Sanya Virani:

Hi, I'm Sanya Virani, and I welcome you to Finding Our Voice: Fresh Perspectives in Psychiatry. A podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry. With a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early-career psychiatrists. Thank you for joining me as we continue our discussions on this segment of the podcast series about structural racism that affects patients and psychiatrists from minority and underrepresented ethnic groups.

Today's episode will be centered on the African American community, and we have two esteemed guests in our myths, Dr. Rachel Talley and Dr. Sarita Metzger. Before we begin, I wanted to give you some food for thought. I finished watching the Queen's Gambit last night, and the concept of the first-move advantage occurred to me. I don't know if all of you are familiar with it, but I was fascinated to learn, especially as it pertains to chess.

Outside of chess, however, in the world of business, it has variable implications. But the general consensus among players and purists is that the player that makes the first move has an inherent advantage. And as we know in chess, it is the white that moves first. Since 1951, compiled statistics support this view. It's been that long. That white consistently wins slightly more than black, usually scoring between 52% and 56%. And I find this fascinating. But I haven't found anything that clearly explains why it is this way. Interestingly enough, however, one of the Grand Masters wrote a series of books on the theme, Black is Okay. Arguing that the general perception that white has an advantage is more founded in psychology than it is in reality. And that is also problematic in and of itself. I think so, at least.

All right, let me get started and introduce you to the two guests we have with us today. Dr. Rachel Talley is a clinical assistant professor of psychiatry at the Perelman School of Medicine at the University of Pennsylvania. She is the director of the University of Pennsylvania's Fellowship in Community Psychiatry. Prior to joining UPenn's faculty, Dr. Talley completed an adult psychiatry residency and public psychiatry fellowship at Columbia University, New York State Psychiatric Institute. Dr. Talley is also an Early Career Representative on the Board of the American Association for Community Psychiatry. Hi, Dr. Talley, welcome to the podcast.

Dr. Rachel Talley:

Hello. Thank you so much for having me. I'm so pleased to be here and found that anecdote you shared at the beginning so fascinating and relevant. Because I think so much of what we will be talking about today are those elements of racism that have to do with the built-in advantages that society can have for certain groups. So thank you for the fascinating anecdotes. Not something I knew so much about chess prior and looking forward to participating and talking today.

Sanya Virani:

Thank you, Dr. Talley. It's such a pleasure having you here. I'm looking forward to our discussion. We also have with us Dr. Sarita Metzger, who is currently a PGY4 at the University of Pennsylvania. She's interested in cultural psychiatry and devoted to furthering mental health equity for people of color and LGBTQ communities. And after graduation, Dr. Metzger plans to continue training in mental health advocacy and policy as a fellow at the University of Pennsylvania's Public and Community Psychiatry Fellowship. Welcome, Dr. Metzger. It's so nice to have you here.

Dr. Sarita Metzger:

Hi, thank you for inviting me. That was a very interesting tidbit that you mentioned about chess. I don't know anything about chess, beyond also the Queen's Gambit, but it's just "interesting," quote, unquote, how even in traditional spheres, white should have an advantage.

Sanya Virani:

Yeah. I am also looking forward to sort of breaking it down a little bit and discussing through the various stories and examples you have to share. So without further ado, let me ask Dr. Metzger to share with us her recent experiences as a trainee. The narratives and incidents, and cases presented by Dr. Talley and Metzger will highlight various elements of structural racism that we hope to continue discussions about. And we would also like to highlight that the names and other detail identifiers have been modified to protect the privacy of the individuals involved. So Dr. Sarita Metzger, over to you.

Dr. Sarita Metzger:

All right. Please feel free to call me Sarita, by the way. So I met Joe and his wife, Stella, this African American couple in their 70s. They've been married almost 20 years a few months into my PGY3 year. Joe was coming to see me for his first outpatient visit, since his two almost consecutive recent hospitalizations for anemia. Prior to events leading up to his hospital stays, he really had no known history of psychiatric illness. Now, he's in my office with slowed speech, slowed movements with an abnormal gait, slowed thinking and complaining of difficulty with balance. Physical exam was significant for a cogwheel with bilateral flexion and some difficulty with coordinated movements.

