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ORIGINAL PAPER

# Young African American Men and the Diagnosis of Conduct Disorder: The Neo-colonization of Suffering

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**Abstract** Existing research attributes the disproportionate number of young African American men diagnosed with conduct disorder to a variety of factors but does not adequately incorporate historical, social, or political analysis. Utilizing the perspectives of Michelle Alexander and Joy DeGruy this article considers how historical stereotypes of Black men influence this diagnostic pattern and examines how slavery and its legacy impact the clinical practice of psychological assessment today. The way in which a client's behavior is defined leads to specific treatment, and thus it is necessary to investigate the psychological models used for assessment and diagnosis as well as explore alternative ways to understand behavioral "symptomology" among young African American men. The purpose of this project is to encourage clinicians to consider how they define the healing and suffering of their clients and to encourage the incorporation of social and historical analysis into their psychological assessment and diagnosis process.

**Keywords** African-American · Conduct disorder · Males · Clinical practice · Diagnosis · Treatment

## Introduction

It is well established that young African American men are currently overrepresented among those diagnosed with conduct disorder and that this likely reflects institutionalized racism within psychological clinical practice. Furthermore, cultural histories that might mitigate biased perspectives are rarely taken into account when assessing for or making diagnoses within a multicultural context. Thus, the primary purpose of this paper is to use the diagnosis of conduct disorder as an exemplar of the social and cultural complexities of such disorders and to expose the urgent need within the field of clinical work to diversify the ways in which we understand another's suffering. This can be achieved by employing more sophisticated discourses that contextualize "symptoms" within a historical Afrocentric framework so the suffering is understood on its own terms and not "colonized" by mainstream Eurocentric models of clinical practice.

Within the last decade, researchers such as Feisthamel and Schwartz (2009) and Mizock and Harkins (2011) have presented various hypotheses about the causes of this phenomenon and proposed potential solutions. We wish to explore the hypothesis that the high rate of conduct disorder diagnoses among young African American men is in part due to the use of psychological models that lack adequate integration of historical and social factors during the process of psychological assessment (e.g., case conceptualizations, intake procedures, treatment plans, psychological testing) and diagnosis. In addition, we also intend to show how this hypothesis is supported by the recent work of Alexander (2012) and DeGruy (2005) and what the implications may be for clinical practice in the future.

Conduct disorder is a *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.; *DSM-5*; American

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Psychiatric Association (APA) 2013] diagnosis with criteria including a disturbance in behavior that causes clinically significant impairment in social, academic, or occupational functioning. Conduct disorder is associated with oppositional defiant disorder (ODD) in younger children and antisocial personality disorder (APD) in adults (APA 2013). All three diagnoses are behavioral descriptions of what was once simply labeled "psychopathy," and an assessment for psychopathy can still be included when a conduct disorder or APD diagnosis is made (Salekin 2002). Historically, APD and psychopathy were considered intractable and resistant to treatment. This belief still lingers within both the clinical and nonclinical domains (Salekin 2002). As conduct disorder is a necessary prerequisite for an APD diagnosis, this may increase the stigma associated with conduct disorder.

Significantly, the *DSM-5* (APA 2013) includes a caveat that encourages clinicians to consider the environment in which the behavior takes place: "Conduct disorder diagnosis may at times be potentially misapplied to individuals in settings where patterns of disruptive behaviors are viewed as near-normative (e.g. very threatening, high-crime areas or war zones). Therefore, the context in which the undesirable behaviors have occurred should be considered" (p. 474). This formal, mandated focus on environmental factors is of central concern when exploring the disproportionate number of young African American men among those diagnosed with conduct disorder, as African Americans—particularly young men—are also more likely to be the victims of violent crime (Harrell 2015).

## Definition of Terms

In a theoretical exploration of a phenomenon that is based upon demographic markers related to race and gender, it is essential to acknowledge the subjective nature of these descriptors and to present operational definitions. The majority of the researchers of the reviewed literature fail to define who counts as "African American" or "White" in their studies, thereby compromising their results as well as reifying unscientific and non-specific definitions of race. To avoid this, we will operationalize the terms "Black" and "African American" (used interchangeably throughout this paper) to refer to someone who is or may be perceived as such and who therefore is likely subject to prejudice. While these labels may most often be applied as the result of skin pigmentation and/or facial features, other factors may also come into play such as form of dress, accent or dialect, or other cultural elements often connected to socioeconomic status. This paper assumes that if one is perceived to be Black then one is potentially impacted by stereotypes and discrimination.

