

## Medical-Mistrust by the Black-American Population: Significance in Pediatrics and the Aggregate of Medicine

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### Abstract

Medical-mistrust adversely affects health-seeking behaviors, and thus, health outcomes in the Black-American population. The Black-American population's overall unfavorable health outcomes ultimately increase social service and healthcare costs, and are a financial and emotional burden to family members of affected and afflicted patients. Medical mistrust is driven by cultural distrust, born out of racism and cultural oppression, targeting the destruction of Black-American collectivism, cultural estrangement, and spiritual alienation. Racism breeds a disproportionate hardship of sickness and untimely death in racial and ethnic minority populations.

Beginning at the time of slavery, Blacks in America incurred a mistrust of White people and White culture. Historically, Blacks in America have suffered from unethical and egregious studies, experimentations, and eugenics, which have fixed a mistrust of medicine in most Black-Americans' psyche. The destructive effects of racism and cultural oppression result in adverse psychological and physiological health outcomes for Black-Americans.

More current racial events (like the death of a Black youth and citizen at the hands of White police) perpetuate the cultural divide and medical-mistrust. A White person might view such a crisis as a singular or isolated event (and respond indifferently or remain to some extent unconcerned); whereas, a Black person—after hundreds of years of abuse—might respond differently with mistrust.

Thus, medical professionals and personnel need to adjust their perspectives to include this particular Black-American mindset and viewpoint. The Black-American pediatric patient population and parents, grandparents, and guardians may harbor cultural-distrust and medical-mistrust. Pediatricians, physician assistants, nurse practitioners, and support staff must be keenly aware of this mistrust. As a whole, medical practitioners need to act, consult, and treat Black patients with understanding, compassion, and patience to achieve better outcomes by nurturing positive and productive doctor-patient relationships.

**Keywords:** *Allostatic Load; Black-American; Biopsychosocial; Cultural-Mistrust; Cultural Paranoia; Racism; Tuskegee*

### Abbreviations

HbA1c: Glycated Hemoglobin; HDL: High-Density Lipoprotein; QoL: Quantity of Life

### Introduction

#### Foundations of cultural-mistrust

This study's theoretical framework is cultural-mistrust, resulting in the mistrust of western medicine by the Black-American population [1]. Elements of the model of "cultural mistrust" were first developed in 1968 by theorists, Grier and Cobbs, who researched inner conflicts and desperation in Black life in the United States. As clinical psychiatrists, they qualitatively interviewed numerous Black male and female victims of racism. Grier and Cobbs (1968) proposed that Blacks in America had developed a profound distrust of White citizens. This distrust was labeled "cultural paranoia" [2 (p178)]. Moreover, they concluded that Black people had developed a psychological need to label every White man as a potential enemy in order to survive in a hostile environment. This adaptive protective contrivance likely originated during slavery to cope with the physical and mental torture thrust upon African people in America [2,3].

Terrell and Terrell (1981) furthered Greer and Cobb's theory, developing four distinct constructs of White-distrust by Blacks. According to the researchers, Blacks harbor White-distrust in education and training, interpersonal relations, business and work, politics, and law. They also posited that this distrust was more of a cultural-mistrust than paranoia [1,4,5]. Thus, "cultural mistrust" has been adopted as the term describing the predisposition of Blacks to doubt Whites.

Numerous studies have utilized cultural-mistrust as a conceptual framework for their research. Benkert, *et al.* (2006) hypothesized that perceived racism influences cultural-mistrust, adversely affecting the patient-provider relationship [6]. Cultural-mistrust was also shown to adversely affect Blacks' health-seeking behaviors regarding mental health needs [7-11].

Hospice care [12,13] and research [14-16] are adversely affected by the Black-American population's cultural-mistrust paradigm. The Black-American community underrepresents hospice care and research participation due to cultural-mistrust [13-15,17-20]. The fundamentals of cultural-mistrust can be extended to the distrust of entire healthcare systems [21]. Thus, cultural-mistrust serves as a guide for understanding the health-seeking behaviors of the Black-American population.

