZARD OF OZ GIVE THE TIN MAN?

- The lion?
- The scarecrow?

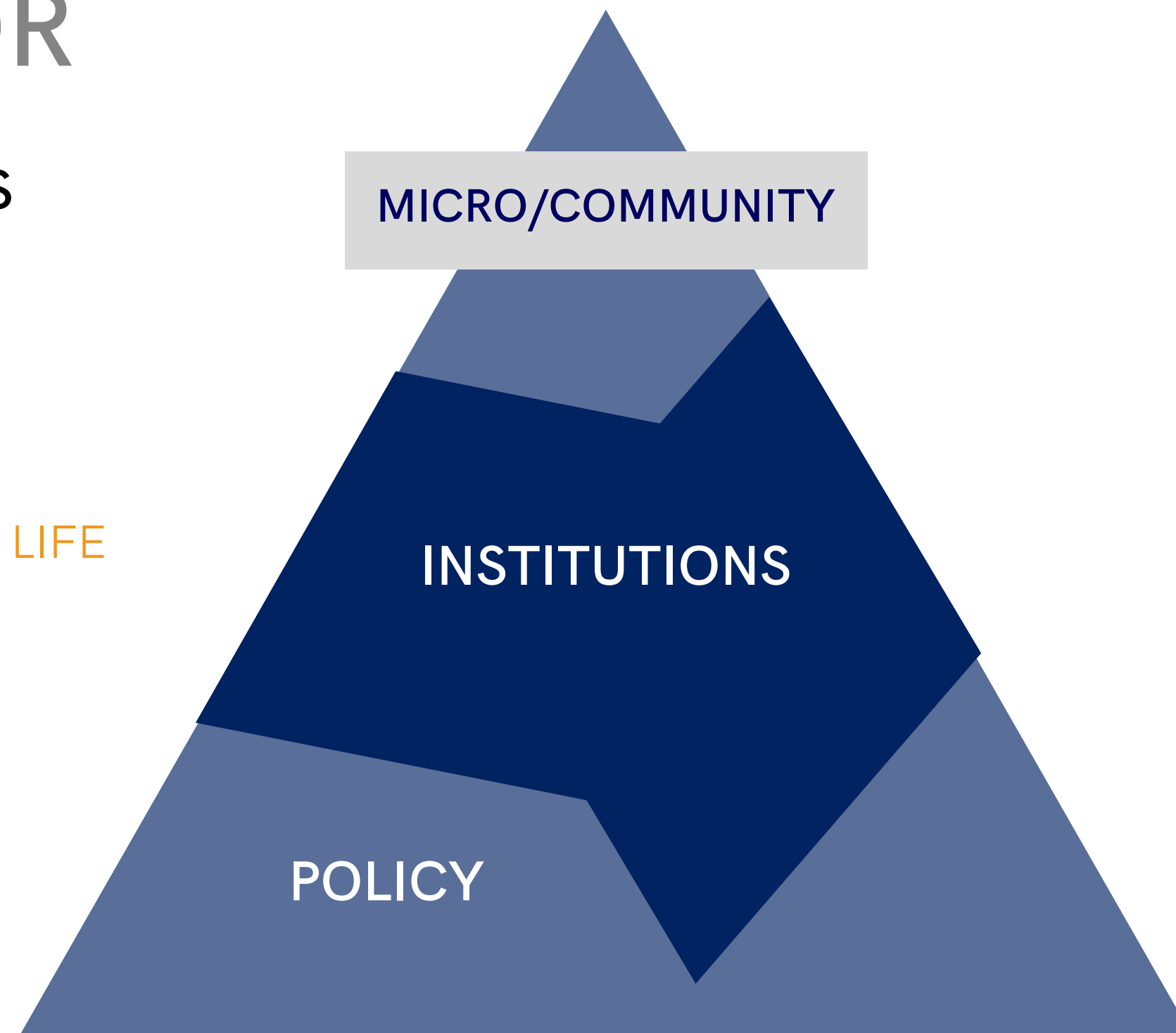
- CAPITALIZE ON STRENGTHS OF FAMILY
- INVOLVE SUPPORTIVE FAMILY
- MINDFUL OF LANGUAGE USED TO DISCUSS CLIENT (in public and in private)
  - *Stigma*



# BEING CULTURALLY RESPONSIVE: ACTING AS AMBASSADOR

## ADVOCATING FOR CHANGE AT SEVERAL LEVELS

- CREATE AN EXPLICIT PLAN WITH CLIENT
  - *Who do they want you to talk to*
  - *What will your role be in the meeting?*
- REACHING OUT TO STAKEHOLDERS IN THE PERSON'S LIFE
- INTERFACING WITH INSTITUTIONS
  - *E.g. work, school, church*
- ADVOCATING FOR CHANGES IN THE BROADER POLICY/COMMUNITY/WORLD THAT SUPPORT YOUR CLIENT(S)

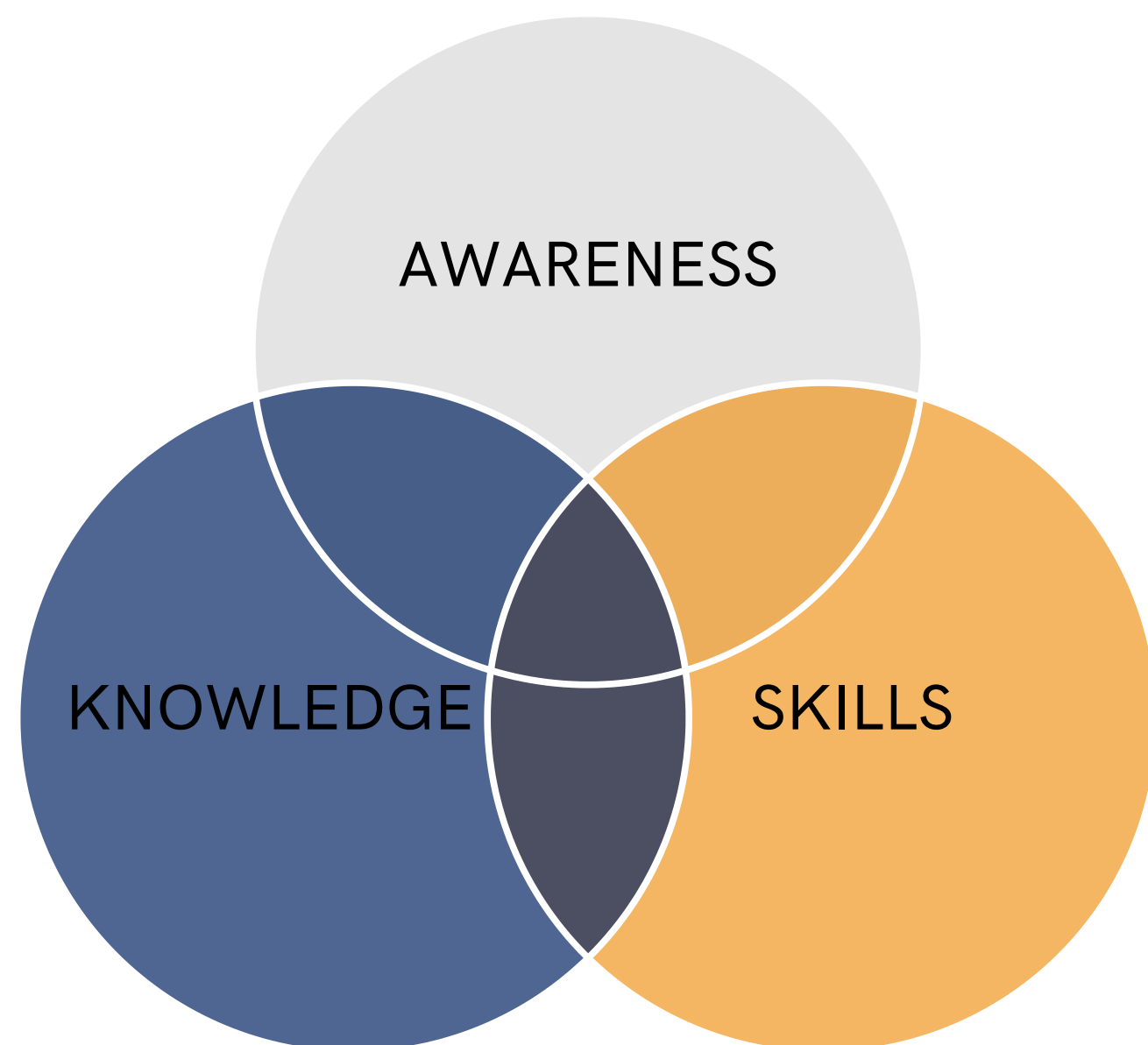


WHO ARE THE STAKEHOLDERS IN YOUR COMMUNITY THAT MAY BE ABLE TO HELP ADDRESS STIGMA/ADDRESS HOLISTIC NEEDS OF CLIENT/FAMILY?

C O M M U N I T Y

# ETHICAL RESPONSIBILITIES TO CLIENTS

## 1.05 CULTURAL COMPETENCE



- Understand culture and strengths within each
- Knowledge guiding practice, skills to serve marginalized groups, and ability to act against social injustices
- Awareness and cultural humility
- Obtain and demonstrate knowledge of social diversity and oppression
- Identify and address barriers to equitable access

NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW)

# ADDITIONAL ETHICAL RESPONSIBILITIES

## RESPONSIBILITIES AS PROFESSIONALS

Not to practice, condone, facilitate or collaborate with any form of discrimination

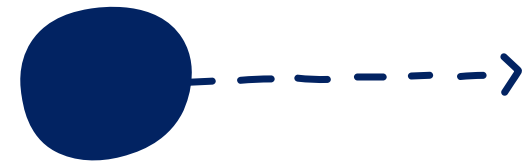
## RESPONSIBILITIES TO BROADER SOCIETY

- Promote general welfare from **local to global levels**; advocate for living conditions conducive to basic human needs; promote values and institutions compatible with social justice.
- **Engage in social and political action** to ensure equal access and opportunity; advocate for changes in policy and legislation to improve social conditions and promote social
- **Promote conditions that encourage respect for cultural and social diversity**

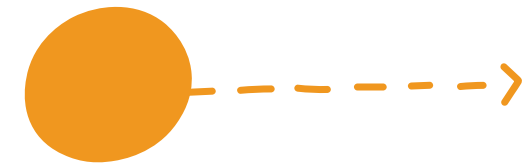
NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW)

# NATIONAL ASSOCIATION OF BLACK SOCIAL WORKERS

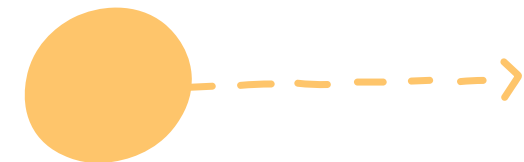
## CODE OF ETHICS



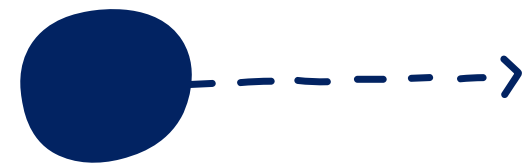
PRIMARY OBLIGATION IS TO THE WELFARE OF THE BLACK INDIVIDUAL, BLACK FAMILY, AND BLACK COMMUNITY



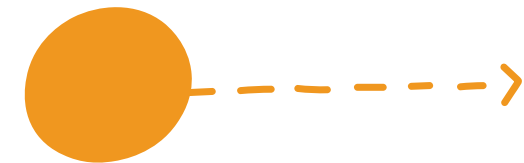
ENGAGE IN ACTION FOR IMPROVING SOCIAL CONDITIONS & GIVE PRECEDENCE TO THIS MISSION OVER PERSONAL INTEREST.



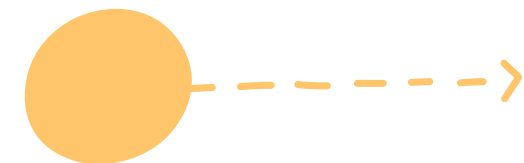
ADOPT THE CONCEPT OF A BLACK EXTENDED FAMILY



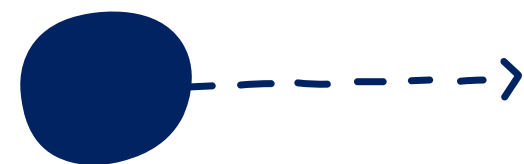
HOLD RESPONSIBILITY FOR THE QUALITY AND EXTENT OF SERVICE I, AND THE AGENCY IN WHICH I AM EMPLOYED, PERFORM



PROTECT THE BLACK COMMUNITY AGAINST UNETHICAL AND HYPOCRITICAL PRACTICE

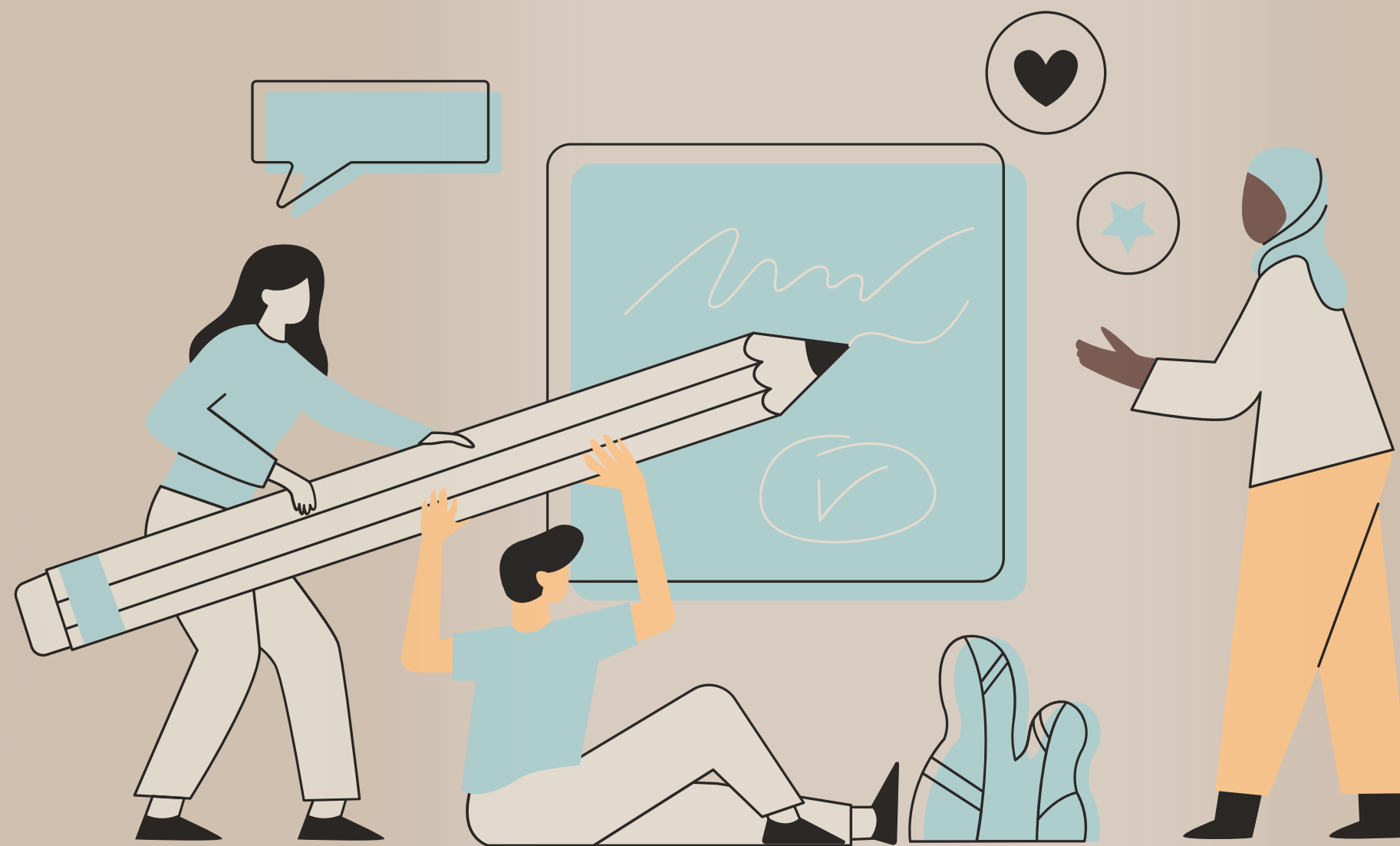


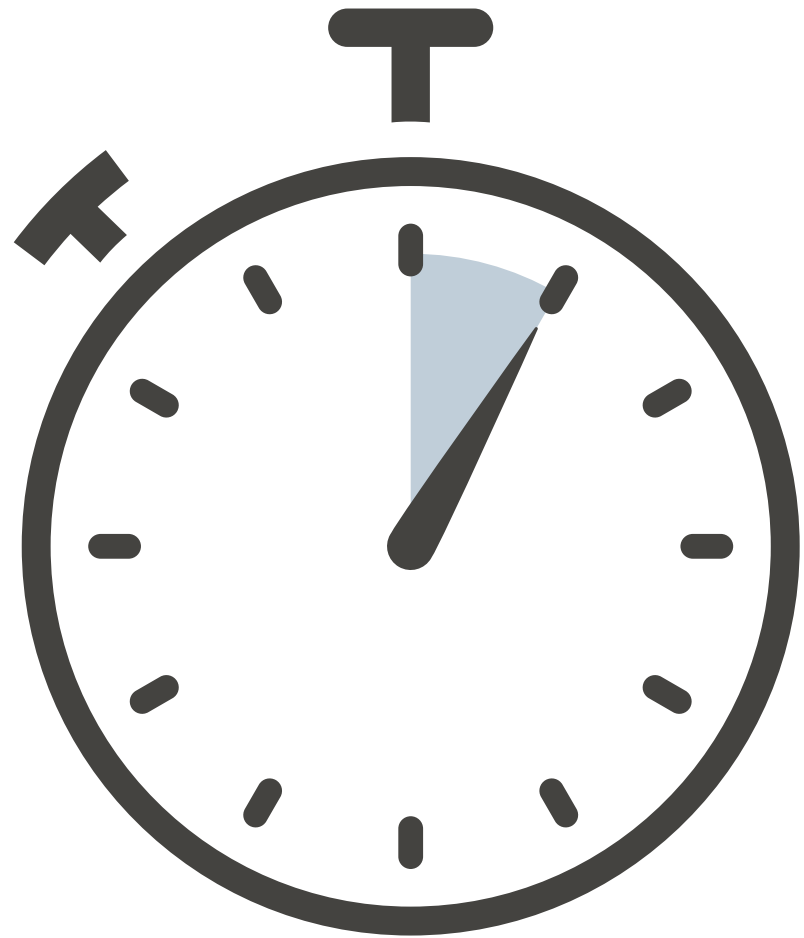
SUPPLEMENT PAID OR PROFESSIONAL ADVOCACY WITH VOLUNTARY SERVICE



BE AN INSTRUMENT FOR SOCIAL CHANGE, WITH PARTICULAR ATTENTION DIRECTED TO THE ESTABLISHMENT OF BLACK SOCIAL INSTITUTIONS.

# HOW DO ETHICAL OBLIGATIONS, AS LAID OUT BY NASW AND NABSW, REFLECT THE THREE ROLES OF THE CULTURALLY RESPONSIVE PROVIDER?







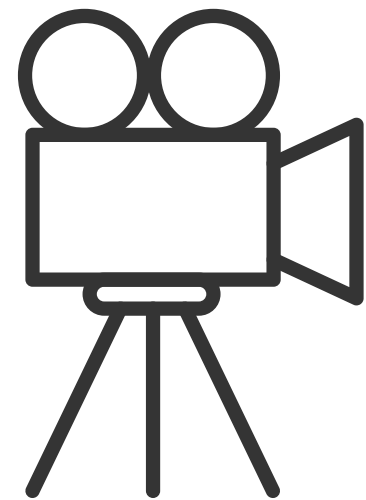
*PLEASE RETURN AT 1:00*



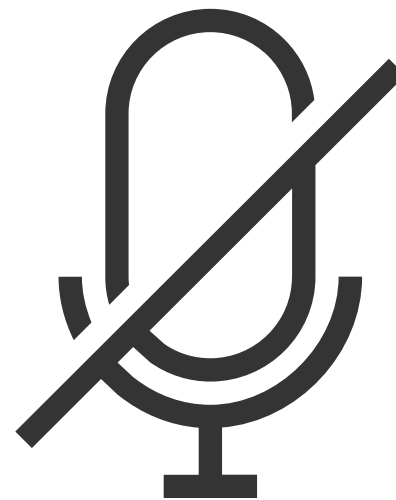
# WELCOME BACK.

## FRIENDLY REMINDERS...

PLEASE KEEP YOUR VIDEO ON



REMAIN MUTED UNLESS SPEAKING



PARTICIPATE IN CHAT BOX



reconnecting  
after the  
break...



WHAT KERNELS OF  
INFORMATION  
ARE YOU TAKING WITH YOU  
FROM THE LAST SECTION?

*Please post your thoughts in the chat*

# PSYCHOSIS

BRIEF HISTORICAL CONTEXT



# HISTORY OF PSYCHOSIS

# BRIEF HISTORY

## ORIGINS OF PSYCHOSIS

**Dementia Praecox:**  
development of a peculiar simple condition of mental weakness occurring at a youthful age.

EMIL KRAEPELIN

1899

PARANOID SUBTYPE APPEARS

Disproportionate diagnoses:  
• Black men diagnosed 5-7x more often than white counterparts

RACIALIZATION & PROTEST PSYCHOSIS  
1980'S

PAUL EUGEN BLEULER

1911

Illness marked by "turning away from reality and into a world of fantasy, wishes, and symbols."  
• Emphasis on spectrum and "neurosis" as a developmental disorder, resulting from "splitting" of basic functions of the personality.  
• Schizophrenia: combination of Greek words for split (schizein) and mind (phren).

FIRST EDITION OF DSM

1952

Schizophrenia: "a psychological reaction characterized by 'emotional disharmony, unpredictable disturbances in stream of thought,' and 'regressive behavior.'"

National Committee for Mental Hygiene's Statistical Manual for the Use of Institutions for the Insane as "the illness [which] afflicts the seclusive type of personality."

1918

SCHIZOPHRENIA DESCRIBED

"Split mind", almost exclusively linked to white bodies.  
• Psychiatrists described patients with schizophrenia as white academics poets, eccentrics, and women.

1920'S-1950'S  
WHITEWASHING OF PSYCHOSIS



# BRIEF HISTORY: RACIALIZED PSYCHOSIS

Cooperation often begins with  
**HALDOL**  
(haloperidol)  
a first choice for starting therapy

**Acts promptly to control aggressive, assaultive behavior**  
Several studies have reported the rapid effectiveness of Haldol in controlling aggressive and assaultive behavior. In one study, 14 days of treatment with Haldol resulted in a 50% reduction in the number of aggressive acts. In another study, Haldol was found to be effective in controlling aggressive behavior in patients with schizophrenia.

**Usually leaves patients relatively alert and responsive**  
Although some patients may experience sedation, Haldol usually leaves patients relatively alert and responsive. In a study comparing Haldol to other antipsychotics, Haldol was found to be more effective in controlling aggressive behavior while leaving patients more alert and responsive.

**Reduces risk of serious adverse reactions**  
Haldol is considered a first-line antipsychotic because of its effectiveness in controlling aggressive behavior and its relatively low risk of serious adverse reactions. In a study comparing Haldol to other antipsychotics, Haldol was found to be more effective in controlling aggressive behavior while leaving patients more alert and responsive.

