

# The Effect of Social Identities of Service-Users and Clinicians on Mental Health Disparities: A Review of Theory and Facts

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## ABSTRACT

Mental health disparities are differences in health status, risks and care favoring members of advantaged over disadvantaged social groups. The contrasting social identities of clinicians and service-users may account for potential disparities found in clinical encounters, reflected, for example, in the provision of substandard care. The imputed mechanisms, however, remain unknown. Drawing on social psychological research we delineate a model to assist in identifying those mechanisms. We review the literature on processes rooted in social categorization (outgroup bias) and in social power (impaired perspective taking, making automatic attributions) and suggest that the contrasting social identities of clinicians and service-users can partially account for why discordant, compared to concordant ethnic identities in clinical encounters may produce worse outcomes, measured by the quality of the working alliance and the accuracy of diagnostic decisions. We provide preliminary evidence for the proposed model and submit a research agenda to inform evidence-based interventions to counter the negative outcomes of discordant encounters.

Health disparities are defined as unequal health status, risks and care favoring members of advantaged over disadvantaged social groups in society (1). Social advantage or disadvantage refers to the relatively favorable or unfavorable socio-demographic (e.g., gender,

ethnicity) economic or political conditions that some groups systematically experience based on their relative position in society (2). For example, in the United States, whites have lower prevalence rates of psychiatric disorders than other ethnic groups in the country, even when potential confounding variables, e.g., socioeconomic status, are controlled (3). Similar findings have been documented in other countries with national health insurance systems, such as Israel and the United Kingdom (4, 5).

Recent studies in Israel show that prevalence rates of mental health disorders are higher among Israeli Arabs, who constitute 20% of the population and are relatively disadvantaged, as compared to Israeli Jews (4). Consistent differences in mental health also exist between immigrants from the former Soviet Union and the Israel-born majority (6), as well as between Mizrahim (Jews of Asian/North African descent) and Ashkenazim (Jews of European/American descent). For example, the prevalence rates of mood and anxiety disorders are approximately twice higher for second generation Mizrahim compared with their Ashkenazi counterparts (7). In accordance with the Convention on the Rights of Persons with Disability (8), these inequalities call for remedial action for those seeking psychiatric care guided by research such as that purported to identify the mechanisms involved in the clinical encounter.

In this paper we review relevant literature from social psychological research and present initial evidence proposing that processes rooted in social categorization and in social power may in part contribute to mental health disparities in the clinic. More specifically, we explore potential mechanisms that may mediate the

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relationship between the social identities of clinicians and service-users and the course and outcomes of the clinical encounter.

#### **THE EFFECT OF SOCIAL IDENTITIES OF SERVICE-USERS AND CLINICIANS IN THE CLINICAL ENCOUNTER ON HEALTH DISPARITIES**

Although differences in genetic susceptibility to disease contribute to differences in health status (e.g., Huntington's disease is most prevalent among people of European ancestry whereas sickle cell anemia most commonly affects people of Mediterranean ancestry; 9, 10), the role played by social factors in the development and persistence of health disparities has been solidly documented (2, 5). Social causation models attribute poor mental health status to adversity and stress among socially disadvantaged groups (11, 12). For example, lower socioeconomic status is associated with limited access to health care (2) and to lower rates of health literacy frequently associated with higher prevalence rates of different psychiatric disorders (13). Other research provided support for the role of perceived discrimination as a significant social stressor that mediates the association between disadvantaged ethnic groups and mental ill-health (14).

Beyond the impact of those macro (or distal) factors, such as genetic and social influences, an additional set of micro (or proximal) factors, such as those arising from the clinical encounter, have been identified as potential contributors to health service disparities (15, 16). This set of factors, which is the focus of the current paper, pivots around elements in the service user-clinician interaction that have the potential to influence the course and outcome of the clinical encounter. At the core of this set of factors lies the notion raised by the 2002 U.S. Institute of Medicine's report: "...when faced with patients who are from different racial or ethnic backgrounds, doctors may find that their uncertainty about the patient's condition and best course of treatment is even greater. This uncertainty can 'open the door' for physicians' stereotypes and biases to affect their judgment of patients and interpretation of their presenting concerns" (1). The report suggested that clinicians from advantaged groups in the U.S. (e.g., a white physician) may provide care of inferior quality to members of disadvantaged groups (i.e., racial and ethnic minorities), due to psychological biases triggered by differences in their respective social identities. Thus, clinical encounters between clinicians from an advan-

tagged group (the vast majority of cases in Western countries; 17) and service-users from disadvantaged groups may involve different psychosocial processes resulting in different outcomes than those between equal ethnic dyads.