#### Cultural-mistrust: linear and curvilinear

Bell and Tracey (2006) deduced and defined cultural-mistrust into two categories: linear and curvilinear [22]. Linear-mistrust, like Grier and Cobb's (1968) "cultural paranoia theory", ascribes that all Blacks must mistrust Whites to have a healthy, albeit protective psyche. Curvilinear-mistrust allows Blacks to assess and identify dangers per specific situations and circumstances. In other words, curvilinear-mistrust allows the individual to assess whom to distrust and not to distrust based on interactions between the individuals involved in a specific situation. According to Bell and Tracey (2006), curvilinear-mistrust is a more optimal and psychologically healthier form of distrust than linear-mistrust. They postulated that mistrusting every White person takes a psychological toll on Blacks; thus, linear-mistrust might be more harmful than curvilinear-mistrust [22]. For instance, linear-mistrust prevents Blacks from seeking health-care at a rate on par with national averages.

At the time Grier and Cobbs (1968) formulated their theory of cultural paranoia, the United States' racial climate was at a crossroads. Antagonistic racial events across the nation manifested in riots in Washington, DC, New York City, and Baltimore, Maryland, and dominated the mood of the country [23]. In part due to the assassinations of civil rights leader Martin Luther King, Jr., and presidential candidate Robert Kennedy, newly introduced civil rights laws and social unrest further agitated the racial climate in the nation [24,25].

At that time, the linear-mistrust of White-Americans by Black-Americans might have served as a more pragmatic defensive mechanism for Blacks-Americans. However, younger Black-Americans have been reared in and exposed to a more diverse and racially-interactive society. Thus, they may harbor less cultural-mistrust of Whites than older Blacks [26].

The study of cultural-mistrust is appropriate as it offers insights into health-seeking behaviors, interpersonal relationships, medical-mistrust causes, distrust, and health disparities in the Black-American community [1,2,27,28]. The theoretical concept of cultural-mistrust has its origin in Grier and Cobbs' research, circa 1968.

According to Grier and Cobbs (1968), Blacks in America have developed a mistrust of White people and the White culture. During slavery, White society constructed an environment that was hostile to Blacks. This unwelcoming, oppressive, and threatening environment caused Blacks to develop cultural paranoia that manifested in self-destructive and detrimental characteristics and behaviors [2,5]. Some of the Black population's self-destructive and detrimental behaviors can be attributed to discrimination and racism [29].

According to Williams (1987), the destruction of the collective Black psyche has been an extensive undertaking and experiment, affecting aspects of Black life. Under scrutiny, cultural-mistrust was built upon two primary constructs; racism and cultural oppression [2,25,30,31].

### **The construct of racism in cultural-mistrust**

Since the time of slavery in the United States, racism has prevented Blacks from seeking healthcare and utilizing medical services on the same level as the rest of society. According to Clark, *et al.* (1999), racism is defined as "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" [32 (p805)]. Thus, racism is perpetuated by beliefs and attitudes formulated by Whites against the African phenotype. Racism caused White people to act in an inhumane manner towards people of African descent. Cultural-mistrust developed from physical and mental abuses against Blacks [6].

Gabbidon (2006) and Jones (2000) described racism as existing on three levels: institutional, personal, and internal. Institutional racism constitutes access to power and control of resources [33,34]. Access to power has historically been denied to Blacks in voting, government, policies, media, infrastructure, and wealth accumulation [33]. The deprivation of resources concerns fair housing, employment, equal education, and adequate medical care [34]. Jones (2000) defined personal racism as "discrimination and prejudice" [34(p1212)]. These behaviors manifest as undue suspicion, lack of respect, avoidance, and devaluation of Blacks and their culture [35].

