Schizophrenia in the Black Community: Issues on Identification, Symptom Management, and Advocacy

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Abstract

In the identification and treatment of schizophrenia, extant work has reported significant disparities when comparing Black individuals with their White counterparts. For instance, empirical work in the last decade has revealed stark differences between Black and White communities in the frequency of schizophrenia diagnoses, treatment protocol for schizophrenia, and quality of life post-treatment. Furthermore, there is increasing literature suggesting that the areas in which Black individuals live may themselves contribute to the risk of developing schizophrenia symptoms. Interestingly, little work has focused on closing the gap. This paper reviews how inadequate medical care (e.g., bias, overdiagnosis, lack of medical resources) for patients with schizophrenia can result in a pronounced negative quality of life, such as the attainment and retainment of jobs, quality of social relationships, and risk for suicide in Black people living with schizophrenia. In addition, this paper discusses how these systematic disparities have long been weaponized against Black communities to further justify their oppression. Creating space for knowledgeable discussions about the ways in which medical attention is deficient for Black patients can stimulate social reform in the field, which can forge an enhanced healthcare system, and in turn, inform social change in other oppressive systems.

Keywords: schizophrenia in the Black community, healthcare disparities, treatment, healthcare reform

Schizophrenia in the Black Community: Issues on Identification, Symptom Management, and Advocacy

Schizophrenia is among the most severe psychiatric diagnoses with a mortality rate of up to 7.4 times that of the general population (Correll et al., 2022). It has a lifetime morbid risk of 7.2% (McGrath et al., 2008), and a lower life expectancy of 10 to 20 years less than people without the disorder, with the largest contributor to this decreased life expectancy being suicide (Sher & Kahn, 2019). Schizophrenia affects all populations, with a prevalence in the range of 1.4 to 4.6 per 1000 and incidence rates in the range of 0.16-0.42 per 1000 (Jablensky, 2000). Furthermore, schizophrenia is known to co-occur with other psychopathology (see Kessler & Lev-Ran, 2019), particularly severe mood symptoms (Escamilla, 2001). While the pathology of schizophrenia remains somewhat elusive, symptoms commonly associated include hallucinations, delusions, disorganized thinking, speech, and behavior. Common risk factors for schizophrenia include genetics, other psychological disorders—such as anxiety—and substance abuse (Davis et al., 2016). Specifically within the Black community, manifestations of racism can lead to intergenerational trauma within Black individuals, which develop the onset of schizophrenia (Lee et al., 2023). As the high overdiagnosis of schizophrenia within the Black community (Barnes, 2004) suggests, it is noteworthy that being Black presents a risk for a schizophrenia diagnosis. Importantly, schizophrenia is known to be diagnosed more frequently in Black people than in other racial-ethnic groups (Bland, 1992; Cohen & Marino, 2013). Indeed, much work has looked at the cultural implications of schizophrenia symptomatology and the diagnosis itself; thus, a comprehensive review of this literature is timely.

Living with schizophrenia is known to come with a myriad of other life consequences, from social interactions to physical health (Bjornestad et al., 2019). It is common for many to assume an unfulfilled life for those who have mental disorders, such as schizophrenia, largely due to the illness's symptoms themselves. While these symptoms do contribute to loss of livelihood, the indirect implications of mental illness are additionally conducive to the worsening of one's life. Due to racist historical policies such as redlining, Black populations have largely received less neighborhood funding, resulting in fewer resources in schools, both of which can impact the amount and quality of education that Black individuals receive (An et al., 2019). These inadequate materials can lead Black people toward a "school-to-prison" pipeline that may include the use of drugs as a means to cope and gain assets, which is conducive to the development of substance-use disorders (McCarter, 2016). Coupled with the heavy over-policing of Black communities, all of these oppressive models of racial discrimination result in the disproportionate incarceration of Black individuals (Hinton et al., 2018; Beckmann et al., 2018), which is a stressor for schizophrenia (Ford, 2015). Black neighborhoods are also more likely to include chronic stressors that can add to and exacerbate pre-existing medical conditions (Anglin et al., 2021). This cycle of oppression not only extends itself to mental health disorders, but also adds to etiology (see Fig. 1). These systemic disadvantages, along with the mental health stigma that already exists toward and within Black communities, can generate joblessness, dispossession, and even lower rates of happiness compared to White communities—24% versus 34%, respectively (Iceland & Ludwig-Dhem, 2019).