Studies conducted primarily in the U.S. and the U.K. support the above suggestion (for a review, see 16). For example, primary care doctors rated African American patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account (18). Similarly, other studies showed that white physicians were less patient-centered (19), engaged in less joint decision-making (20), and had shorter encounters (21) when interacting with African American than with white patients. Also, both British and U.S. psychiatrists were more likely to prescribe antipsychotic medications, use involuntary admission, and place patients in seclusion once hospitalized, when treating non-white relative to white patients, independent of appropriateness and clinical factors (22, 23).

It is thus not surprising that African American patients show higher premature dropout rates when treated by a white clinician than by an African American clinician (24), and were found to perceive white clinicians as less credible than African American clinicians (25). African American patients tended to be more satisfied with the medical encounter and their care when their physician was African American than when their physician was white (26). They also had a general preference for African American clinicians (27). Taken together, the accumulating evidence suggests that the concordant or discordant social identities of service-users and clinicians may relate to the course and outcomes of the clinical interaction.

#### **EFFECTS OF SOCIAL IDENTITIES ON CLINICAL OUTCOMES: DATA FROM THE ISRAELI CONTEXT**

Although health disparities have been studied in Israel for over half a century (28) and gained growing attention in recent years (29), little work has examined the effect of ethnic identities on the outcomes of the clinical encounter. To investigate this topic, we conducted two studies focusing on the Mizrahi-Ashkenazi intergroup context.

Although the common perception is that differences in power and status between Ashkenazim and Mizrahim are

long gone (30), consistent evidence from both the Central Bureau of Statistics and health studies (7, 31-33) document that inequality between the groups are still apparent in levels of education, average income and health status. All these indicators favor the Ashkenazim. Beyond these objective measures of resources, Saguy et al. (34) demonstrated that psychological processes characterizing minimal groups (laboratory groups formed based on a random criterion) of either high and low power replicated fully among Ashkenazim and Mizrahim. (e.g., Ashkenazim were less supportive of egalitarian social policies than Mizrahim). Similarly, Levin and Sidanius (35) found that the same responses Israeli Jews had toward Israeli Arabs (a socially disadvantaged group) in terms of affect and resistance to change replicated among Ashkenazim with regard to the Mizrahim. Thus, both structural and psychological aspects of power associated with social identities characterize the relations between Ashkenazim and Mizrahim, providing a suitable context for the study of the effect of processes related to those identities on health care.

In the studies we conducted we investigated whether a Mizrahi compared with an Ashkenazi alleged patient elicits different evaluations of therapeutic alliance by Ashkenazi participants. Items were extracted from the Working Alliance Inventory which has been widely used to assess quality of patient-clinician relationship in different settings, including single-session-encounters (36). Study I was conducted among a sample of psychology students ( $N=48$ ;  $M_{age}=26.33$ , 71% female) and Study II was conducted among a group of practicing mental health clinicians recruited through snow-ball sampling ( $N=20$ ;  $M_{age}=39.90$ , 80% female). Each participant read a vignette of a patient presenting depressive symptoms and then rated the extent to which the alleged patient is expected to be cooperative in treatment on five different items (e.g., “to what extent would he cooperate with treatment?”; Cronbach’s  $\alpha=.88$  in Study I,  $\alpha=.82$  in Study II). Responses to these items were given on a 1 (not at all) to 10 (very much) scale. In each study, we manipulated the name of the patient to sound either Ashkenazi (Shtern) or Mizrahi (Abutbul).

