Anti-Black racism and behavioral medicine: confronting the past to envision the future

Jessica Y Breland, Michael V Stanton

Abstract

Behavioral medicine research and practice have not traditionally acknowledged the detrimental effects of anti-Black racism (and other forms of systemic oppression) on health, interventions, or research. This commentary describes four ways that behavioral medicine researchers and clinicians can address the past to envision the future of behavioral medicine to promote equitable health for all: 1) name anti-Black racism, 2) ensure interventions address structural inequities, 3) advocate for systemic change, and 4) change expectations for publications.

Issue Section:
Commentary/Position Paper
Implications

Practice: Behavioral medicine practitioners should understand the legacy of anti-Black racism and consider how anti-Black racism might affect patients' treatment, engagement and outcomes, adjusting interventions, and professional practices as needed.

Policy: Behavioral medicine research funding should prioritize Black and other underrepresented scientists and topics that impact Black populations; and the behavioral medicine workforce should advocate for systemic change to combat anti-Black racism and promote health equity.

Research: Behavioral medicine researchers should understand the history of anti-Black racism, name anti-Black racism in their work, and develop and analyze interventions within the context of systems of oppression.

Behavioral medicine researchers and clinicians traditionally focus on individual behavior change, which has resulted in interventions equal to or more effective than medications for conditions such as insomnia and prevention programs for diabetes [1, 2]. However, behavioral medicine interventions usually ignore the near impossibility of changing health behaviors without access to healthy foods, safe places to sleep and exercise, disposable income, or health insurance that allows for repeated visits, ongoing customization of medications, or ongoing physical therapy. It is even less common for behavioral medicine researchers and clinicians to acknowledge that access to these types of care is inexorably linked to systems of oppression, such as anti-Black racism. Nor do researchers typically develop or test interventions specifically

to address inequities caused by these systems of oppression among Black patients or patients from other marginalized groups.

Anti-Black racism is systemic, pervasive, enduring, and deadly. It kills not just through overtly racist murders, but by systematically depriving Black people of the wealth and safety required to obtain health care and achieve health in the USA. Centuries of racist policies contribute to these wealth and safety disparities, including slavery, segregation, forced sterilization, and New Deal policies excluding predominantly Black professions [3]. Post-World War II policies, including but not limited to the GI bill and redlining, blocked access to government subsidized education and mortgages, resulting in vast amounts of lost wealth over a single generation [4, 5]. Furthermore, as a result of climate change, those redlined neighborhoods are oppressively hot [6–8], negatively affecting health and limiting opportunities for physical activity to this day.

By focusing on individual behavior change and ignoring anti-Black racism and its effects on health, behavioral medicine researchers and clinicians contribute to maintaining and widening health disparities. In the USA, medicine and medical research often strengthen systems of oppression by using the bodies of the most marginalized, often Black people, to develop and perfect treatments that are ultimately inaccessible to marginalized people [3]. Yet, this history is not usually taught in behavioral medicine programs, despite the fact that the harmful effects of systemic racism are well documented [9, 10].

Behavioral medicine must account for this history by broadening its scope to address anti-Black racism, a root cause of poor health and health disparities. The following recommendations for behavioral medicine researchers and clinicians focus on intervention research and anti-Black racism, but are applicable to other research areas and other forms of systemic oppression, such as racism against other racial and ethnic groups, misogyny, anti-gay discrimination, and anti-trans discrimination, among others (Table 1).

Table 1

Areas of focus to help behavioral medicine addresses anti-Black racism

1. *Name anti-Black racism* in models, frameworks, grants, publications, and presentations.
2. *Ensure interventions address structural inequities* by designing interventions with the history of anti-Black racism in mind and by not blaming individuals for systemic problems.
3. *Advocate for systemic change* within workplaces, professional organizations, and communities.
4. *Change expectations for publications* to include barriers related to anti-Black racism, particularly in relation to null results.