Stella joined us near the end of the evaluation and peppered everything she said to me with, "This just isn't like him." And she knew her husband to be an active, friendly, vital veteran who was enjoying his retirement for the past years. She's very concerned about his physical and mental health and alarmed with the significant changes she noticed between his admission and discharge from the hospital.

Stella also worked in mental healthcare, so she came to the visit with a laundry list of specific questions and concerns. She was very assertive in asking about his current and past symptoms, his treatment plan, medication side effects, what we could expect in the short term, longer term, treatment goals, everything. So I tried to be very patient with her. I had a great example in my attending. They really were a great example of patients. So at the end of that 90-minute encounter, as I was walking a couple back to the front desk for checkout, Stella pulled me aside, and she said, "I work in this fitness and I am so glad he has a Black doctor."

So working in Philadelphia, I see many Black patients. So I'd heard this before, and sometimes the reasoning is the same, sometimes it's a little different. But one thing patients describe is thinking that because I'm also Black, I can relate to them better. And in some ways, I can. There is some shared experience there, but in some ways, there are many, many assumptions being made since I actually did not grow up in the US. And as Stella's case, she felt like I would right by them, that I would give them the time and patience they deserved and really listen.

So in follow-up visits, Joe and Stella described what I'd heard from multiple other patients before. Feeling condescended to you by their non-Black healthcare providers, feeling unheard, and as so the treatment care experience were not really collaborative. It was, "Do this, do this, do this, do this." Or, "You're non-compliant." And they didn't really give them an honest space to ask why, to ask about decision-making. So of course, this is frustrating. And Stella would say that if she tried to assert herself in much the same way that she did with me when we first met, she think to herself that everyone was thinking that she was some kind of angry lady and act like they didn't have time for her or husband.

Sanya Virani:

Wow. My ears stood up when I heard the statement that Stella made. I think you mentioned which she said, "But I have a black doctor and I'm so glad." Just that statement could lead to so many different kinds of problems. Just it points to the various assumptions I guess, that the patients and the family members seem to make when they see somebody, a provider from the same ethnicity. My head was totally bubbling with all kinds of ideas and questions while you were speaking. So first of all, I was wondering if you want to elaborate for our listeners what the patient's experiences had been with non-Black healthcare providers.

Dr. Sarita Metzger:

Sure. I do my best when I meet new patients to listen a little to what their past experiences were like in the mental health system to get a sense of where they're coming from and their expectations. The difficult, maybe not difficult, but crucial part for me is staying within what I consider to be my professional limits and not throwing other providers under the bus, so to speak, but also validating the experience of the patient in front of me. You're hyper-aware that the story being relayed to you is their singular perception, but it does exist within a very real racist, social, and historical context.

And also, as I touched on before, you have to be aware that the patient is ascribing a lot to you in terms of expectations because they quoted you as Black based on your appearance. There is some presumption of a shared understanding, or shared experience, or a shared identity that may or may not be reality because race is just one aspect of identity.

Sanya Virani:

Sorry, I just wanted to interject. Sorry. I'm so sorry for doing this, but just because I thought of something right away. The themes of transference and countertransference, especially as it pertains to providers and clinicians and patients either belonging to the same ethnicity or different. So this phenomenon, I guess I read it somewhere, was identified by Comas-Díaz and Jacobsen, I think it was back in the 1990s. Something that is called the ethnocultural transference and countertransference, where I think I read that patients often have a sense of over-compliance and even friendliness. Sometimes just a denial plain about the ethnicity and culture. And on the flip side, a whole lot of mistrust, suspicion, and hostility, and maybe even ambivalence towards treatment and management. I just wanted to throw that out there and just see what your thoughts are. Have you heard of this?