Internal racism [34] or cultural racism [33] are caused by accepting negative inputs from the dominant group, adversely affecting the minority's intrinsic worth. It is the acceptance that White culture is superior to Black culture. This acceptance causes Blacks to tend to view themselves in a negative light [24]. The feelings of hopelessness, anguish, and desperation can cause Blacks to engage in self-destructive and detrimental behaviors, such as drug use, violence, and unsafe health practices [2].

Racism contributes to health disparities in Black-Americans. Thomas (2001) postulated that racism causes "an unequal burden of illness and premature death experienced by racial and ethnic minority populations" [36 (p1046)]. According to Clark, *et al.* (1999), racism should be dissected into a "biopsychosocial model" when inquiring about Black health [32].

Consequently, there are three general assumptions regarding the biopsychosocial model. First, racism inflicts stress that can cause adverse "biopsychosocial" health outcomes for Blacks. Second, various coping responses, secondary to the perception of racism, may explain poor health outcomes in Blacks. Third, if racism is the determining factor for poor health outcomes in Blacks, then prevention and interventional tools must be developed that consider the untoward effects of racism [32].

A suspected racist environment can trigger physiological and psychological responses, influencing behaviors, socio-demographics, and coping responses in Blacks [1,2,25,32,37,38]. In turn, these responses can adversely affect health outcomes in those individuals. Clark, *et al.* (1999) further indicated that health behaviors and outcomes are influenced by the moderator and mediator variables within

a biopsychosocial paradigm [32]. Moderator variables consist of constitutional, socio-demographic, psychological, and behavioral factors. Mediator variables comprise racism as a perceived stressor, coping responses, psychological responses, and health-outcome stress responses [6,30,32,37,39].

### **Moderator variables caused by racism**

Constitutional factors are environmental events that influence the relationship between health and outcome. Racist events have been linked to increased blood pressure in Black women. McNeilly, *et al.* (1995) described how racial confrontations between White and Black women negatively impacted Black women's blood pressures. The study concluded that racist stimuli caused an elevation in heart rate and blood pressure in Black women. Permanent hypertension could become a long-term negative effect of such racist stimuli [40]. Moreover, constitutional factors might increase the likelihood of poor health outcomes in the affected group.

Socio-demographic factors include education, age, gender, socioeconomic status, and health insurance coverage. Disparities in these factors cause additional stress in Black-Americans' lives, leading to hardship and psychological distress and resulting in self-destructive and detrimental behaviors. Many Black-Americans lack health insurance. The lack of health insurance results in diminished health-seeking behaviors and increased stress [41]. This added stress depreciates health status: an increase in poor health outcomes and low quality of life (QoL) occur secondary to the compounded pressure of socio-demographic stressors [33].

Behavioral and psychological factors consist of low self-esteem, perceived lack of control (autonomy), anger, inhibited expression, emotional suppression, neuroticism, and hostility [2,30,32]. Environmental stimuli of racist events precipitate these behavioral mechanisms. How the individual copes with such events determines the degree of psychological harm to that person. Some negative psychological changes in Blacks are made manifest in diminished health status [42]. Some Black-Americans develop depression secondary to a racist environment [10,43]. Blacks tend to respond poorly (psychologically and behaviorally) to a variety of racist stimuli.

### **Mediator variables caused by racism**

Perceived racism stressor is the subjective experience of discrimination or prejudice sensed by an individual [32]. Blacks perceive racism differently as it relates to normal, everyday life. Some Blacks, for example, perceive racism in 1) education and training, 2) interpersonal relations, 3) business or work environment, and 4) politics and law [1]. These perceived racist environments contribute to adverse health outcomes by increasing the level of stress responses or coping mechanisms in Blacks [37].