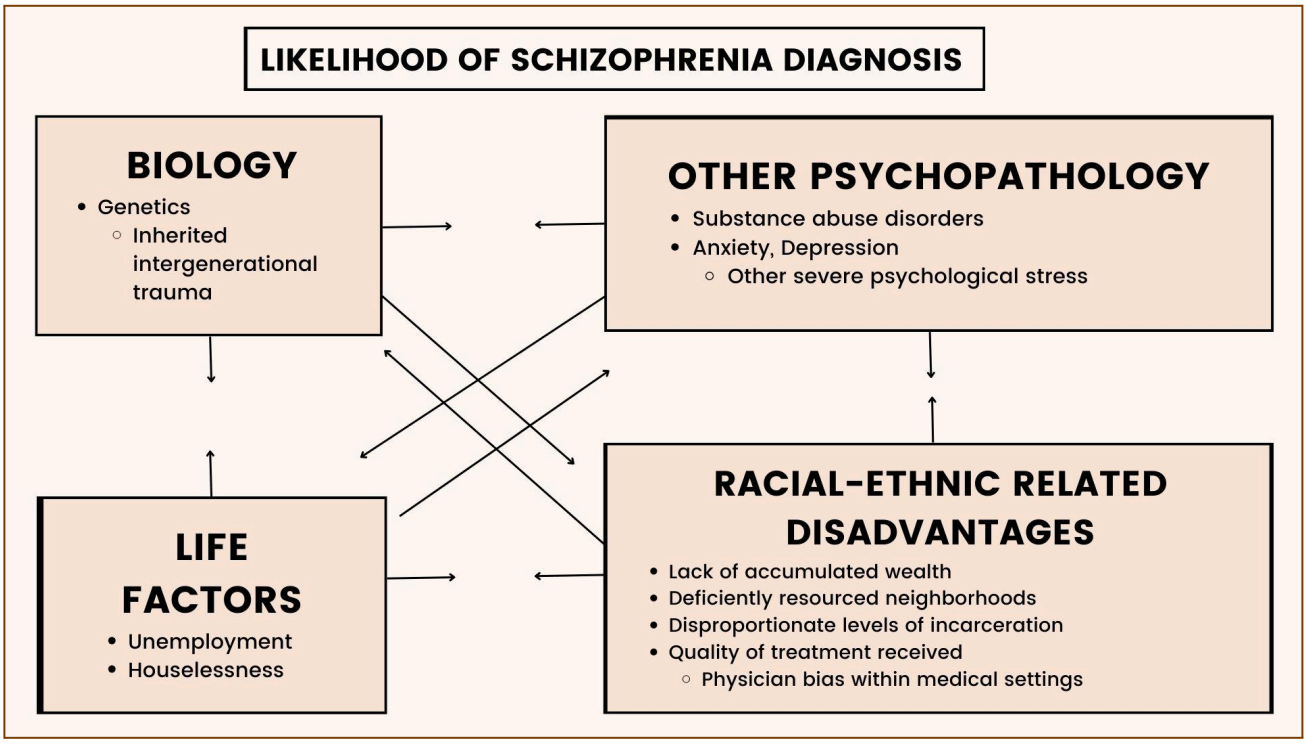

Figure 1
Systemic disadvantages have a bi-directional correlation, which particularly impact Black people with schizophrenia and underlie a myriad of poor outcomes.

Physician Bias

A large body of evidence suggests that Black individuals perceive their racial-ethnic identity as a disadvantage when receiving medical care (see Alang, 2019 for review; Shavers et al., 2012). Further, physicians, including psychiatrists, tend to appraise symptoms differently across racial groups. For instance, Hoffman & associates (2016) found that White medical students and residents endorsed inaccurate views about biological differences between Black and White patients and held that Black patients experienced less pain. Unsubstantiated medical beliefs, such as these and other stereotypes, inform physicians' diagnoses, indicating why, in part, there is an overdiagnosis of schizophrenia within the Black community (Barnes, 2004) and a higher rate of schizophrenia diagnoses in Black communities compared to White ones (Gara et al., 2019), despite there being no genetic evidence suggesting that schizophrenia symptoms are more prevalent within the Black community (Eack et al., 2012). In another paper, Mallinger & colleagues (2006) suggest that Black people with schizophrenia are less likely to receive gold-standard antipsychotic medication, indicating a clear disparity in treatment. In all, physician bias seems to significantly influence the prevalence and treatment of Black individuals with schizophrenia. Moreover, this failure of the healthcare system has created another avenue for sanist oppression—which is the systemic discrimination against individuals seen to have a mental disorder—to bolster itself against Black individuals, thus supporting the stigma of mental illness in marginalized communities.