Dr. Sarita Metzger:

I have heard of that concept, and I think that one I've seen it a lot myself where just because I feel like the patient is coming to visit. And I feel like they're listening to me and understanding what I'm saying, and we're agreeing to a treatment plan does not necessarily mean that they follow the treatment plan. But I also feel like it works the other way from providers. Sometimes, there can be an assumption that because there's the shared racial identity, that they assume that the patient is going to just follow the treatment plan, and then there's a lot of frustration on both sides later.

Sanya Virani:

Yeah, I totally agree. I have seen that happen also. I just didn't know that this was recognized as a phenomenon and it was called something, and people have written about it. So it was just fascinating to read about.

Dr. Sarita Metzger:

Yeah, it's interesting because in general, I feel like a lot of concepts that I've been learning about... I think more recently, terms like intersectionality and microaggressions have come into our consciousness. They have been written about for decades, but just because not in our field specifically, we just didn't know about it.

Sanya Virani:

It's good to have a phrase to the phenomenon, something to identify, call it.

Dr. Sarita Metzger:

Yeah, helps us all communicate better.

Sanya Virani:

Yeah, sorry. I'm sorry, I interrupted you. Just what were you saying?

Dr. Sarita Metzger:

Oh no, I was just thinking that it's your responsibility as a provider to keep all of that in mind. You have to build and maintain rapport to provide the best clinical care that you can while also not colluding with the patient in ways that can be harmful later. And like we mentioned before, providers can also be susceptible to bias, just as patients are despite standards of care.

Sanya Virani:

Absolutely. I absolutely agree. And just I think that a similar process like you were mentioning is obviously happening when a patient encounters a non-Black provider and obviously, they have a whole different set of expectations and assumptions of how they will be treated by the non-Black provider if they've just stepped into the room and coded them as a non-Black person who they don't identify with.

Dr. Sarita Metzger:

Do you have any other questions about Joe and Stella specifically?

Sanya Virani:

Yeah, I was going to ask you, what was the quality of experiences you think that Joe and Stella could have had that may have possibly impeded the formation of a collaborative care plan?

Dr. Sarita Metzger:

Their first interface with the mental health system was, unfortunately, through involuntary hospitalization and the crisis response center. Most of their complaints were about providers on the inpatient unit, though. Joe mentioned having multiple doctors and being confused about what all their roles were since no one would introduce themselves or tell me anything. They just asked me if I was suicidal every day. And the biggest complaints were around medications and informed consent.

Joe felt like he wasn't given an opportunity to really ask questions or tell them how tired he was, how tired the medications were making him. He told this to his wife, and she thought maybe she could ask questions on his behalf. Stella told me she'd go to the unit to find a doctor, but nursing would intervene. And she described him as being very dismissive like, "Yeah, yeah. Okay, whatever. We'll get to it." And

she wanted to know why he seemed so lethargic during her visits, why he was sleeping all day and slurring his words. She said one of the doctors, she eventually got a hold of, told her that's just how the medication works and it's complicated, and Joe was okay. And she said that he clearly wasn't okay, and she felt like the doctor was speaking to her as if she was stupid.

Sanya Virani:

That's unfortunate.

Dr. Sarita Metzger:

So I think that the bottom line really was communication were being very poor, and why was it so poor? I don't think we can really know, but we've all been on a busy in-patient unit, having multiple responsibilities, don't have time to figure out all the paperwork before someone's discharged. But you have to prioritize some tasks and deprioritize others. And you also have to examine how you're making those decisions about how you're prioritizing certain tasks.

And it sounds like in the case of Joe and Stella, spending time with them to explain the disease process, how the medications were chosen, medication risks and benefits, adverse effects he was experiencing specifically, and how those could be minimized, and just taking the time to have them communicate back so you can gauge their understanding and feel confident that the consent was informed. All of that was deprioritized, and it sounds like a lot and time-consuming, but that's just our responsibility. That's what we signed up for. Otherwise, you just left with a patient that feels disrespected, unheard, confused, and no buy into the care plan.