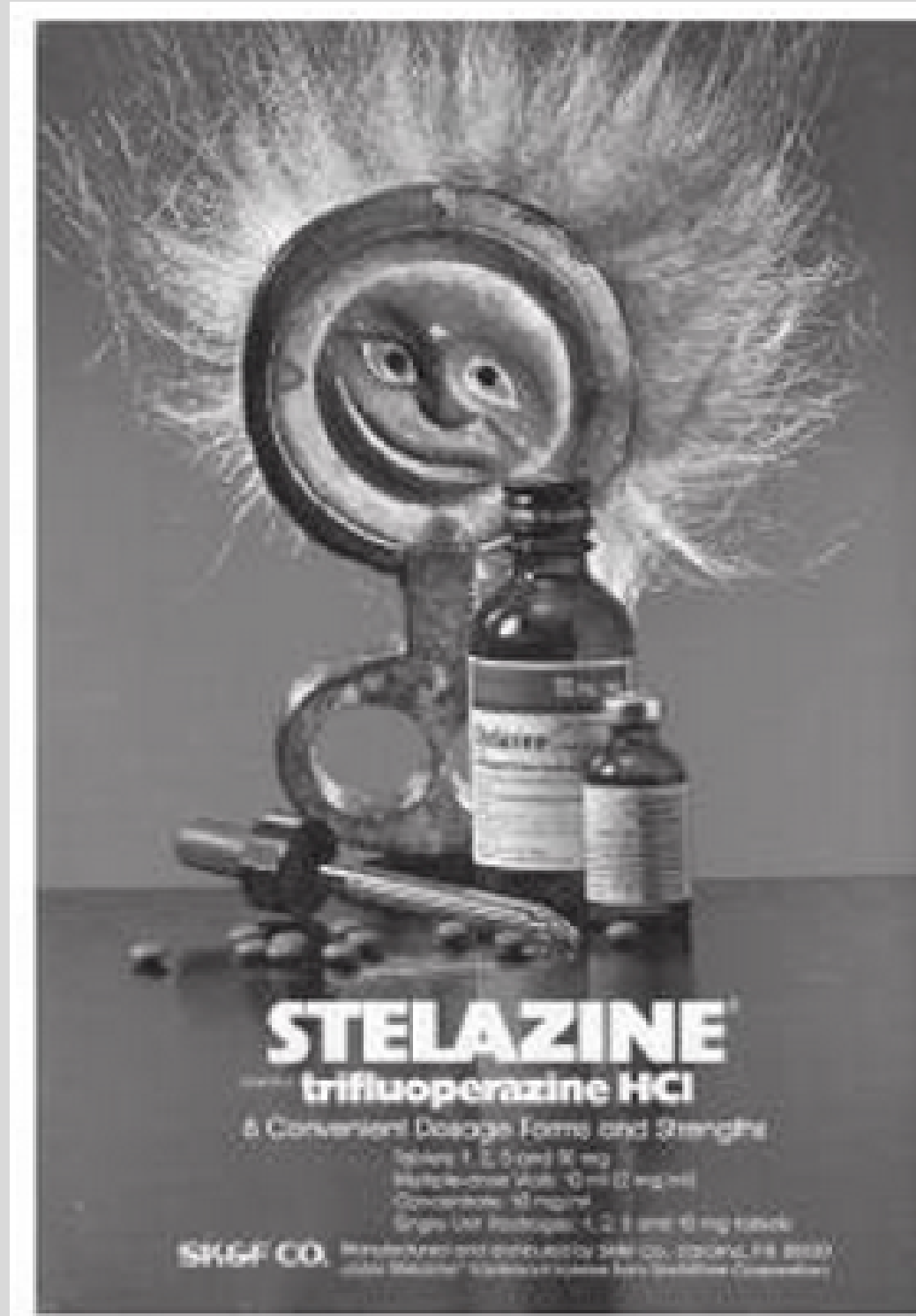
© 1974, Janssen Pharmaceutica, Inc. All rights reserved. Haldol is a registered trademark of Janssen Pharmaceutica, Inc. Haldol is a first-line antipsychotic because of its effectiveness in controlling aggressive behavior and its relatively low risk of serious adverse reactions.

**Haldol Advertisement.**  
Archives of General Psychiatry,  
Volume 31, no. 5,  
1974, p. 732.

Assaultive and belligerent?



# BRIEF HISTORY: RACIALIZED PSYCHOSIS



# PSYCHOSIS

CLINICAL FEATURES & THEORIES OF  
DEVELOPMENT



# PSYCHOSIS

Loss of contact with reality; impaired ability to perceive and respond to one's environment

## A Syndrome

Disorders differ by:

- Duration and progression of psychotic symptoms
- The presence of depressive or manic symptoms or medical illness or substance use

# THREE TYPES OF PSYCHOTIC SYMPTOMS (DSM-5 'CRITERION A')

## POSITIVE SYMPTOMS (Behavioral Excess)

- Hallucinations
- Delusions

## NEGATIVE SYMPTOMS (Behavioral Deficits)

- Social Withdrawal
- Decreased Motivation
- Limited Facial Expression
- Decreased Activity

## DISORGANIZED SYMPTOMS

- Disorganized Speech
- Disorganized/Catatonic Behavior

# POSITIVE SYMPTOMS INCLUDE:

## DELUSIONS

When a person has strong beliefs that are not true and may seem irrational to others. For example,

*Individuals experiencing **delusions** may believe that people on the radio and television are sending special messages that require a certain response, or they may believe that they are in danger or that others are trying to hurt them.*



## HALLUCINATIONS

When a person sees, hears, smells, tastes, or feels things that are not actually there.

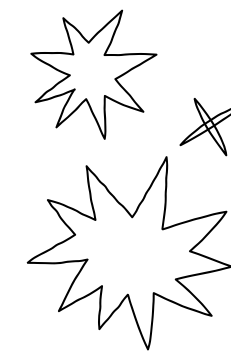
Hearing voices is common for people with schizophrenia. People who hear voices may hear them for a long time before family or friends notice a problem.

## THOUGHT DISORDER

When a person has ways of thinking that are unusual or illogical. People with thought disorder may have trouble organizing their thoughts and speech. Sometimes a person will stop talking in the middle of a thought, jump from topic to topic, or make up words that have no meaning.

## MOVEMENT DISORDER

When a person exhibits abnormal body movements. People with movement disorder may repeat certain motions over and over.



# PSYCHOSIS SYMPTOMS

## Delusional symptoms can include:

- Suspiciousness/paranoia
- Religious content
- Cultural content
- Beliefs about self, others & the world

### EXAMPLES:

- "I THINK PEOPLE ARE TALKING ABOUT ME"
- "SOMEONE IS FOLLOWING ME"
- "PEOPLE ARE TALKING ABOUT ME TO PLOT AGAINST ME"
- "ALIENS ARE SENDING ME MESSAGES THROUGH THE TV"



## Hallucinations: perceptual and/or sensory abnormalities

- Auditory, visual, tactile
- Auditory or "hearing voices" is the most common



# DISCUSSION

WHAT ARE SOME BELIEFS/EXPERIENCES THAT COULD BE PSYCHOSIS OR CULTURAL/CONTEXTUAL?

# VIDEO DISCUSSION

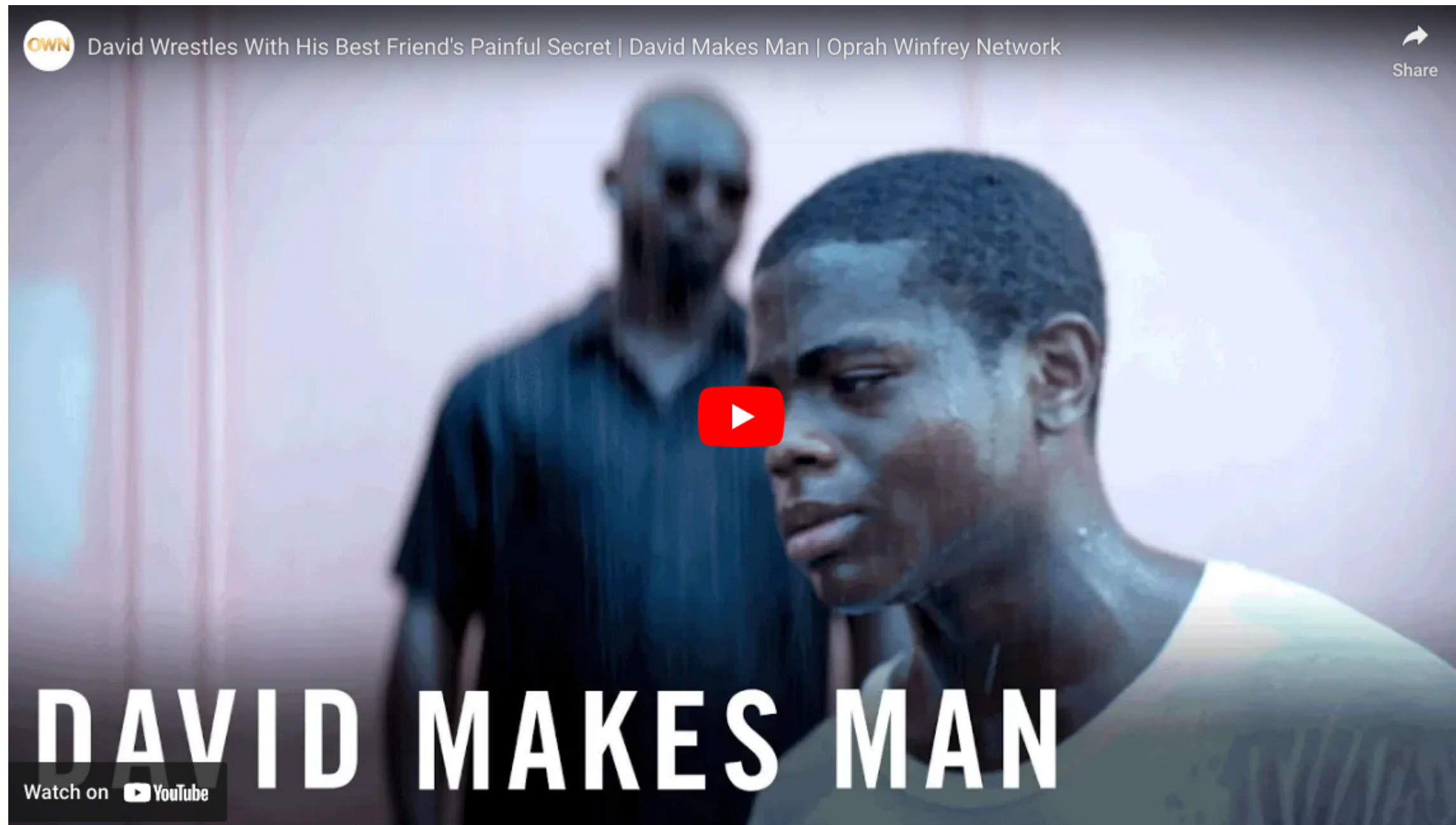
***CONSIDER...***

**WHAT DO YOU SEE?**

**WHAT IS GOING ON IN THIS VIDEO?**

**WHAT IS THIS PERSON'S CONTEXT?**

# DAVID MAKES MAN



**WHAT DO YOU SEE?**

**WHAT IS GOING ON IN THIS VIDEO?**

**WHAT IS THIS PERSON'S CONTEXT?**

# WHO EXPERIENCES PSYCHOSIS?

- Onset is typically between the ages of 15-25
  - May begin in adolescence and continue through young adulthood
- Occurs slightly more often in biological males than females
  - Males typically present with the illness in their late teens and early 20s
  - Females typically present with symptoms in their early 20s to early 30s

# ADOLESCENCE & YOUNG ADULTHOOD

- For those who develop psychosis, adolescence and young adulthood are critical periods
- Transition age is a time of changes:
  - Social
    - Peers, parents, romantic relationships
  - Role
    - School and work
    - Growing independence
      - Increased risk-taking and identity development

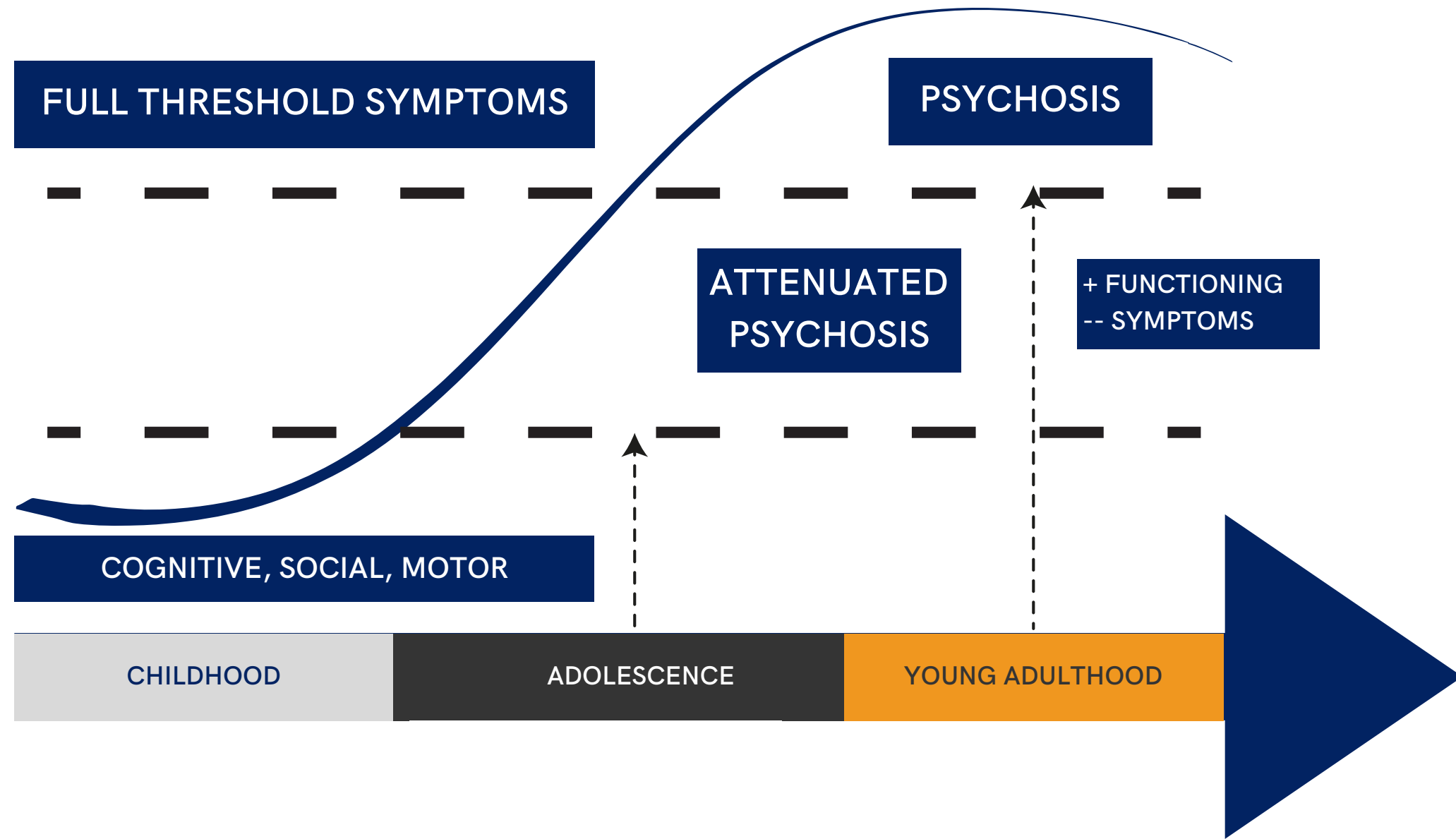
**1-3% Lifetime Psychosis Diagnosis  
Nationally**

**100,000 adolescents and young  
adults experience a first episode of  
psychosis annually**

2,000 per year in MD

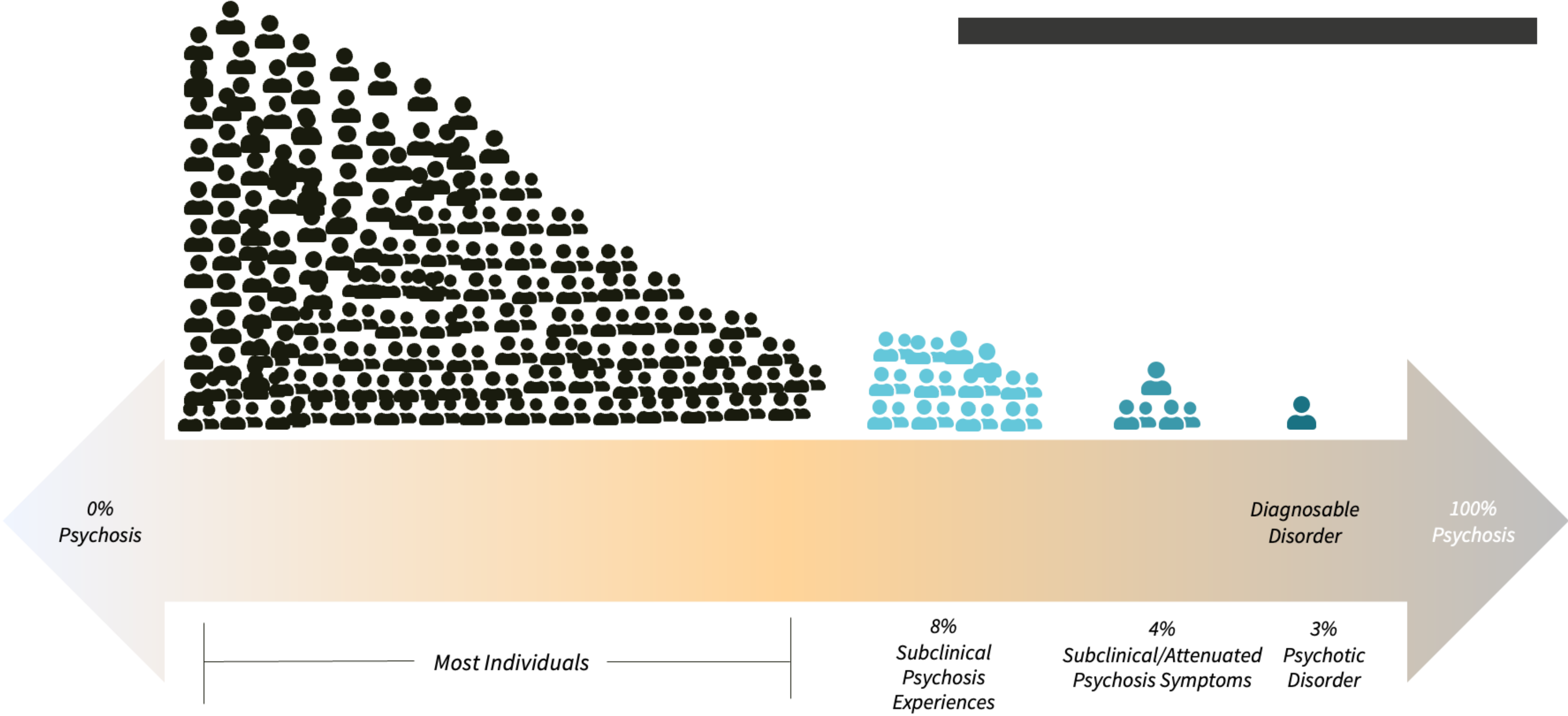
~ 50 young people each week in MD  
experiencing FEP

# PSYCHOTIC & ATTENUATED PSYCHOSIS SYNDROMES



HOWES & MURRAY, 2014

# PSYCHOSIS SPECTRUM



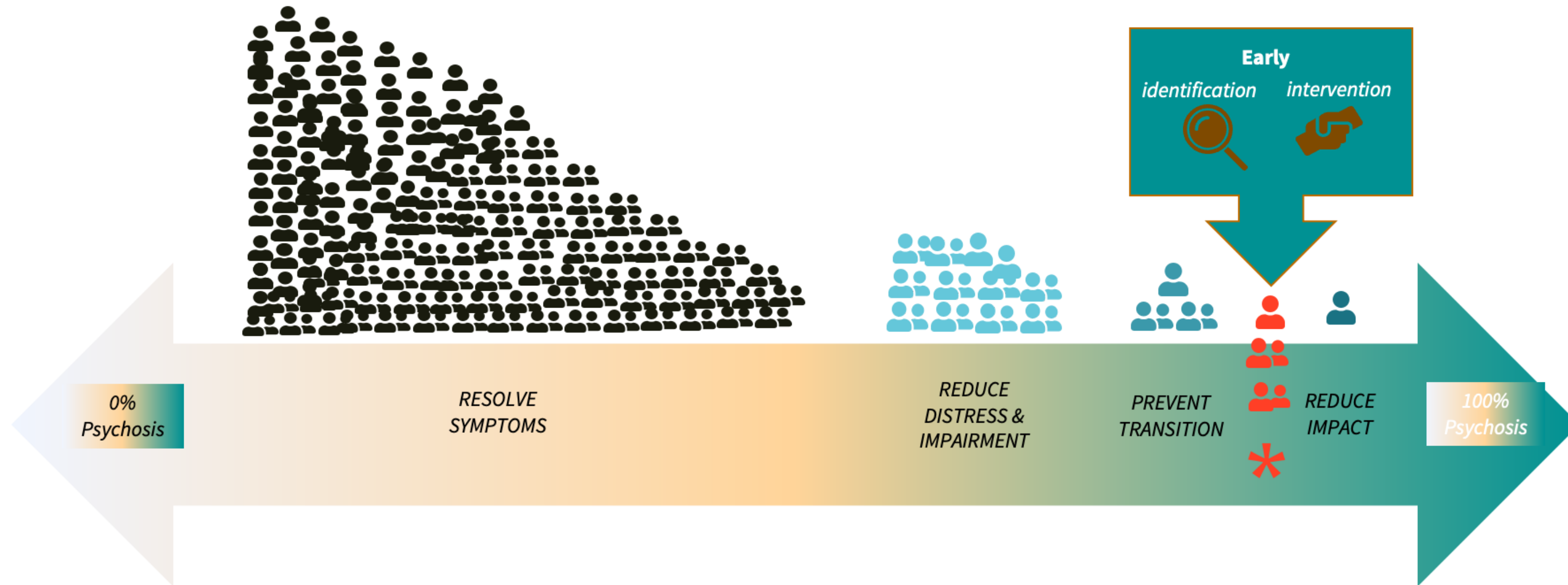
Rakhshan Rouhakhtar, 2022; Van Os et al., 2009

*Early intervention for individuals at CHR is an essential step to the prevention, reduction, and delay of the onset of psychosis.*

*Delays in early psychosis treatment can negatively impact clinical outcomes AND have been associated with increased suicide risk.*

# PSYCHOSIS SPECTRUM:

## ASSESSMENT & TREATMENT



Kwapil & Barrantes-Vidal, 2015; McGlashan, 1999; Perala et al., 2007; Rakhshan Rouhakhtar, 2022; Van Os et al., 2009

Sometimes in a crowded room I hear someone calling my name, but it's unlikely anyone actually did.

When I'm home alone, I often hear someone talking to me, even though there is no one there. It's scary, so I usually stay in my room and lock the door, but I know it's in my head.

I hear a voice narrating what I'm doing. I tell it to go away, but it stays. I don't know who it is but I know it's not in my head and it's distracting when I talk to people.

**SUBCLINICAL**

**ATTENUATED SEVERITY**

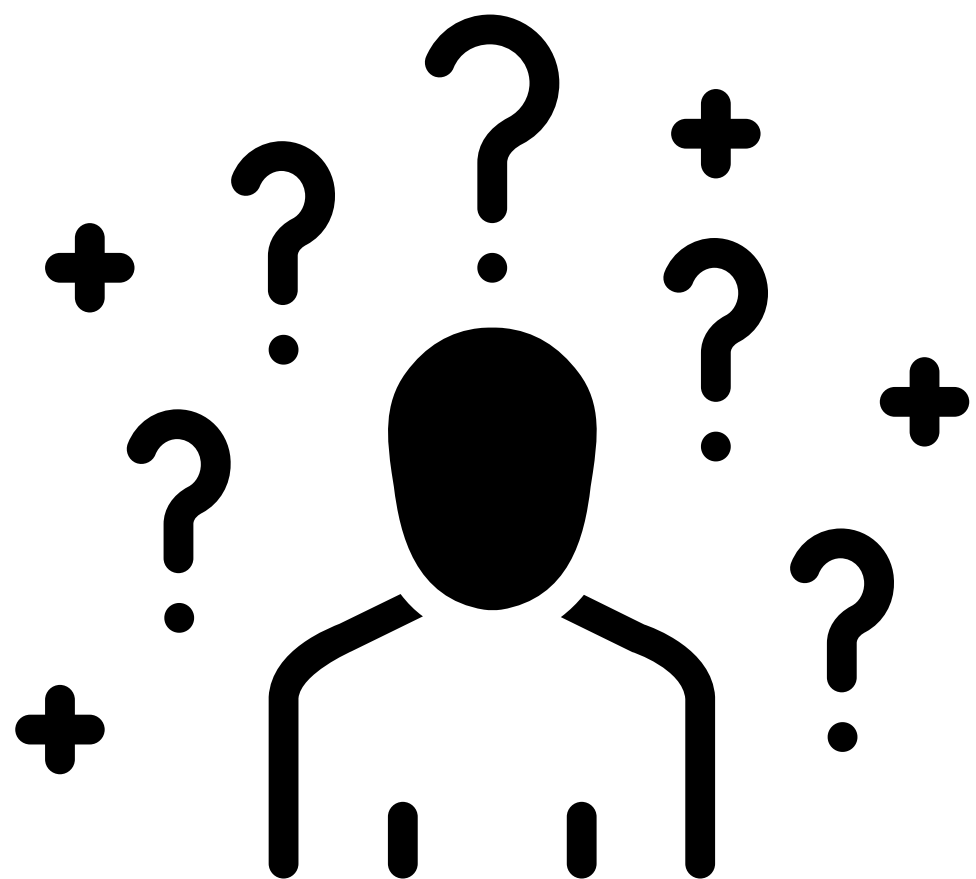
**PSYCHOTIC SEVERITY**

Sometimes when I'm tired, I see things out of the corner or my eye. I do a double take, but don't think about it afterward.