## Limitations of the Current Analysis

As White female clinicians and researchers, we are in many ways operating from a Eurocentric perspective, and thus we must rely upon the accounts, writings, and theories generated by those more directly impacted by the overdiagnosis of conduct disorder. As White people in the United States, we inherently have, at the very least, an unconscious investment in racism, as many of the privileges to which we have had access (education, resources, employment) are a direct result of racism. While we make consistent and conscious attempts to be aware of our privilege and to make choices in discourse that do not further racist epistemologies, the benefits we receive from this system, the privileges we have as White people, and our overall racial socialization within the current racial hierarchy are potential limitations to our research. Therefore, our primary theoretical frameworks are rooted in the work and perspectives of African American scholars.

## Gaps in the Literature

While research on the overrepresentation of young African American men among those diagnosed with conduct disorder is extensive, analysis related to the social and historical context of African Americans in the United States is missing from the reviewed literature. For example, Mizock and Harkins (2011) outline various factors that contribute to the high rates of conduct disorder diagnoses among young African American men, including the impact of racial discrimination, exposure to violence, and low socioeconomic status. Significantly, they do not discuss the impact of history, such as the legacy of slavery, and its associated social and political consequences on young African American men today. Although Feisthamel and Schwartz (2009) cite "social adversity" as one possible cause of conduct disorder, they do not mention historical factors in their analysis (p. 55). This paper expands upon existing thought about possible causes of this phenomenon and provides a missing perspective by combining clinical theory with historical and social context.

## Race-Based Diagnostic Patterns

Historically, African American people have been under- and over-represented among those who receive various diagnoses. For example, decades of research indicate that African American men have been overrepresented among those diagnosed with schizophrenia and conduct disorder and underrepresented among those diagnosed with affective disorders (Adebimpe 1981; Alegría et al. 2008;

Cameron and Guterman 2007; DelBello et al. 2001; Fabrega et al. 1993; Feisthamel and Schwartz 2009; Kilgus et al. 1995; Mandell et al. 2007; Neighbors et al. 2003; Wu et al. 1999). We do not argue for or against specific diagnoses, but we consider this research relevant because the incorporation of social and historical analysis into the psychological assessment and diagnostic process may affect these patterns. The structural development of the *DSM-5* (APA 2000) occurred partially as the result of widespread acceptance that the 5-axis system in combination with behaviorally focused criteria generated diagnostic consistency and avoided clinician bias across theoretical orientations and professional disciplines (Pottick et al. 2007). Yet, despite this acceptance, research consistently demonstrates that a client's race and ethnicity are commonly correlated with specific diagnoses (DelBello et al. 2001; Feisthamel and Schwartz 2009; Kilgus et al. 1995; Neighbors et al. 2003; Pottick et al. 2007).

Researchers have hypothesized about the variables that contribute to these race-based outcomes, ranging from the misinterpretation of symptoms due to clinician bias to the possibility that people of particular ethnic backgrounds genuinely experience higher rates of certain conditions (Adebimpe 1981; Cuffe et al. 1995; DelBello et al. 2001; Mizock and Harkins 2011; Feisthamel and Schwartz 2009; Kilgus et al. 1995). The latter conclusion, however, does not acknowledge the impact of institutional, clinician, or referral bias, and considering the extensive history of racial bias within psychiatry, these possibilities require further exploration (Thomas and Sillen 1991). Adebimpe (1981) and Lewis et al. (1980) discuss the impact of racism on diagnostic patterns, noting that psychiatry has historically considered African Americans fundamentally different from White people—as, for example, "too jovial to be depressed or too impoverished to experience object losses" (Adebimpe 1981, p. 281). Furthermore, the very notion of "racial difference" is problematic. This concept says more about the racial stereotypes and conditioning of the clinician than it does about the accuracy of diagnoses. The overdiagnosis of conduct disorder among young African American men provides a springboard from which to explore the incorporation of historical and social analysis into the psychological assessment and diagnostic process.

## Conduct Disorder and Young African American Men

A DSM diagnosis can play a significant role in defining an individual's problem within both the mental health and criminal justice systems. While a diagnosis is only one small piece of the puzzle that explains the cause and consequence of an individual's suffering, a misdiagnosis can dramatically impact and limit the range of available treatments. Each diagnostic category inherently highlights certain aspects of an individual's experience and obscures others.