Physician bias may reveal itself in a physician's beliefs about the demographic of patients that they are treating. Stereotypes such as the incorrect idea that Black individuals are

inherently more dangerous, aggressive, and untrustworthy than White individuals correlate with the disparities mentioned above in schizophrenia diagnoses within Black communities; that is, routine emotions shown by Black individuals may be wrongfully characterized as symptoms of schizophrenia. Historically, the 1974 printing of the DSM-II focused on the "hostile subtypes of schizophrenia" within Black communities, leading to an association between Black individuals—particularly Black men—and schizophrenia, along with general mania. While this taxonomy issue has been revised to exclude these racist perceptions within diagnostic criteria, the acumen of Black individuals as dangerous and dishonest has lingered in various forms. Additionally, sanist perceptions of people with schizophrenia as violent and dishonest link the biases together, even where diagnostic criteria do not support the bias (Kennedy, 2022). These faulty associations may be another cause for the overdiagnosis of schizophrenia within Black communities (Barnes, 2004).

Researchers of schizophrenia have largely underrepresented Black communities in their clinical studies (Durant et al., 2011), thus disregarding specific risk factors for Black people that may contribute to the presence of schizophrenia in an individual, such as intergenerational trauma (Lee et al., 2023). Furthermore, this lack of inclusion within clinical study samples does not allow for the results of the study to be generalizable to whole populations—extant work has found that many groups who are underrepresented, or altogether excluded, in clinical trials may have specific circumstances regarding their health that will affect how they respond to a new medicine (Beglinger, 2008; Crawley et al., 2003; Garcia et al., 2016; Ramamoorthy et al., 2015).

The efficacy of the provided treatment is known to be influenced, in part, by the empathy shown by medical providers (Elliot et al., 2018; Priebe et al., 2019). Derksen & colleagues (2013) found that empathy shown by physicians correlated with significantly better clinical outcomes for patients, while Roberts & associates (2021) observed that an empathy gap may exist for patients of multiple race/ethnic groups, including Black people and African Americans, as compared to White patients. This lack of empathy in clinical spaces for Black individuals may not only result in wrongful diagnoses and substandard treatments, but also in the discouragement of people from Black communities from following medical advice altogether (Yeary et al., 2015). In relation to the taxonomy issues of previous DSMs, physicians have been taught—through uninformed medical curricula—that Black patients are, for example, in less need of pharmaceutical drugs and have thicker skin (Louie & Wilkes, 2018). Consequently, physicians are, on a large scale, taught the biases that form the empathy gap, leading to disparities in care for Black communities.

Distrust of the Healthcare System

Medicine has a long history of disregarding and intentionally manipulating minority groups while justifying their actions for the sake of advancement. Historically, unconsenting Black communities have been used as test subjects for researchers to experiment on (e.g. the Tuskegee Syphilis Study; see Scharff et al., 2010 for review). This occurrence, of which there are many others (see Baptiste et al., 2022), has resulted in a deep mistrust of the healthcare system within the Black community. Importantly, this unfortunate history demotivates Black individuals from seeking treatment (Schraff et al., 2010). This issue is also related to the underrepresentation of diverse individuals in clinical studies. Black individuals make up only 5% of clinical trial participants (Alegria et al., 2021); when scouting for voluntary trial participants, many researchers do not make Black individuals feel comfortable enough to take part in their study, as the healthcare system has historically exploited them. For example, in a certain cancer

study, Black and Hispanic individuals had a lower phase 1 enrollment than Asian individuals (Perni et al., 2021). In addition, a lack of diverse clinicians and researchers—as of 2018, only 5% of doctors in the United States were Black, compared to 56.2% of White physicians (*Diversity in Medicine: Facts and Figures 2019*, 2019; Lloyd Jr & Miller, 1989)—can further discomfort Black individuals and discourage them from participating in medical research (Scharff et al., 2010). Moreover, Goode-Cross & Grim (2014) found that there was a level of connection between Black therapists and Black patients, leading many Black clients to prefer a Black clinician (Cabral & Smith, 2011; Townes et al., 2009).

Barriers to Treatment

According to the 2021 National Survey on Drug Use and Health, only 39% of Black individuals and African Americans received mental health services, compared to 52% of White people, despite both groups having similar reported rates of mental illness. Black individuals are also much less likely to seek care than White individuals (Alegría et al., 2008; Cook et al., 2014; Jimenez et al., 2013; Roll et al., 2013; Wells et al., 2001). Interestingly, Black individuals are more likely than their White counterparts to be given antipsychotic medication and higher-potency antipsychotic medications at higher doses, in addition to less evaluation time with clinicians once treatment has been initiated (Segal et al., 1996). Furthermore, Li & colleagues (2011) suggest that Black schizophrenia patients experience significantly less improvement in thought disorder symptoms of schizophrenia (such as thinking, language, and communication abnormalities—see Özbek & Alptekin, 2021), negative and general psychopathology symptoms, as well as functioning, even after adjusting for the baseline differences in clinical and sociodemographic characteristics, than White participants. Indeed, the lack of resources shared by treating physicians may contribute to low treatment effectiveness rates. Among physical barriers, such as large locational distances and the inability to obtain transportation due to transportation costs or otherwise, physician bias and a distrust of the healthcare system can beget the ineffectiveness of treatment or caution those in the Black community from seeking treatment itself.