And then it's even more of a blow when a patient like Joe can look around the unit and feels like everyone's not getting dismissed in the same way that he is. And it's not really a small thing that the care plan wasn't collaborative because a direct result of that was Joe getting rehospitalized two weeks after discharge. And he got home, he discontinued all his medications because he and Stella were concerned they're creating more problems, and then he relapsed.

Sanya Virani:

That's really sad. Thank you for sharing that. These are really valuable insights. And I had one final question about the case of Joe and Stella. I think in this example that you described for us, point to the presence of implicit or explicit bias among providers, and do you think this would lead to patients dropping out of treatment?

Dr. Sarita Metzger:

Yeah, so explicit and implicit bias are rooted in race-based stereotypes. I really can't speak to the explicit bias or the conscious views of the inpatient providers, but generally speaking, we know that provider explicit bias can influence diagnosis and treatment. I do think a lot of what Joe and Stella told me could be explained by negative implicit bias.

It's subconscious, it's automatic, it can be positive or negative, and it's particularly insidious because it's instinctive. And not just in psychiatry, but across medicine. It's been shown that the greater the implicit bias of the provider, the poorer the patient-provider communication and the poorer the patient-centered communication. Joe and Stella's experience really reflects this. What has not been consistently shown is if implicit bias affects treatment recommendations and outcomes. In their case, I also wonder about the role of implicit bias in how Joe was initially even admitted involuntarily because we know that

African Americans are more likely to be admitted this way. Because we have to do it so often, I think that it's sometimes easy to forget that involuntary hospitalization does imply a loss of civil liberty.

And on the unit, I think implicit bias of the providers included assumptions about Joe and Stella's level of education or capacity to engage in meaningful discussion about the treatment. I'm thinking about Stella's assumption that a Black doctor would provide her husband with better care, but the shameful reality is, the studies have shown that in addition to African Americans having less access to outpatient mental healthcare, there really is a racial disparity in this psychiatric outpatient setting. And there is a completely understandable cultural mistrust on the mental health system by non-white patients. And it's a mistrust based in a history of medical abuses and discrimination.

I think African Americans are more likely to receive substandard care and they're discriminated against. So yeah, I think all of these factors can lead to an African American patient to drop out of treatment because of explicit and implicit bias.

Sanya Virani:

Thank you, Dr. Metzger. You summarized it so beautifully for us. You just hit on a number of different points, which we all have to think about in our interactions with Black patients, number one, and then patients in general. So now we're going to talk with Dr. Talley about her patient Brian, and learn about the enormous impacts of social determinants of mental health as they relate to minority populations and what is known to us from recent literature. Dr. Talley, hi.

Dr. Rachel Talley:

Hello. Happy to jump in here and tell you a little bit about as patient example of Brian. So Brian came to see me for a monthly medication management visit in a community mental health clinic where I work. And as soon as he walked in the door, I already knew by just the slump in his shoulders, the expression on his face that there'd been a setback in the process that came up at pretty much every visit I had with him, just the subject of finding stable housing.

Brian held back tears of anger as he described that yet another paperwork obstacle had delayed his housing voucher, which then impeded his planned move into an apartment that would be big enough to accommodate both him and his son. He spoke about the excitement he had felt this week about finally having a place where his son could have his own room that would be clean and quiet without issues of pests and utility problems that have been coming up in his current unit.

He said, "I know there were times that I messed up in the past, doctor, but I've been doing everything the right way this time. I've been sending it all the paperwork, I've been going to all the appointments. I don't know what else they want from me. Sometimes it feels like I can't ever get ahead no matter what I do." As Brian was speaking, I felt a rising frustration in myself, thinking about how the lack of a decent living environment is the most common issue raised by my patients as contributing to their depression, anxiety, and general sense of distress. And I often feel fairly powerless in my role as a psychiatrist. How are antidepressants supposed to solve the sadness triggered by not having a home of your own? What use for sleep aids for those who don't have a comfortable, clean-living environment where they can rest?