### **Coping mechanisms of the racism-stress response**

According to Clark, *et al.* (1999), there are two types of coping mechanisms used commonly by individuals under stress: maladaptive and adaptive [32]. Maladaptive coping responses are commonly used when a racist environmental stimulus triggers a psychological (such as anger) or physiological stress response. An adaptive coping response reduces the likelihood of an intractable event through avoidance [33]. Accordingly, the individual understands that the racist environmental stimulus will cause them stress; therefore, they avoid it. For this reason, cultural-mistrust is primarily an adaptive response that protects the individual from psychological and physical harm [1,2,33,44,45]. Both maladaptive and adaptive coping mechanisms influence the intensity of psychological and physiological stress responses [32,46].

According to Grier and Cobbs (1968), psychological and physiological stress responses are ways that Black-Americans respond to racism through various reactions, including anxiety, anger, paranoia, frustration, fear, and resentment [2]. These behavioral responses have

caused Black-Americans to develop a set of demeanors that evoke feelings of depression, helplessness, hopelessness, and distrust [1,2]. These stress responses provoke unfavorable health activities, habits, and outcomes.

### **Allostatic load: a predictor of physiological deterioration**

Carlson and Chamberlain (2004) noted that Blacks experience adverse physiological events due to racism [47]. Karlamangla, *et al.* (2002) posited that ten health indicators could predict physiological deterioration according to stress [46]. The researchers defined these ten health indicators as “allopathic load”: diastolic blood pressure, systolic blood pressure, cholesterol ratio, waist/hip ratio, total cholesterol/ high-density lipoprotein (HDL), urinary cortisol, dehydroepiandrosterone-S, glycated hemoglobin (HbA1c), urinary epinephrine, HDL cholesterol, and urinary norepinephrine [46]. When stress causes three or more of these indicators to increase beyond their normal physiological ranges, adverse health conditions result.

Carlson (2004) stated that allostatic load could lead to an increased risk of morbidity, new cardiac events, a decline in physical functioning, decreased cognitive ability, and mortality. Further, the researcher showed that stressful racist events are possible contributors to increased mortality and morbidity within the Black health spectrum [47].

Health outcomes due to racism are associated with various symptoms. Barksdale, *et al.* (2009) and Watkins, *et al.* (1989) found that discrimination and racism contribute to an increase in mental health stress in Blacks [10,48]. Paradies (2006) performed a meta-analysis of 138 quantitative studies that investigated self-reported racism and health. The study discovered a strong association between self-reported racism and poor health in oppressed racial groups [43]. The strongest correlation between racism and poor health was in mental health. The researcher concluded that racism causes negative mental health issues in minorities [43].

Racism causes Black-Americans to increase adverse health events due to added stress, resulting in health disparities for Blacks. All age groups in the Black-American community are affected by racism. Cultural-mistrust helps Black-Americans cope with the cruelties of racism by mentally preparing them to manage a hostile environment [49]. Coping with racism is only one facet in the formation of cultural-mistrust. Cultural oppression promotes the same damaging effects as racism; however, it occurs due to a distinctive dynamic.

### **The construct of cultural oppression in cultural-mistrust**

According to Schiele (2005), cultural oppression includes inequality, suppression, interpretations, and domination by a culture other than the indigenous ethnic group. As such, Black-Americans have been adversely affected by cultural oppression in three distinct areas: 1) cultural estrangement, 2) destruction of the Black collectivism, and 3) spiritual alienation [25].

#### **Cultural estrangement**

Cultural estrangement involves the severing from a people of ancestral contributions, traditions, and customs. This estrangement results in a loss of group history and tradition, vital for a healthy cognitive identification [31]. The systematic suppression of African history and loss of cultural customs have harmed and impaired Black-Americans. The destruction of a group’s traditions, customs, and values results in a lack of self-esteem and self-confidence, and promotes servitude to the dominant culture [24,25,50]. This systematic cultural estrangement has blocked many Black Americans from maintaining well-adjusted mental health.

European and African cultures clash when it comes to customs and traditions. The European culture is based more on individualism, competition, and materialism [25,51], whereas, African culture is more adjusted towards spirituality, family, life-balance, and human nature [23,51,52]. As the dominant White culture suppresses African culture, Blacks lose their human particularity essential for positive group potentiality [25].