Effects of Schizophrenia Diagnosis in the Black Community

The current state of psychiatric medicine has disadvantaged Black communities in that well-validated treatments for severe diagnoses, like schizophrenia, are few and far between for non-WEIRD populations (referring to those raised in Western, Educated, Industrial, Rich Democracies). A combination of racial-ethnic disparities in clinical research and an abhorrent history of medical research in marginalized communities unsurprisingly deters individuals in the Black community from seeking care; these disparities in clinical research underlie poorer clinical outcomes for Black individuals with schizophrenia and a myriad of other social, economic, and physical consequences.

Extant work has suggested a bidirectional correlation between unemployment and psychosis (Bouwmans et al., 2015). According to a report by the Bureau of Labor, joblessness in Black communities is particularly high—8.6% compared to 4.7% in White communities (*Labor Force Characteristics by Race and Ethnicity, 2021: BLS Reports: U.S*, 2023). Joblessness is linked to poverty (Rachidi, 2018; *Why Poverty Persists | NBER*, 2005), and as Black communities generally already have less generational wealth than their White counterparts (Harris & Wertz, 2022), impoverished Black communities are more likely not to have the financial resources needed to fund medical treatment (Santillo et al., 2022). On the one hand,

Boydell & associates (2012) found unemployment and the development of psychosis to be positively correlated; further, this relationship was found to be stronger in Black Caribbean and Black African individuals than in White individuals. In terms of employment after onset, symptoms may make working more difficult; according to Global Burden of Disease Studies, schizophrenia accounts for a high degree of disability (Charlson et al., 2018; Jablensky, 2000; Velligan & Rao, 2023). Recent work has also shown schizophrenia symptom severity to be negatively related to success in the job market (Martini et al., 2017). In addition, Black individuals already face discrimination when applying for jobs (Schaeffer, 2023). Untreated symptoms make everyday tasks challenging, and as stated above, make it more difficult to work. Importantly, unemployment itself is positively correlated with poor health outcomes, such as high blood pressure, stroke, heart attack, heart disease, and arthritis (*Employment - Healthy People 2030 | Health.gov*, 2020; Hintikka et al., 2009; Jin et al., 1997) which uniquely leaves members of the Black community vulnerable.

In addition to poverty and joblessness, mental illness is also correlated with houselessness, which is another trigger for psychosis (Padgett, 2020). When they are not living close to medical facilities, many people may find it difficult to travel large distances to find medical care. Predominantly Black neighborhoods, which are generally impoverished, have more public hospital closures and fewer primary care physicians than predominantly White neighborhoods, and many lack proper resources for effective medical treatment (Caldwell et al., 2017).

Stigma of Mental Disorders within the Black Community

Joblessness and houselessness are external factors that prevent Black individuals from seeking care, but stigma within the Black community can internally prevent Black individuals from seeking care as well. As explained above, due to a general mistrust of the healthcare system, there is a disinclination to seek medical care, particularly for mental health. Furthermore, some Black individuals believe that they will be discriminated against for mental illness and feel uncomfortable speaking about mental health, sometimes within their own social circles (Alvidrez et al., 2008; Keating & Robertson, 2004; *The Annual State of the Communities Report With Diverse Communities*, 2019). This issue can be related to unemployment concerns, where being diagnosed with a mental health condition can make finding a job more difficult (Bouwmans et al., 2015).

Conclusion

Schizophrenia is disproportionately diagnosed in Black communities, and this discrimination is perpetuated by physicians who do not give the same care to Black patients that they do to White patients, resulting in a reluctance from Black individuals to seek treatment from an already untrusted healthcare system. Black communities are largely underrepresented in clinical studies, and Black clinicians are few, which contributes to poor treatment outcomes. Unemployment, houselessness, and stigma all hinder Black individuals from finding treatment as well. These structural systems of oppression work in conjunction to keep Black individuals in a cycle of oppression that does not allow them to find proper care. For the healthcare system to properly serve its patients, these issues must be addressed and improved upon.