Now, very few of the patients that I serve, the majority of whom identify as Black or African American actually own their own property. A few of them rent, some of them that... Many are shuffled between shelters and safe havens, staying with friends, or on a relative's couch, or some of their situation that doesn't provide a sense of stability and belonging. Now, I've learned from my time practicing and training in community psychiatry that housing, which is one of the key social determinants of health and

mental health, affects all people regardless of race, ethnicity, religion, and other identities. However, knowing the history of discriminatory policy involving housing in this country, it's particularly devastating to observe the ways in which structural inequalities built into the fabric of our society can ripple down by generations for people of certain backgrounds, particularly people who identify as Black or African American perpetuating a lot of mental distress.

Sanya Virani:

Thank you, Dr. Talley. This was the perfect example to bring us to the discussion about how policies have shaped up, at least in the past four decades, and with regard to one of the most important contributors of mental health, and that's housing. So another thing I recently revised as part of my exam prep was the DSM-5, and I came across the V codes of DSM-5 and ICD-9 as well, and the Z codes in ICD-10, also known as other conditions that may be the focus of clinical attention and addresses issues that are the focus of clinical attention or affect the diagnosis course and prognosis or treatment of a patient's mental disorder. However, these codes are not mental health disorders per se, so housing and economic problems are part of the V codes of the DSM-5. And just as an FYI, they belong to V Code 60.0 onwards.

So the DSM-5 and the ICD-9 and 10 also recognize housing as one of the indicators, social determinants of mental health, and we're, as clinicians, physicians just advised to maybe document that in a patient's chart so that everyone's aware. So just wanted to put out there. Also, this brings to mind some of the work that Dr. Michael Compton and Dr. Ruth Shim had done. I recently came across a book which was titled... I think it was Social Determinants of Health, and there is a whole chapter that is dedicated essentially to poor housing quality and housing instability. So that might be a useful resource to use. Dr. Talley, I wanted to also speak a little bit about the concept of redlining and home ownership, which actually might be totally relevant to this patient because he falls within the lower income bracket, according to my understanding at least. And I really wanted to hear from you what you think is pertinent about this in Brian's case.

Dr. Rachel Talley:

Absolutely, absolutely. And I can see how at first glance, it could seem like Brian's story doesn't have anything to do with this country's racist history in terms of investment in particular neighborhoods and limiting mortgage opportunity or redlining. As you were highlighting, this is somebody who is in the rental and voucher system and isn't looking at ownership himself. However, we have to consider the factors that might have led Brian to have limited financial resources in the first place.

Obviously, there are any number of reasons as to why that could be, but I really want to emphasize limited financial resources rather than just income. We have to consider how his current income is only one piece of the puzzle. So redlining is one of an array of policy samples by which Black Americans have been systematically shut out of wealth generation or wealth creation for generations. Now, I'm no financial expert, that's not my expertise, but a lesson that I've often heard growing up from folks that I respect, parents and other advisors, is that home and property ownership is one of the most stable and valuable investments that you can make. There's a key part of accumulating wealth in society.

Owning a home can be the first step in generating wealth that can support all sorts of opportunities, both for the owner and for the generations that follow. Helping with the financing of educational opportunities, of future investments, future ownership. Now we have to think about when an entire race of people is shut out of the process of home ownership for generations, consider the impact that has on the ability to build any form of generational wealth. I think about some of my own background. In terms of income, I'm very fortunate to be in a comfortable high-income bracket compared to many in this country, regardless of background. However, significant wealth generation through property

ownership was virtually impossible for many in my parent's generation and earlier because of our background. And that's a very different story than for many of my Caucasian counterparts. And being able to generate wealth in that way can make a critical difference in terms of the opportunities that can be passed down to the next generation.

If we set home ownership... I'll also say for Brian that if we set home ownership and redlining aside, we still must consider the structural factors that could have led Brian to this point. Now, this isn't to say there couldn't be aspects of Brian's own decision-making that have caused his financial difficulties, but as a Black person in this country, he lives in a country where significant limitations on his educational and employment opportunities were literally built into the foundations of this society.