A conduct disorder diagnosis impacts the outcomes of young African American men within both the mental health system and the juvenile justice system. Within the mental health system, the stigma that is connected to a conduct disorder diagnosis and its association with psychopathy may influence mental health care providers to make more pessimistic predictions about the chances of recovery, which may lead to less effective treatment (Mizock and Harkins 2011; Salekin 2002). Additionally, if conduct disorder is misdiagnosed, as some researchers suggest may be the case, the incorrect diagnosis could impede detection of a more accurate etiology of symptoms and thus prevent access to necessary and appropriate treatment (Alegría et al. 2008; Kilgus et al. 1995; Mandell et al. 2007; Mizock and Harkins 2011).

Many studies have shown that White youth with serious mental health needs access hospitalization and treatment far more easily than do African American youth, as the latter are instead steered towards the juvenile justice system (Atkins et al. 1999; Cohen et al. 1990; DelBello et al. 2001; Kilgus et al. 1995; Lewis et al. 1980). For example, Cohen et al. (1990) found that African American youth in the correctional setting had similar scores on the Child Behavior Checklist, a standardized tool that measures symptoms and behaviors, and similar lawbreaking behaviors compared to White youth in the hospital, indicating that the African American youth perhaps should have been served by the hospital system instead of by the correctional system. Significantly, conduct disorder is one of the most frequent diagnoses given to youth within the juvenile justice system (Drerup et al. 2008; Mizock and Harkins 2011; Teplin et al. 2002). For example, in a study of 597 court-involved youth, conduct disorder was the most common diagnosis (Drerup et al. 2008). Teplin et al. (2002) found that conduct disorder and ODD diagnosis rates within the juvenile justice system were as high as 40 %.

Further, it has been shown that labels such as conduct disorder or psychopathy can have a significant impact in legal proceedings, can influence decision making in a punitive direction, and can result in youth being transferred to adult courts or ordered to serve longer sentences (Mizock and Harkins 2011; Petrila and Skeem 2003). Mental health clinicians working within the juvenile justice system can influence sentencing decisions through their suggestions to judges, and thus it is particularly important to consider their responses and opinions in this setting (Rockett et al. 2007). Rockett et al. (2007) demonstrated in a study with 109 state-employed mental health clinicians working in juvenile justice facilities in Texas, Virginia, and

Wisconsin that clinicians are more affected by clinical labels like conduct disorder than are nonclinical staff. The researchers asked clinicians (who were mostly White) to read a vignette of a mock psychological evaluation and then complete a survey. The results showed that clinicians were more likely to anticipate future violence and criminality when psychopathological personality features were present, as defined by the Youth Version of the Psychopathy Checklist (Rockett et al. 2007). This anticipation of future criminality could feasibly influence how clinicians present cases to judges, which could in turn influence sentencing. It also seems plausible that therapeutic pessimism based on labels could influence engagement, treatment planning, therapeutic alliance, and outcome.

While studies have shown that the conduct disorder label has less influence on nonclinical than on clinical staff, judges and probation officers appear to base their decisions on conduct-related behaviors of youth such as engaging in physical fights with peers or vandalizing property (Murrie et al. 2007). This highlights the importance of a comprehensive psychological assessment that accounts for behavioral issues by going beyond the surface symptomology. For example, if a clinician believes that a youth's behaviors stem from an affective disorder that is treatable, such as clinical depression (as opposed to conduct disorder), it seems reasonable to assume that this perspective of the clinician could affect a judge's decision about whether to direct the youth toward treatment or toward punishment.

Previous research about the prevalence of mental health issues among youth involved in the juvenile justice system has led to the creation of mental health courts around the country (Gardner 2011). These courts provide intensive case management and mental health support for youth with mental health diagnoses in order to facilitate sustainable connections to community-based services such as mental health treatment that will to support the youths' exit from the juvenile justice system and prevent future recidivism (Gardner 2011). Some of these courts, however, exclude youth diagnosed with conduct disorder from such programs (Gardner 2011). Furthermore, Teplin et al. (2002) argue that due to the influence of managed care provided by private insurance and public benefits, youth diagnosed with conduct disorder often do not have access to mental health care services, especially once they are within the juvenile justice system. Thus, these youth may have significantly less ability to receive the needed support and treatment that could facilitate their healing and perhaps prevent recidivism.