Black-Americans' loss of traditional African culture has resulted in a social structure that is a mixture of African traditionalism, European values, and historical experiences within the United States [52]. Thus, Blacks have suffered damaging psychological effects from this incongruous contemporary mixture.

Wallace and Constantine (2005) noted that a person's culture serves to validate and provides a sanctuary for an individual's and a group's mental wellness [52]. With the loss of African culture, Black-Americans have no means or system to foster mental uplift or potentiality [25]. This loss of cultural identity results in psychological distress, self-concealment, and low self-esteem [49,52,53]. The loss of cultural group purpose has adversely affected Black collectivism.

### **Destruction of Black-American collectivism**

During the era of slavery, Blacks were forbidden to organize for group betterment. This prevention of a collective-cohesion was brought on by inequalities in access to education, cultural pride, healthcare, social status, and wealth [24,54]. This form of cultural oppression perpetuated individual achievement over group collectivism [54]. Thus, many Black-Americans have taken on the Eurocentric cultural values of individualism and materialism [25]. The dismantling of Black-American collectivism has resulted in Blacks being disunited in group efforts for a collective betterment.

The Civil Rights and the Black Power movements of the 1960s could have functioned as more powerful movements if combined [23,51]. However, the movements were unable to function coherently due to outside forces exerted by White society [31]. Government agencies served to disrupt or suppress any forms of unity or Black collectivism that could have resulted in more constructive social outcomes for Black-Americans [23].

The lack of group collectivism also prevented the Black-American community from addressing health disparities within its population [53]. Obesity, hypertension, and other disorders and illnesses are disproportionate in the Black-American community, and are not addressed collectively. The collective group effort is thwarted in solving health problems in the Black-American community [53].

### **Spiritual alienation**

Cultural oppression is also manifested by spiritual alienation. Spiritual alienation was first described by Schiele (1996) as the "disconnection of nonmaterial and morally affirming values from concepts of human self-worth and the character of social relationships" [25 (p289)]. Consequently, Blacks view themselves as fragmented and disconnected from their indigenous supreme being. Black-Americans have been forced to accept a deity other than their primordial own. The effect of this spiritual alienation results in foreign morality that is seen through the eyes of others. According to Aten., *et al.* (2011), Christianity is now the primary religion of the Black-American community [55]. However, African captives, brought to North America for slavery, were mainly Islamic or of traditional African faith [23,31,53,56]. Thus, the original Africans brought to North America have been alienated from their original belief system.

This spiritual alienation has resulted in the acceptance of racist ideologies integrated into Eurocentric religions. For instance, slavery was justified as a punishment for Blacks by God [23]. According to some religious texts, Blacks are viewed as inherently evil [25]. Thus, spiritual alienation can perpetuate harmful effects by causing Blacks to view themselves negatively compared to others. These negative effects manifest as feelings of hopelessness, distrust for others (cultural-mistrust), and depression [1,2,44]. These contrary feelings result in poor health outcomes, due to a poor self-image that diminishes health-seeking behaviors, hope and trust in medicine (and the practitioner), and treatment compliance [50,53,56].

### Summary

The Black-Americans' distrust of medicine and medical practitioners originates in cultural-mistrust. The primary components of this distrust are the paradigms of cultural-mistrust and racism spurred by cultural oppression. Both paradigms contribute to changing the behaviors and interpersonal relationships that Black-Americans have with other groups [45]. The injurious effects of racism and cultural oppression result in adverse psychological and physiological health outcomes for Black-Americans.