About once a week I think I see a person out of the corner of my eye. I know it's not real but it is upsetting and I think about it afterward.

Every day I see someone in my house. My brother doesn't see them and thinks I'm crazy, but I know they're there. I'm always friendly toward them in case they're dangerous.

# PSYCHOTIC & ATTENUATED PSYCHOTIC SYNDROMES



Conditions are often differentiated by:

- Intensity and severity of symptoms
- Degree of conviction
- Doubt, question, and insight

"*I'm pretty sure* the man in the black suit is following me, *but that doesn't make any sense, right?*"

"*I think* I hear footsteps at night, but no one else does. I don't see anything when I go and check, *so I don't know.*"

# CODIFYING THE AT-RISK STATE

- Recognized syndrome in DSM-5 (p. 122)
  - Attenuated Psychosis Syndrome
- Early Phase Terminology
  - Clinical High Risk
  - Ultra High Risk
  - Hypopsychosis
  - At-Risk Syndrome
  - Prodrome

## Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

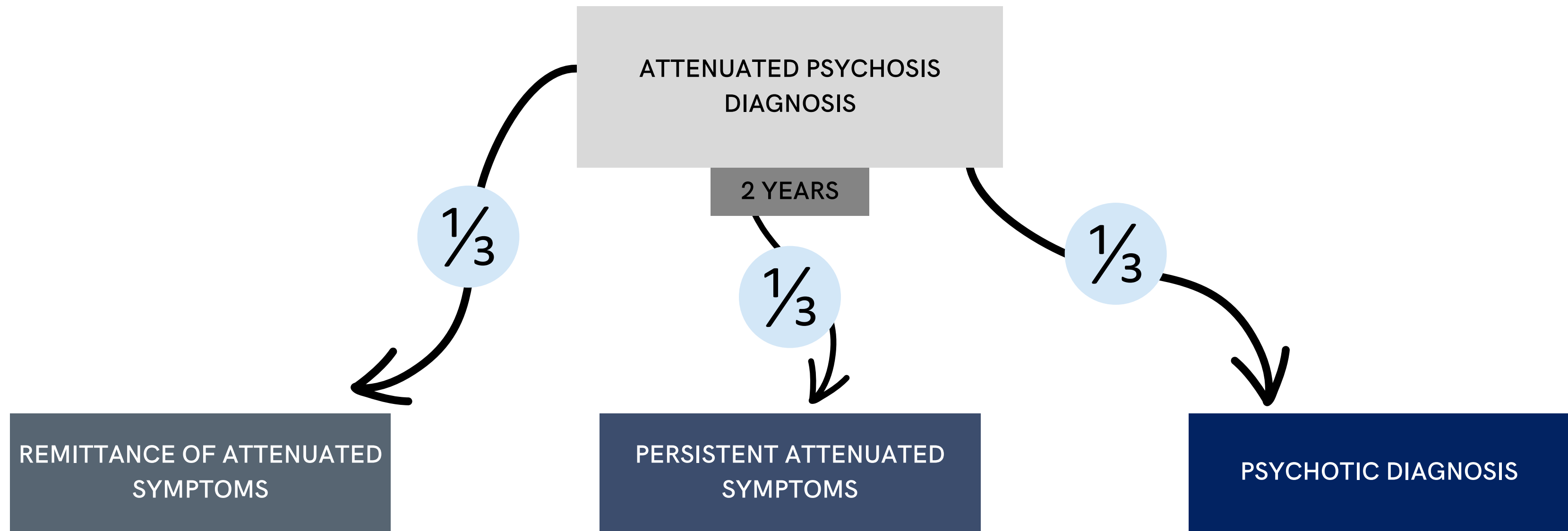
**298.8 (F28)**

This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class. The other specified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum and other psychotic disorder. This is done by recording “other specified schizophrenia spectrum and other psychotic disorder” followed by the specific reason (e.g., “persistent auditory hallucinations”).

Examples of presentations that can be specified using the “other specified” designation include the following:

1. **Persistent auditory hallucinations** occurring in the absence of any other features.
2. **Delusions with significant overlapping mood episodes:** This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).
3. **Attenuated psychosis syndrome:** This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained).
4. **Delusional symptoms in partner of individual with delusional disorder:** In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.

# PSYCHOTIC & ATTENUATED PSYCHOSIS SYNDROMES



# PSYCHOSIS: OUTLOOK

Negative outcomes are often associated with psychosis...

*Despite this:*

- Full and successful lives
- Positive changes from psychosis
  - Personal strength
  - Spiritual growth

Strengths-Based Approach

- Holistic Understanding of Individuals

PEOPLE WITH  
PSYCHOSIS AND  
THOSE WITHOUT ARE  
MORE SIMILAR THAN  
DIFFERENT

# DEVELOPMENT OF PSYCHOSIS

THEORETICAL PERSPECTIVES  
AND  
RISK & RESILIENCY FACTORS

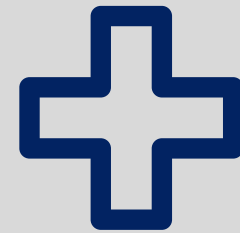


# THEORETICAL PERSPECTIVES

## STRESS VULNERABILITY MODEL

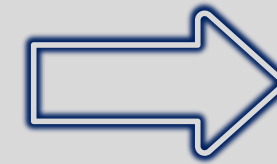
**INTRINSIC  
VULNERABILITY**

ABNORMAL BRAIN  
FUNCTIONAL  
ORGANIZATION



**PSYCHOSOCIAL  
STRESSORS**

LIFE CRISES,  
SUBSTANCE ABUSE,  
INTERPERSONAL AND  
OCCUPATIONAL  
STRESSORS

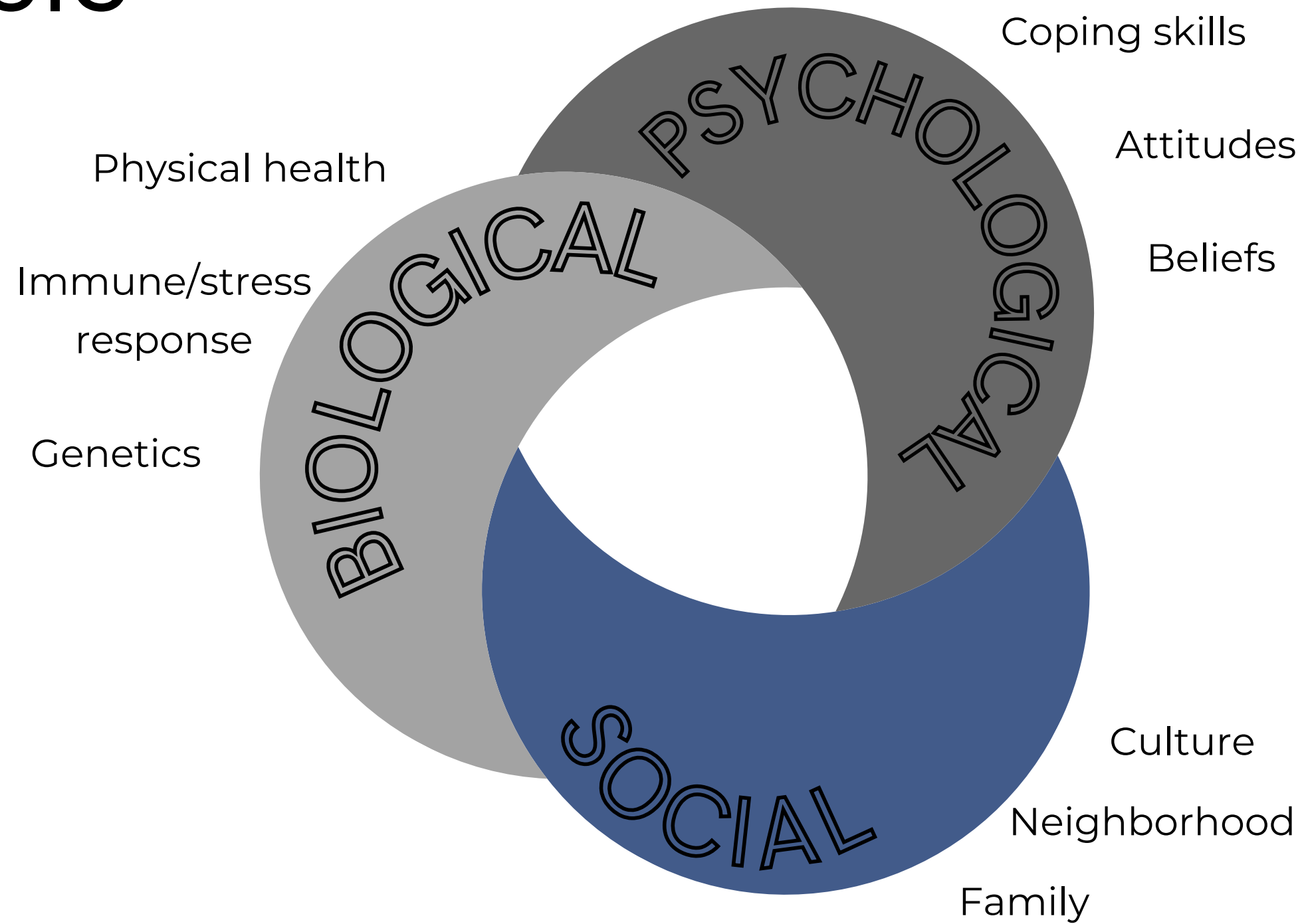


**MENTAL  
ILLNESS**

PSYCHOSIS,  
DEPRESSION,  
BIPOLAR DISORDER,  
PTSD, ANXIETY  
DISORDERS

The Stress Vulnerability Model (Zubin 1977) continues to be useful for identifying and treating relapses in a variety of mental illness. It suggests that human persons inherit genetic predisposition to mental illness. This 'vulnerability' in itself is not sufficient to manifest the disorder and requires interaction with bio-psychosocial stressors.

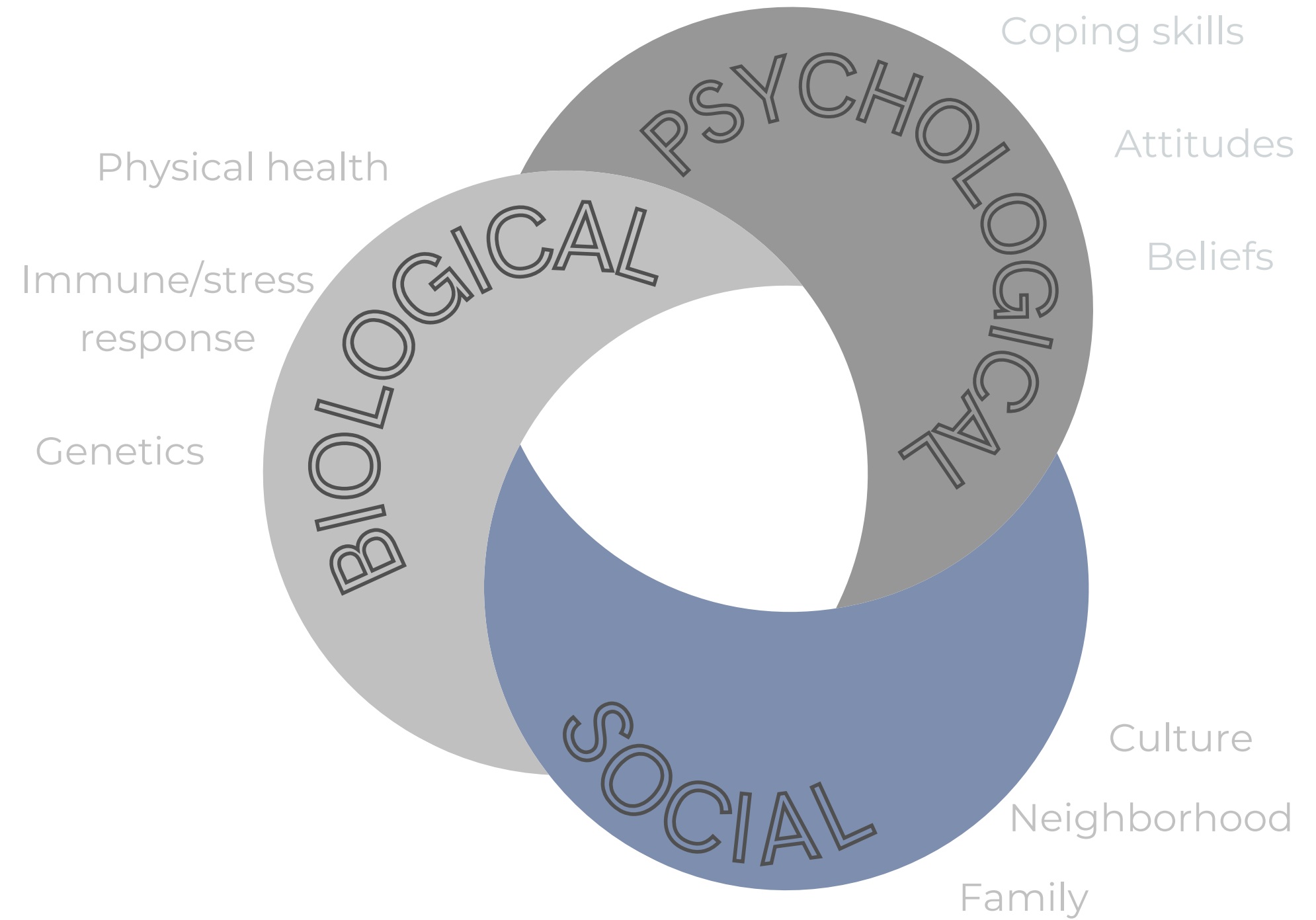
# DEVELOPMENT OF PSYCHOSIS





# DEVELOPMENT OF PSYCHOSIS

*WHAT ARE SOME OTHER FACTORS THAT MAY INFLUENCE THE DEVELOPMENT OF PSYCHOSIS SYMPTOMS?*



# PSYCHOSIS: RISK & RESILIENCE



LD

## PROTECTIVE FACTORS

Decrease the likelihood of negative outcomes among those at risk

## RESILIENCE

Ability to successfully adapt to very difficult circumstances

## RISK FACTORS

Enhance vulnerability to developing psychosis and/or experiencing adversity or negative mental health outcomes

- Systemic factors (e.g., racial discrimination, housing instability, exposure to violence) can relate to increased risk for mental health issues across the lifespan
- Adversity affects people in different ways
- Responses to adversity can be understood as a form of **resilience**
- To understand both of the concepts (adversity and resilience) we need to consider context and systemic factors to promote wellbeing and change systems that perpetuate inequality

# RISK & PROTECTIVE FACTORS INFLUENCING THE DEVELOPMENT OF PSYCHOSIS

## RISK FACTORS

- **Discrimination** -> independent risk factor for psychosis
  - "Experiencing multiple forms of discrimination increases the risk of developing psychosis in a dose-dependent fashion (Stickley et al. 2019)."
- Trauma and Adversity
- Substance Use
- Genetics

## PROTECTIVE FACTORS

- Access to mental health culturally responsive resources and/or specialized care
- Social or community support; sense of connectedness
  - Social engagement
  - Spirituality and faith
  - Peer support
- Abstinence from substance use
- Wellness (sleep, nutrition, activity)

# TRAUMA & PSYCHOSIS

*LONG LIVE THE ROSE  
THAT GREW FROM CONCRETE*



# TRAUMA & PSYCHOSIS

- Several factors have contributed to racial disparities related to the assessment and treatment of psychosis among Black and urban populations
- Racism is NOT a thing of the past - instead, racism played an integral role in shaping the institutional structure, procedures, and policies of psychiatric practice today
  - Effects of historical, intergenerational trauma
  - Clinician biases, negative racial attitudes, and discrimination
  - Limitations in access to adequate care

***"Not only are Black people vulnerable to being violently traumatized, but there is a shared vulnerability within Black communities based on historical and present-day events where day-to-day experiences of racism, discrimination, microaggressions, and macroaggressions touch on the collective trauma carried over generations."***

*(Bolden, 2020, p. 164)*

BOLDEN ET AL., 2020; HARDY & MUESER 2017; SOTERO 2006

# TRAUMA & PSYCHOSIS

**Historical trauma** in African American and urban populations may contribute to increased vulnerability to developing psychosis AND/OR contribute to clinicians' misdiagnoses of psychosis.

**Historical trauma is the "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences."**

(Brave Heart, 2003, p. 7)

*The following are the four basic assumptions of historical trauma theory (Sotero 2006):*

- Mass trauma is intentionally inflicted on the target population.
- Trauma is not a singular event but a continuous and prolonged exposure.
- Traumatic events resound throughout the population, creating a collective experience.
- The developmental trajectory of the targeted population is irrevocably altered, resulting in inequities that persist through generations.

BOLDEN ET AL., 2020; HARDY & MUESER 2017; SOTERO 2006

# ACCESS & TREATMENT CONSIDERATIONS IN PSYCHOSIS

FROM AN ETHICAL LENS



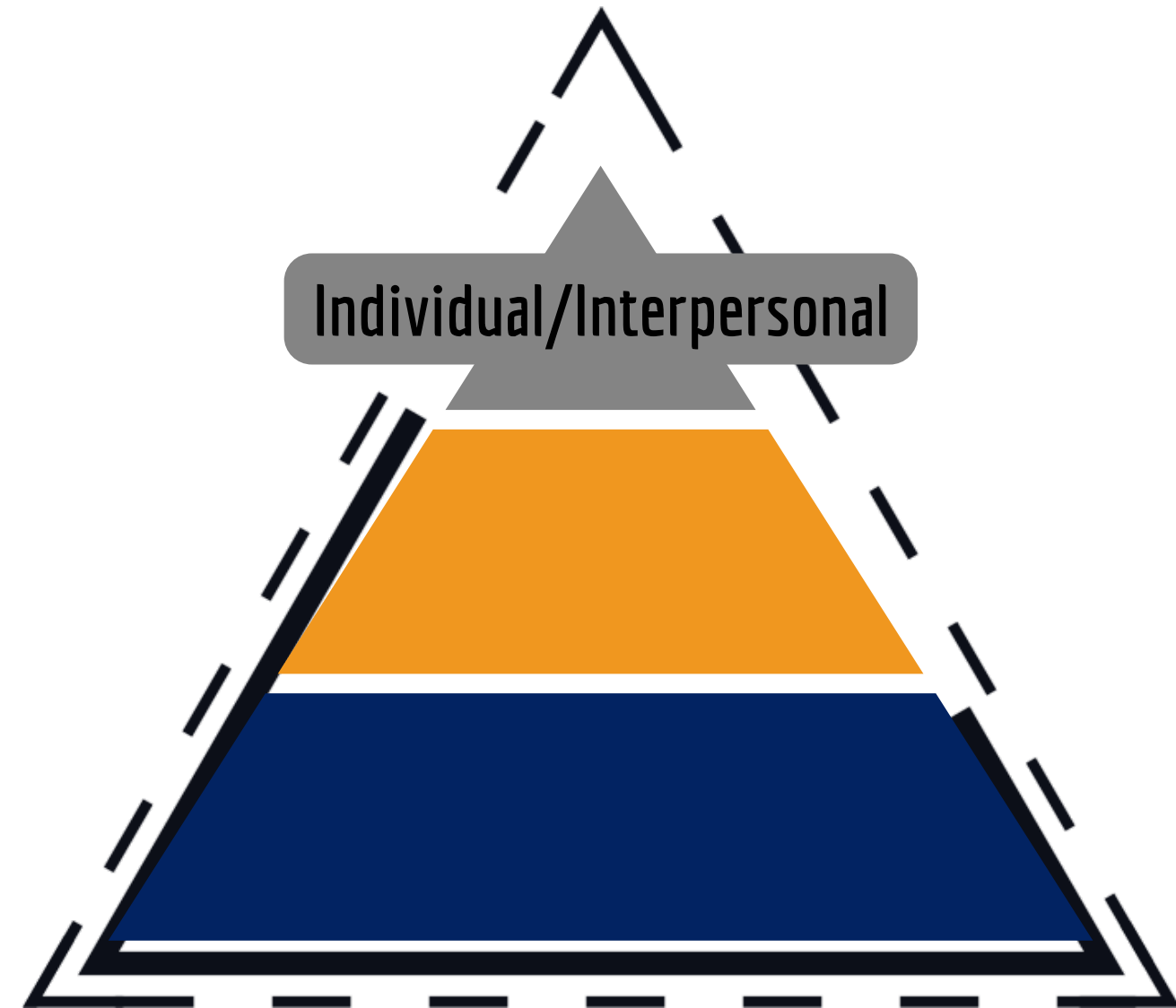
"Behavioral health **equity** is the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."