Consistent with our hypotheses, Study I revealed that psychology students of Ashkenazi descent expected a Mizrahi alleged patient to be significantly less cooperative in treatment (Mean=6.4, SD=1.8) compared to an Ashkenazi alleged patient (Mean=7.7, SD=1.0),  $t(46)=3.09$   $p<.01$ , Cohen’s  $d=0.88$ . Importantly, the finding replicated among mental health clinicians in Study II,

providing a large effect size, Mean = 6.7 (SD=1.3) vs. Mean=8.1 (SD =.8 ),  $t(18)= -2.88$   $p=.01$ , Cohen’s  $d= 1.33$ . These results demonstrated that despite their equidistant role as clinicians, the ethnic identity of an alleged patient led Ashkenazi clinicians to respond less favorably to a patient from a Mizrahi descent and to rate him as less cooperative. Thus, these local findings agree with the U.S. Institute of Medicine’s report (1) arguing that processes rooted in biases on the part of clinicians may contribute to health disparities among those who seek help.

Notwithstanding this emerging focus on the clinical processes rooted in social identities, the mechanisms contributing to their influence on health care remain unclear. What exactly happens when a clinician from a certain ethnicity meets a patient from a different ethnicity? Why is this interaction different from the one between a clinician and a patient who share the same ethnicity? Does the status associated with the ethnicity matter? Would a clinician from an advantaged group who treats a patient from a disadvantaged group be more biased than a clinician from a disadvantaged group who treats a patient from an advantaged group?

Our initial studies do not allow us to answer these questions (as we only considered clinicians from an advantaged ethnicity and patients from a disadvantaged ethnicity), they provide us with an essential starting point which documents that group membership matters in clinical encounters. Our next step is to develop a theory that would help identify the different processes which may contribute to the biases rooted in group membership. Such a theory would then set the stage for new studies which could identify specific mechanisms, and different identity structures, as predicting outcomes of the clinical encounter. Identifying those mechanisms is crucial for informing evidence-based interventions aimed at countering the processes contributing to the negative course and possible outcomes of discordant encounters.

#### **A MODEL TO ACCOUNT FOR POTENTIAL MECHANISMS**

Our proposed model suggests potential mechanisms that may mediate the relationship between the social identities of clinicians and service-users and course and outcomes of the clinical encounter drawing on social psychological research. We begin by reviewing relevant literature on social categorization and the role it might play in clinical encounters. We then turn to review psychological processes related to power differences arising from contrasting status, and consider how those might play a role in the service user-clinician interaction. We

chose to focus on social categorization in particular because, as prominent social psychologists have argued over the years (38-40), it stands at the root of encounters between people belonging to different social groups and can therefore serve as a fertile ground for understanding processes characterizing discordant clinical encounters. The issue of power is one such process, deriving from social categorization. In addition, although here we focus on ethnic social identities we acknowledge that similar processes may play a role also in concordant and discordant clinical encounters based on other social identities such as gender (41) and socioeconomic status (42).

### **SOCIAL CATEGORIZATION AND HEALTH DISPARITIES**

Social categorization shapes and perpetuates intergroup biases. Just as people categorize objects, so too, they categorize each other into ingroups (the groups containing the self) and outgroups (the groups not containing the self) (39, 40). This tendency to categorize people into “us” and “them” is both rapid and automatic, and has important implications for the way people think, feel and behave toward group members. Importantly, research has documented an automatic favoritism for the ingroup over the outgroup (39). For example, in the U.S., white participants are found to be faster in associating whites, over African Americans, with positive valence (for a review, see 43). People were also found to experience more positive affect toward their ingroup over outgroup members (44); to help ingroup members more (45); to expect ingroup members to be trustworthy (46); and share one’s attitudes and values more than outgroup members (47).