For generations, society was essentially set up for a person like him to fail. I want to also... I'm so glad that you brought up Dr. Compton and Dr. Shim's crucial work on the social determinants of mental health. I'm fairly early in my clinical career in community psychiatry, but I'll often feel a frustration about how so many of the mental health symptoms that I am treating in the clinic where I work are really symptoms of upstream social determinants. And those certainly have a disproportion impact on black patients. And so, I would also encourage listeners to check out that book and particularly the chapter on racial discrimination in that book by Dr. Michael Compton and Dr. Ruth Shim.

Sanya Virani:

Points duly noted, Dr. Talley, these are so many valuable insights, and while there is all of this talk about social determinants of mental health, I was wondering, Dr. Metzger, has this ever come up in didactics since we're both residents and fellows? Has this ever come up in didactics or mentioned on a test, and do you ever wonder about how much information on racism and history is never really delivered in residency or even tested on an exam? I've really am curious to know your thoughts about this.

Dr. Sarita Metzger:

Well, I ask myself those questions all the time because short answer, my opinion is no. I have a few didactic sessions on cultural psychiatry. Mostly, there were discussion of cultural humility and the cultural variance and presentation of certain disorders. I think more recently, an emphasis has been placed on highlighting the social determinants of health. But what's interesting is systemic racism is the driving force of these, quote, unquote, "social determinants of health," but the word racism is really never used. I think traditionally, it's just been considered too strong a word and something I rarely hear in the formal didactic setting. At least before this year, I think the phrase social determinants of health is definitely much more palatable intellectual language that was preferred up until a few months ago. I think the shift happened because of the police killing of George Floyd in May, and that sparked a lot of global unrest. And here in the US institutions that have propped up racist norms like medicine, and we're focusing on psychiatry. They've really been forced to reckon with this and examine our field.

As far as exams, I've taken the pride exam, I've taken about three times now, and maybe I'm wrong, but I can't recall any questions explicitly speaking to racism, there were definitely a few questions addressing health equity, but I feel like their focus was more on health equity for children and adolescents exploring their gender and sexuality. Pride really does love testing on the history of multiple psychological theories and theorists, but not so much the history of racism. But none of this is to say that the scholarship on racism and racial health disparities doesn't exist. You guys just mentioned some great sources. I think the scholarship out there is really robust, but as a medical student and now resident, I had to find it on my own or through individual conversations with mentors, I'm really grateful, grateful that I've had mentors and the opportunity to interact with people who supported my learning

over the years, and I'm fortunate enough to have program directors and co-residents who support me, and we can invite speakers to talk about these issues.

So the opportunities for learning are definitely there. I guess I wish that it just wasn't so optional and that it didn't take another killing of a Black person to push it into general consciousness. This year particularly, a lot of these conversations are framed as, quote, unquote, "timely" in the context of Mr. Floyd's death, but he wasn't the first, and he wasn't the last. So it's not a 2020 timely issue. These are decades-old issue that psychiatry swept under the rug and really not brought to the forefront in terms of education and testing.

Sanya Virani:

Thank you so much, Dr. Metzger, and I hope that training curriculums start to include pieces of racism, history, and all the other information that is very relevant for people to know and obviously pertains to clinical care in more ways than we're just aware of.

So let's proceed to another example, an interesting one that Dr. Talley has for us, but this time about how she interacted with her trainee, Emily, from a different ethnic background than her own, and then she experienced some difficulty while trying to offer her some advice. Over to you, Dr. Talley.