(SAMHSA)

# FACTORS IMPACTING ACCESS

## INDIVIDUAL/INTERPERSONAL

Pre-judgment, bias, stereotypes or generalizations about an individual or group based on identity/characteristics

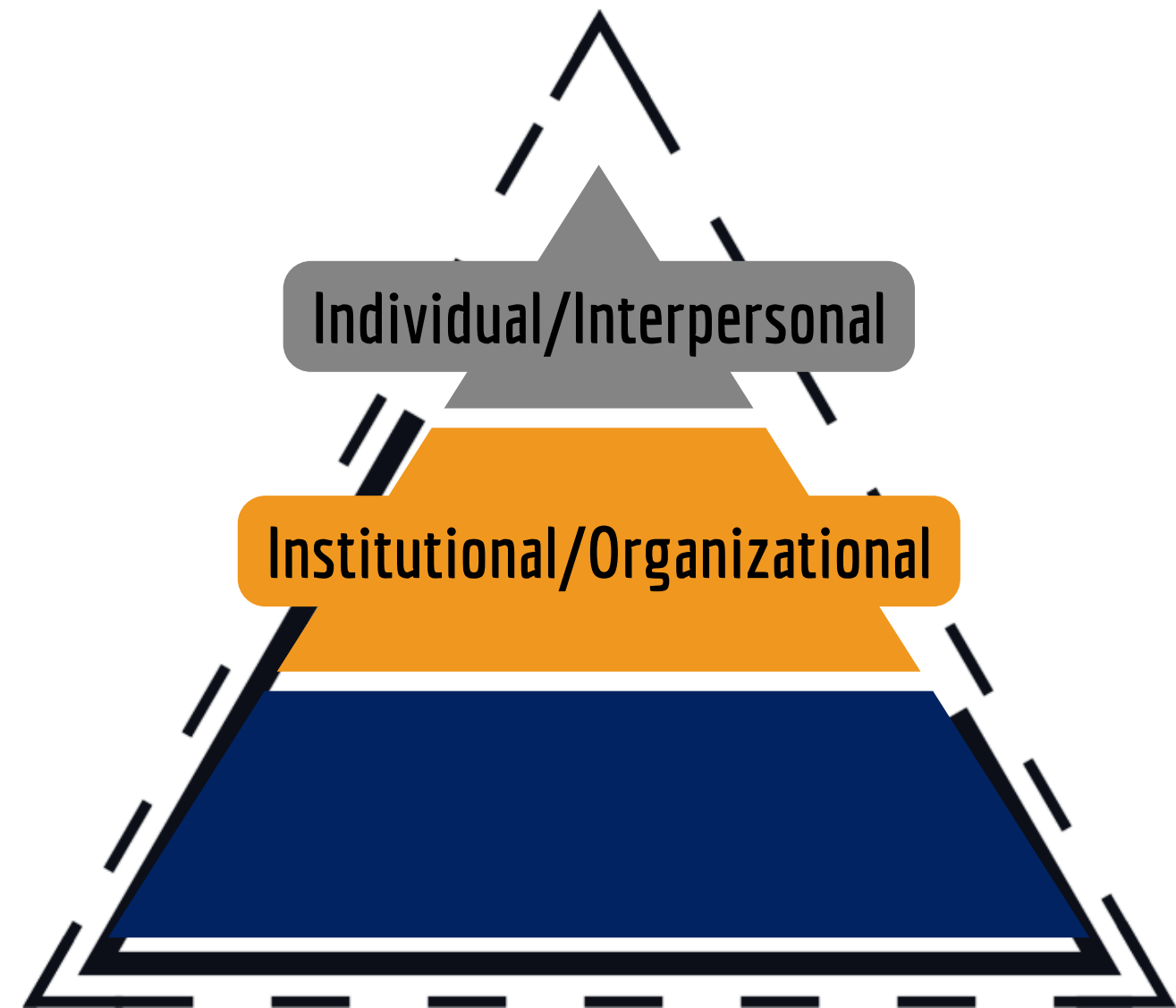


# FACTORS IMPACTING ACCESS

## INSTITUTIONAL/ORGANIZATIONAL

Policies, practice, and procedures that work to the benefit of a group and the detriment of people of another group

Can be unintentional or inadvertent



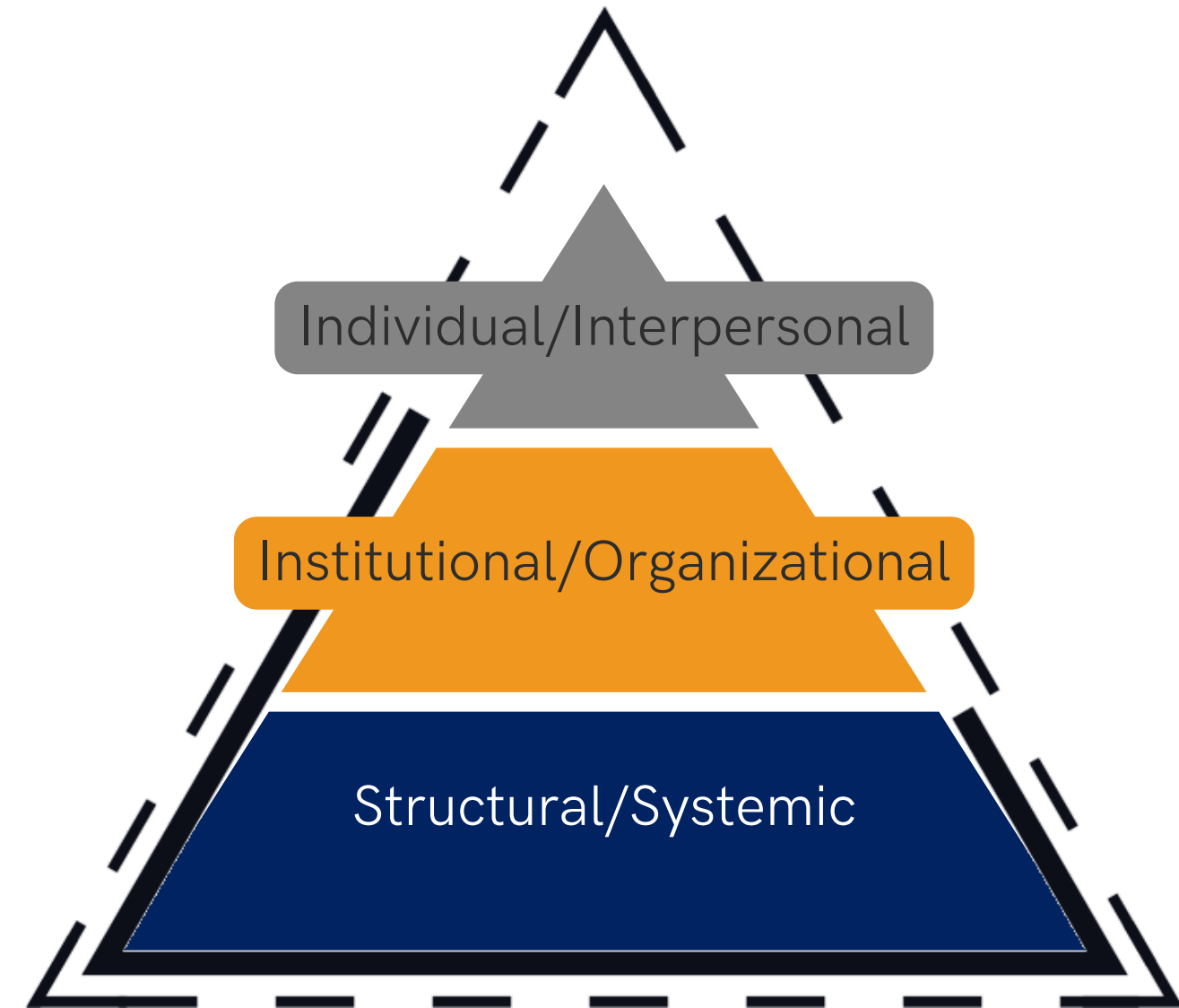
# FACTORS IMPACTING ACCESS

## STRUCTURAL/SYSTEMIC

Interplay of policies, practices and programs of differing institutions

Leads to adverse outcomes and conditions for particular communities

Occurs within the context of historical and cultural conditions



# PSYCHOSIS & CULTURE/CONTEXT: A UNIQUE CHALLENGE



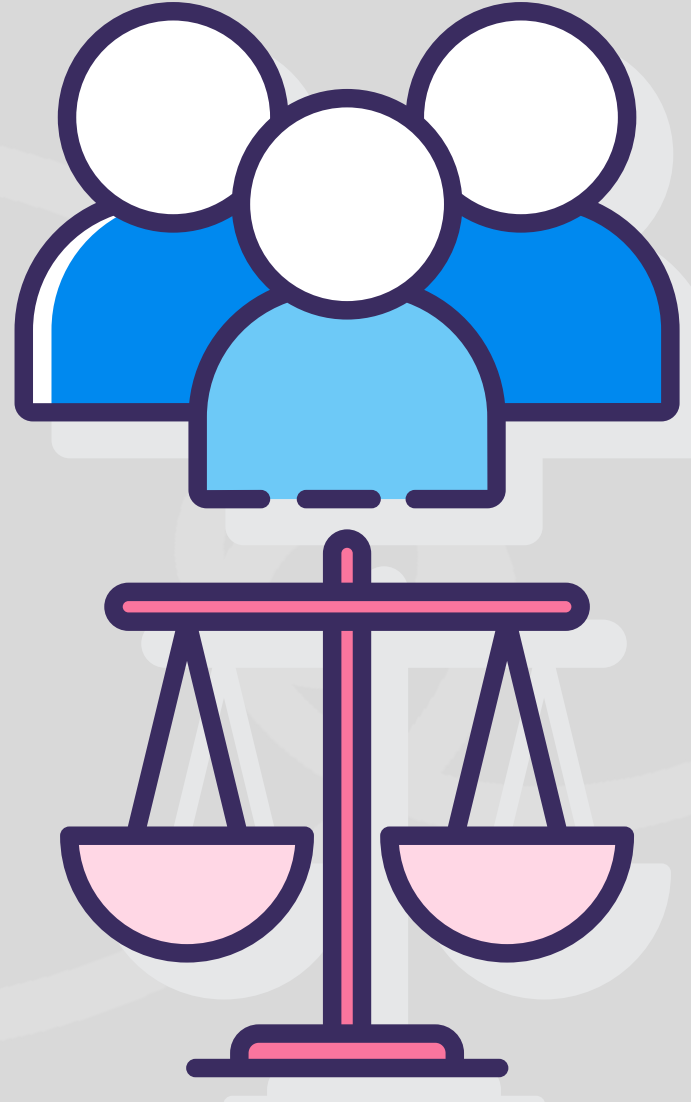
**Disparities in all care domains & processes for minoritized and underserved youth & communities**

ANGLIN ET AL., 2021; COMPTON & SHIM, 2015; DELUCA ET AL., 2022; JONES ET AL., 2002; MISRA ET AL., 2022; NAZROO ET AL., 2020; VAN DER VEN & KIRKBRIDE, 2018

# EARLY IDENTIFICATION & INTERVENTION

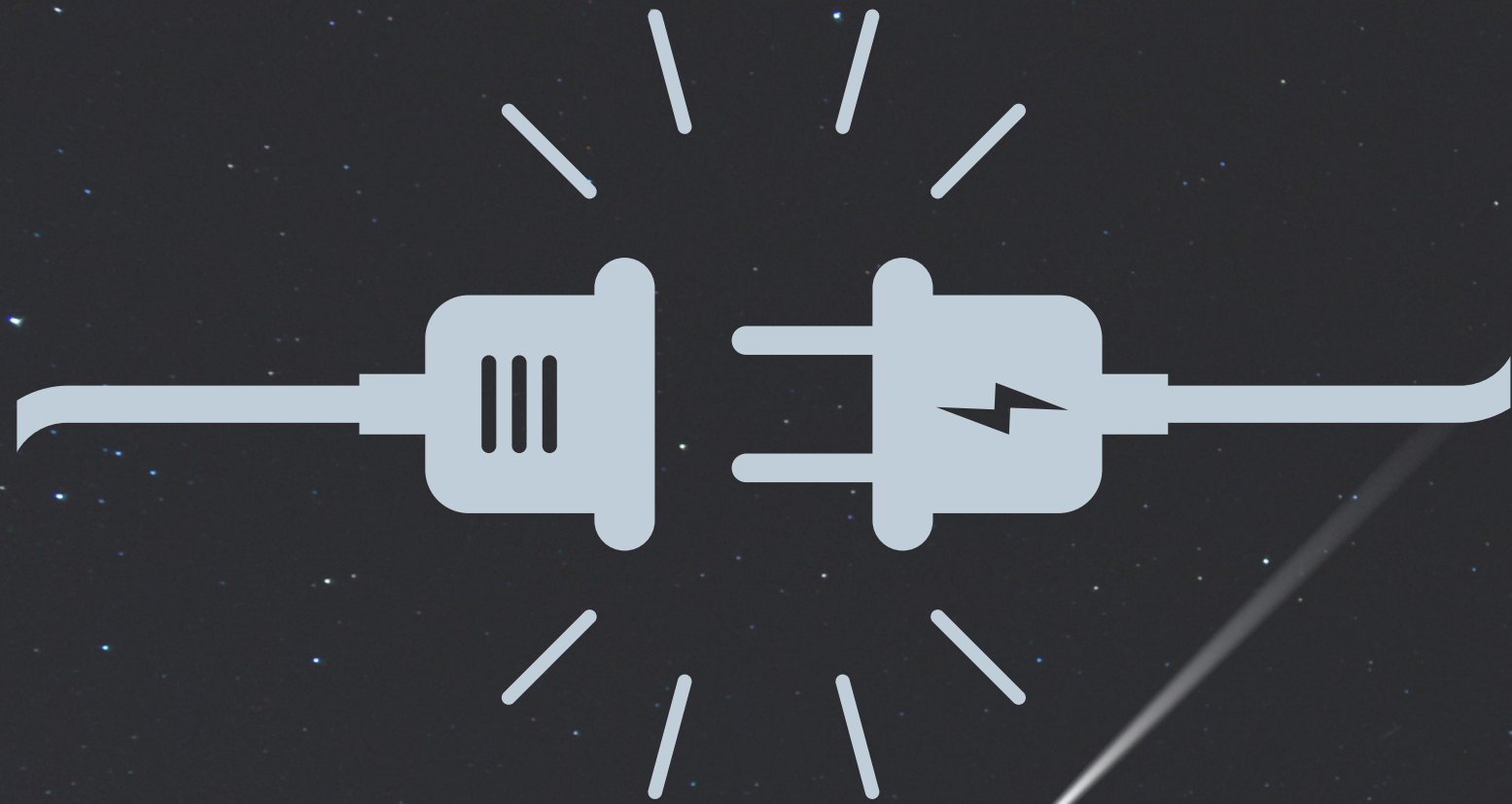
Assessment/Treatment with diverse populations in absence of cultural sensitivity

Total avoidance of cultural/contextual content when assessing & treating early psychosis



Overpathologizing, substandard treatment, microaggressions, harmful care

Inequities in who receives preventative care & optimal support from EIP services



What connections  
did you make  
from the last  
section?

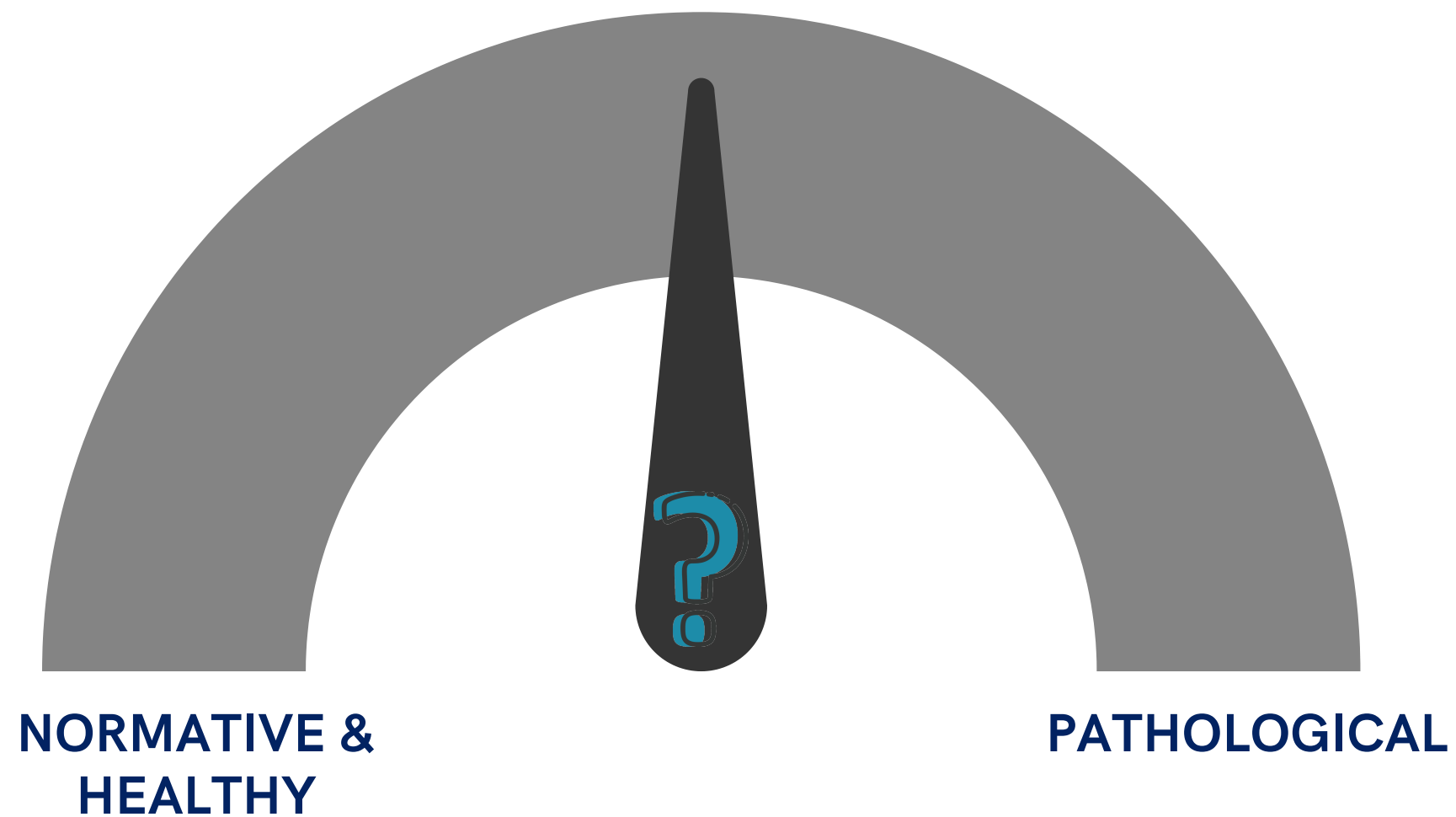
*Please post your thoughts in the chat*



# ASSESSMENT: ETHICAL CONSIDERATIONS



# CONTEXTUALIZING "NORMALITY"



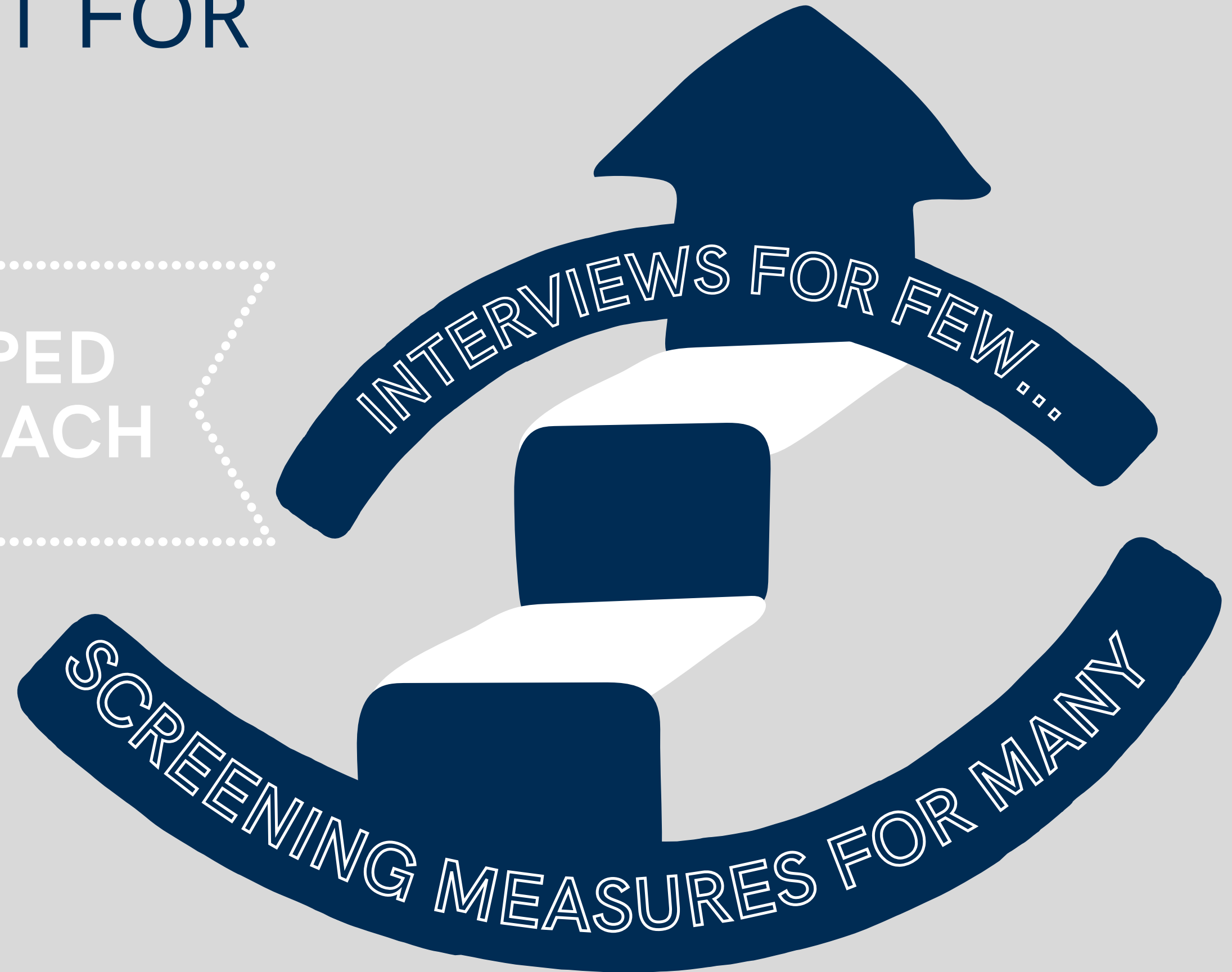
## Beliefs & Psychopathology

*"Rarely is a mind so disordered, however, that even in illness it does not make extensive use of cultural materials"*

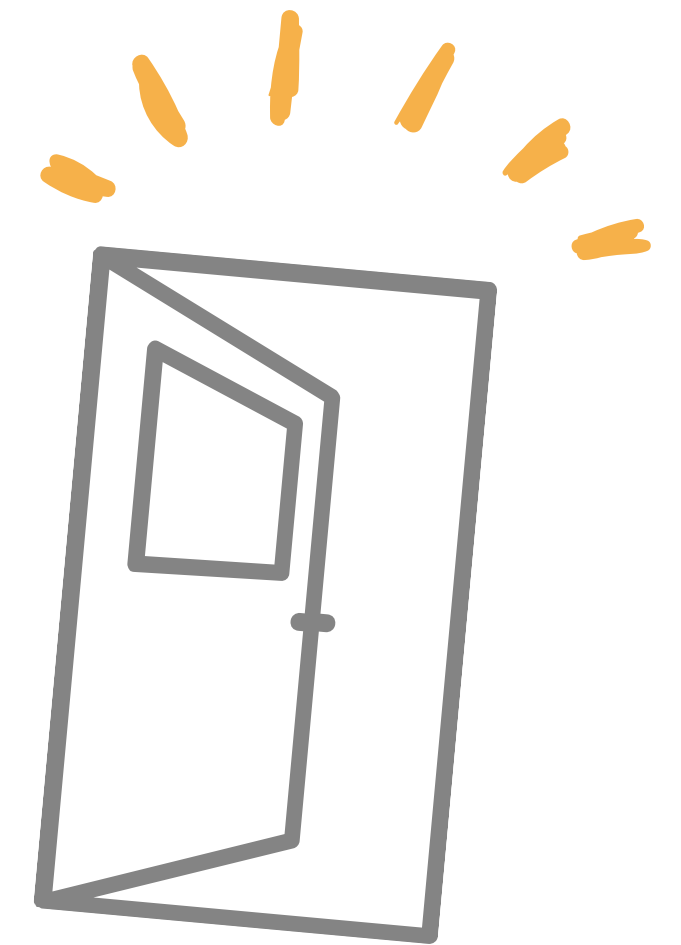
BASSET & BAKER, 2005

# ASSESSMENT FOR PSYCHOSIS

STEPPED APPROACH



# IMPORTANCE OF EARLY IDENTIFICATION & INTERVENTION



# CLINICAL TOOLS: GATEWAYS TO ADEQUATE CARE

## SELF-REPORT SCREENERS

e.g., PRIME Screen

## CLINICAL INTERVIEWS

e.g., Structured Interview for  
Prodromal Syndromes (SIPS)

# CHR ASSESSMENT: SELF-REPORT MEASURES

## THE PRIME SCREEN QUESTIONNAIRE

- 12-ITEM SCALE
- 7-POINT LIKERT SCALE RESPONSE OPTIONS
- DEVELOPED FROM THE SIPS

### Evidence for Differential Predictive Performance of the Prime Screen between Black and White Help-Seeking Youths

Zachary B. Millman, M.A.<sup>1</sup>, Pamela J. Rakhshan Rouhakhtar, M.A.<sup>1</sup>, Jordan. E. DeVlyder, Ph.D.<sup>2</sup>, Melissa Edmondson Smith, Ph.D.<sup>3</sup>, Peter L. Phalen, Psy.D.<sup>4</sup>, Scott W. Woods, M.D.<sup>5</sup>, Barbara C. Walsh, Ph.D.<sup>5</sup>, Brittany Parham, Ph.D.<sup>4</sup>, Gloria M. Reeves, M.D.<sup>4</sup>, Jason Schiffman, Ph.D.<sup>1</sup>

<sup>1</sup>Department of Psychology, University of Maryland, Baltimore County

<sup>2</sup>Graduate School of Social Service, Fordham University

<sup>3</sup>School of Social Work, University of Maryland, Baltimore

<sup>4</sup>Department of Psychiatry, University of Maryland School of Medicine

<sup>5</sup>Department of Psychiatry, Yale University

#### Abstract

**Objective:** Self-report screening instruments for emerging psychosis have the potential to improve early detection efforts by increasing the number of true-positives among those deemed to be at “clinical high-risk” for the disorder, but their practical utility depends on their validity across race. This study sought to examine whether a commonly-used self-report screening tool for psychosis-risk performs equally among black relative to white youths in its ability to predict risk status.

**Method:** Black ( $n = 58$ ) and white ( $n = 50$ ) help-seeking individuals ages 12–25 (61% female) were assessed with the Prime Screen and the Structured Interview for Psychosis-risk Syndromes (SIPS). A logistic regression model estimated race differences in the strength of relations between Prime Screen scores and SIPS-defined risk status.