Several social psychological theories attempt to account for these findings, such as people’s limited cognitive capacities, which often lead to reliance on heuristics, or mental short-cuts, e.g., stereotypes (48, 49), that confirms pre-existing views of the in- or outgroup. Structural theories argue that competitive relations between groups, and associated threats, lead to negative outgroup perceptions (e.g., Realistic Group Conflict theory; 50, 51, and Group Position models; 52, 53). Social identity theory (54), suggests that individuals derive an important part of their self-concept, including their social identity, from their group membership. Because social identity bears directly on one’s self-definition, people are generally motivated to enhance or protect the value attached to their group. This need can be easily satisfied by comparing one’s own group to others, in a way that would reflect a positive value for the ingroup and devalue the outgroup (“we are better

than them”). An example of intergroup comparison that can reflect positively on one social identity is when a person with a chronic mental disorder is devalued and stigmatized by a person who has no disorder (e.g., 55).

Although limited, recent literature links biases associated with social categorization to quality of health services (56-59). In particular, implicit bias, which refers to unconscious negative feelings and attitudes that operate automatically during social interactions (60), was found to influence the way clinicians approach service-users belonging to outgroups (18, 61). For example, Green et al. (62) measured U.S. physicians’ explicit and implicit attitudes toward African American alleged patients. They found that when presented with vignettes about patients with symptoms of myocardial infarction, physicians higher in implicit bias were less likely to recommend appropriate drugs for African American patients compared with white patients.

Thus, processes of categorization and associated intergroup biases, which are prevalent in a variety of contexts, also take place in the health field, in cases of discordant clinical encounters (see also 16, 63). Beyond the above-cited processes of outgroup biases, clinical encounters are also characterized by asymmetrical social power, as discussed next.

### **SOCIAL POWER AND HEALTH DISPARITIES**

Social power, defined as the ability to influence the outcomes of others through control over material (e.g., money) or social (e.g., knowledge) resources, has been shown to impact human behavior (64-66). Any service user-clinician interaction is by definition hierarchical, because the latter holds both the knowledge and expertise (67). However, in identity-discordant encounters, another layer of power is added, namely, power by virtue of group membership (34, 53). This layer adds to the already existing amount of power-by-social-role, resulting in a clinician from an advantaged group having overall more social power in discordant encounters.

Whereas researchers in the area of health disparities have identified the problems arising in discordant encounters (18-23), little attention has been given to the specific psychological processes associated with social power. We hypothesize that the greater amount of clinician’s social power in discordant encounters which parallels societal power (i.e., a clinician from an advantaged group and a patient from a disadvantaged group) can lead to worse health care compared with concordant encounters. Two processes that characterize power-hold-

ers and are particularly relevant to the clinical encounter are hypothesized to account for these effects: impaired perspective taking and tendency to perform automatic rather than complex attributions.

Research on power and perspective taking, the ability to step outside of one's own experience and imagine the emotions and perceptions of others (68), demonstrates that the psychological experience of power can impair perspective taking. Galinsky et al. (66) found a negative correlation between people's sense of power in social relationships (a measure that correlates with occupation of powerful social roles) and their tendency to adopt the psychological point of view of others, which can affect empathic ability. Similarly, participants primed with an experience of power (compared to a neutral experience) were less accurate in detecting others' emotions (cf. 69). In another experiment in which participants were given a supervisor role over an outgroup member, perspective taking was lower compared to a control condition (70).

In clinical encounters, the ability to take the patient's perspective is considered crucial and stands at the core of the therapeutic alliance (71, 72). Yet, clinicians were shown to vary in the degree in which they include patients' perspective in medical decisions (73), and some have suggested that this ability is particularly impaired in discordant encounters (74). Building on the work demonstrating impaired perspective taking among high power individuals, we suggest that clinicians who experience a greater sense of social power in clinical encounters might be less able to take their patients' perspective. Such impaired perspective taking can in turn undermine the clinician's perception of the patient as cooperative and pleasant – factors that underlie the quality of working alliance which we have shown to be undermined in discordant encounters. Thus, we propose that the power differences that exist between a clinician from an advantaged group and a patient from a disadvantaged group might hinder the clinician's ability to take the perspective of the patient, which in turn can result in worse therapeutic alliance.

