Diversify and Conquer: A Call to Promote Minority Representation in Clinical Psychology

Catherine E. Stewart, Sharon Y. Lee, Anders Hogstrom, and Monnica Williams, University of Connecticut

What Is the Problem? Why Should We Care?

The current racial makeup of the psychology workforce reflects systemic barriers to becoming a clinical psychologist. In 2013, the U.S. Census Bureau reported that 83.6% of active psychologists were White (U.S. Census Bureau, 2005–2013), which is consistent with the American Psychological Association’s (APA) report that 81% of their Society of Clinical Psychology members in 2015 were White (APA, 2015). APA members identifying themselves as Asian, Hispanic, or Black each comprised between 2–3% of the membership. Multiracial and American Indians each represent less than 1% of members and the remaining member identities were not specified. According to the U.S. Department of Education’s most recent statistics, 78% of full-time faculty at colleges and universities were White, and 84.1% of psychology faculty members were White (National Center for Education Statistics, 2008, 2016). In 2016, when ABCT members were asked to select a category describing their racial and ethnic background, 75.9% selected White (T. Schuler, personal communication, December 15, 2016). In 2013, approximately 37% of psychology bachelor’s degrees were conferred to students of color and 28% of Ph.D. degrees in psychology were awarded to students of color (National Center for Education Statistics, 2014a, 2014b), indicating a notable disparity in the representation of individuals majoring in psychology versus pursuing a career in clinical psychology. The underrepresentation of racial/ethnic minorities in the field is maintained by multiple factors that influence individuals, institutions, and organizations.

Increasing diversity is critical from the perspective of mental health treatment. People of color in the United States experience increased rates of some mental health problems, such as PTSD, that are further exacerbated by race-based stress (Carter, 2007; Jackson et al., 2004). Among individuals with access to evidence-based mental health care, people of color face greater barriers and utilize fewer services than their White counterparts (Alegría et al., 2002; Gary, 2005; Kataoka, Zhang, & Wells, 2002). Treatment is less likely to be evidence-based and more likely to be delivered by a non-mental-health clinician for treatment-seeking individuals of color (Sue & Zane, 2006; Young, Klap, Sherbourne, & Wells, 2001). Furthermore, ignoring cultural differences in assessment and treatment may contribute to increases rather than decreases in symptoms. Evidence suggests that adopting a colorblind approach and ignoring issues related to race and ethnicity contribute to greater racial bias and negative affect in Whites, as well as higher rates of internalizing symptoms in people of color (Constantine, 2007; Holoien & Shelton, 2011; Richeson & Nussbaum, 2004).

Additionally, clients of color may prefer a clinician of the same race, based on their own stage of ethnic identity development and cultural needs (Flicker et al., 2008; Pole, Gone, & Kulkarni, 2008). Therefore, it is necessary to increase the number of therapists of color as well as to continue promoting cultural competence among all psychologists.

What Caused and Is Maintaining the Problem?

The field of psychology has been impeded in its effort to diversify both its leadership and its client base. One explanation for this lack of diversification points to automatic cognitive biases on individual and systemic levels. Due to the automaticity of these biases, they often go unexamined and affect the way psychologists grow the field and the profession. Research has shown that even when people of color overcome logistical barriers to mental health care, such as insurance coverage, therapists are unwittingly more likely to select White clients (Kugelmass, 2016; Shin, Smith, Welch, & Ezeofor, 2016). This bias further encumbers access to people of color in need of services.

Bias also greatly affects all levels of the education system. Because of the structure of locally funded public schools and racial/socioeconomic segregation, a White student receives on average $334 more per year in recourses than a student of color (Spatig-Amerikaner, 2012). This difference in funding translates into differential quality of education for Black and White students (Hanushek, 2001). A related hurdle is the inherent privilege required to enter a clinical psychology doctoral program. Access to such programs is contingent on access to prior educational institutions (e.g., attendance at competitive colleges), financial resources (e.g., fees for the Graduate Record Examinations and applications), and mentorship (e.g., sympathetic faculty who support students’ professional development).

