Race Against the Mental Status Exam

Olivia Shadid, MD

Racism is a system of oppression that justifies inequities through purported differences based in "race." Race itself was promulgated and enshrined by colonists, enslavers, and imperialists to describe social groups.[1,2,3] Racial categorization is not determined by genetics, but instead via interaction: how a person understands and experiences herself treated by others as a result of, or in spite of, the color of her skin and the structure of her features.[4] "Race," as understood as a biological fact, does not predict health, choices, and flourishing.[5] Racism does.[6,7] If race is a subjective measure, why is race so often included in the mental status exam (MSE), the objective portion of a child and adolescent psychiatrist's assessment of a patient?

As I plunged into my first year as a psychiatry resident, I began asking myself this question. It arose from a tumbling together of my roles as an observer and as the observed. As an observer, a busy intern on the psych wards, I was completing several MSE's day after day, noting the vacillating presentations of my patients over the course of hospitalization. Often, "appearance" is listed as the first domain in the MSE and a racial description as one of the first or second adjectives within this domain. As is commonly taught, I was documenting over and over again what I interpreted a person's race to be and employed the typical terms, drawing from tidy discrete boxes: "Black," "Latinx," "White," "Indigenous," etc. Over time, with more nuanced understanding of my patients' experiences of racial profiling, my own experiences as a Brown woman in a position of visibility, and amidst the cries for racial justice reverberating throughout medicine and the country, I came to find these descriptors limited in utility and far from the objectivity we as physician-scientists want them to hold.

I found that my visibility as a physician can be a wonderful privilege, facilitating intimate encounters with a broad swath of persons. However, being observed by patients also made me acutely aware of how I myself did not fit into the boxes I was forcing my patients into. As with many young people today, I appear ethnically ambiguous.[8] Throughout the year I found patients and staff asking me, "Where are you from?," "What nationality are you?," or even "What are you?" Unprompted, many would volunteer their guesses, ranging from South American to Native to Latina, sweeping through Spanish, Middle Eastern, Persian, Indian, and on to Thai. Many of these comments were meant to establish a connection, perhaps to the person's own heritage, though too often they came from older male patients and seemed tinged with exoticism. Regardless of intent, often I felt myself treated as an "other" in such moments and that those who were asking assumed I did not belong, that my appearance precluded my belonging to the "American" category.

I began to wonder how I would be described in an MSE, and how often I might find myself protesting a conclusion that a clinician would claim as objective. I took that curiosity to my own practices and patient care. I began to notice the features of my patients' physical presentations which I was skimming over so that each patient would fit into a box. I began to recognize when I was relying on non-physical factors, such as surname and accent, to influence what I deemed their "appearance" to be. I became more uncomfortable with squeezing my patients into these categories and claiming this was an objective observation. Doing so felt like I was affirming biological racial essentialism.

Using pat racial terms in the MSE might seem like a small thing. However, it is these subtle acts of dressing up subjectivity—often as seen through a White, cis-het, able-bodied, male lens—as scientific objectivity that make up the links of the many chains that undergird racism in medical practice, research, and training.[9] Nephrology and pulmonology have recognized the limitations of race-based assessments of glomerular

filtration rate and spirometry.[10,11] Medical research is increasingly aware of the complexities that come with including race among demographic characteristics.[12,13] It is now time for psychiatry to recognize our own problematic use of racial categorization. Psychiatry has been complicit in deep and deleterious racism, ranging from the characterization of enslaved Black people's desire for freedom as pathologic ("drapetomania") to the overdiagnosis of psychosis in Black civil rights activists and the simultaneous under-prescription of our most effective antipsychotic to patients identified as Black.[14,15,16] Evidence suggests that our bias as psychiatrists extends to our youngest patients. We are more likely to diagnose the same presentation as attention deficit/hyperactivity disorder in a child we identify as White and as oppositional defiant disorder or conduct disorder in a child we identify as "non-White," circumscribing access to treatment and solidifying outcome trajectories for already vulnerable children.[17] While we address the structural racism woven into psychiatry and research, how do psychiatrists avoid perpetuation of reductionist and racist practices in our individual patient interactions?

Yearning for valid objectivity and a way to avoid the erasure and smudging that racial categorization demands, as a corrective, I began employing that most basic of scientific and writing skills: observation. Rather than patently claim to know a patient's race, I chose to describe in richer detail the traits I actually observed. Looking beyond the borders of the boxes we usually check, a whole new language erupted. Phrases like tan-complexioned, high cheek-boned, pockmarked cheeks, a mess of dark unkempt curls, and slender build offered more vivid, textured datasets that not only brought patients to life in my documentation, but also offered clues to my patients' emotional and cognitive states. This practice felt true to the utility of an MSE without assuming I understood how my patient's appearance had affected his subjective experience. Medical research and clinical medicine continue to move away from using appearance as a proxy for genetics, meanwhile recognizing that racial identity and racism do have potent effects on clinical outcomes.[13] The approach offered here is a middle path that allows the whole of the patient to be present, neither eliminating racial/ethnic identity nor reverting to non-evidence-based, outdated understandings of biological race.

Race cannot be observed by others, it can only be claimed by an individual's lived experience. If race is assigned by those who assume based on what they observe, it reduces and morphs the lived reality. Identification is mediated by the communities a person has lived among, the racism that has impacted their family, and the cultural narratives they have internalized or struggled against. Identification comes out of the experience of a life lived in a skin, not the skin itself. Any attempt to deduce a patient's racial identity based on appearance will always be doomed to fail since any apperception of race will always be filtered through the clinician's own subjective groupings of humans and no two clinicians will share the same filters.

Most people socially identify with a racial or ethnic group and this is important to their experience of themselves, their world, and society's treatment of them. We can find out how a patient conceptualizes her racial identity, its development over her lifespan, and its impact on her mental health by simply asking. Undoubtedly, a patient's social identifications should be noted in our subjective assessments and critically factored into our formulations and treatment plans. I am not advocating washing away race, or its intersections with other social groupings such as class and gender, from our assessments; rather, I am encouraging us to adhere to true objectivity when we assert its use. Seeing clearly the patient before us, with all their complexities, contradictions, and social roles, while mindfully teasing apart what they are bringing to the interview room vs what lenses we are applying, are core features of good therapy and good science. Such attentive practice will help us to identify racial essentialism and eradicate it from our everyday practice.

Take Home Summary

A patient's racial or ethnic identity is not an objective fact that can be observed. Using concrete descriptive language in the appearance portion of the mental status exam avoids assuming a patient's racial identity, is truly objective, and eschews racial essentialism.

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Olivia Shadid, MD, is a second-year psychiatry resident with the University of New Mexico, Albuquerque. Her scholarly, advocacy, and forensic work is with migrant children and families fleeing persecution and seeking asylum. She is interested in how intercultural transitions and cultural categorizations, such as race and gender, affect mental health.

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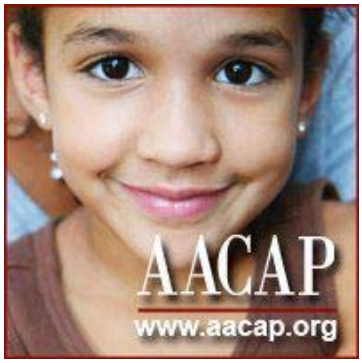

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