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A socioecological psychology of racism: making structures and history more visible

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Psychology has been accused of 'psychologizing' racism. Here, we summarize the argument that Psychology routinely neglects structural racism and historical legacies of racism. We then discuss two cases—healthcare and police use of force—in which studying individual bias could benefit from incorporating a focus on structures and history. We close by echoing others who have advocated that Psychology move forward with a better integrated view of racism; in particular, we suggest a socioecological view that contextualizes individual bias within the relevant realities of historical and structural racism.

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Has the field of Psychology 'psychologized' racism? Do we focus too much on individual bias and not enough on structural racism? Do we emphasize present barriers, while neglecting historical harms? We first summarize an argument—prevalent in Sociology, African American Studies, History, and Law—that Psychology routinely neglects structures and history. We then discuss two cases, in which studying individual bias could benefit from incorporating a focus on structures and history. We close by echoing others who have advocated that Psychology move forward with a better integrated socio-ecological view that contextualizes individual bias within relevant realities of historical and structural racism.

Psychologizing racism

Race is not a biologically meaningful category. It is a social construct. The use of race to classify people emerged at the end of the 17th century and was formalized as slavery transitioned from a transitory state to a permanent and hereditary one. By the early-to-mid 19th century, scholars used nascent theories of evolution to claim that the Negro was a separate and ancestral race, closer to apes, and that natural selection had eventually produced the more advanced European. More generally, Blacks were stereotyped negatively, as inferior. These beliefs were used to legitimize slavery and, later, continued discrimination and violence against oppressed people [1–3,4••,5–9].

Today, many people believe race is biological and this belief is largely independent from individual bias [10]. Indeed, this belief seems reasonable to many because race co-varies with physical features (e.g. skin tone). But, these physical features exist on a continuum and within-group variance is large [11,12,13••]. Race, then, is not *true*, it is not a scientifically defensible category; but it is *real*, it has real consequences because of racism.

Racism is "a system in which individuals or institutions intentionally or unintentionally exercise power against a racial group defined as inferior" [14]. Racism is thus a multi-level construct, from individual bias to institutional racism. Individual bias, or what Jones [15] calls "personally mediated racism", is defined as "differential assumptions about the abilities, motives, and intentions of others according to their race" and "differential actions toward others according to their race". Institutionalized racism, in contrast, is when racialized groups have differential social and economic opportunities and access to resources, upheld structurally by the laws, customs, institutions, and practices in a society [15].

To date, work in Psychology addressing racism has focused almost exclusively on individual bias. Indeed, the majority of social psychology textbooks characterizes racism as an individual-level problem, with a focus on stereotyping, prejudice, and discrimination [16]. To be sure, Psychology has contributed major insights. It has revealed the very real and often motivated ways in which whites easily and readily categorize, stereotype, dehumanize, and discriminate against people of color. But too often, it has failed to contextualize individual bias within the historically created and presently upheld structures [17,18••,19–21].

Two examples

Here, we discuss two cases, in which studying individual bias could benefit from incorporating a focus on structures

and history. We focus on healthcare and police violence because they have 'life and death' implications. They are two domains, in which Black people die at the hands of institutions, often in ways that are seen as acceptable and legitimate.

Healthcare

According to a 2016 National Healthcare Quality and Disparities Report. Black and Hispanic patients receive worse care on about 40% of healthcare measures collected [22]. Psychology has contributed to our understanding of these disparities; for instance, it has shed light on whether and how *physician bias* impacts healthcare. It has shown that physician bias does *not* always or systematically affect treatment decisions; rather, it affects the tone and tenor of physician–patient interactions, and undermines patient trust and compliance [23,24]. Some readers might conclude from this that racism contributes to racial disparities only a little and only indirectly (via patient trust). They might also come to believe that interventions ought to focus on Black patients and increasing their trust. Such a view, however, neglects historical and structural racism.

First, it ignores a history of scientific misconduct and its impact on patient trust and health. For instance, the Tuskegee Syphilis Study—a study in which Black men were unknowingly infected with syphilis—had measurable health impacts among the broader Black community. Research has shown that the disclosure of the study in 1972 is associated with a decrease in healthcare utilization, presumably due to decreased trust in the medical community, and commensurate increase in mortality among Black men [25••]. Strikingly, this relationship between the disclosure of the study and mortality was most pronounced for Black men living closest to the study site, regardless of whether they were a part of the study. For Black patients, then, physician bias is another piece of evidence that their mistrust is not misguided. Their mistrust is legitimate and grounded in a history of abuses.

Second, an individual-level account of disparities ignores continued adherence to racist ideology in the medical community. Indeed, biological beliefs about race continue to plague healthcare and medicine. The race-specific drug BiDil is a prime example [26]. BiDil was a drug tested in the African–American Heart Failure Trial and found to reduce heart failure significantly. Because it had been tested on African Americans, it was then patented for and marketed to African Americans only.[3] The argument was that race must be a proxy for biology. But race is not biological. Reinforcing race-as-biology has been scientifically and politically dangerous [26]. Scientifically, it has pushed science in the wrong direction, allowing innovation in medicine to treat race as biology. Politically, it focuses policy-makers, advocates, and activists on biological solutions to health disparities rather than policy solutions to racism [see also Ref. 27••].