While the impact of a conduct disorder diagnosis may often be detrimental, it is important to note that this is not likely to be the intention of the diagnosing clinician. We assume that most clinicians are well intended and may even see the conduct disorder diagnosis as a useful tool that will enable a client to access services and will be helpful in guiding treatment planning and healing. Good intentions do not, however, explain or justify the actual impact of this diagnosis. At times, a clinician may deem the conduct disorder diagnosis necessary in order to indicate the urgency and high level of risk. In this situation, an Afrocentric historical and social analysis can still be incorporated into the assessment process.

## Misinterpretation of Symptoms by Clinicians and Diagnostic Bias

The inclusion of a social and historical analysis in the assessment and diagnostic process may allow for exploration of the possibility that the root of young African American men's behavioral issues may be symptoms of untreated affective disorders, Posttraumatic Stress Disorder (PTSD), or substance abuse (Atkins et al. 1999; DelBello et al. 2001; Feisthamel and Schwartz 2009; Mizock and Harkins 2011). Studies point to the high rates of comorbidity of conduct disorder and affective disorders. For example, Atkins et al. (1999) found in a comparative study of youth in juvenile justice, community, and hospital settings that there was a significant comorbidity rate among incarcerated youth diagnosed with conduct disorder. Forty percent of incarcerated youth within their study were diagnosed with conduct disorder, and among this group 96 % carried another Axis I diagnosis. This points to the possibility that the conduct-related behaviors exhibited in these youth are actually symptoms of other untreated mental health issues, such as an affective disorder (Atkins et al. 1999; Mizock and Harkins 2011).

DelBello et al. (2001) and Feisthamel and Schwartz (2009) hypothesize that African Americans are less likely than European Americans to seek out treatment for an affective disorder, substance abuse issue, or PTSD due to distrust of the mental health system and lack of access to services. Mizock and Harkins (2011) also argue that youth may use alcohol or drugs as a way to cope with anxiety, depression, and PTSD, and that substance abuse can lead to conduct issues. Thus, it is possible that misdiagnosis of affective or substance abuse-related disorders plays a significant role in the disproportionate number of young African American men diagnosed with conduct disorder. The addition of social and historical analysis into the assessment and diagnostic process may expand the clinical conversation about the etiology of behavioral issues among young African American men, potentially altering diagnostic patterns. These studies do not discuss how social and historical factors may contribute to clinicians' bias towards a diagnosis of conduct disorder for young

African American men (Atkins et al. 1999; DelBello et al. 2001; Feisthamel and Schwartz 2009; Mizock and Harkins 2011).

It is also possible that misdiagnoses occur due to cultural differences between the clinician and client (DelBello et al. 2001; Fabrega, et al. 1993; Jones and Gray 1986). Fabrega et al. (1993) suggest the possibility that White clinicians are generally better able to connect with and understand White clients, which could lead to a more complex and nuanced picture of White psychopathology and a less complex understanding of other cultural groups. They argue that it is possible that one ethnic group may be more or less prone to manifest symptoms of a particular disorder, such as depression, or may manifest a disorder in a qualitatively different manner than do other ethnic groups, due to socioculturally learned modes for expressing distress (Fabrega et al. 1993). Some clinicians may incorrectly assume that the clinical presentation of a particular disorder looks the same across all ethnic/cultural groups (Kilgus et al. 1995). It is essential for clinicians to learn about and consider general differences between ethnic groups, but it is important to note that this runs the risk of reifying the notion of static "cultures" that can be read about, learned about, and fully understood. This idea fits into the historical, racist narrative that African American people are fundamentally different from White people (Lewis et al. 1980).

Diagnostic bias also relates to statistical assumptions and availability heuristics on the part of clinicians working with African American clients, based on behavioral stereotypes and beliefs about the rates of diagnosis (Mizock and Harkins 2011). Simply put, clinicians may assign diagnoses based on inaccurate assumptions about higher rates of specific disorders among particular ethnic groups, thereby creating a self-fulfilling loop.