Ethnic/racial minorities tend to be at a disadvantage on all these dimensions. Pathological stereotypes, such as assuming that Black males on a college campus are criminals rather than students, hamper the efforts of minority students to access and feel belongingness in the ivory tower (Smith, Allen, & Danley, 2007). This may be one reason that minority students are less likely to attend a 4-year college and when they do, tend to drop out at disproportionate rates (Camera, 2015). With respect to financial means, minorities tend to have lower incomes compared to Whites and therefore are pressured to secure employment rather than sit out of the workforce for years while finishing a doctorate (with the exception of some Asian groups; Proctor, Semega, & Kollar, 2016). Concerns about employment are particularly salient for people of color, who experience higher rates of poverty; Whites have the lowest poverty rate (9.1%) compared to Blacks (24.1%), Hispanics (21.4%), and Asians (11.4%).

Finally, minorities may receive inadequate mentorship from members of the dominant society that reifies pathological stereotypes (e.g., encouraging a Hispanic student to seek blue-collar work rather than graduate education) or lacks necessary sociocultural support (e.g., failure to understand why a gay Black student has hesitations applying to programs in the rural South). Recent research by Milkman and colleagues (2014) illustrates that university faculty are more receptive to mentoring White male students compared to students from other groups, suggesting that entry into academia’s informal pathway is made particularly challenging for students of color.

Essentially, these race-related cognitive biases are influencing psychologists’ ability...
to provide mental health care as well as opportunities to diversify the field. By continuing to ignore or passively enable these biases, the individual and systemic decisions made by psychologists will continue to reflect these biases.

**What Needs to Happen to Fix the Problem?**

**Academia**

To address these systemic barriers, psychology programs and organizations should take meaningful steps to increase diversity at all levels. Hiring faculty from different cultural backgrounds and faculty who research diversity issues is imperative. The strong presence of diverse faculty implicitly communicates to potential graduate students of color that programs welcome them. As a consequence, more minority graduate students are likely to apply and be accepted into these programs. While having culturally similar mentors in psychology could benefit many undergraduate and graduate students of color, the paucity of minority psychologists makes this a chicken-or-egg problem. Therefore, White faculty will need to start mentoring more students of color if we expect to increase the diversity in our field.

With respect to academic training, faculty must discontinue teaching from a “colorblind” approach that ignores the intersection of race, ethnicity, gender, and culture in psychopathology (Terwilliger, Bach, Bryan, & Williams, 2013). By being champions of a more complex and integrated view of our clients and research participants, faculty can set an example for undergraduate and graduate students in terms of encouraging research from a multicultural perspective and fostering connections with different populations via psychotherapy (Miller et al., 2015).

**Working With Diverse Groups**

The study and application of clinical psychology requires recognizing the inherent diversity of the human experience. To adequately understand behavior and dysfunction, we must consider the individual’s culture, which incorporates race, ethnicity, language, religion, gender, sexual orientation, and other aspects of identity (Kagawa-Singer, Dressler, George, & Ellwood, 2015). One important way to promote diversity within psychology and strengthen the quality of the mental health care is to increase the diversity of mental health providers, educators, and researchers.

One important step is removing barriers to accessing psychological services for minority individuals. Common psychological treatments are often constructed by and for White individuals (Hays, 2009). The development of culturally sensitive interventions has been a slow process, in part because White psychologists have tended to undervalue (or not study at all) how cultural differences impact treatment outcomes (Williams, Tellawi, Wetterneck, & Chapman, 2013). As a result, psychologists of color have often had to complete this research on their own. This phenomenon is sometimes dismissed as “me-search” by White psychologists, many of whom ironically fail to recognize that by focusing their research on White samples, they too are engaging in “me-search” (Ray, 2016). The stakes are high: If an individual from a minority group encounters culturally insensitive therapies or hears about aversive experiences from peers of the same cultural background, they may believe that psychotherapy is an unwelcoming practice and may not pursue services. Therefore, it is important that all psychologists are trained in culturally sensitive intervention methods not only for therapeutic effectiveness (a worthwhile goal in and of itself), but also to demonstrate that psychology is an inclusive field.

Those with the highest unmet need for clinical psychologists’ services are best addressed with culturally competent and diverse practitioners. In clinical work as in life, individuals draw from their own experiences to understand individuals who present to them, and this is especially true in clinical interviewing (Granger, 2002; McKinnon, 2016). When clinicians have similar racial/ethnic backgrounds or experiences, this limits the degree to which they are able to understand their clients. Psychology as a field has a history of predominantly White practitioners and clients. To credibly portray that psychological interventions have the potential to help a more diverse group, psychology needs to demonstrate this in the expert clinicians and academics the field graduates who are developing interventions (DeLapp & Williams, 2015).