Dr. Rachel Talley:

Absolutely, thank you. But before I dive into that anecdote, I think I do... I want to reemphasize Sarita's point about this difference and this hesitation sometimes to talk about racism specifically rather than terms like social determinants, which are related. Sometimes include racism as an element, but are often proxy language people sometimes use, and that I think it's so critical for we in psychiatry to not just look externally at the policies, the structures that facilitate racism against our patients outside of psychiatry, but to look in our own house as well. As far as the very real history of racism in psychiatry that has influenced the way we train and practice. And I'll just throw out another wonderful resource, is a book edited by Dr. Morgan Medlock and colleagues, I believe, through APA publishing on the history of racism as well as practical interventions. The exact title is escaping me right now, but I think that's a wonderful resource, in any case, to the example that I'm bringing up here.

As an early career attending, I'm always pretty flattered and excited when a trainee reaches out to me for extra help with the case or clinical issue, particularly if it's somebody who's not specifically assigned to me for supervision. But there was a recent example of this that really made me reflect on some structural barriers that Black professionals in academia faced with advancement and how this impacts the training experience.

So a Caucasian trainee, John, recently reached out to me to discuss one of his cases and describe an incident related to colorism that one of his African American patients had brought up in therapy. This patient reported struggling with issues around self-hatred. Now, John was unfamiliar with the history and impact of colorism on the Black community and its roots in white supremacy.

He expressed feeling lost in terms of how to address these identity issues through a psychodynamic lens. John was very blunt in commenting to me that most of my supervisors are older white guys, and I'm finding that I just don't quite know what to say, that they just don't know quite what to say about what is going on here and what I should or shouldn't do. Now, I, as a supervisor, in part, I felt a sense of satisfaction at being able to offer this trainee some perspective on the issue of colorism. It reminded me of why I went into medicine and why I've stayed in the academic realm, knowing that there are so few people of my background that can speak to some of the unique issues around identity that may come up in psychotherapy with patients that share elements of my identity or background.

But at the same time, I also found myself feeling a sense of frustration that the academic realm still has so few people that can offer that viewpoint. As is the case for many Black providers in academia, I'm one of the few Black people in many of my professional circles. In recent months, I've experienced an innovation of interest in my speaking to issues around race, in psychiatric teaching, and treatment. While part of me finds this fulfilling in the sense that I aspire to be a voice for underrepresented people in these circles, it also causes me to reflect on the many professional barriers that lead to such limited representation.

Sanya Virani:

Dr. Talley, thank you so much for sharing that. I am still stuck on the words that John said to you. He said, "Most of my supervisors are older white guys." Right? That's what he said?

Dr. Rachel Talley:

That was it verbatim.

Sanya Virani:

Well, this is just opening up conversation about so many recruitment and retention problems. I think that they're most seen in academia than on the outside. Of course, we know at least through anecdotal evidence, that that is the case, but what were you thinking when he said that to you?

Dr. Rachel Talley:

Sanya, it was such a mix of things. There's certainly some positive thoughts that it's nice to be able to be in the position to break down some barriers, so to speak, as far as being the first person or one of the first people in the room who looks like me. I've been really fortunate to be afforded many opportunities that other people of my identity have not had. And so, I've done my best to use those opportunities to reach for roles and positions where I'm often one of the few Black people present due to historical and structural factors.

I cannot claim to be an expert on issues of race and psychodynamic psychotherapy. I do think there is a value in my being able to provide a trainee with some perspective on certain issues around identity relevant to the Black experience that some Caucasian trainees might be less familiar with. In this case, colorism, an identity issue rooted in a white supremacy that impacts the Black psyche and Black self-image and self-esteem. But the other thought that came to mind as he said those words was a sense of loneliness and frustration.

In most of the academic institutions where I have worked, a significant number of the patients served have been of Black and brown identities, and those identities are rarely reflected in the teaching faculty. And there can be this feeling that you're expected to be the sole representative on issues related to race because you're one of the few people around of a particular background, and at times, it can feel like a burden and unrealistic expectation. How can one or two of us possibly represent for the totality of the Black experience?

Again, my main expertise, so to speak, is my own personal experience as a Black person in society. The intersection of Black identity and psychodynamic work is an area of professional and scholarly interest that I'm starting to familiarize myself more with available literature, but I'm by no means an expert, and yet I end up in the position of expert because of who I am. Beyond that I, what I would... Oh, sorry. Go.