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References

[1] AAMC. (2019). *Figure 18. Percentage of all active physicians by race/ethnicity, 2018*. Association of American Medical Colleges. https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

[2] Alang, S. M. (2019). Mental health care among blacks in america: Confronting racism and constructing solutions. *Health Services Research*, *54*(2), 346-355. https://doi.org/10.1111/1475-6773.13115

[3] Alegria, M., Sud, S., Steinberg, B. E., Gai, N., & Siddiqui, A. (2021). Reporting of participant race, sex, and socioeconomic status in randomized clinical trials in general medical journals, 2015 vs 2019. *JAMA Network Open*, *4*(5), e2111516. https://doi.org/10.1001/jamanetworkopen.2021.11516

[4] Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C.-N., Takeuchi, D., Jackson, J., & Meng, X.-L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the united states. *Psychiatric Services*, *59*(11), 1264-1272. https://doi.org/10.1176/ps.2008.59.11.1264

[5] Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2008). The experience of stigma among black mental health consumers. *Journal of Health Care for the Poor and Underserved*, *19*(3), 874-893. https://doi.org/10.1353/hpu.0.0058

[6] An, B., Orlando, A. W., & Rodnyansky, S. (2019). The physical legacy of racism: How redlining cemented the modern built environment. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3500612

[7] Anglin, D. M., Ereshefsky, S., Klaunig, M. J., Bridgwater, M. A., Niendam, T. A., Ellman, L. M., DeVylder, J., Thayer, G., Bolden, K., Musket, C. W., Grattan, R. E., Lincoln, S. H., Schiffman, J., Lipner, E., Bachman, P., Corcoran, C. M., Mota, N. B., & Ven, E. van der. (2021). From womb to neighborhood: A racial analysis of social determinants of psychosis in the united states. *American Journal of Psychiatry*, *178*(7), 599-610. https://doi.org/10.1176/appi.ajp.2020.20071091

[8] Baptiste, D., Caviness-Ashe, N., Josiah, N., Commodore-Mensah, Y., Arscott, J., Wilson, P. R., & Starks, S. (2022). Henrietta lacks and america's dark history of research involving african americans. *Nursing Open*, *9*(5), 2236-2238. https://doi.org/10.1002/nop2.1257

[9] Barnes, A. (2004). Race, schizophrenia, and admission to state psychiatric hospitals. *Administration and Policy in Mental Health*, *31*(3), 241-252. https://doi.org/10.1023/b:apih.0000018832.73673.54

[10] Beckmann, D., Myrick, K. J., & Shtasel, D. (2018). Mental illness, addiction, and incarceration: Breaking the cycle. *Racism and Psychiatry*, 71-86. https://doi.org/10.1007/978-3-319-90197-8_5

[11] Beglinger, C. (2008). Ethics related to drug therapy in the elderly. *Digestive Diseases*, *26*(1), 28-31. https://doi.org/10.1159/000109382

[12] Bjornestad, J., Hegelstad, W. T. V., Berg, H., Davidson, L., Joa, I., Johannessen, J. O., Melle, I., Stain, H. J., & Pallesen, S. (2019). Social media and social functioning in psychosis: A systematic review. *Journal of Medical Internet Research*, *21*(6), e13957. https://doi.org/10.2196/13957

[13] Bland, R. C. (1992). Psychiatric disorders in america. *Journal of Psychiatry and Neuroscience*, *17*(1), 34-36. PMCID: PMC1188384