Finally, Fabrega et al. (1993) highlight the influence and impact of gatekeepers biases as they manifest in referral patterns. Fabrega et al. (1993) found that African American adolescents exhibited a lower level of symptoms as compared with White adolescents and that there was a weak yet significant trend for African Americans to show a higher level of social aggression. The researchers suggest that this may particularly alarm adult gatekeepers and could help to explain the high number of conduct disorder diagnoses (Fabrega et al. 1993). Fabrega et al. (1993) hypothesize that as care for adolescents is often mandated by systems, this trend indicates a lower level of tolerance by gatekeepers of symptoms exhibited by African American youth. Though Fabrega et al. (1993) does not discuss possible reasons for this intolerance, it may occur partially as the result of the stereotype of the Black male "criminal," a historically relevant image that has existed since slavery.

## Historical Analysis Based on the Work of Alexander and DeGruy

The existing literature does not include an examination of the impact of historical, social, and political forces on the implicit bias of clinicians and other gatekeepers. Alexander (2012) considers the historical roots of stereotypes that portray young African American men as "criminals." The development and maintenance of this stereotype likely has great impact on the implicit bias and decisions of gatekeeping professionals such as probation officers, judges, police officers, and clinicians. Alexander (2012) notes that cognitive bias research indicates that both implicit and explicit bias lead to discriminatory action, regardless of an individual's intention.

For example, Bridges and Steen (1998) conducted a study based on 223 narrative reports written by probation officers in three counties in a western state between 1990 and 1991. The researchers found that attribution for crime was directly linked with race; probation officers made more internal attributions (personality traits) for Black youth but more external attributions (environmental influences) for White youth (Bridges and Steen 1998). Furthermore, Black youth were considered more likely than White youth to reoffend. The study shows that "attributions about youths and their crimes are a mechanism by which race influences judgments of dangerousness and sentencing recommendations" (Bridges and Steen 1998, p. 567). Thus, attributions for crimes (behavior) have a concrete and powerful impact within the juvenile and criminal justice systems, and the connection between race and attribution is clearly demonstrated in this study (Bridges and Steen 1998). An additional study found that probation officers' narratives giving attributions of delinquency became legal evidence that supported outcome decisions (Harris 2009).

Graham and Lowery (2004) examined the ways in which unconscious racial stereotypes impact the treatment of adolescent offenders by probation officers and police. In their two-part quantitative study, participants read two vignettes about a hypothetical youth of no specified race who had committed a crime. Some of the vignettes included subliminally implanted words intended to invoke unconscious connections to African American people. The study found that when this was done, both probation officers and police officers reported that they believed that the offender had more negative traits, a higher chance of recidivism, and greater culpability and that harsher punishment was warranted. The researchers believe that this same bias likely functions across professions (Graham and Lowery 2004). Another recent study conducted by Goff et al. (2014) of 123 mostly White, female college students asked questions designed to assess for perceived innocence of children of various races. This study found that participants perceived Black children of 10 years of age and older as significantly less innocent than their White peers (Goff et al. 2014).

These studies indicate that implicit bias significantly affects the perception of young African American men by probation officers, police, and White women. They additionally highlight the power of the existing association of African American men with criminality and guilt (Bridges and Steen 1998; Goff et al. 2014; Graham and Lowery 2004). This stereotype has been maintained through local news shows that highlight Black men as "criminals." DeGruy (2005) points out a notable example of this inaccurate portrayal. She states that while over half of the people who participated in the riots following the death of Rodney King were Hispanic and the rest were a mixture of African Americans, Whites, and Asians, the media focused mainly on the Black rioters, thus greatly skewing the public's perception of the event.

Degruy's (2005) *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing* provides a useful lens through which to view behaviors by considering the impact of the legacy of slavery on the health of young African American men today. Her framework requires clinicians to incorporate historical and social analyses into the assessment process, and thus her analysis may be of benefit to clinicians seeking alternative frameworks.

Social workers are strongly encouraged to include family history in the assessment of a client, but equally important is the history of racism, classism, and any other form of oppression that has impacted the client or his ancestors. Also important is the way in which this history may affect the clinician's perception of the client, based on stereotypes that may operate in the clinician's conscious or subconscious mind (especially if they identify as a White clinician), potentially leading to implicit bias. A brief history of the laws and practices that have restricted and controlled African Americans through the times of slavery and Jim Crow demonstrates the ongoing impact of the legacy of slavery and its contribution to the persisting stereotype of the African American male "criminal." Alexander (2012) outlines the transition from the end of slavery to the Black Codes. Mississippi and South Carolina first enacted the Black Codes in 1865, near the beginning of the Reconstruction era (1863–1877) and directly after the end of the Civil War. These laws included provisions that required all Black people to have written proof of employment for the coming year at the beginning of January (History.com 2010). If they left before the end of their contract, they were forced to forfeit their wages and were subject to arrest. Furthermore, both states implemented convict and vagrancy laws, which led to heavy fines and forced labor as penalty for those who were unemployed (History.com 2010).