Sanya Virani:

I'm sorry to interrupt you. I was saying, that speaks a lot to the whole concept of minority tax, which has recently become so popular and has based a lot of strain, especially on people in academic institutions.

Dr. Rachel Talley:

Absolutely. You took the words from it. I think this minority tax is such a critical piece and that it's like... While those of us who are in these institutions don't feel, we certainly feel, I think, excited and grateful to have the roles that we do and be able to speak to certain issues when there's this constant stream of us to be a representative for an entire set of people and really what is truly an array of multiple cultures that are sometimes subsumed under one identity. It can be quite stressful at times.

And beyond that minority tax, there's also the impact on the institution when certain viewpoints aren't represented. In this institution of learning, in the case example that I provide, this trainee was trying to find well-informed, culturally congruent care to a panel of patients with a diverse array of backgrounds, and yet, his teaching was drawn from a pool of people not reflecting that same diversity.

Is my meaning that old white guys, so to speak, can't provide supervision on issues of race? No, not necessarily. Of course, it's possible, but I think what this trainee was feeling is that a piece was really lost in terms of his psychodynamic psychotherapy education when all of the supervision came from people who might be quite similar in terms of how their biases and perspectives around race inform their psychodynamic lens. And what does that mean for the patients served and the care that they'll receive.

Now, this certainly isn't an issue that's isolated to academic medical departments, of course. I mean, you look at any institution of medicine, whether it's professional societies, the boards of healthcare, nonprofit organizations, anywhere you look, if you peruse the higher leadership, you aren't likely to see many people who look like me and Dr. Metzger. The decision-making that flows from that leadership in terms of policies, regulations, and other structures that dictate how medical care is delivered by definition does not include certain viewpoints.

And to me, this is where personal biases, cultures, and viewpoints start flowing into our structures and become structural inequities. Now, you could argue that lack of representation does not mean that these policies, regulations, and structurals will definitely promote inequity, and it doesn't always have to be the case. But when an entire institution and the rules by which it operates is built by a set of individuals that does not include people of a particular experience and viewpoint, will the needs of those people be considered?

In the example I've given, I've shown how lack of diverse viewpoints can affect the teaching experience in academic medicine. But what if we think beyond that to every decision that goes into structuring a healthcare organization, who decides on the strictness of the no-show policy? Who decides which type of treatment is offered to each patient? Who's making hiring and promotion decisions in the organization? The list goes on and on, and it's so critical that the decision-makers at the table have a broad sense of how their decisions will affect everyone in the population served, particularly those who are historically marginalized.

Even leadership and management decisions that we might think of as very data-driven and objective will inherently be colored by some degree, by the decision maker's biases and perspectives shaped by his or her personal life experience. Black people have been systematically shut out from leadership and decision-making roles for generations, so should we be surprised that our medical institutions seem to leave so much to be desired for Black patients in terms of disparities and care?

Sanya Virani:

Thank you, Dr. Talley. These are such amazing thoughts. Truly, I'm mind blown. There are so many things going on in my head right now, and although this is not going to solve anything, but I feel like, at the very beginning, thoughtfulness is what is required on the part of everyone, whether it is a trainee, whether it is somebody at a higher level in an academic institution or somebody in administrative leadership. With that, we come to the end of this episode of Finding Our Voice, fresh perspectives in psychiatry. And our deepest gratitude to our guests, Dr. Talley and Dr. Metzger.

We are so thankful for your time, for your stories, and for everything you discussed and the insights you provided. We've really enjoyed learning, learning about your various experiences at the University of Pennsylvania and outside. At closing, I'd like to leave you with a few final thoughts. Life is offered to us as a form of self-expression, and the highest form of that expression is through acts of kindness. I hope that we will always keep this in mind in all our interactions with people going forward. I'll be back soon with more guests and more stories. Until then, be well and take care. Thank you.

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Speaker 4:

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