[14] BLS. (2023). *Labor force characteristics by race and ethnicity, 2021*. U.S Bureau of Labor Statistics. https://www.bls.gov/opub/reports/race-and-ethnicity/2021/home.htm
[15] Bouwmans, C., Sonneville, C. de, Mulder, C. L., & Hakkaart-van Roijen, L. (2015). Employment and the associated impact on quality of life in people diagnosed with schizophrenia. *Neuropsychiatric Disease and Treatment*, 2125. https://doi.org/10.2147/ndt.s83546
[16] Boydell, J., Bebbington, P., Bhavsar, V., Kravariti, E., Os, J. van, Murray, R. M., & Dutta, R. (2012). Unemployment, ethnicity and psychosis. *Acta Psychiatrica Scandinavica*, *127*(3), 202-209. https://doi.org/10.1111/j.1600-0447.2012.01921.x
[17] Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537-554. https://doi.org/10.1037/a0025266
[18] Caldwell, J. T., Ford, C. L., Wallace, S. P., Wang, M. C., & Takahashi, L. M. (2017). Racial and ethnic residential segregation and access to health care in rural areas. *Health & Place*, *43*, 104-112. https://doi.org/10.1016/j.healthplace.2016.11.015
[19] Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G., McGrath, J. J., & Whiteford, H. A. (2018). Global epidemiology and burden of schizophrenia: Findings from the global burden of disease study 2016. *Schizophrenia Bulletin*, *44*(6), 1195-1203. https://doi.org/10.1093/schbul/sby058
[20] Cohen, C. I., & Marino, L. (2013). Racial and ethnic differences in the prevalence of psychotic symptoms in the general population. *Psychiatric Services*, *64*(11), 1103-1109. https://doi.org/10.1176/appi.ps.201200348
[21] Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research*, *49*(1), 206-229. https://doi.org/10.1111/1475-6773.12095
[22] Correll, C. U., Solmi, M., Croatto, G., Schneider, L. K., Rohani-Montez, S. C., Fairley, L., Smith, N., Bitter, I., Gorwood, P., Taipale, H., & Tiihonen, J. (2022). Mortality in people with schizophrenia: A systematic review and meta-analysis of relative risk and aggravating or attenuating factors. *World Psychiatry*, *21*(2), 248-271. https://doi.org/10.1002/wps.20994
[23] Crawley, F. P., Kurz, R., & Nakamura, H. (2003). Testing medications in children. *New England Journal of Medicine*, *348*(8), 763-764. https://doi.org/10.1056/nejm200302203480821
[24] Davis, J., Eyre, H., Jacka, F. N., Dodd, S., Dean, O., McEwen, S., Debnath, M., McGrath, J., Maes, M., Amminger, P., McGorry, P. D., Pantelis, C., & Berk, M. (2016). A review of vulnerability and risks for schizophrenia: Beyond the two hit hypothesis. *Neuroscience & Biobehavioral Reviews*, *65*, 185-194. https://doi.org/10.1016/j.neubiorev.2016.03.017
[25] Derksen, F., Bensing, J., & Lagro-Janssen, A. (2013). Effectiveness of empathy in general practice: A systematic review. *British Journal of General Practice*, *63*(606), e76-e84. https://doi.org/10.3399/bjgp13x660814
[26] Durant, R. W., Legedza, A. T., Marcantonio, E. R., Freeman, M. B., & Landon, B. E. (2011). Willingness to participate in clinical trials among african americans and whites previously exposed to clinical research. *Journal of Cultural Diversity*, *18*(1), 8-19. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241443/

[27] Eack, S. M., Bahorik, A. L., Newhill, C. E., Neighbors, H. W., & Davis, L. E. (2012). Interviewer-Perceived honesty as a mediator of racial disparities in the diagnosis of schizophrenia. *Psychiatric Services*, *63*(9), 875-880. https://doi.org/10.1176/appi.ps.201100388
[28] Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, *55*(4), 399-410. https://doi.org/10.1037/pst0000175
[29] Escamilla, M. A. (2001). Diagnosis and treatment of mood disorders that co-occur with schizophrenia. *Psychiatric Services*, *52*(7), 911-919. https://doi.org/10.1176/appi.ps.52.7.911
[30] Ford, E. (2015). First-Episode psychosis in the criminal justice system. *Harvard Review of Psychiatry*, *23*(3), 167-175. https://doi.org/10.1097/hrp.0000000000000066
[31] Gara, M. A., Minsky, S., Silverstein, S. M., Miskimen, T., & Strakowski, S. M. (2019). A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. *Psychiatric Services*, *70*(2), 130-134. https://doi.org/10.1176/appi.ps.201800223
[32] Garcia, M., Mulvagh, S. L., Bairey Merz, C. N., Buring, J. E., & Manson, J. E. (2016). Cardiovascular disease in women. *Circulation Research*, *118*(8), 1273-1293. https://doi.org/10.1161/circresaha.116.307547
[33] Goode-Cross, D. T., & Grim, K. A. (2014). "An unspoken level of comfort." *Journal of Black Psychology*, *42*(1), 29-53. https://doi.org/10.1177/0095798414552103
[34] Harris, B., & Wertz, S. S. (2022). *Racial Differences in Economic Security: The Racial Wealth Gap*. U.S. Department of the Treasury. https://home.treasury.gov/news/featured-stories/racial-differences-economic-security-racial-wealth-gap
[35] Hintikka, J., Lehto, S. M., Niskanen, L., Huotari, A., Herzig, K.-H., Koivumaa-Honkanen, H., Honkalampi, K., Sinikallio, S., & Viinamäki, H. (2009). Unemployment and ill health: A connection through inflammation? *BMC Public Health*, *9*(1). https://doi.org/10.1186/1471-2458-9-410
[36] Hinton, E. K., Henderson, L., & Reed, C. (2018). An Unjust Burden. *Vera Institute*. https://www.issuelab.org/resources/30758/30758.pdf
[37] Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, *113*(16), 4296-4301. https://doi.org/10.1073/pnas.1516047113
[38] Hoynes, H., Page, M., & Stevens, A. (2005). *Poverty in america: Trends and explanations*. National Bureau of Economic Research. https://doi.org/10.3386/w11681
[39] Iceland, J., & Ludwig-Dehm, S. (2019). Black-white differences in happiness, 1972–2014. *Social Science Research*, *77*, 16-29. https://doi.org/10.1016/j.ssresearch.2018.10.004
[40] Jablensky, A. (2000). Epidemiology of schizophrenia: The global burden of disease and disability. *European Archives of Psychiatry and Clinical Neuroscience*, *250*(6), 274-285. https://doi.org/10.1007/s004060070002
[41] Jimenez, D. E., Cook, B., Bartels, S. J., & Alegría, M. (2013). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society*, *61*(1), 18-25. https://doi.org/10.1111/jgs.12063