**Mentorship and Organizational Involvement**

It is also critical for currently practicing clinical psychologists from minority backgrounds to serve as mentors for the current generation, to both demonstrate the possibility of this career path and to offer emotional and practical support for overcoming the myriad of obstacles that minority individuals face in higher education. Within psychology there is a drop in the percentage of students of color between the undergraduate and graduate levels of study (National Center for Education Statistics, 2014a, 2014b). Psychology faculty can become more aware of their own racial biases when making decisions about undergraduate student mentees, research assistants, and graduate students.

Professional organizations, such as ABCT, have a unique responsibility to ensure representation of members from diverse groups, promote the training of culturally competent evidence-based clinicians and clinical supervisors, and encourage research that is relevant to clients of diverse backgrounds. To increase and diversify member involvement, organizations can provide resources that will benefit a broader array of trainees, clinicians, and client populations. Academic journals that are sponsored by an organization can make concerted efforts to report ethnographic demographics in papers and publish research that features diverse samples or examines cultural issues, such as this issue and past issues of the *Behavior Therapist*, as well as those of *Behavior Therapy* and *Cognitive and Behavioral Practice*. Such research on diverse populations is necessary to develop therapies for all clients, yet in one mental health organization’s flagship journal (Depression and Anxiety) over a 16-month period of 127 articles published, 53.5% did not report any demographic ethnographic information at all (Smith, Davis, & Williams, 2013). These omissions limit our understanding of psychopathology in diverse groups. Additionally, featuring panels and presentations at scientific conferences about the diversity gap in our field will continue to promote greater awareness and brainstorming for solutions.

Making these types of changes is easier said than done. While the modern American social and political climate purports to value diversity and inclusion, individuals continue to hold implicit biases which are often difficult for them to identify but may have large social impacts (Greenwald, Banaji, & Nosek, 2015). Perhaps as a result of this cultural shift away from explicit racism, White individuals (who continue to be overrepresented in political office; Krogstad, 2015) are often uncomfortable discussing the ways in which they perpetuate systemic inequality. In fact, many White individuals are uncomfortable even acknowledging that systemic racial
inequality still exists at all (DiAngelo, 2011).

Until privileged individuals acknowledge inequality as a current important problem, change will continue to be slow. Based on the most recent presidential election, many Americans do not prioritize treatment of minorities as a key issue when considering a candidate (Pew Research Center, 2016). This suggests that Americans as a whole may not be receptive to making changes to benefit minority individuals; this election has demonstrated that many Americans are comfortable at least overlooking racially charged rhetoric (not to mention the potential appeal of this rhetoric to many).

Notable Progress So Far

Despite these barriers to progress towards cultural competence and a multicultural view, some notable progress has been made. The APA’s continued emphasis on cultural diversity in training programs is a promising avenue for addressing these lapses in the field. Although not yet uniformly implemented, current APA accreditation requires cultural competence and diversity in all training areas for students and efforts to maintain a diverse faculty and student body (APA, 2016).

ABCT’s 51st Annual Convention Theme is “Applying CBT in Diverse Contexts” and aims to highlight research, clinical work, and training (ABCT, 2016a). ABCT maintains active special interest groups specifically for racial and ethnic minority groups. This includes African Americans in Behavior Therapy, Asian American Issues in Behavior Therapy and Research, Hispanic Issues in Behavior Therapy, and Native American Issues in Behavior Therapy and Research (ABCT, 2016b). Ethnic/cultural diversity is one topic area that can be selected by all podium presenters. Presenters at the most recent Annual Convention selected a total of 1,897 topic areas, with ethnic/cultural diversity was selected as a topic area 37 times out of 1,897 by presenters (T. Schuler, personal communication, December 14, 2016). ABCT as an organization, as well as clinical psychology as an entire field, is taking steps to demonstrate that diversity is important as a topic for research and clinical practice, and representation of diversity among psychologists in our field is a worthy goal.

Conclusion

While notable progress has been made, there is a clear gap in ethnic and racial diversity within psychology. It is critical to continue to address the lack of diverse members within our field in order to accurately reflect the population of U.S. and improve treatments. It is vital that privileged individuals within the clinical psychology structure and the broader American culture recognize the influence of culture and commit to working to address systemic barriers to education, access, treatment, and professional opportunity.

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Correspondence to Monnica Williams, Ph.D., Psychological Sciences Department, Bousfield Psychology Building, 406 Babcock Road, Unit 1020, Storrs, CT 06269; monnica.williams@uconn.edu

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