Although the Black Codes were struck down in court in 1868, the Southern White backlash against Reconstruction continued to rage (Alexander 2012; DeGruy 2005). Alexander (2012) cites Thomas Blackmon's *Slavery by Another Name,* noting that tens of thousands of African Americans were arbitrarily arrested during this period. The convict leasing system, in which prisoners were contracted out as laborers to plantation owners and private companies, started in 1846 in Alabama and lasted until 1928 (Alexander 2012; DeGruy 2005). Conditions were harsh, and in South Carolina half of the individuals subject to this system died within the first 12 months due to hard labor and severe physical punishments (DeGruy 2005). Although this system was not originally designed for African Americans, after the end of slavery it served as a convenient tool to oppress and disempower freed Black people and to line the pockets of White plantation and corporation owners (DeGruy 2005). By 1898, 75 % of Alabama's state revenue came directly from convict leasing (DeGruy 2005). There was thus a clear monetary incentive to charge and convict Black men with crimes so as to expand the free labor force. Furthermore, after the Civil War, Southern Whites anticipated and dreaded a great uprising by Black people, a fear that Alexander (2012) describes as further contributing to the stereotype of Black men as aggressive, dangerous predators who might hurt White men or rape White women. These misperceptions gave rise to the image of the Black male "criminal."

In 1866 the Ku Klux Klan (KKK) was established in Tennessee and began its terrorizing of Blacks and their White allies (DeGruy 2005; PBS 2002). Lynching, designed to intimidate and subordinate Blacks, was one of the most egregious abuses. Between the years of 1882 and 1967, two hundred bills were presented to the U.S. Congress to outlaw lynching, and seven different presidents advised Congress to take action. Congress rejected every one of these proposals, and lynching continued unpunished (DeGruy 2005). The KKK relied upon the stereotype of Black men as criminals to justify its acts of brutal violence. In 2005, the U.S. Senate finally apologized for this "domestic terrorism" that had primarily affected Black people (DeGruy 2005, p. 93).

In 1982, when President Ronald Wilson Reagan declared the "War on Drugs," allegedly to combat rampant drug addiction in the United States, drug use was actually in decline (Alexander 2012). Crack cocaine hit the streets of the United States shortly thereafter, however, and the Reagan Administration took the opportunity to introduce and implement racially biased policy (harsh drug laws) under the guise of race-neutral language (e.g., being "tough on crime"), all within the context of "colorblindness" (Alexander 2012, p. 53). In 1984, Congress amended the Comprehensive Drug Abuse Prevention and Control Act in order to permit "federal law enforcement agencies to retain and use any and all proceeds from asset forfeitures, and to allow state and local police agencies to retain up to 80 % of the asset's value" (Alexander 2012, pp. 78–79). Thus, law enforcement agencies made significant money from the Drug War and were invested in its continuation. This stake in the material rewards generated from the Drug War was obscured by the "tough on crime" rhetoric, and even Democrats jumped on board in order to win public approval (Alexander 2012, p. 55). Propaganda related to Reagan's Drug War furthered the stereotyping of Black men as criminals, both in print and on the radio, in which shows depicting crime featured mostly Black people in the roles of criminals and used terms such as "crack whores," "crack babies," and "gangbangers" (Alexander 2012, p. 52).

Courts of law implicitly and explicitly condoned the use of racial profiling for stops and searches conducted by the police (Alexander 2012). This established precedence for enactments of implicit bias on the part of law enforcement officers, based on racial stereotypes of those whom they believed looked like a "criminal." This put Black men at risk of profiling due to the pre-existing and powerful stereotype of African American men as dangerous predators.