[42] Jin, R. L., Shah, C. P., & Svoboda, T. J. (1997). The impact of unemployment on health: A review of the evidence. *Journal of Public Health Policy*, *18*(3), 275-301. https://doi.org/10.2307/3343311
[43] Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health and Social Care in the Community*, *12*(5), 439-447. https://doi.org/10.1111/j.1365-2524.2004.00506.x
[44] Kennedy, B. (2022). Pathologizing Bias: Racial Disparities in The Diagnosis of Schizophrenia. *Brandeis University*. https://www.brandeis.edu/writing-program/write-now/2021-2022/kennedy-bridget/
[45] Kessler, T., & Lev-Ran, S. (2019). The association between comorbid psychiatric diagnoses and hospitalization-related factors among individuals with schizophrenia. *Comprehensive Psychiatry*, *89*, 7-15. https://doi.org/10.1016/j.comppsych.2018.12.004
[46] Lee, A. T., Chin, P., Nambiar, A., & Hill Haskins, N. (2023). Addressing intergenerational trauma in black families: Trauma‐informed socioculturally attuned family therapy. *Journal of Marital and Family Therapy*, *49*(2), 447-462. https://doi.org/10.1111/jmft.12632
[47] Li, H., Eack, S. M., Montrose, D. M., Miewald, J. M., & Keshavan, M. (2011). Longitudinal treatment outcome of african american and caucasian patients with first episode psychosis. *Asian Journal of Psychiatry*, *4*(4), 266-271. https://doi.org/10.1016/j.ajp.2011.08.004
[48] Lloyd, S. M., & Miller, R. L. (1989). Black student enrollment in US medical schools. *JAMA*, *261*(2), 272-274. PMID: 2909025
[49] Louie, P., & Wilkes, R. (2018). Representations of race and skin tone in medical textbook imagery. *Social Science & Medicine*, *202*, 38-42. https://doi.org/10.1016/j.socscimed.2018.02.023
[50] Mallinger, J. B., Fisher, S. G., Brown, T., & Lamberti, J. S. (2006). Racial disparities in the use of second-generation antipsychotics for the treatment of schizophrenia. *Psychiatric Services*, *57*(1), 133-136. https://doi.org/10.1176/appi.ps.57.1.133
[51] Martini, L. C., Barbosa Neto, J. B., Petreche, B., Fonseca, A. O., Santos, F. V. D., Magalhães, L., Marques, A. G., Soares, C., Cordeiro, Q., Attux, C., & Bressan, R. A. (2017). Schizophrenia and work: Aspects related to job acquisition in a follow-up study. *Revista Brasileira De Psiquiatria*, *40*(1), 35-40. https://doi.org/10.1590/1516-4446-2016-2128
[52] McCarter, S. (2016). The school-to-prison pipeline: A primer for social workers. *Social Work*, *62*(1), 53-61. https://doi.org/10.1093/sw/sww078
[53] McGrath, J., Saha, S., Chant, D., & Welham, J. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiologic Reviews*, *30*(1), 67-76. https://doi.org/10.1093/epirev/mxn001
[54] NAMI. (2019). *The Annual State of the Communities Report with Diverse Communities*. National Alliance on Mental Illness California. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://namica.org/wp-content/uploads/2019/12/nca_Diverse-Communities-ASoCR-Summary-18-19_Final.test_.pdf
[55] NSDUH (Ed.). (2023). *2021 NSDUH Annual National Report*. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
[56] OASH. (2020). [Employment literature summary]. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment#cit39