**Results:** Higher Prime Screen scores significantly predicted risk status among white ( $p < .01$ ) but not black ( $p = .23$ ) participants. Self-reported prime screen scores among black youths at low risk more closely resembled scores of participants at high risk than scores of white peers who were also at low risk.

**Conclusions:** Results suggest that consideration of race or ethnicity and associated cultural factors is important when screening for clinical high-risk status. Findings support the need to develop culturally valid early psychosis screening tools to promote appropriately tailored early intervention efforts.

# CLINICAL TOOLS: GATEWAYS TO ADEQUATE CARE

## SELF-REPORT SCREENERS

e.g., PRIME Screen

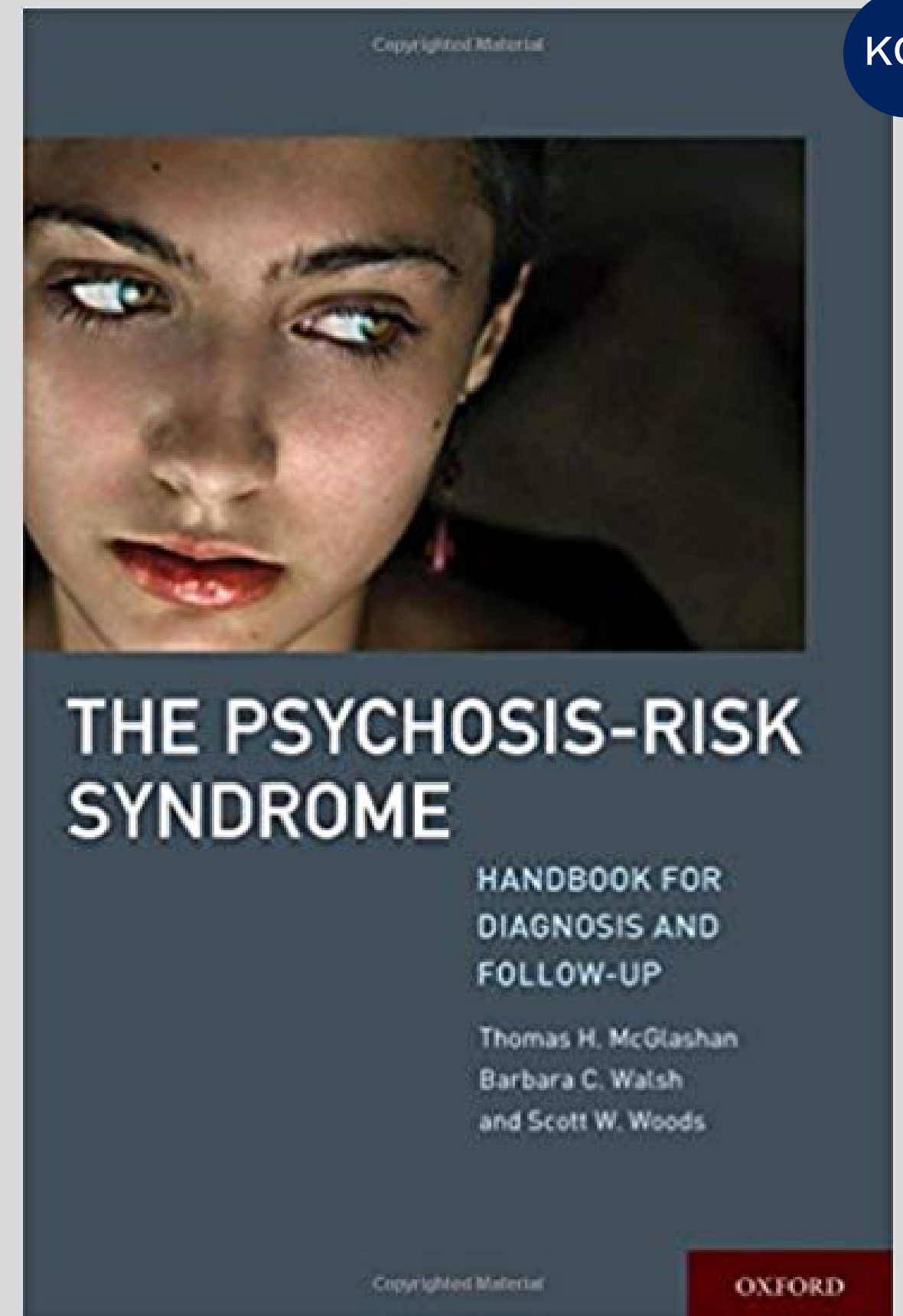
## CLINICAL INTERVIEWS

e.g., Structured Interview for  
Prodromal Syndromes (SIPS)

# CHR ASSESSMENT: CLINICAL INTERVIEW

THE STRUCTURED INTERVIEW FOR  
PSYCHOSIS-RISK SYNDROME (SIPS)

- ▶ Most common in North America
- ▶ Attenuated positive symptoms
- ▶ Low-risk, high-risk, and psychosis
  - Interviews completed by a clinician
  - Structured or semi-structured
  - Presence, absence, and severity of symptoms



# IMPACT OF SOCIOCULTURAL FACTORS: NEIGHBORHOOD

RESEARCH  
QUESTION  
Does neighborhood  
crime impact  
responses to SIPS?

## Context matters: The impact of neighborhood crime and paranoid symptoms on psychosis risk assessment



Camille Wilson<sup>a</sup>, Melissa Edmondson Smith<sup>b</sup>, Elizabeth Thompson<sup>a</sup>, Caroline Demro<sup>a</sup>, Emily Kline<sup>c</sup>,  
Kristin Bussell<sup>d</sup>, Steven C. Pitts<sup>a</sup>, Jordan DeVylder<sup>b</sup>, Gloria Reeves<sup>d</sup>, Jason Schiffman<sup>a,\*</sup>

<sup>a</sup> University of Maryland, Baltimore County, Department of Human Services Psychology, 1000 Hilltop Circle, Baltimore, MD 21250, United States

<sup>b</sup> University of Maryland, School of Social Work, 525 W. Redwood St., Baltimore, MD 21201, United States

<sup>c</sup> Beth Israel Deaconess Medical Center, Department of Public Psychiatry, 75 Fenwood Road, 5th Floor, Boston, MA 02115, United States

<sup>d</sup> University of Maryland School of Medicine, 655 W. Baltimore St., Baltimore, MD 2120, United States

# IMPACT OF SOCIOCULTURAL FACTORS: NEIGHBORHOOD

SIPS ITEMS:  
EXAMINING SUSPICIOUSNESS...

WHAT MIGHT  
MAKE A "YES" TO  
ANY OF THESE  
MAKE SENSE?

Context matters: The impact of neighborhood crime and paranoid symptoms on psychosis risk assessment



KOD

Camille Wilson<sup>a</sup>, Melissa Edmondson Smith<sup>b</sup>, Elizabeth Thompson<sup>a</sup>, Caroline Demro<sup>a</sup>, Emily Kline<sup>c</sup>, Kristin Bussell<sup>d</sup>, Steven C. Pitts<sup>a</sup>, Jordan DeVyllder<sup>b</sup>, Gloria Reeves<sup>d</sup>, Jason Schiffman<sup>a,\*</sup>

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- "Have you ever found yourself feeling mistrustful or suspicious of other people?"
- "Do you ever feel that you have to pay close attention to what's going on around you in order to feel safe?"
- "Do you ever feel like you are being singled out or watched?"

# IMPACT OF SOCIOCULTURAL FACTORS: NEIGHBORHOOD



Context matters: The impact of neighborhood crime and paranoid symptoms on psychosis risk assessment

Camille Wilson<sup>a</sup>, Melissa Edmondson Smith<sup>b</sup>, Elizabeth Thompson<sup>a</sup>, Caroline Demro<sup>a</sup>, Emily Kline<sup>c</sup>, Kristin Bussell<sup>d</sup>, Steven C. Pitts<sup>a</sup>, Jordan DeVyllder<sup>b</sup>, Gloria Reeves<sup>d</sup>, Jason Schiffman<sup>a,\*</sup>

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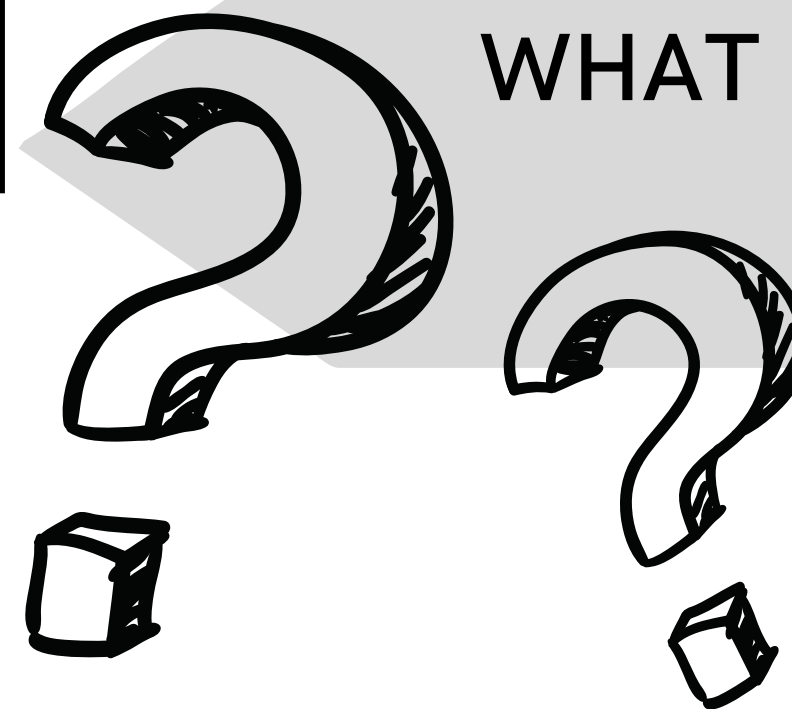
<sup>b</sup> University of Maryland, School of Social Work, 525 W. Redwood St., Baltimore, MD 21201, United States

<sup>c</sup> Beth Israel Deaconess Medical Center, Department of Public Psychiatry, 75 Fenwood Road, 5th Floor, Boston, MA 02115, United States

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## Findings:

- Neighborhood crime correlated with suspiciousness:  $r = .32^{**}$
- Independent effect from attenuated psychosis symptoms



WHAT DO WE MAKE OF THIS?

**Table 5**

Multiple regression predicting suspiciousness, controlling for SIPS psychosis risk symptoms and neighborhood crime.

Predictor	Stdized $\beta$	$t$	$p$	Sq. semi-partial	$f^2$
SIPS Pos, no P2	0.69	7.57	<.001	.461	1.06
Neighborhood crime	0.20	2.14	.04	.031	0.08

# IMPACT OF SOCIOCULTURAL FACTORS: NEIGHBORHOOD

Context matters: The impact of neighborhood crime and paranoid symptoms on psychosis risk assessment



Camille Wilson<sup>a</sup>, Melissa Edmondson Smith<sup>b</sup>, Elizabeth Thompson<sup>a</sup>, Caroline Demro<sup>a</sup>, Emily Kline<sup>c</sup>, Kristin Bussell<sup>d</sup>, Steven C. Pitts<sup>a</sup>, Jordan DeVlyder<sup>b</sup>, Gloria Reeves<sup>d</sup>, Jason Schiffman<sup>a,\*</sup>

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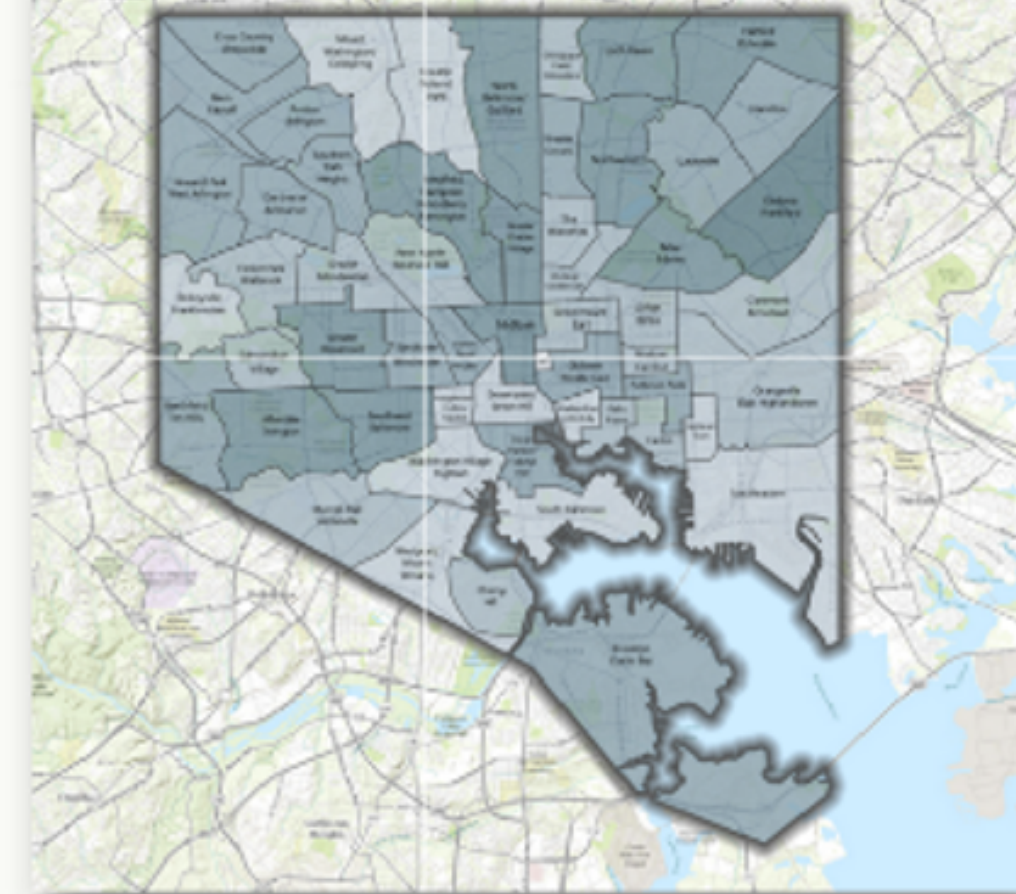
<sup>c</sup> Beth Israel Deaconess Medical Center, Department of Public Psychiatry, 75 Fenwood Road, 5th Floor, Boston, MA 02115, United States

<sup>d</sup> University of Maryland School of Medicine, 655 W. Baltimore St., Baltimore, MD 2120, United States

## DISCUSSION:

- Neighborhood has an effect beyond just “psychosis”
- Importance of context in individual symptom reports
- Healthy cultural mistrust vs. psychopathology
- Could also be stressor/risk factor that increase risk

## Baltimore Neighborhood Indicators Alliance



# PSYCHOSIS ASSESSMENT CONFOUNDS

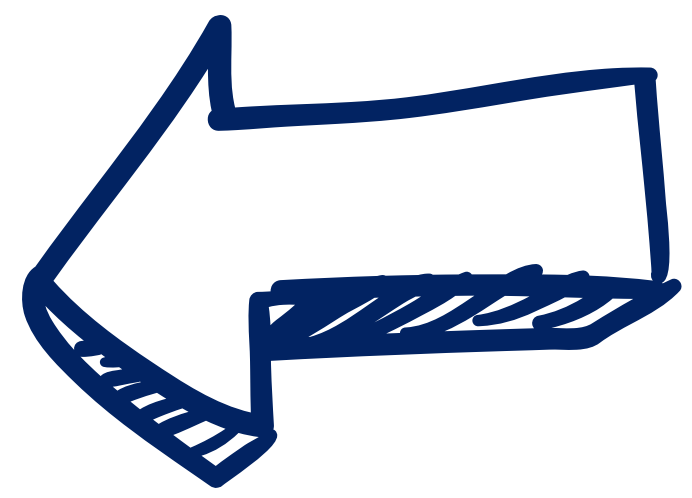
PSYCHOSIS  
DIAGNOSIS

SYSTEMIC FACTORS  
(e.g., social adversity,  
neighborhood crime)

SUSPICIOUSNESS?  
PARANOIA?

- CULTURE
- CONTEXT
- INTERVIEWER BIASES

CULTURAL HUMILITY  
& MULTICULTURAL  
AWARENESS,  
KNOWLEDGE &  
SKILLS



CULTURALLY INFORMED &  
RESPONSIVE ASSESSMENT

# LIMITATIONS & ETHICAL CONSIDERATIONS

## ASSESSMENT TOOLS

## DISCUSSION

### SELF-REPORT SCREENERS:

- PRIME Screen does not adequately assess Black youth
- Potentially lacks required context
- Screening alone may over pathologize

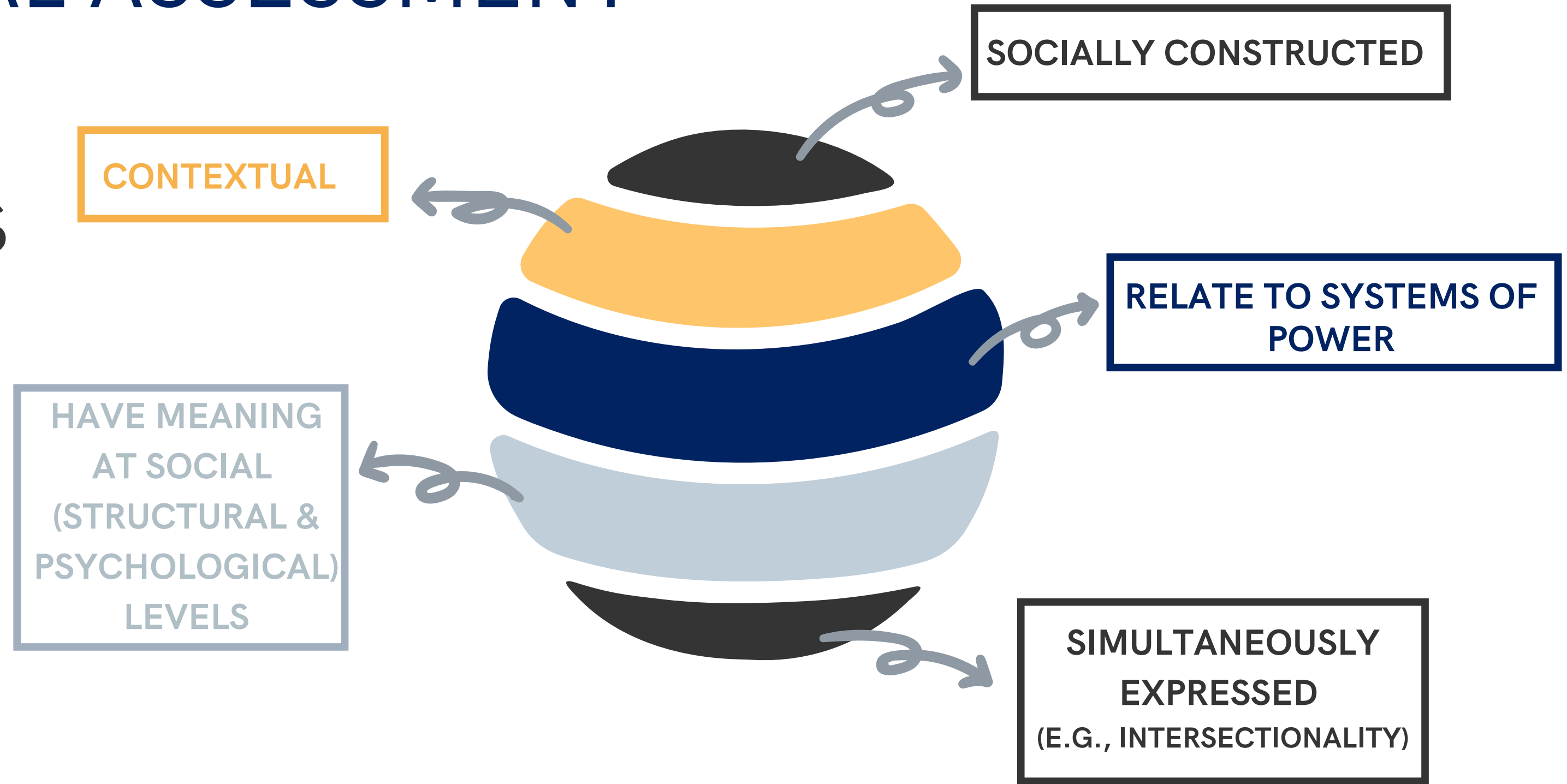
### CLINICAL INTERVIEWS:

- Failure to contextualize clients' experiences may produce false positive psychosis risk symptoms

**BLACK YOUTH SHOULD NOT BE  
CONSIDERED MONOLITHICALLY**

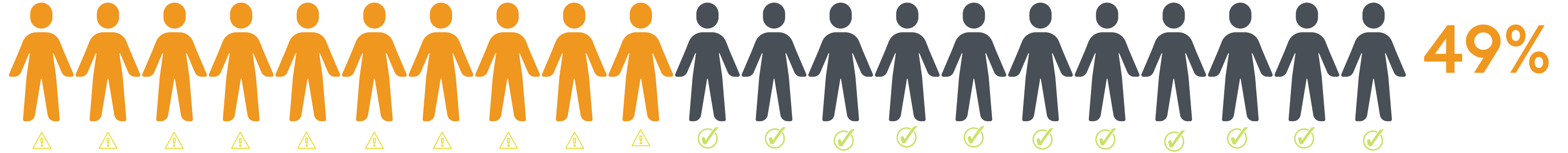
# ETHICAL CONSIDERATIONS: CULTURAL ASSESSMENT

THESE  
CONCEPTS  
ARE...