Slavery and its legacy have had significant impacts on African American families and individuals throughout history, likely leading to certain patterns of behavior and outcomes among African Americans today. Dr. DeGruy (2005) states that African Americans have a life expectancy that is 5–7 years lower than that of whites, that the Black infant mortality rate is twice that of Whites, and that African Americans have the highest number of deaths per capita as a result of heart disease, diabetes, HIV/AIDS, hypertension, homicide, influenza, and pneumonia (DeGruy 2005). She links these outcomes to the impact of the ongoing trauma of African Americans in the United States, starting with the 180 years of the Middle Passage between various countries in Africa and the Americas, 246 years of slavery, and 100 years of "illusory freedom" (p. 107). She describes the trauma of the Black Codes, convict leasing, Jim Crow, lynchings, medical experimentation (e.g. Tuskegee), redlining, disenfranchisement, brutality by police, and unequal treatment of African Americans at many levels of society (DeGruy 2005). She argues that the impact of the adaptations that African Americans had to make in order to survive, as well as the systematic denial of opportunity for African American men to be fathers during slavery, have had far-reaching effects and help to explain some of the behaviors presenting in some African American people today.

Based on this history and what she observes today, DeGruy (2005) proposes a new diagnosis: Post Traumatic Slave Syndrome (PTSS) (p. 13). Unlike the diagnosis of conduct disorder (APA 2000), PTSS names the source of the problem within its definition. DeGruy (2005) defines PTSS as "…multigenerational trauma together with continued oppression and absence of opportunity to access the benefits available in the society [real or imagined]," in which "[a] syndrome is a pattern of behaviors that is brought about by specific circumstances" (p. 121). She specifies a number of the patterns of behavior that she believes to be the direct results of slavery and its legacy: "vacant esteem" (little or no sense of self-worth), ever-present anger, and, most importantly, racist socialization (DeGruy 2005).

Racist socialization refers to "adoption of the slave master's value system" and includes the internalization of the White ideal of beauty (leading to the privileging of straight hair, lighter skin, and Aryan facial features) (DeGruy 2005, p. 135). DeGruy also notes that it is not uncommon for people to take on the views and attitudes of their captors relatively quickly. Slave owners frequently utilized anger and violence as ways to maintain control, and DeGruy (2005) argues that African Americans may also have taken on these attributes. Further, she argues that African Americans may feel threatened by the accomplishments of others as a result of divide-and-conquer strategies utilized by slave owners that continued after the end of the Civil War (DeGruy 2005). DeGruy advocates for positive *racial* socialization in lieu of *racist* socialization and outlines how this could include education about institutional racism, history, past struggles and successes, and the teaching of coping mechanisms and skills needed in order to survive in the current environment. She cites existing strengths in African American communities that could support this change, including faith-based communities (DeGruy 2005).

## Clinical Implications of the Work of Alexander and DeGruy

The historical events and social issues that are outlined by both Alexander (2012) and DeGruy (2005) come strongly into play during the clinical process of case conceptualization, assessment, diagnosis, and treatment. Knowledge of the history of the current system of mass incarceration is essential in order to understand the behaviors and presentations of young African American men today so as to mitigate the impact of clinicians' implicit bias, especially for those clinicians who identify with majority culture. Historical analysis should therefore be incorporated into the process of psychological assessment, diagnosis, and treatment.

The work of these scholars is critical and central to our argument because they demonstrate that there is an unjust social arrangement (particularly as it plays out in clinical work) even though we assume that people make choices about their actions and identities in a system that is fair and equal towards all persons. The social arrangement that we all participate in should be organized in such as way that it gives each of us a chance to flourish, but this is not the case.

Most importantly, Alexander (2012) and DeGruy (2005) suggest that there is a continued epistemological and linguistic assault on the identities of Black youth and that violence continues through the threads of clinicians' language, descriptions, and conceptualizations of minority groups when formulating diagnostic pathology. Scholars, students, professors, and researchers are typically well aware that the history of the United States is that of a racialized nation and that the discourse of race is intricately interwoven with the experience and memory of dispossession, displacement, and impoverishment. Clinicians may also be aware of the power differential within the therapeutic relationship and the biases that may emerge from this uneven distribution. However, when it comes to redressing oppressive histories in the context of case conceptualization or diagnosis and treatment, there is an enormous gap both in research and practice. Clinical practice, in relation to the diagnosis of conduct disorder, might serve as a vehicle of social justice against the backdrop of a prejudiced criminal justice system and mental health delivery system that is driven by insurance and pharmaceutical companies whose agendas are aligned with the continued existence of specific diagnoses (Liebert 2013).