[57] Özbek, S. U., & Alptekin, K. (2021). Thought disorder as a neglected dimension in schizophrenia. *Alpha Psychiatry*, *23*(1), 5-11. https://doi.org/10.5152/alphapsychiatry.2021.21371
[58] Padgett, D. K. (2020). Homelessness, housing instability and mental health: Making the connections. *BJPsych Bulletin*, *44*(5), 197-201. https://doi.org/10.1192/bjb.2020.49
[59] Perni, S., Moy, B., & Nipp, R. D. (2021). Disparities in phase 1 cancer clinical trial enrollment. *Cancer*, *127*(23), 4464-4469. https://doi.org/10.1002/cncr.33853
[60] Priebe, S., Conneely, M., McCabe, R., & Bird, V. (2019). What can clinicians do to improve outcomes across psychiatric treatments: A conceptual review of non-specific components. *Epidemiology and Psychiatric Sciences*, *29*. https://doi.org/10.1017/s2045796019000428
[61] Rachidi, A. (2018). The persistence of poverty and joblessness in US households. *AEI Economics Working Paper*. https://policycommons.net/artifacts/1296072/the-persistence-of-poverty-and-joblessness-in-us-households/1899316/
[62] Ramamoorthy, A., Pacanowski, M., Bull, J., & Zhang, L. (2015). Racial/ethnic differences in drug disposition and response: Review of recently approved drugs. *Clinical Pharmacology & Therapeutics*, *97*(3), 263-273. https://doi.org/10.1002/cpt.61
[63] Roberts, B. W., Puri, N. K., Trzeciak, C. J., Mazzarelli, A. J., & Trzeciak, S. (2021). Socioeconomic, racial and ethnic differences in patient experience of clinician empathy: Results of a systematic review and meta-analysis. *PLoS One*, *16*(3), e0247259. https://doi.org/10.1371/journal.pone.0247259
[64] Roll, J. M., Kennedy, J., Tran, M., & Howell, D. (2013). Disparities in unmet need for mental health services in the united states, 1997–2010. *Psychiatric Services*, *64*(1), 80-82. https://doi.org/10.1176/appi.ps.201200071
[65] Santillo, M., Braga, B., Blavin, F., & Gangopadhyaya, A. (2022). *Communities of Color Disproportionally Suffer from Medical Debt*. Urban Institute. https://www.urban.org/urban-wire/communities-color-disproportionally-suffer-medical-debt
[66] Schaeffer, K. (2023). *Black workers' views and experiences in the U.S. labor force stand out in key ways*. Pew Research Center. https://www.pewresearch.org/short-reads/2023/08/31/black-workers-views-and-experiences-in-the-us-labor-force-stand-out-in-key-ways/
[67] Scharff, D. P., Mathews, K. J., Jackson, P., Hoffsuemmer, J., Martin, E., & Edwards, D. (2010). More than tuskegee: Understanding mistrust about research participation. *Journal of Health Care for the Poor and Underserved*, *21*(3), 879-897. https://doi.org/10.1353/hpu.0.0323
[68] Segal, S. P., Bola, J. R., & Watson, M. A. (1996). Race, quality of care, and antipsychotic prescribing practices in psychiatric emergency services. *Psychiatric Services*, *47*(3), 282-286. https://doi.org/10.1176/ps.47.3.282
[69] Shavers, V. L., Fagan, P., Jones, D., Klein, W. M. P., Boyington, J., Moten, C., & Rorie, E. (2012). The state of research on racial/ethnic discrimination in the receipt of health care. *American Journal of Public Health*, *102*(5), 953-966. https://doi.org/10.2105/ajph.2012.300773
[70] Sher, L., & Kahn, R. S. (2019). Suicide in schizophrenia: An educational overview. *Medicina*, *55*(7), 361. https://doi.org/10.3390/medicina55070361

[71] Townes, D. L., Chavez-Korell, S., & Cunningham, N. J. (2009). Reexamining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preference for a black counselor. *Journal of Counseling Psychology*, *56*(2), 330-336. https://doi.org/10.1037/a0015449

[72] Velligan, D. I., & Rao, S. (2023). The epidemiology and global burden of schizophrenia. *The Journal of Clinical Psychiatry*, *84*(1). https://doi.org/10.4088/jcp.ms21078com5

[73] Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, *158*(12), 2027-2032. https://doi.org/10.1176/appi.ajp.158.12.2027

[74] Yeary, K. H.-C. K., Stewart, M. K., Lensing, S., Dockter, N., Bachelder, A., & Haynes, T. (2015). Women's perceptions of provider empathy in the context of healthcare disparities. *Race, Gender & Class (Towson, Md.)*, *22*(3-4), 154-171. PMCID: PMC6867610.