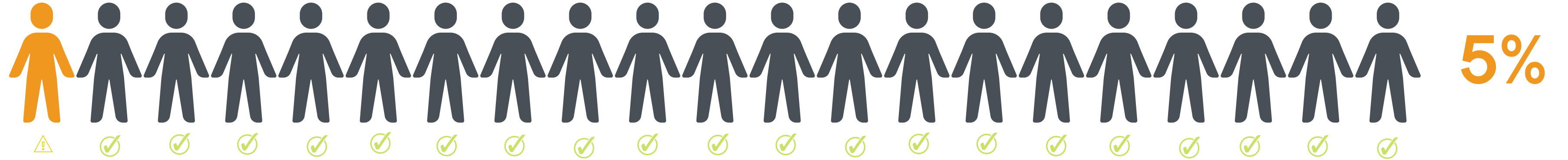


# PSYCHOSIS & CULTURE/CONTEXT: A UNIQUE CHALLENGE

ETHNICALLY DIVERSE IMMIGRANTS & REFUGEES IN CANADA  
REVIEWED MEDICAL RECORDS, RE-DIAGNOSIS (IF NEEDED) USING CULTURALLY  
SENSITIVE DIAGNOSTIC TOOL



Initially Diagnosed with Psychosis-Spectrum Disorders

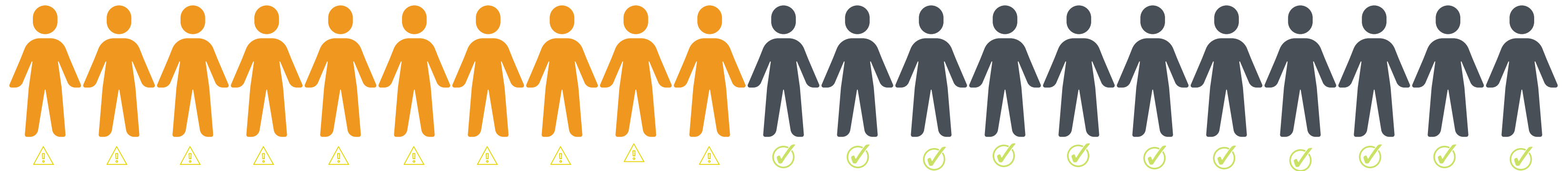


Other Non-Psychosis-Spectrum Disorders

ADEPONLE ET AL., 2012

# PSYCHOSIS & CULTURE/CONTEXT: A UNIQUE CHALLENGE

PTSD & Adjustment  
Disorder



Psychosis-Spectrum Disorders

ADEPONLE ET AL., 2012

~ break ~  
5 minutes



**What is your main  
take-away from  
the last section?**

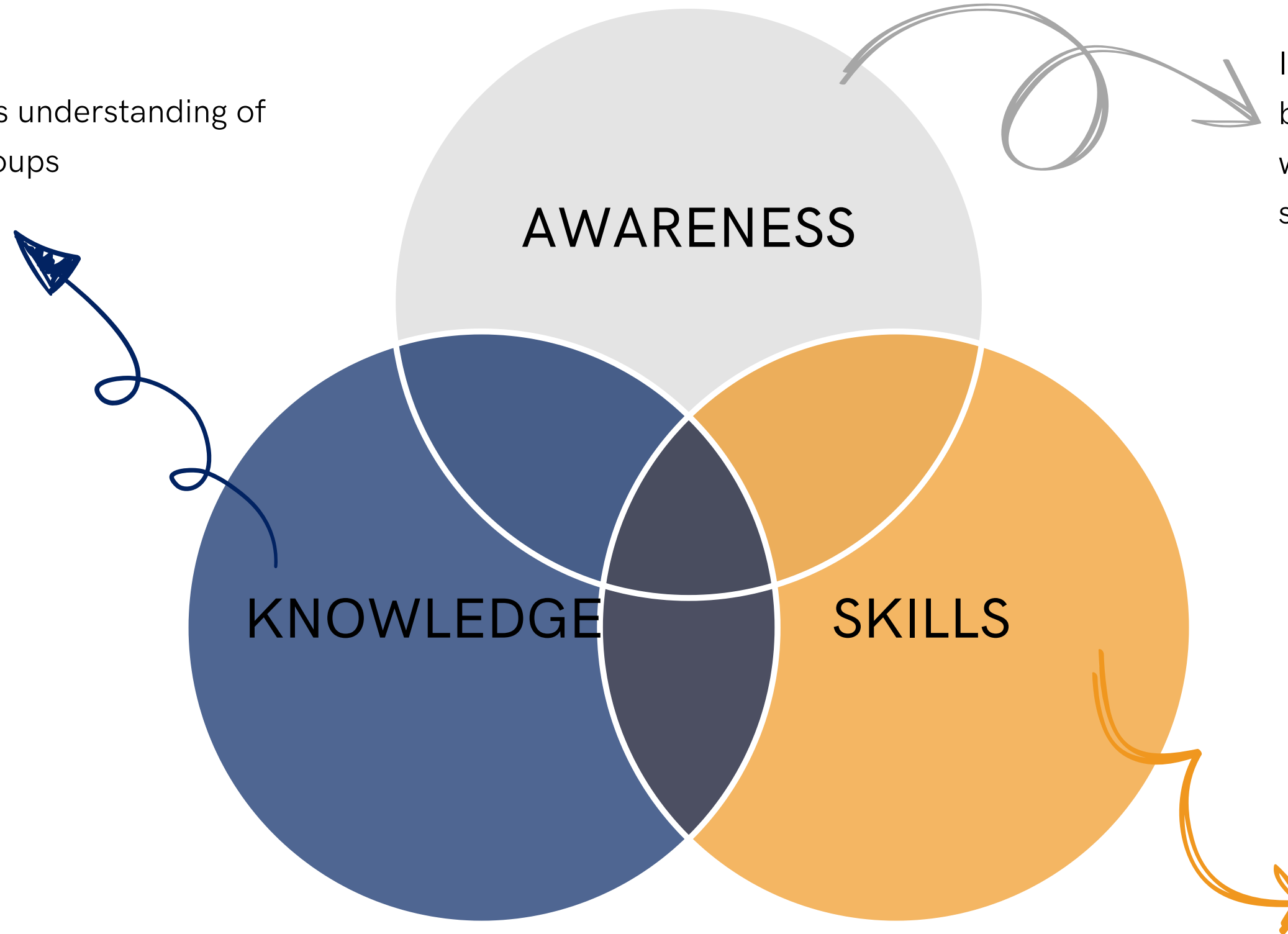
*Please post your thoughts in the chat*

*reconnecting  
after the  
break...*



# MULTICULTURAL RESPONSIVENESS

Integration of one's understanding of diverse cultural groups

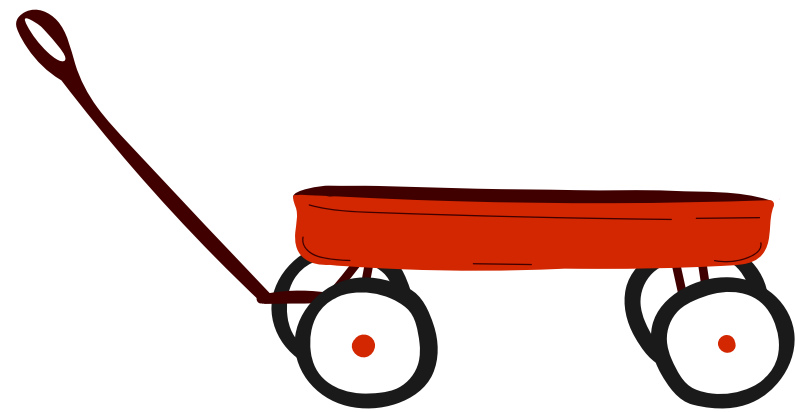


Individuals' understanding of biases, stereotypes, and worldviews that result from sociocultural conditioning

Application of cultural knowledge and awareness to their clinical interactions with diverse or marginalized populations

# REFLECTING ON MY IDENTITY

MY LITTLE RED  
WAGON



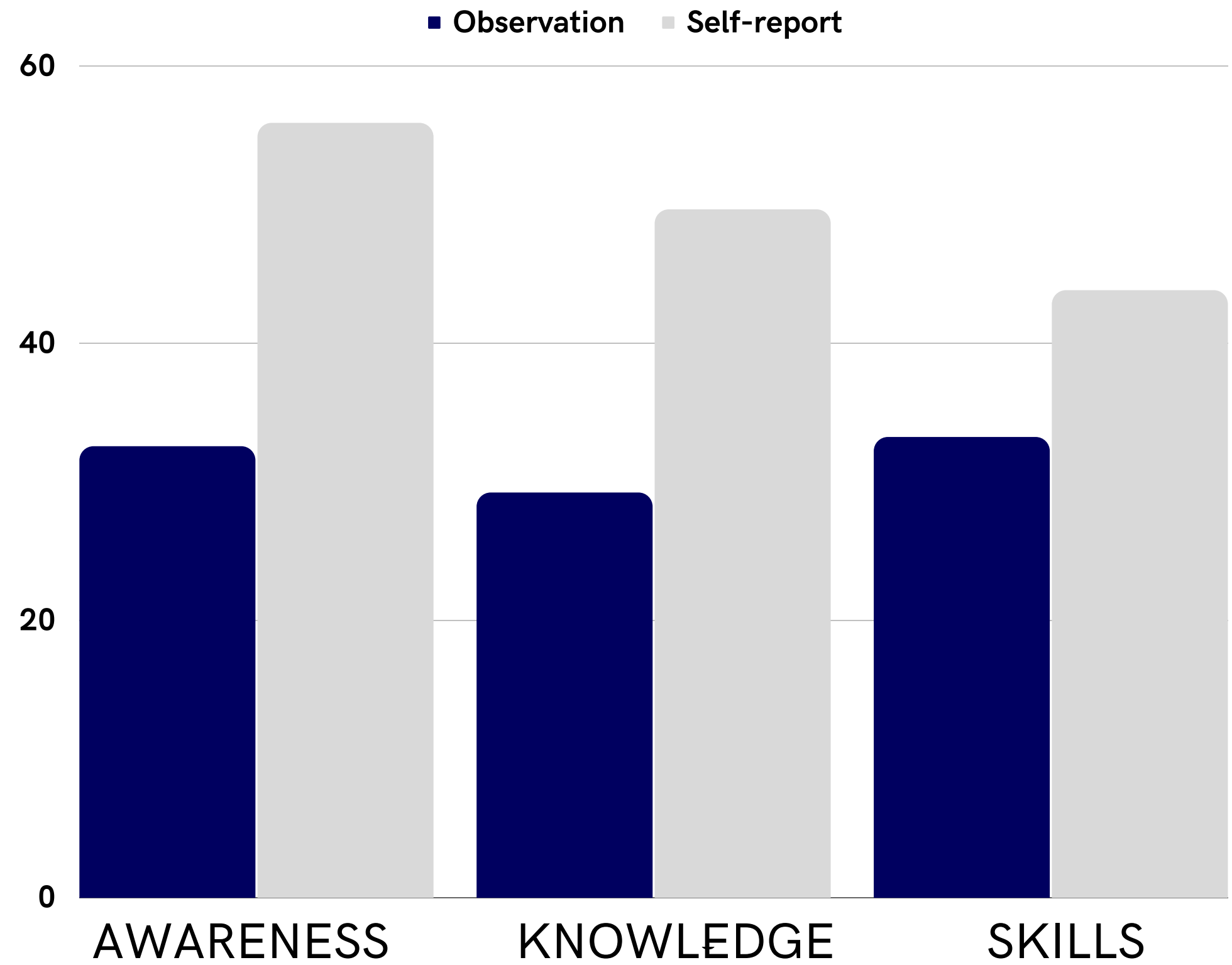
## WHAT ARE YOU BRINGING INTO THIS SPACE?



PERCEPTION  
VS.  
OBSERVATION



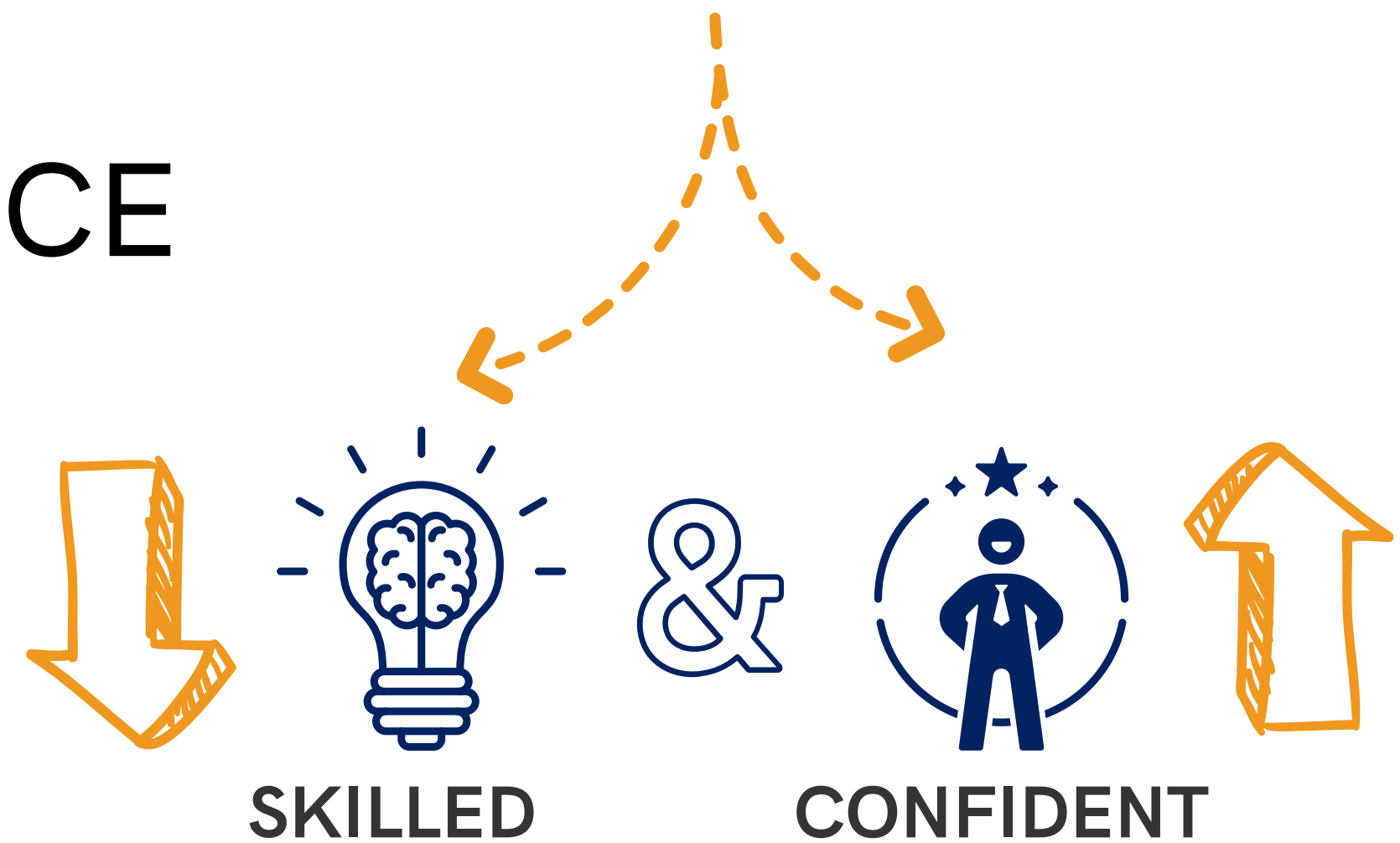
CLINICIAN RATED  
VS.  
OBSERVED CULTURAL  
COMPETENCE  
DURING COUNSELING VIDEOS



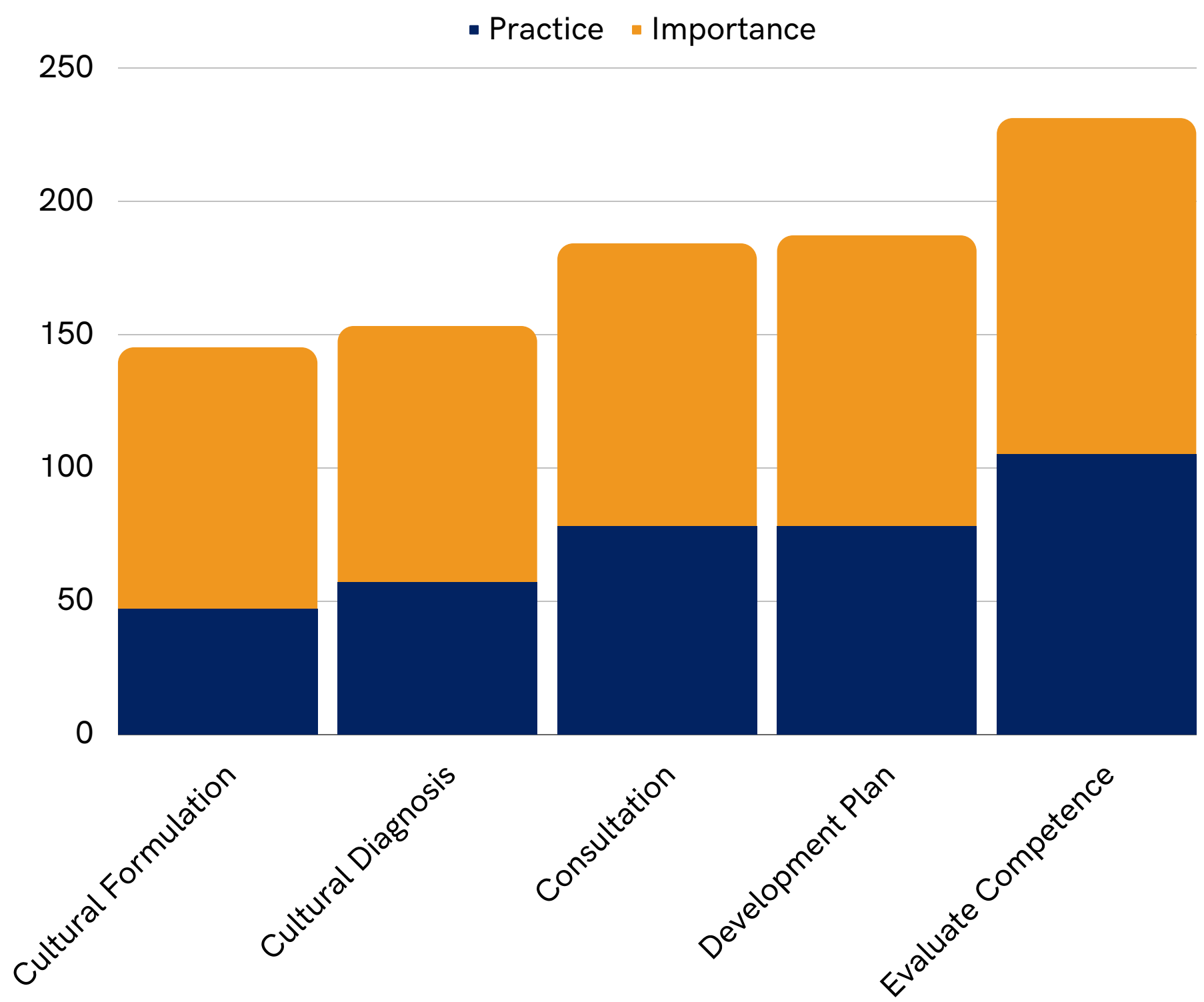
# META-ANALYSIS OF PHYSICIANS' SELF-PERCEPTION OF CULTURAL COMPETENCE



*Overconfident?!*



# CLINICIAN RATINGS OF MULTICULTURAL GUIDELINES



APPLICATION



PERCEIVED IMPORTANCE



HANSEN ET AL., 2006

# IMPLICATIONS OF PROVIDERS' CULTURAL RESPONSIVENESS

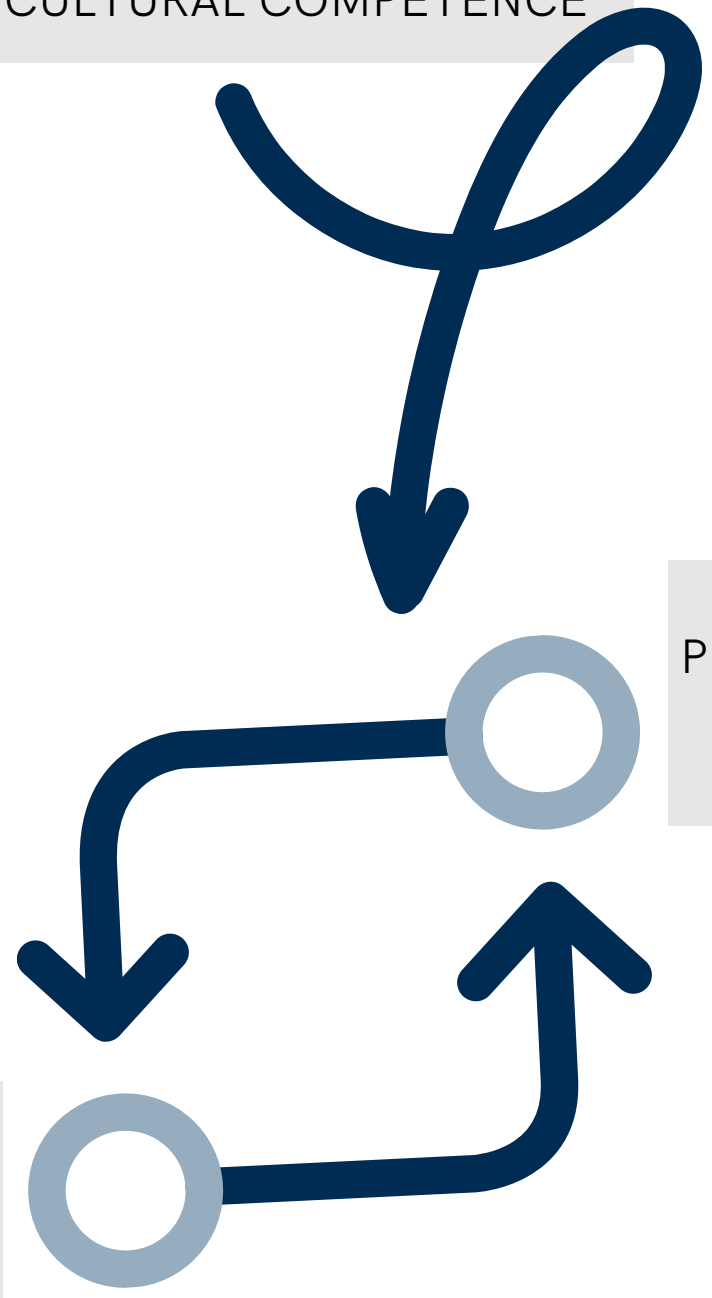
# IMPLICATIONS OF PROVIDERS' CULTURAL RESPONSIVENESS

Reduced racial and associated multicultural awareness are known to be associated with diminished ability to complete a cultural conceptualization of clients and impact trust within the clinical dyad...



PROVIDERS ARE MORE LIKELY TO PERCEIVE BEHAVIORS THAT LED TO HIGHER RATES OF DIAGNOSES OF PARANOID SCHIZOPHRENIA

CLIENTS PERCEIVED PROVIDERS TO LACK CULTURAL COMPETENCE



PROVIDERS RATED GREATER CULTURAL MISTRUST IN THE CLINICAL DYAD

BURKARD & KNOX, 2004; CONSTANTINE, 2001; CONSTANTINE & GUSHUE, 2003

As providers, it is our ethical responsibility to understand these constructs and work actively to challenge oppressive systems, as well as to enhance our cultural awareness, knowledge, and skills.

*CULTURAL  
MISTRUST*

*RELATIONAL.  
BIDIRECTIONAL.  
SYSTEMIC.*

*INTERPRETATION*

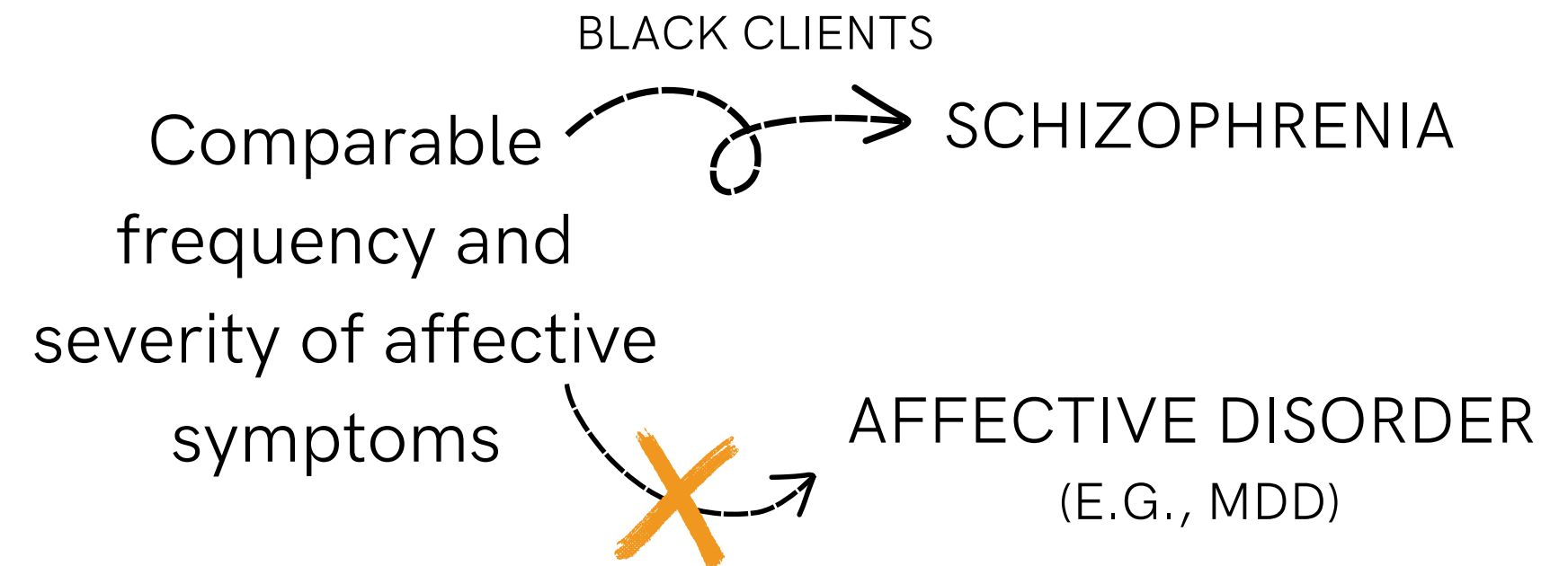
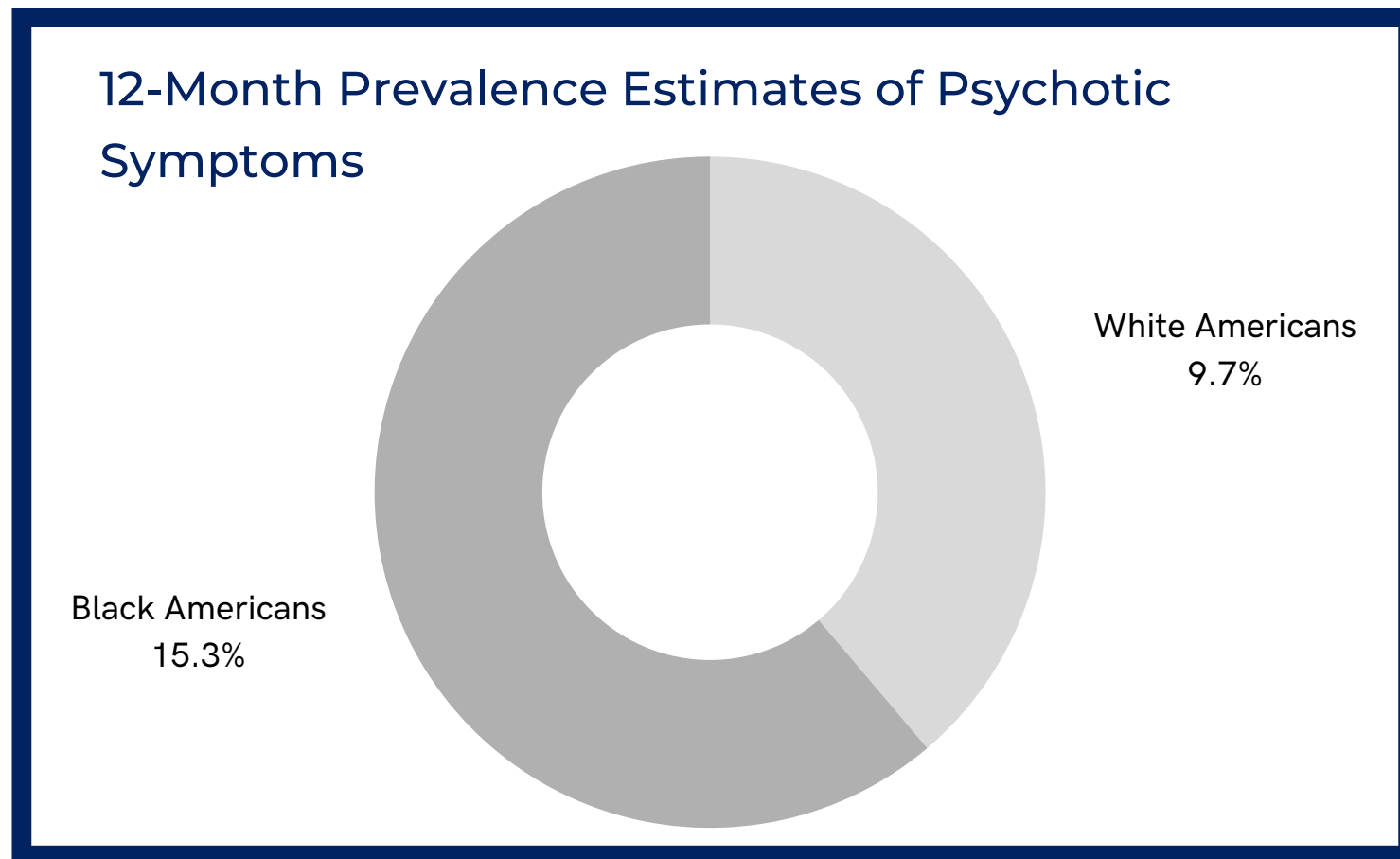
*DIAGNOSIS*