A second process that we propose might impact the quality of the clinical encounter relates to the effects of power on the way people interpret others' behavior, namely, their tendency to make automatic rather than complex attributions. Automatic attributions are relatively rapid, effortless, and associated with the use of cognitive heuristics and simple rules to make judgments (75, 76), usually resulting in dispositional inferences of behavior which rely on stereotypes and pre-existing schemas (77). In contrast to automatic inferences, complex

attributions involve more deliberate considerations of situational constraints (78). Pettigrew (79) has shown that group membership plays a significant role in attribution processes. People tend to attribute negative behaviors of outgroup members to *inherent* dispositions whereas negative behaviors of ingroup members are attributed to more *situational* factors. Social power was further shown to moderate this tendency such that members of advantaged, relative to disadvantaged groups, were found to be more likely to make more dispositional attributions to negative actions of outgroup members (80). These results are in line with work showing that power holders are prone to make automatic judgments and discount complex stereotypically-inconsistent information about others' behavior (e.g., 77, 81).

We suggest that the tendency of power holders to make less complex attributions may characterize clinicians in identity discordant clinical encounters, and can ultimately lead to worse diagnostic decisions. Because psychiatric diagnostic decisions rely heavily on the way clinicians collect (information variance; 82) and weigh the information presented by service-users (decision variance), attribution complexity can significantly impact diagnostic decisions. Although as of now we do not have direct evidence from the local context about diagnostic decisions in discordant encounters, research conducted in the US supports the notion that discordant encounters may result in worse diagnostic decisions (see 16 for a review). For example, Alegria et al. (83) found that even with similar information collected during the intake, mental health clinicians weighed the information differently to assign a diagnosis depending on service-users' ethnicity. Specifically, U.S. Hispanics, who during their intake raised issues of family history of abuse, were more likely to be given depression diagnosis than non-Hispanic whites who raised similar information. Thus, diagnostic decisions seem to be impacted by the identity of the patient, yet the processes contributing to this effect remain unexplored. Our proposition is that differences in the tendency to make complex attribution may account for this effect.

Finally, if our proposed hypotheses on the impact of power associated with advantaged group membership on the way clinicians think and behave in clinical encounters are accurate, then such processes should be particularly pronounced among those committed to their ethnic group (an Ashkenazi clinician who strongly identifies himself/herself as Ashkenazi). Extensive social psychological research demonstrates that people who are

strongly committed to their groups show greater levels of group-based biases (84, 85). Thus, clinicians highly identified with their advantaged group may be more motivated to reaffirm their group's power (86, 87).

Individual variables pertaining to service-users are also likely to play a role in this interactional context. For example, a Mizrahi service-user might be more or less identified as such, and, as a result, elicit different responses from an Ashkenazi clinician. Recent research in the area of group identity demonstrates that members of advantaged groups indeed detect level of identification of outgroup members, even given minimal information such as facial features (88) and react more negatively to high, compared with low identifiers (89).

Although more infrequent in public care, discordant identities that reverse societal power dynamics between groups (e.g., a Mizrahi clinician and an Ashkenazi service-user) are also of interest. Such clinical encounters may result in better outcomes than concordant encounters because power differences are more balanced. Another contrasting possibility, however, is that the disadvantaged group status of the clinician will debilitate clinical decision-making through processes of behavioral inhibition (65). Although we cannot make ad hoc predictions regarding discordant encounters in which societal power dynamics are reversed, these encounters are worthy of exploration.

## RECOMMENDATIONS FOR FUTURE RESEARCH

In this paper we suggested that processes rooted in social categorization and in social power may contribute to mental health disparities in the clinic. We propose that these processes should become part of a research agenda aimed at better understanding the course and outcome of clinical encounters. In addition, individual-level variables (i.e., level of implicit and explicit bias, level of ethnic identification) need to be incorporated into the research design and methodology. Both experimental designs in which the social identities of alleged service-users will be manipulated and field studies in which real-life concordant and discordant interactions are studied can help illuminate the causal links between the different factors we proposed.