Open in new tab

NAME ANTI-BLACK RACISM

Behavioral medicine researchers do not typically name anti-Black racism or other forms of oppression in theoretical models, frameworks, interventions, grant proposals, manuscripts, or presentations. Although socioecological models or sociopolitical factors are sometimes described, behavioral medicine researchers often focus on the individual level, which unfairly places the burden to resolve anti-Black racism on Black people. Or, researchers describe disparities instead of focusing on addressing root causes. Calling anti-Black racism by its name as a putative factor will improve existing models and research. It will save time and money by allowing researchers to identify and then address root causes of disparities, instead of focusing on poor proxies, such as self-reported race. For example, naming the effects of anti-Black racism on neighborhoods might lead researchers conducting outdoor physical activity interventions to assess participants' access to physically safe outdoor environments as a moderator, or even design interventions that account for related barriers. Researchers must also acknowledge that merely adjusting for socioeconomic status does not substitute for adjusting for the effects of anti-Black racism. We know, for example, that infant mortality among Black women with a doctorate or professional degree is higher than infant mortality among White women with a high school degree [11]. The Healthy People 2030 Social Determinants of Health provides one possible framework for considering how anti-Black racism may affect participants, intervention components, and/or outcomes.

Behavioral medicine clinicians can name anti-Black racism when working with patients. This can be explicit, for example, by validating a patient's experience with racism without questioning or trying to re-frame the experience. This will not only build rapport, but will help treatment focus on factors that improve outcomes (e.g., addressing how to manage stress related to anti-Black racism before attempting to complete cognitive behavioral therapy for insomnia). "Racial stress, trauma, and empowerment therapy" is a promising adjunctive approach that could be added to existing behavioral interventions [12, 13].

ENSURE INTERVENTIONS ADDRESS STRUCTURAL INEQUITIES

Behavioral medicine researchers can design interventions that help people advocate for systemic change to make healthy living accessible to all (i.e., not just to those in a given intervention). Multilevel interventions that impact at least two levels (e.g., patients and policy) are an important component of this work. For example, the best weight management intervention may include training clinicians and patients in grassroots organizing so they can petition civic leaders for equitable access to healthy food, housing, work, and community spaces, or training people to run for political office to enact their own change. The Strong Hearts, Healthy Communities studies provide an example. In this community-based intervention, women with overweight or obesity learn about improving their own eating and activity habits while also working to effect social, cultural, environmental, and political change in their communities to foster healthy eating and activity behaviors on a broader scale. Results of randomized effectiveness trials suggest that participants lose weight and improve health behaviors [14, 15], while also achieving civic goals [16, 17]. Paskett et al. provide additional background and examples on multilevel interventions, including design considerations and the importance of policy, that may be useful for behavioral medicine researchers [18]. For researchers interested in policy change to address the effects of

systemic racism, Williams and Cooper's evidence-based suggestions may provide a starting point. For example, they discuss developing communities of opportunity to reduce the effects of systemic racism and enhance child development [19]. The Center for the Study of Social Policy guide on anti-racist policymaking is another resource for researchers [20].

Behavioral medicine clinicians may not design interventions, but they often implement interventions that do not account for structural inequities, like anti-Black racism. For example, much of the diet change literature is based on studies that control the exact food content each participant consumes. As a result, these studies have little relevance to eating in real world contexts, especially for individuals affected by discriminatory policies who live on limited or fixed incomes [21]. Behavioral medicine clinicians must consider how to modify these interventions for specific patients to combat systemic forces acting against these patients. In the context of empirically supported treatments, this may mean focusing on the broad toolkit of evidence-based techniques (e.g., goal setting, behavioral activation) as opposed to minute-by-minute treatment manuals. This recommendation parallels the call for intervention trials to focus on the function of interventions (i.e., goals) as opposed to solely their form (i.e., how they are delivered) [22]. At the same time, it is usually individuals that clinicians see in clinics. Balancing the importance of context and systemic problems with the needs of individual patients is at the core of equitable behavioral medicine practice.

ADVOCATE FOR SYSTEMIC CHANGE

Disparities will increase if only marginalized populations are working on political change while majority groups focus on their individual health. Therefore, behavioral medicine researchers and clinicians must also advocate for systemic change within their professional organizations, workplaces, and communities. The Society of Behavioral Medicine (SBM) has a Civic and Public Engagement Committee that facilitates this work, for example, by talking to Congress, writing policy briefs, and funding members' participation in the Op Ed Project. SBM and other organizations, like the American Psychosomatic Society, have established anti-racism task forces to improve equity from within their organizations and advocate for meaningful anti-racist actions in the greater community. Not only will advocating for systemic change within organizations ultimately help reduce disparities, it will also counteract the anti-Black history of medical organizations, such as the American Medical Association, that historically barred Black members [23] and often advocated for policies that deepened disparities (e.g., fighting the establishment of a federal health care system in the 1930s and 1940s [24]). Advocating for change within one's workplace may be constrained by rules (e.g., regulations related to partisan elections). However, many workplaces have legal and/or public affairs offices that can help determine what is and is not permitted. Behavioral medicine researchers and clinicians should consider this sort of advocacy a core part of their mission to improve health through behavior change. Systemic changes resulting from advocacy will likely have a greater impact on people's health than the individual interventions that are often the focus of behavioral medicine research and practice.