Despite this history, medical school curricula continue to teach or at least imply that race is biological [28], and this may have serious consequences. For example, white medical students and residents who believe in biological differences between Blacks and whites (e.g. that Blacks have less sensitive nerve endings; that Blacks have denser bones) were more likely to report that Black patients feel less pain and require less pain medication [29••]. Perceptions that Blacks feel less pain do not appear to be consistently related to individual bias [30; *cf.*, 31]. Instead, many of the biological beliefs measured in the 2016 study can be directly traced to centuries-old beliefs that were used to justify slavery.

Third, an individual-level account of disparities ignores other structural barriers. In one telling study, researchers created an index of structural racism that included four dimensions, all known to reflect deeply entrenched institutional racism: (1) political participation; (2) employment and job status; (3) educational attainment; and (4) judicial treatment. They found that higher levels of structural racism were related to greater odds of myocardial infarctions among Black but not white residents [32]. More broadly, research has shown that the most fundamental form of structural racism—segregation—affects health [33,34]). It restricts economic and employment opportunity [33,35], which indirectly affect health by restricting access to resources (e.g. food, medicine, healthcare). It also affects health by directly restricting access to food [36], pharmacies [37], and physical and mental health services [38,39].

Taken together, this work makes clear that racial disparities in healthcare are not just the result of physician bias, but long-held narratives about the Black body and persistent structural racism. Redressing disparities will, thus, require not only increasing patient trust but challenging long-held narratives and upending structural racism. Moreover, increasing patient trust may require more than reducing physician bias. It will likely require some reconciliation process for contending with a history of abuses.

Police use of force

According to the Department of Justice, police officers are over three times more likely to shoot a Black (versus White) person. In some counties, police officers are 20 times more likely to shoot a Black person [40]. Early work on outgroup threat, ingroup favoritism, and intergroup empathy (or the lack thereof) laid the foundation for thinking about individual bias as a cause. Then, seminal work showed that lay-people are biased to 'shoot' unarmed Black (versus White) men in a simulated shooter

[3] Notably, drugs tested on White Americans are routinely patented and marketed to all people, regardless of race.

task. This work provided initial evidence that individual bias—conscious or not—might play a role in police shootings of unarmed Black men [41]. But subsequent work has shown that police officers may not reliably exhibit this individual bias [42–45]. Some readers might conclude from this that racism is not a major contributor of police shooting disparities and that claims of racial discrimination are guided by ideologically driven anti-police sentiments. But again, such a view neglects historical and structural racism.

First, it ignores a history of abuses by police. The modern police force stems from Slave Patrols and Night Watches in the American South, and constables in New England [46,47]. These institutions all had one common purpose: to control people of color and maintain the social, cultural, political, and economic order; in other words, to maintain white supremacy. Second, it ignores continued abuses and adherence to racist ideology. The Department of Justice made this clear in its 2015 report of the Ferguson Police Department [48]. They wrote, "Ferguson's police and municipal court practices both reflect and exacerbate existing racial bias . . . Ferguson's own data establish clear racial disparities... The evidence shows that discriminatory intent is part of the reason for these disparities". Some research shows this too. It has shown that police officers who associate Black people with apes are more likely to use force against Black juveniles [49••]. It has also shown that police officers are more likely to disrespect Black (versus white) community members [50]. And third, an individual-level account of disparities ignores other structural barriers. In one telling study, researchers created an index of structural racism that included five dimensions: (1) residential segregation, (2) disparities in incarceration rates, (3) education disparities, (4) economic disparities, and (5) employment disparities. They found a strong relationship between structural racism and police shootings [51••; see also Ref. 40].

Taken together, this works make clear that police shootings are not or not just the result of individual bias, but a history of institutionalized violence and current prevailing conditions including residential segregation. Redressing these disparities will require challenging structural racism. Moreover, increasing community members' trust in police may require more than behavioral change among officers; it will likely require a reconciliation process for contending with a history of abuses.

Making structures and history more visible

Focusing on individual bias reduces racism to people; it 'naturalizes' prejudice, legitimizes race, and minimizes racism [16,19,27••,52,53]. Focusing on the social context—history and structures—is necessary. The social context has always been central to psychology and social psychology in particular [54]. Socioecological psychology—the science of how individuals are shaped by their social environments and, in turn, how these environments shape individuals—provides a compelling framework for broadening that focus once more [55; see also Ref. 18••]. From a theoretical perspective, it invites us to (A) broaden theory to consider history and structures; and then (B) identify psychological mechanisms and phenomena that connect history and structures to outcomes [e.g. 49••]. From a methodological perspective, it suggests a multipronged approach. To study individual and institutional racism, we can (1) measure exposure to systems and structures, and test associations with psychological mechanisms and outcomes [e.g. 51••]; (2) manipulate salience of historical harms or systems [e.g. 56]; and (3) leverage 'natural experiments' [e.g. 25••].

Psychologists are uniquely poised to do this work—in collaboration with historians, legal scholars, African American studies scholars, sociologists, economists, and others—and illuminate how individual bias *in the context of history and structures* contributes to disparities. Psychologists will then be in a position to contribute to conversations about implicit bias training, cultural competency training, and intergroup interventions, and also police reform, healthcare reform, and desegregation efforts. They will then have a seat at the policy table.

Conflict of interest statement

Nothing declared.

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