For example, an experiment conducted among practicing mental health clinicians can test whether the social identity of their patients impacts the clinician's appraisal of the quality of the working alliance (via the mediation of perspective taking) and their accuracy of diagnostic

decisions (via the mediation of attribution complexity). An alleged patient's social identity can be manipulated through the presentation of a videotaped clinical vignette in which an analogue service-user (either advantaged or disadvantaged) would present a multifaceted clinical problem (including details identifying ethnic origin, level of identification, psychiatric symptoms, and stressors). Clinicians would be randomly assigned to view either an advantaged or disadvantaged service-user who is either high or low in ethnic identification. Accuracy of diagnostic decisions and quality of reported alliance by clinicians can serve as indicators of the quality of the clinical interaction. Similar field studies, though would not allow us to test causal links, can provide external validity to suggested links in the model.

Another form of laboratory study can be designed to further investigate whether it is the difference in identity per se that produces biased orientations, or the differences in status and power which accompany it. In such a study, one can independently manipulate the identity of an alleged patient to be of different ethnicity, but one time with higher status and another time with a lower status. For example, one can choose a sample of Mizrahi providers and have them encounter an Ashkenazi alleged patient in one condition (a different group, advantaged patient) and an Ethiopian alleged patient in another condition (a different group, disadvantaged patient). In such design, both conditions involve an outgroup patient, but each time the status of the patient's ethnicity is different. Indeed, such a design would complement the initial studies we conducted, in which it is difficult to determine whether it is the differences in social identities, or differences in status, which produced the effect.

Future studies should also include indicators of attribution complexity, which were missing from our pilot investigation. For example, clinicians can be presented with a list of factors that could account for the patient symptoms (e.g., situational factors, ability, family history, mood problem), and be asked to assign a weight to each factor, based on how strongly they think it accounts for the patient's symptoms. Attribution complexity can be assessed by the magnitude of the variability among weights assigned to the different factors, such that less variability (i.e., considering more factors as equally important) would indicate more complex attributions (90, 91)

After specifying the processes by which discordant social identities hinder the course and outcomes of clinical encounters, the proposed research agenda can further

inform evidence-based interventions aimed at ameliorating such processes. Extensive social psychological research has identified both individual-level factors and contextual influences, which impact processes of intergroup biases. This body of work can be effectively used to develop relevant interventions in the clinical encounters. For example, a substantial amount of research, dating back to the classic work of Gordon Allport (40) on *the contact hypothesis*, has established that positive intergroup interactions (*i.e.* those involving equal status, cooperation, potential for personal acquaintance, and institutional support) can lead members of advantaged groups to hold more positive and less biased attitudes toward members of disadvantaged groups. Over the past 60 years, both researchers and practitioners have relied on contact theory in attempts to ameliorate the detrimental consequences of intergroup biases (see 92 for a meta-analysis summarizing over 515 studies). This work further examined the effects of different types of interaction “contents,” ranging from encounters which solely focus on cross-group commonalities to those emphasizing diversity (93, 94). An example for an application that can be relevant to our purposes is work done by Rudman et al. (95), in which students have undergone a diversity training seminar taught by a minority instructor. These students showed a significant decrease in implicit and explicit indicators of prejudice, relative to students who were taught neutral content by the same instructor or were taught neutral content by an instructor from the majority group. Such “unlearning” of group-based biases can be applied to the mental health field by offering special diversity training programs to clinicians, taught by disadvantaged group members.

Evidence-based interventions can be further developed to target the specific processes of impaired perspective taking and automatic reasoning. For example, building on studies which identified ways to increase perspective taking, clinicians can be asked to write an essay from the perspective of a patient from a disadvantaged group and emphasis will be placed on imagining the other person’s feelings (96). This type of intervention can be also incorporated into diversity training sessions, which could be specifically designed to target clinicians from advantaged groups. Along the same lines, clinicians can be further taught and trained to improve their attribution style to be more complex when encountering minority patients. Such interventions should take into consideration individual-level factors likely to further influence people’s general tendency to make biased judgments when encountering

outgroup members. Such factors include people’s general orientations toward hierarchy (as reflected by their Social Dominance Orientation; 97), their political attitudes (98), and also structural factors such as income and education level (99, 100).

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