CHANGE EXPECTATIONS FOR PUBLICATIONS

This recommendation most directly applies to researchers, but also affects clinicians who consume behavioral medicine research. First, journals could help authors more accurately report on disparities by encouraging them to follow Boyd et al.'s recommendations, including defining race, citing experts, and rejecting genetic definitions of race [25].

Second, the null results section of *Translational Behavioral Medicine* could play an especially important role. What might seem like a null finding may actually demonstrate that focusing on patient-level health behaviors is insufficient to overcome systemic problems. For example, patients with diabetes in a low-income, predominantly Hispanic neighborhood in New York City believed the stress of trying to find healthy food was worse for their health than eating unhealthy food [26]. They also tied stress and the lack of healthy food in the neighborhood to racism. Participants in diet-focused intervention trials with null results may have similar experiences, but such experiences are rarely probed or reported. Reporting these contextual factors would help researchers and clinicians understand whether an intervention is ineffective or simply has the wrong target (e.g., increasing vegetable consumption vs. increasing access to vegetables.) As such, describing null results within the context of anti-Black racism (and other forms of oppression) would provide more actionable information than the generic conclusion that "more research is needed."

Finally, journals can ask authors to specifically state the barriers that forms of oppression pose to carrying out the intervention under investigation. Behavioral medicine interventions often advocate for behaviors that are conceptually linked to improved health without acknowledging systemic influences on those behaviors. As a result, a researcher may conclude, for example, that increasing one's physical activity improves mental and physical health. It follows that if a physical activity intervention fails to improve physical or mental health, it is the fault of the person using the intervention. However, a more thoughtful conclusion might be, "physical activity can improve physical and mental health under favorable conditions and with abundant resources, but this can be difficult for those without the time or a safe place to exercise." By normalizing and acknowledging these complexities, researchers can avoid blaming participants for poor treatment outcomes, which is a common if not commonly acknowledged reaction to null results.

CONCLUDING CONSIDERATIONS

The suggestions in the piece are merely a starting point. Other areas that need to be addressed include training, funding, and study recruitment. Furthermore, given our background, we focus on behavioral medicine research and clinical work in the USA. However similar systems of oppression are at play in international work and we hope they will be interrogated by others with the requisite expertise.

Training may be the most important next frontier and should occur across the broad range of disciplines that engage in behavioral medicine including, psychology, medicine, public health, and epidemiology, among others. Such training will require an understanding of U.S. history and an appreciation of the many scholars who have worked to identify and reduce disparities for decades [10, 19, 27], including among others, Kimberlé Crenshaw, who coined the term intersectionality [28] and Drs. Zinzi Bailey and Mary Bassett's work, which may be especially

helpful as an introduction to understanding pathways between anti-Black racism and health outcomes [29].

As noted by others [30], funding reform is needed to ensure equitable resources for researchers from underrepresented backgrounds and equitable research focus on issues specific to underrepresented populations. Finally, while a sole focus on patient-level treatments ignores systemic racism and health inequities linked to systemic racism; it would only increase disparities and reinforce the paternalistic history of medicine to prevent marginalized populations from accessing these treatments because they may be less likely to benefit from them. Yet, that often occurs when researchers choose to recruit homogenous groups to reduce confounding variables, like discrimination or lack of opportunity. Therefore, future funding should ensure that behavioral medicine researchers incorporate more diverse samples with more realistic access to resources.

In summary, we believe that the best way for behavioral medicine to confront the past and envision the future is for its researchers and clinicians to: (a) name anti-Black racism, (b) ensure interventions address structural inequities, (c) advocate for systemic change, and (d) change expectations for publications. We acknowledge that to achieve some of these goals, populations, institutions, and individuals that have traditionally benefited from the inequitable distribution of power must surrender some power, so that others, who traditionally had less power, can benefit. However, making these changes and ushering in a new standard for behavioral medicine research and practice is the only way behavioral medicine researchers and clinicians can truly achieve SBM's goal of proven science and better health.

Acknowledgments

Funding