Pieterse (2012) conducted a meta-analysis of 18,140 studies, published between January 1996 and April 2011, on the association between racism and mental health among Blacks. Using a random-effects model, the researcher determined a positive correlation between perceived racism and psychological distress ( $r = .20$ ). Further, a moderation effect for psychological outcomes, such as anxiety, depression, and other psychiatric symptoms, were associated with racism as a stressor [57]. Cultural oppression and racism adversely impact Black health status [1,2,25,32,33,39,43,44,46-49,52,53,57].

According to a seminal work by Pruitt and Kerna (2020) titled, "400 Years of Reasons: Medical-Mistrust by the Black-American Population (and Its Adverse Effects on Healthcare Outcomes and Cost to Society)", unethical studies and eugenics experiments on Black patients (the most notable and despicable of which was the Tuskegee Syphilis Study) embedded medical-mistrust into the Black-American psyche [3]. This deep-rooted mistrust of medicine has been forged by the flames of cultural-mistrust (racism, and cultural oppression: cultural estrangement, destruction of Black collectivism, and spiritual alienation).

The resultant effects of the historical tragedies of slavery, unethical studies, experiments, and eugenics are perpetuated and compounded by contemporary racial and political events (such as the death of a Black man at the hands of White police). Wherein, a White person might view such a contemporary crisis as a singular or isolated event (and respond indifferently or remain to some extent unconcerned), a Black person—after hundreds of years of abuse—might respond differently with mistrust. White society, especially medical professionals and personnel, need to adjust its perspective to include this particular Black-American mindset and viewpoint.

In the United States, the disparity in health status and health-seeking behavior should not be viewed as a Black-only phenomenon in a multi-culture collective. What has happened to (and continues to happen to Blacks) in this disparaging regard can happen to any ethnic minority and even a White sub-group (unemployed, disabled, or otherwise disadvantaged). Nomel and Kerna (2019), in "The Ghost of Tuskegee and the Persistent Distrust of the U.S. Healthcare System by African Americans", concluded: "The sequelae of slavery and Jim Crow pervade in domains like healthcare. Racism remains a relentless factor in how people of color are treated in our medical facilities. The Tuskegee Syphilis Experiment has cast a long and long-standing shadow of distrust by many African Americans of the U.S. healthcare system, seeing it not as an angel guiding them to the gates of a healthcare 'heaven' but as a ghoulish dragging them through a hell of sickness and disease until a suffering death. Such historical tragedies, as occurred in Tuskegee, should not be forgotten, so they will not be repeated ..." [58].

Black-Americans are fundamental and vital threads in the tapestry of historical and contemporary America. Nevertheless, they suffer poorer health outcomes than the general population due to destructive health-seeking behaviors and the underutilization of medical services based, in large part, on their mistrust of Western medicine.

### Conclusion

Low healthcare status in the Black-American population occurs primarily from medical-mistrust by that group. Poor health outcomes result in increased costs to society and a burden to involved family members, and perpetuate the cultural divide between Black-Americans and White-Americans and avoidable illnesses, deaths, and despair.

The pediatric patient population consists of persons age 0–18 years and involves parents, grandparents, and more advanced-age guardians. Thus, pediatricians, physician assistants, nurse practitioners, and support staff must be keenly aware of Western medicine's mistrust that has been ingrained in the psyche of the Black-American population and individuals. Medical practitioners in aggregate need to act, consult, and treat Black patients with understanding, compassion, and patience to achieve better outcomes by nurturing positive and productive doctor-patient relationships—without which, many public health programs and initiatives (intended to solve health disparities) will fall short of the mark or fail altogether.

### Conflict of Interest Statement

The authors declare that this paper was written in the absence of any commercial or financial relationship that could be construed as a potential conflict of interest.

### Supplementary Information

The authors intend to publish several interdependent papers on this topic—this being one of them. These research papers will be made available through E-Cronicon of the United Kingdom by the same team of researchers and authors. This paper is based on prior doctoral research: Pruitt K.D. (2013). "Medical Mistrust According to Age in the Black Population" (unpublished doctoral dissertation). Walden University. Minneapolis, Minnesota, USA.

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