ANGLIN ET AL., 2014; COKLEY ET AL., 2019; SCHWARTZ & BLANKENSHIP, 2014; SNOWDEN, 2003;  
TRIERWEILER ET AL., 2006; WHALEY, 1997; WHALEY, 2001

# DISPROPORTIONATE RATES OF PSYCHOSIS

## DIAGNOSIS

- Threefold elevated risk of schizophrenia spectrum diagnoses for Black individuals compared with white individuals



ADEBIMPE ET AL., 1981; ANGLIN ET AL., 2020; HAMPTON, 2007; MUKHERJEE ET AL., 1983; NEIGHBORS ET AL., 2003; SCHWARTZ & BLANKENSHIP, 2014; STRAKOWSKI ET AL., 1996; WHALEY, 1997.

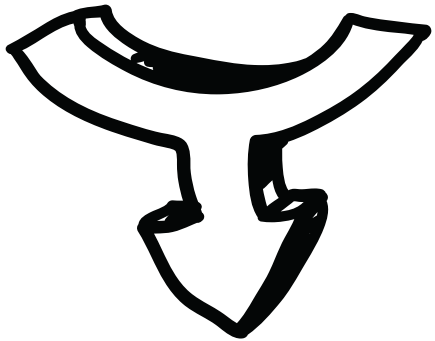
# ETHICAL ASSESSMENT: RACIAL DISPARITIES & IMPLICATIONS

DISPROPORTIONATE RATES OF PSYCHOSIS DIAGNOSIS  
SCHIZOPHRENIA BECOMING A "BLACK DISEASE"

OVERDIAGNOSIS  
OF PSYCHOSIS

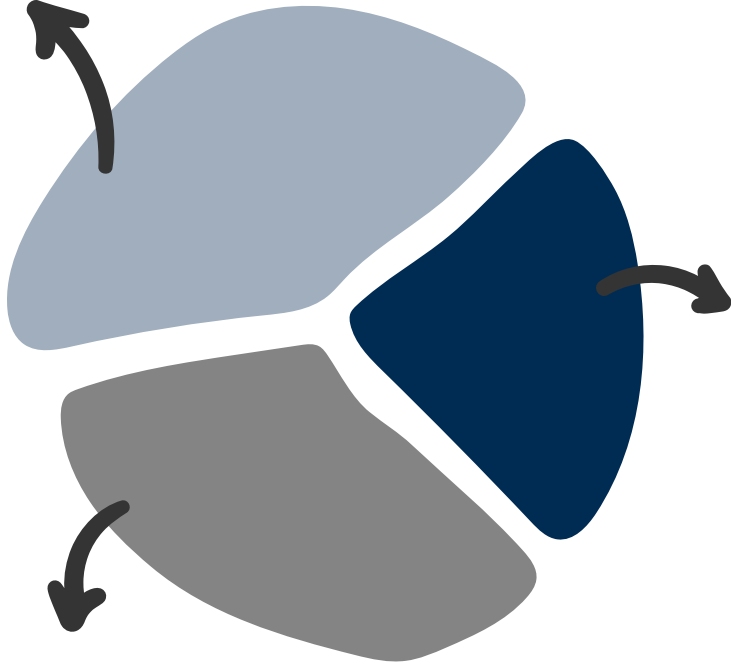
& / OR

UNDERDIAGNOSIS  
OF PSYCHOSIS



# MISDIAGNOSIS

*Treatment decisions that do not adequately address patients' mental health needs*



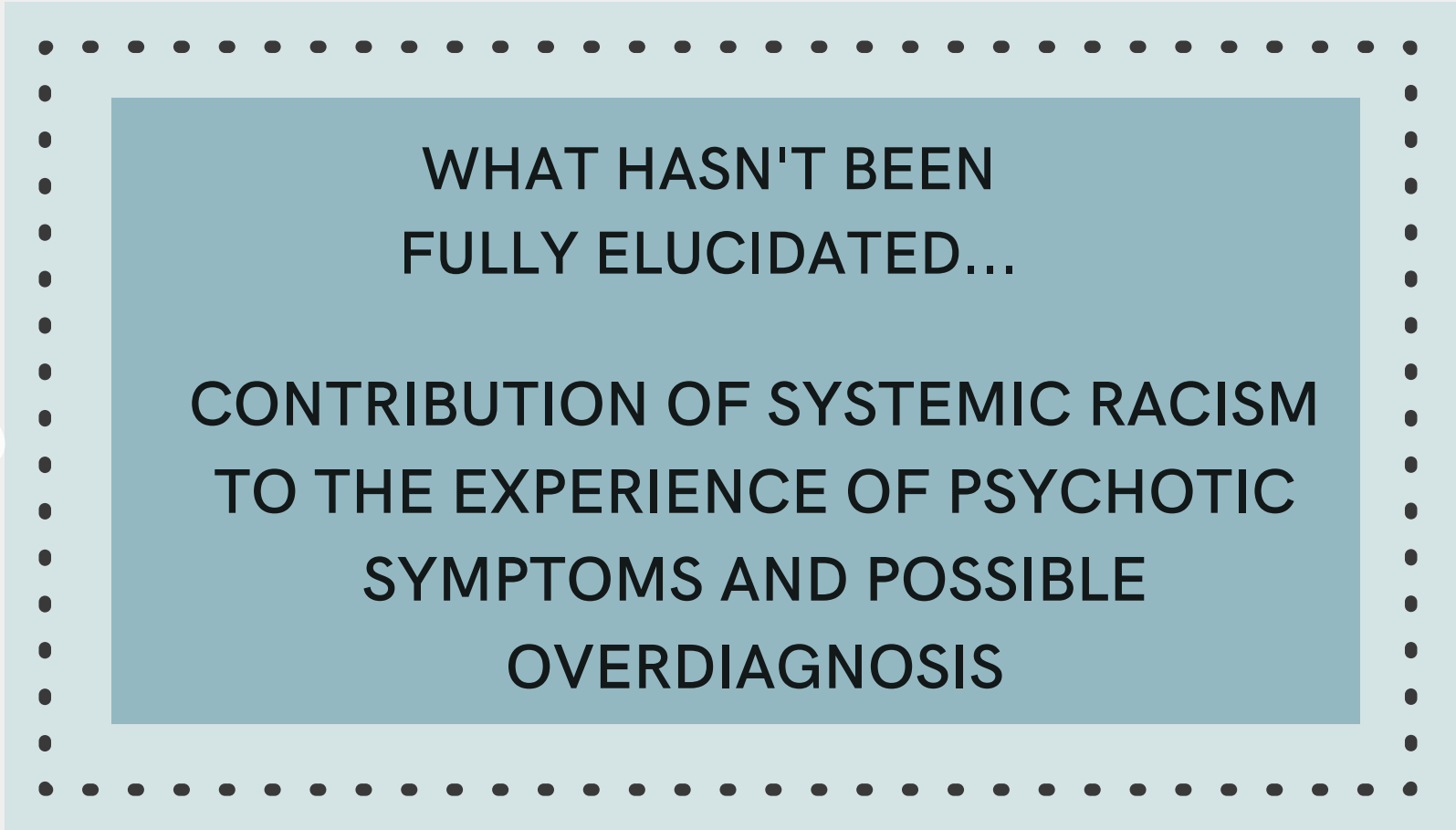
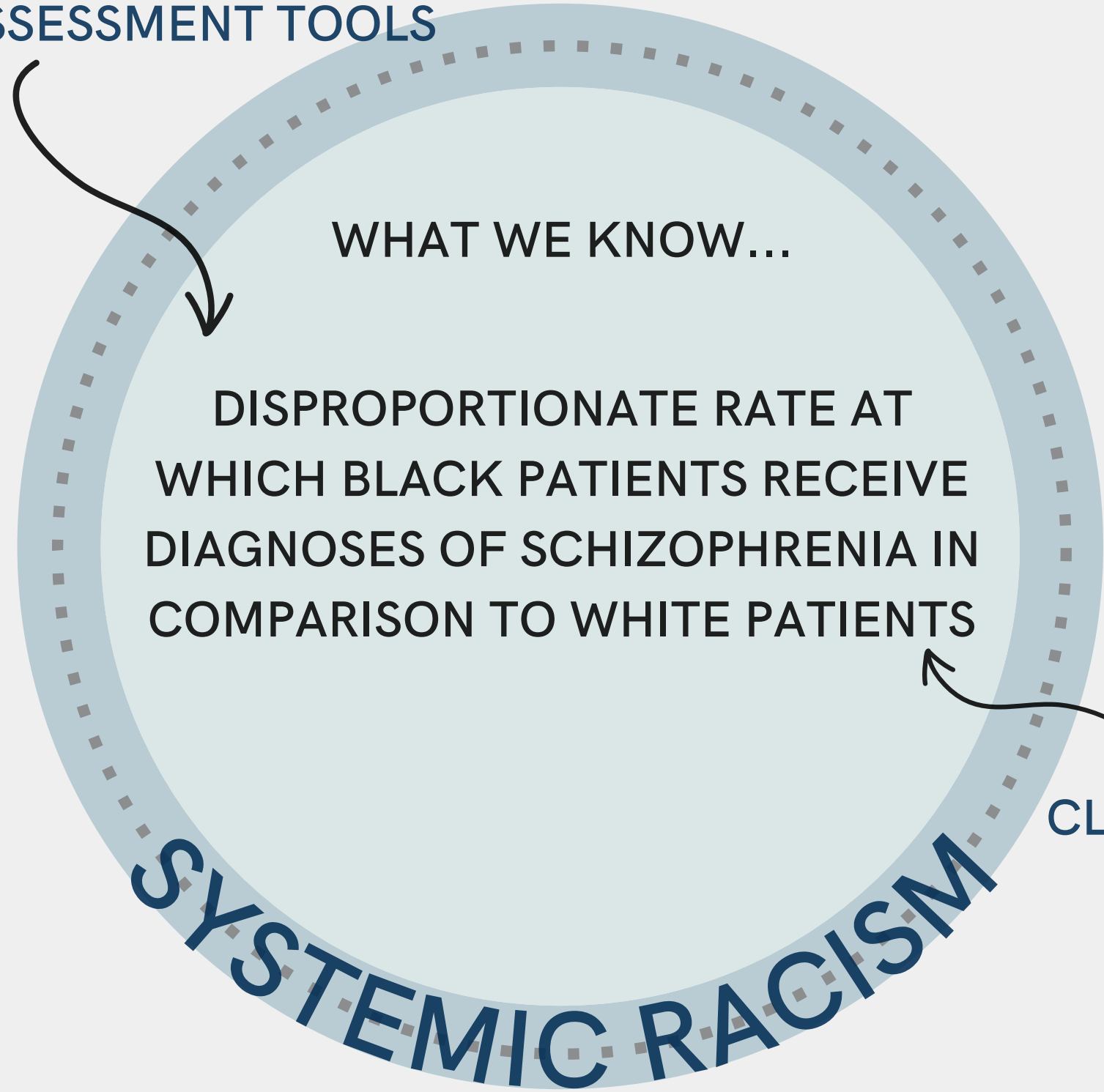
*Poorer global mental health outcomes*

*Promote further stigmatization and marginalization of patients from racially minoritized backgrounds*

ANGLIN ET AL., 2020; HAMILTON ET AL., 2018; SCHWARTZ & BLANKENSHIP, 2014; TRIERWEILER ET AL., 2005

# DISPROPORTIONATE RATES OF PSYCHOSIS DIAGNOSIS

LIMITED CULTURAL RESPONSIVENESS OF ASSESSMENT TOOLS



CLINICIAN BIAS

ANGLIN ET AL., 2020; HAMILTON ET AL., 2018; SCHWARTZ & BLANKENSHIP, 2014; TRIERWEILER ET AL., 2005

# ETHICAL ASSESSMENT

SOCIOCULTURAL  
FACTORS

## NEIGHBORHOOD SAFETY

IS SUSPICIOUSNESS PATHOLOGICAL OR  
NORMATIVE?

---

## ASSESSOR FACTORS

ADDRESSING BIAS & MISDIAGNOSIS

HUMILITY

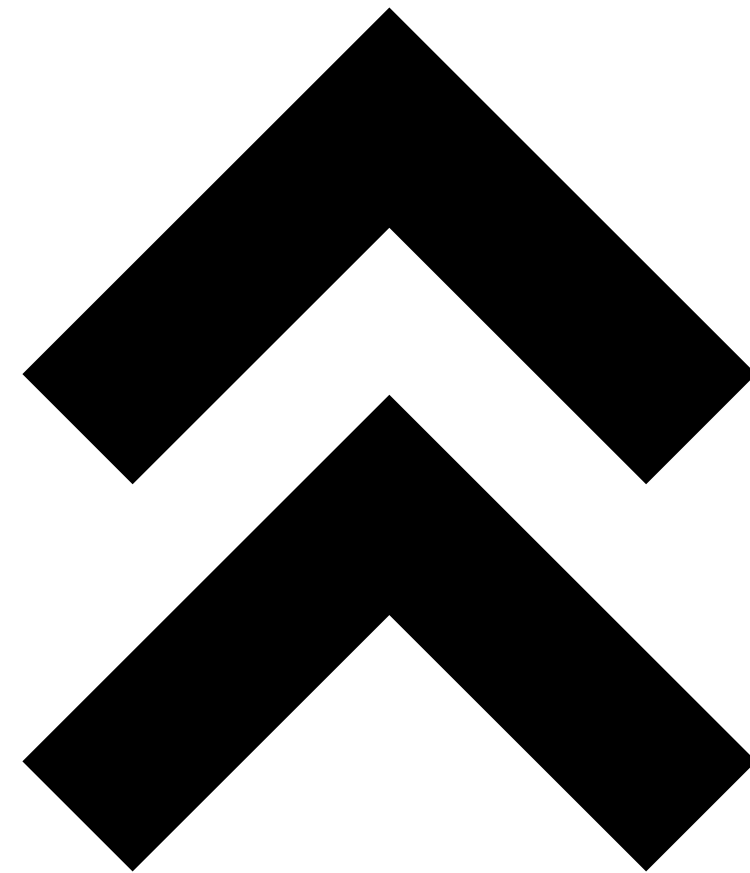
MULTICULTURAL AWARENESS,

KNOWLEDGE & SKILLS

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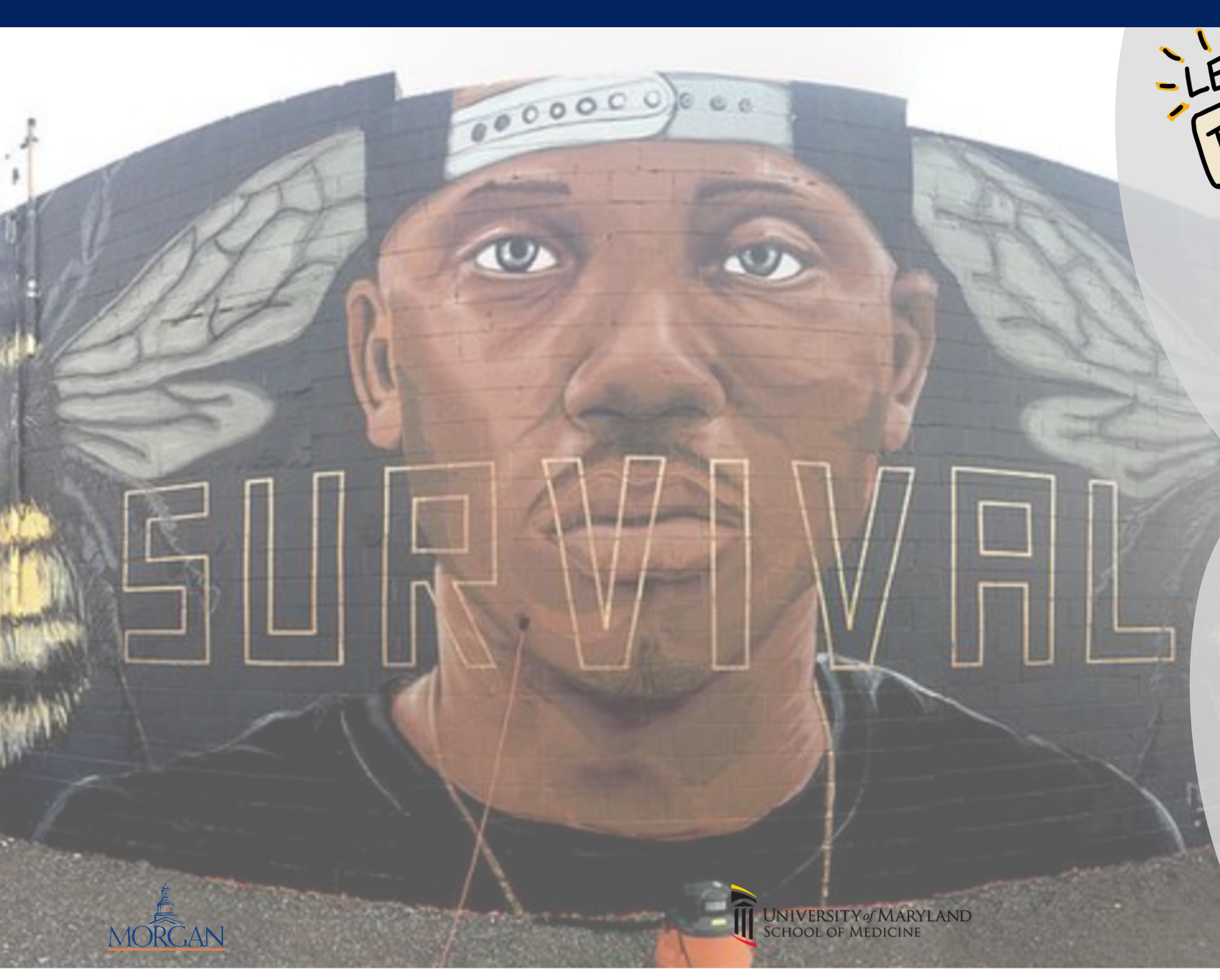
# MULTICULTURAL RESPONSIVENESS

CLINICIANS'  
CULTURAL  
AWARENESS &  
SENSITIVITY



BETTER CLIENT  
OUTCOMES

- Higher treatment satisfaction
- Increased trust in clinical dyad
- Lower therapy attrition rates



LET'S  
TALK



KOD

WHAT  
OVERARCHING  
IDEAS/THEMES DO  
YOU SEE?



WHAT CALLS TO  
ACTION FOR YOU  
AS A CLINICIAN?



~ break ~  
5 minutes





reconnecting  
after the  
break...

How would you  
change your  
practice, based  
on what you  
learned?

*Please post your thoughts in the chat*



# IMPACT OF SOCIOCULTURAL FACTORS

ETHICAL CONSIDERATIONS &  
MENTAL HEALTH DISPARITIES



# EVERYTHING IS CULTURED

## SOCIOCULTURAL FACTORS INFLUENCE ALL ASPECTS OF MENTAL HEALTH

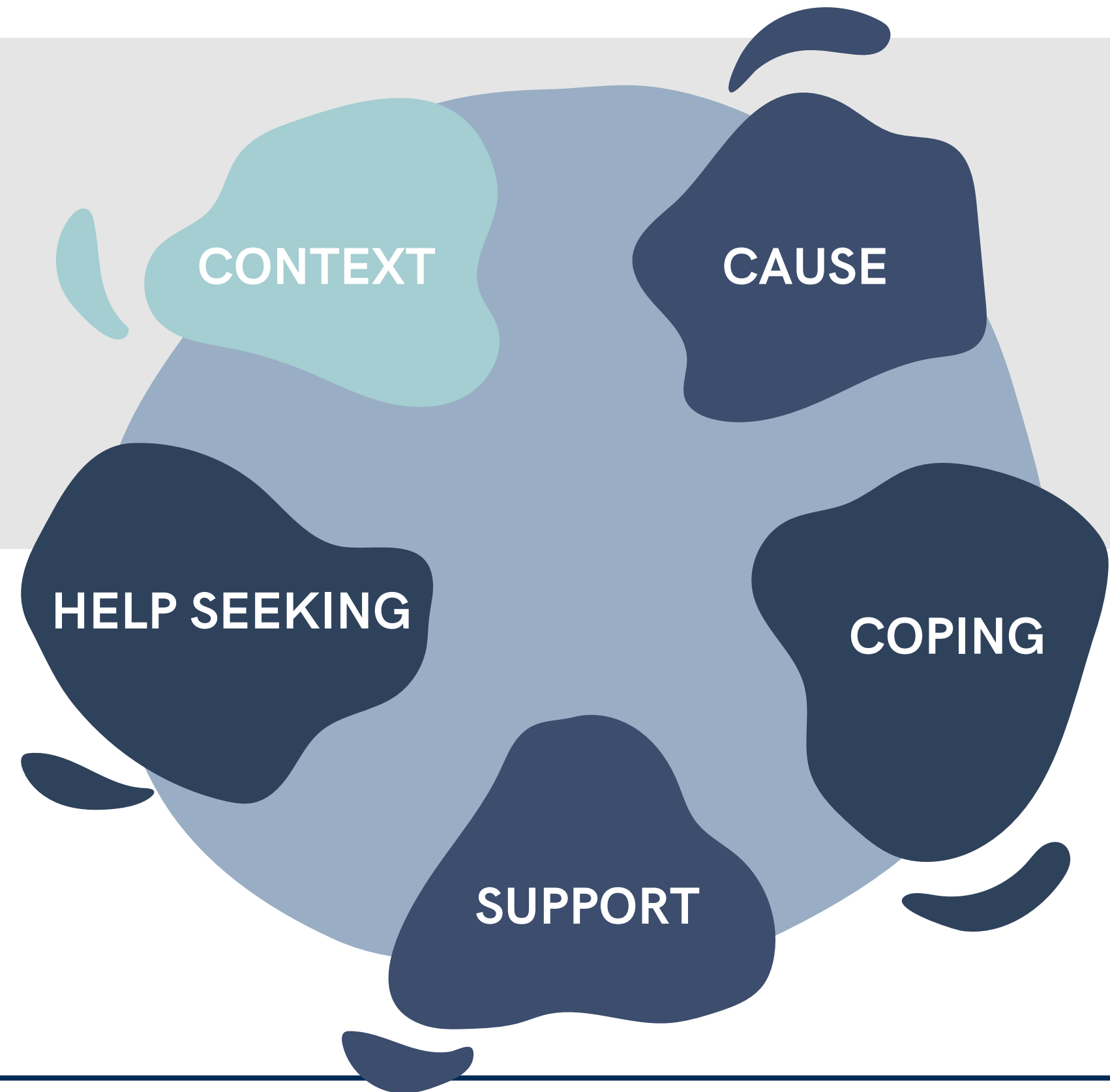
- *Inform what is considered normative/adaptive within and across cultures*
- *Often influence which disorders develop, the form they take, their prevalence, and their course*

# CULTURAL & SYSTEMIC FACTORS



There is an imperative to discontinue the existing narrative that racial minority status in and of itself leads to greater psychological issues; rather, we should be asking:

What are the more proximal factors influencing the relation between race and psychological distress?



Beyond diagnostic differences, psychosis-related mental health disparities include:

- Limited access to specialized care;
- Higher frequency of receiving treatment in inpatient settings; and,
- Longer duration of untreated psychosis
  - *Leading to long-term functional disability and disrupted social and role functioning*

**Race *itself* does not cause or lead to psychosis or other psychological issues but, instead, systemic inequity and systems of oppression are more likely mechanisms.**

*At the same time...*

**exposure to systemic racism likely has both direct and indirect effects on mental health outcomes...**

---

Together, these findings highlight the important etiological role of the social environment (e.g., social inequality, adversity) and discrimination in psychosis risk

BARNES, 2013; OLBERT ET AL., 2018

# MENTAL HEALTH DISPARITIES

"STRESSORS ASSOCIATED WITH MEMBERSHIP IN MINORITIZED CULTURAL/RACIAL/ETHNIC GROUPS, INCLUDING SOCIAL EXCLUSION & DISCRIMINATION ARE THOUGHT TO ACT AS A VULNERABILITY TO EXPERIENCE PSYCHOSIS-SPECTRUM SYMPTOMS, OR A TRIGGER TO EXACERBATE EXISTING SYMPTOMS."



ANGLIN ET AL., 2016; ANGLIN E AL., 2021; BARDOL ET AL., 2020; JANSSEN ET AL., 2003; MILLMAN ET AL., 2019; RAKHSHAN ROUHAKHTAR ET AL., 2019; RAKHSHAN ROUHAKHTAR ET AL., 2021; SALEEM ET AL., 2014; SELTEN ET AL., 2020; SHAIKH ET AL., 2016; WILSON ET AL., 2016.

# IMPLICATIONS

## Involuntary Hospitalization

## Disparities in Treatment

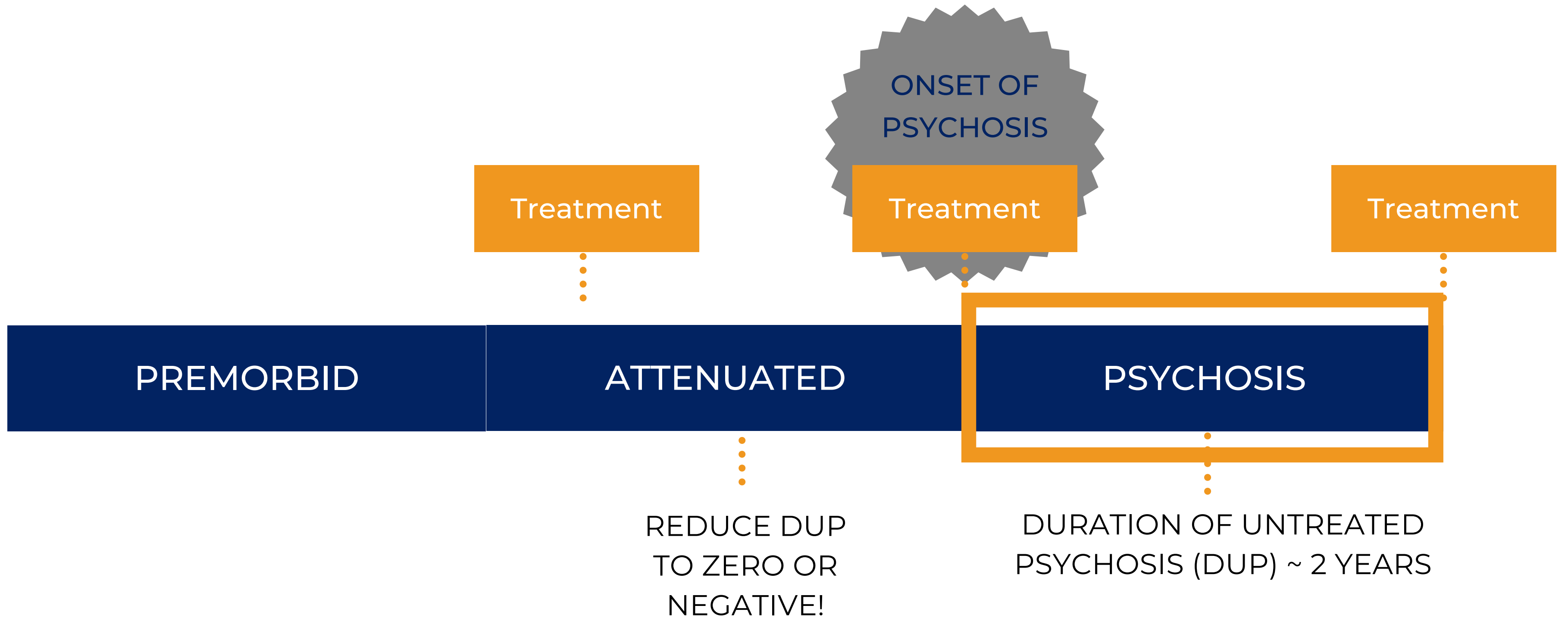
- Medication
  - *Higher risk for excessive doses*
  - *Older medications*
- Limited access to outpatient, specialized care

## Disparities in Mental Health Outcomes

- Prolonged DUP

## Disruption of Social & Role Functioning

# DURATION OF UNTREATED PSYCHOSIS (DUP)



# EIP PROGRAMS & PATHWAYS TO CARE

- Systemic inequity and marginalization **impact EIP treatment utilization and engagement**
- Clients from oppressed, minoritized, or disadvantaged backgrounds have **disproportionate access to treatment**
- **Alternative cultural explanations** for mental health difficulties, cultural distrust, and community stigma may influence EIP treatment engagement

## LONGER DUP

- ✗ Worse long term outcomes
- ✗ More intensive services
- ✗ More negative symptoms
- ✗ More social impairment
- ✗ More occupational impairment
- ✗ More neuropsychological deficits
- ✗ More psychological distress
- ✗ Likely increased costs/burdens to the system

## SHORTER DUP

- ✓ Better long term outcomes
- ✓ Less need for intensive services
- ✓ Less negative symptoms
- ✓ Less social impairment
- ✓ Less occupational impairment
- ✓ Less neuropsychological deficits
- ✓ Less psychological distress
- ✓ Less costs/burdens to the system

# DURATION OF UNTREATED PSYCHOSIS

## FACTORS

- Lack of familiarity with psychosis
- Clients and providers not knowing where to turn for help
- Specialized services may not be integrated into accessible settings

## SOLUTIONS

- EDUCATION
- SCREENING QUESTIONNAIRES, CULTURALLY RESPONSIVE ASSESSMENT PROCEDURES
- IMPROVEMENT OF REFERRAL PROCESS
  - ACCESS AND KNOWLEDGE

# GROUP DISCUSSION



KOD



Given the importance of early  
identification of psychosis,

**HOW WOULD YOU**

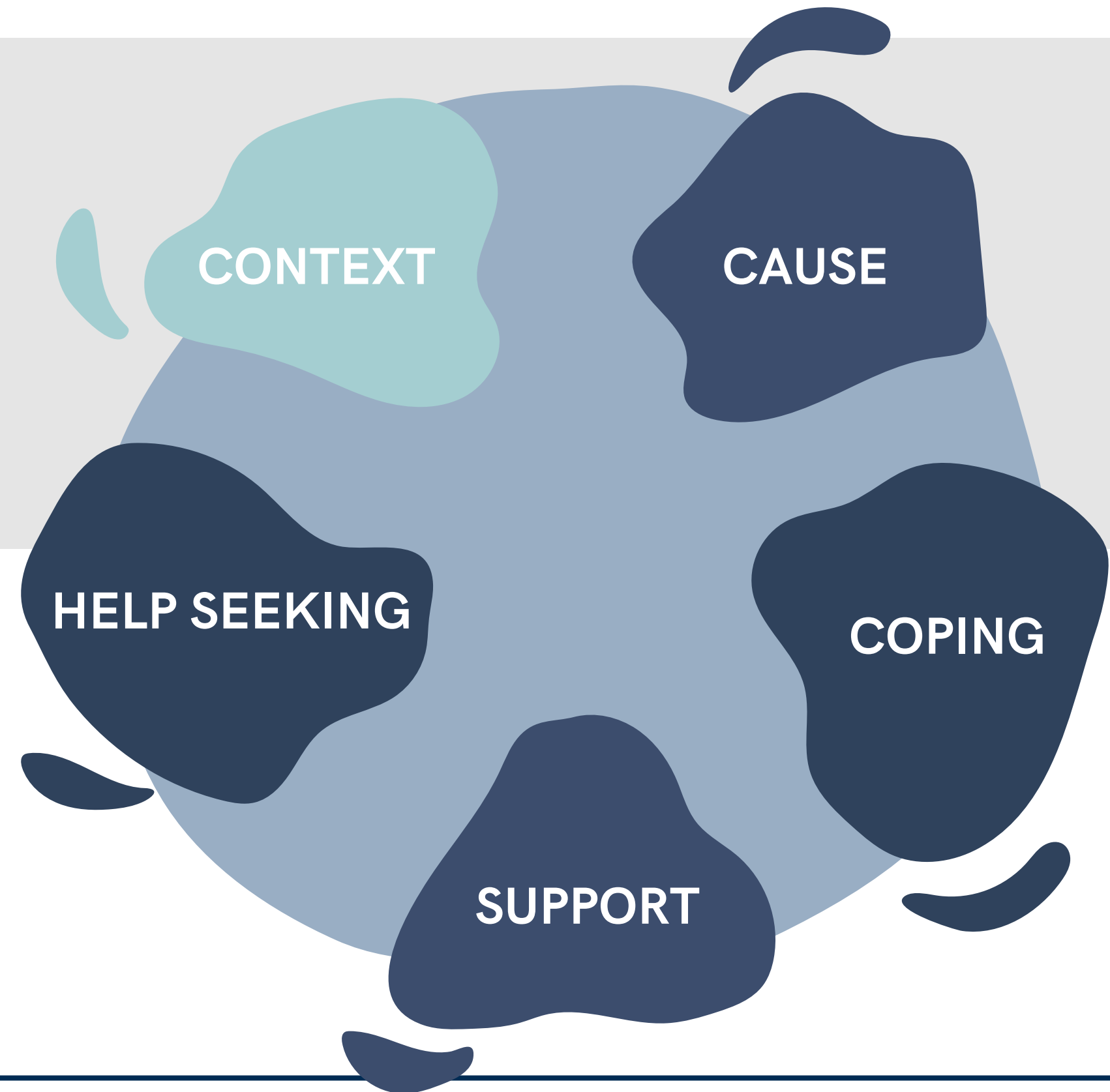
propose integrating cultural factors in  
assessment & diagnosis?

# CULTURAL & SYSTEMIC FACTORS



There is an imperative to discontinue the existing narrative that racial minority status in and of itself leads to greater psychological issues; rather, we should be asking:

What are the more proximal factors influencing the relation between race and psychological distress?



*Considering all that we have covered today...*

Based on what you learned today, how would you change your practice?

# WRAPPING UP

## SUMMARY: GOALS

*INCREASE UNDERSTANDING OF BEST PRACTICES FOR SERVING ADOLESCENTS AND YOUNG ADULTS WITH POTENTIAL PSYCHOSIS FROM A CULTURALLY RESPONSIVE, STRENGTH-BASED, HOLISTIC AND NON-STIGMATIZING PERSPECTIVE.*

## OBJECTIVES

1

Increase knowledge and skills for applying a historically & contextually informed clinical lens by fostering cultural humility through self-reflection.

2

Learn the importance of ethical standards related to cultural competence for the early identification and intervention of mental health concerns, including psychosis.

3

Understand the impact of sociocultural, systemic, risk, and resiliency factors on young adults' lived experience of psychosis symptoms.

**BUILDING UPON TODAY'S CONTENT, OUR NEXT WORKSHOP WILL FOCUS ON:**

- Psychosis Assessment & Intervention
- Pathways to Care
- Culturally-Informed Best Practices in Early Psychosis Identification & Treatment

Thank you

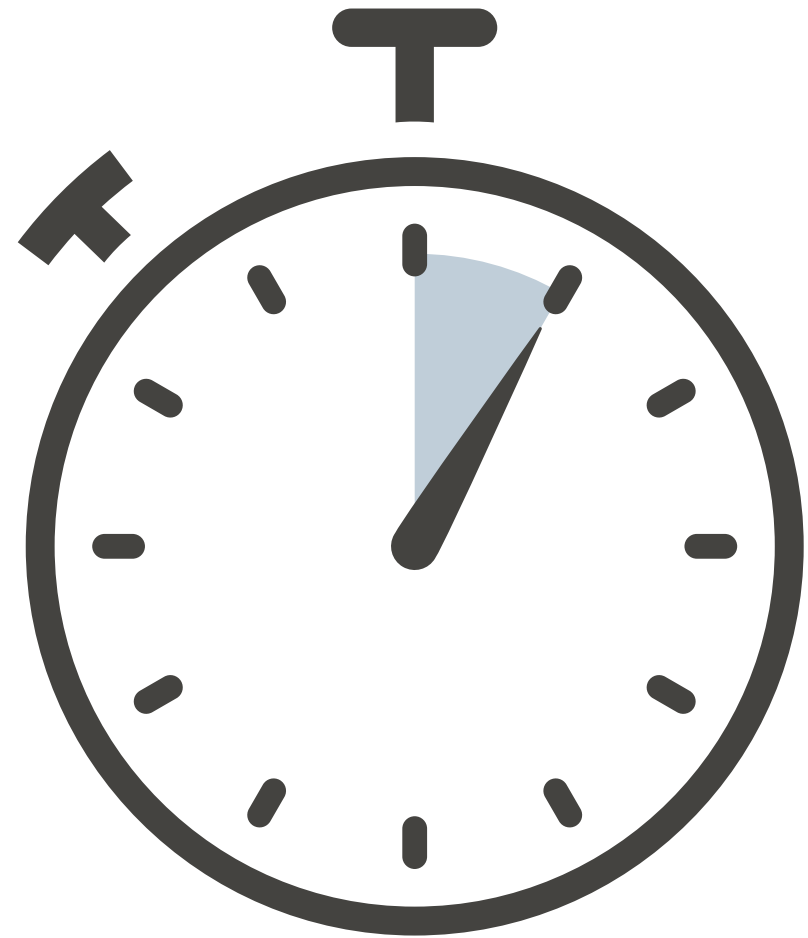
FOR YOUR THOUGHTFUL  
CONTRIBUTIONS, ENERGY,  
TIME, AND COMMITMENT TO  
LEARNING WITH US



REMINDER

- PLEASE COMPLETE THE EVALUATION TO EARN YOUR CEU'S
- CERTIFICATES OF COMPLETION WILL BE PROVIDED WITHIN 8 WEEKS

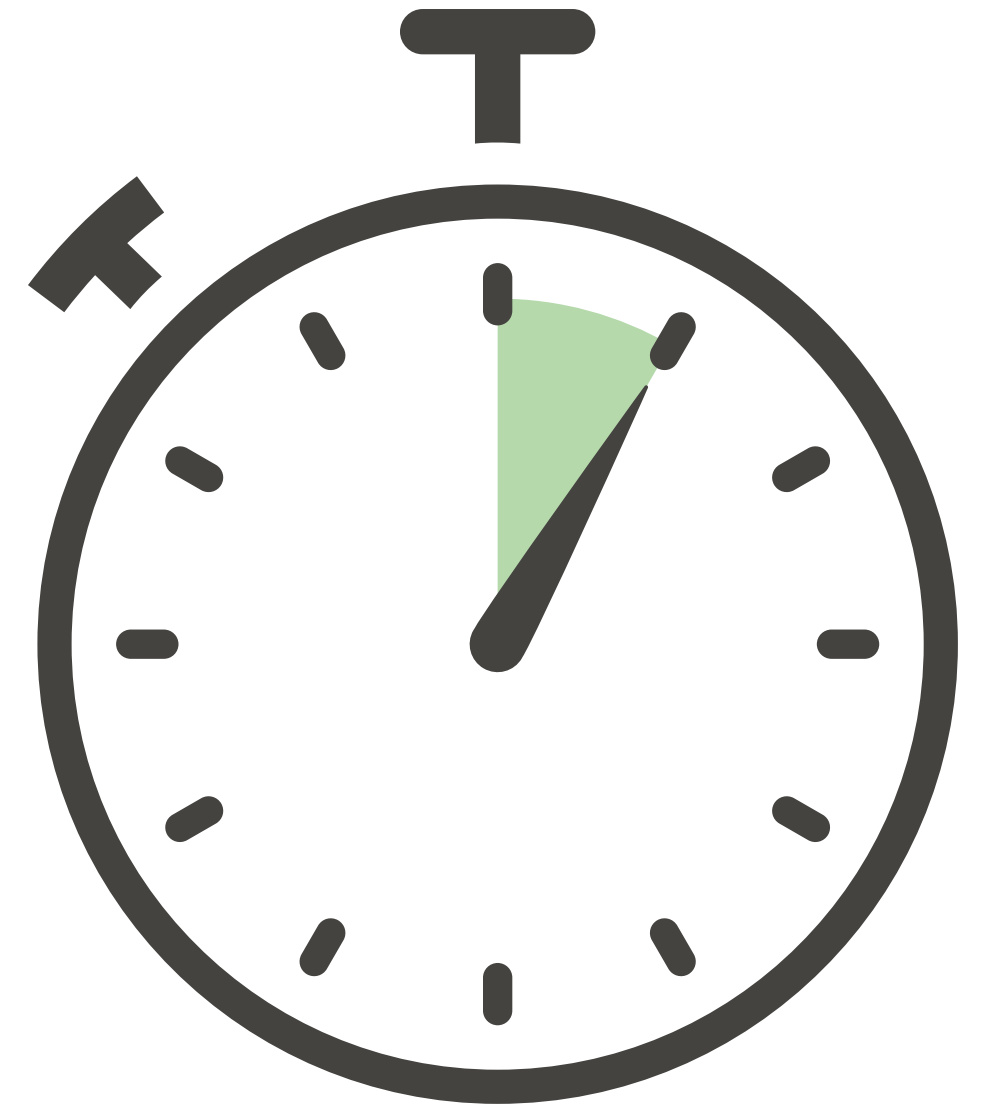




~ break ~  
15 minutes

~ break ~

5 minutes



reconnecting  
after the  
break...

**What is your main  
take-away from  
the last section?**

*Please post your thoughts in the chat*



**What is your main  
take-away from  
the last section?**

*Please post your thoughts in the chat*

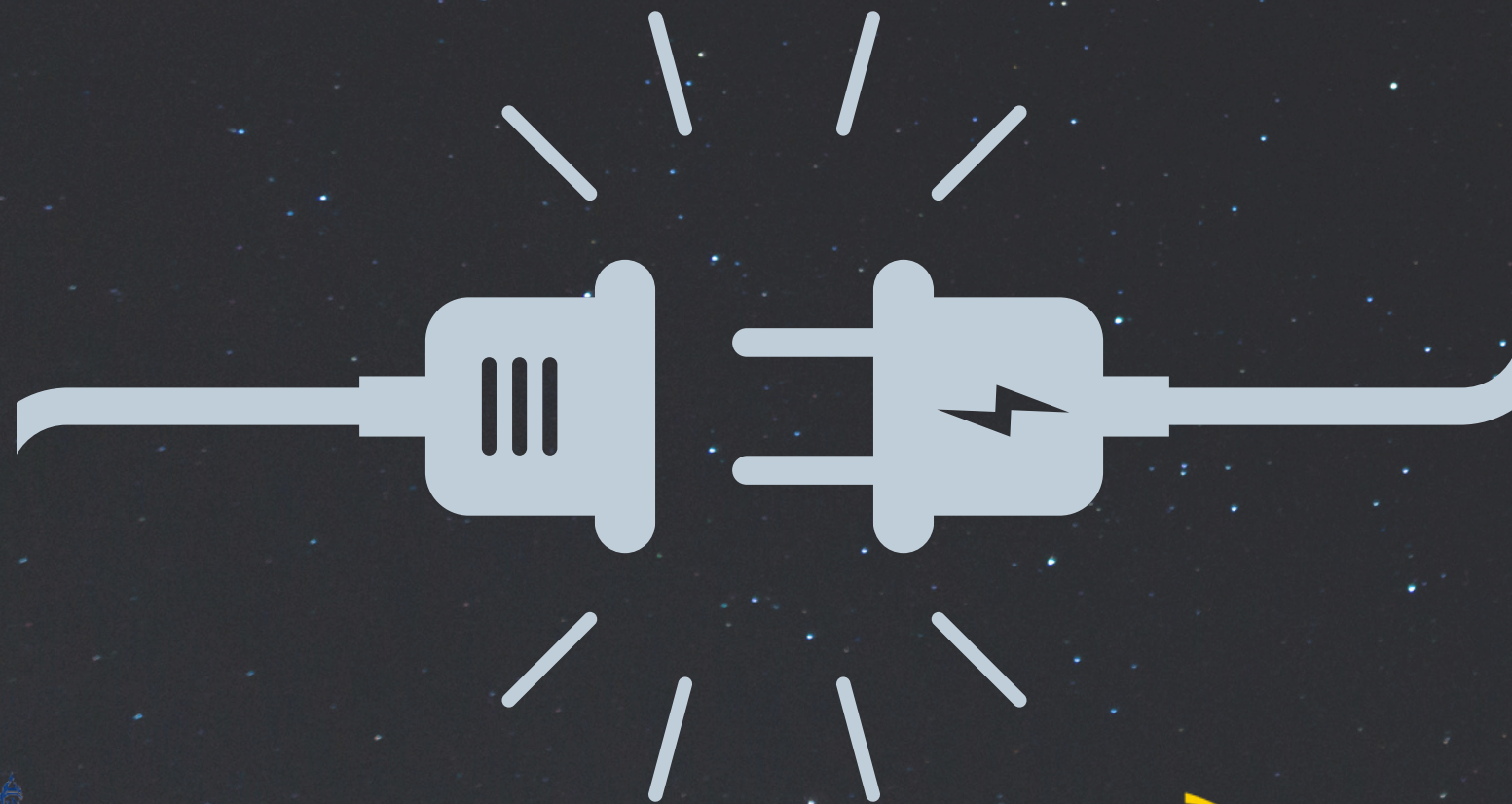
*reconnecting  
after the  
break...*

reconnecting  
after the  
break...



What connections  
did you make  
from the last  
section?

*Please post your thoughts in the chat*



reconnecting  
after the  
break...



WHAT KERNELS OF  
INFORMATION  
ARE YOU TAKING WITH YOU  
FROM THE LAST SECTION?

*Please post your thoughts in the chat*

## INFO FOR US



DR. DARRELL

**SLIDES:**

- 12-20
- 54-58
- 95-97



BRITT

**SLIDES:**

- 21-36



NIKITA

**SLIDES:**

- 37-38



DR. SINCLAIR

**SLIDES:**

- 1-11
- 39-53
- 98-101



PAMELA

**SLIDES:**

- 54-94



KEIRA

**SLIDES:**

- 109-163



RANIYA HOLMES

**SLIDES:**

- 15 (LRW ACTIVITY)



DOHA

**SLIDES:**

- 102-108
- 164-168
- 169-171?