Furthermore, the medicalization of psychic suffering, through the *DSM* and related systems (Cushman 1995), has continued to shape treatment practices and their respective languages that "carve out the possible horizons for experience" (Goodman 2014, p. 6) and dictate the possibilities for recovery (e.g., through medication or evidence-based treatment practices). It is therefore vital that we deepen our models of clinical practice so that we understand healing from a historical perspective, as it might already exist within a person or community. The alternative is to align our position as clinicians with a kind of colonizing force that seeks to obliterate symbolic registers through the renaming of cultural and social suffering within an established society. What follows then is that one may rename a symptom in order to make a person's suffering useful to our own professionalism and training, evaluating the symptoms through our own pre-established paradigms without questioning how the paradigms perpetuate violence even at the linguistic or symbolic level. In other words, is "conduct disorder" actually the renaming of a much deeper suffering caused by a moral betrayal that occurred in the history of the United States? As wa Thiong'o (2009) writes, "Their relationship to both European and African languages remains problematic. How do you raise buried memory from the grave when the means of raising it are themselves buried in the grave or suffocated to the level of whispering ghosts?" (p. 41). Wa Thiong'o goes on to argue that much of the dismemberment that took place in the African diaspora did not just happen in physically destructive events but also occurred in the violence that wove poisonous threads into the fabric of language, landscape, law, custom, and identity. Thus, we need frameworks that are able to conceptualize the transformation required to move out of an historical catastrophe and into creative forms of existence and identity.

In the process of colonization, the colonizing forces have always assumed a "right to dispose" and have regarded themselves "as the sole power to judge its own laws" (Mbembe 2001, p. 25). In a sense, psychodiagnostic processes, and especially the administration of psychological tests or self-report forms, use self-interpreting language that gives order and meaning and serves to justify the "necessity and universalizing mission" (p. 25) of the discipline itself. As Mbembe writes,

> We should first remind ourselves that as a general rule, the experience of the Other, or the problem of "I" of others and of human beings we perceive as foreign to us, has almost always posed virtually insurmountable difficulties to the Western philosophical and political tradition. Whether dealing with Africa or with non-European worlds, this tradition long denied the existence of any self but its own. (2001, p. 2)

Thus, in essence, we are arguing for the need for human desire, suffering, memory, justice, subjectivity/identity, and temporality (as it relates to one's need to produce one's own humanity) to be embedded within the very language we may use to describe another. Therefore, any encounter in therapy or in case conceptualization should be considered a historical and political encounter in time as lived in that moment. But how can this be done? We believe interventions need to be conducted within both the systemic (social systems, community agencies) and epistemological domains, where "clinical" knowledge and language is restructured in such a way as to account for African diaspora axiology.

First, a few community-based agencies across the country have mission statements that include working with individuals, families, and systems from relational therapeutic models while acknowledging and actively addressing the social and historical context. These agencies utilize a therapeutic approach that crosses disciplinary boundaries so that therapists, social workers, psychologists, and psychiatrists work together to navigate larger systemic forces. In addition, these agencies advocate a community-based model where the clinician enters the world of the client rather than the client visiting the clinician in an office setting. One such clinic, based in Oakland, California, works primarily with minority youth to better understand their own problems on their own terms and uses the language of the client in formal testing reports to characterize the "problem," writing personal letters to clients in response to the original referral in addition to the formal psychological report. What is vital about this method of practice is that it targets the intervention of healing at the site of language itself, where those who experience suffering *express it using their own language derived from their own lived worlds and communities*.

Children who are perceived by the community to be "unworkable" often have histories of behavioral conduct issues, but they also carry collective cultural memory that is just as fierce as their own personal traumas. As Barbara Mercer (2011), in her article "Psychological Assessment of Children in a Community Mental Health Clinic," writes,

> When we go into the community and leave the safety of our clinic walls, we enter the realm of trauma, poverty, and stress that we might have been fortunate to avoid in our own lives. Or if we are from a similar background, difficult or unbearable feelings could be triggered in the process of seeing a neglected child living in a deprived or violent environment or hearing details of sexual abuse. When we conduct assessment literally on the road, we, like our clients, the foster children, face a kind of displacement and rootlessness as we attempt to create an appropriate therapeutic frame… How do we, deep down, view those whom we assess?

I (Macdonald) have written elsewhere (Macdonald 2010) on the importance of incorporating African American history and axiology directly into the case conceptualization in an attempt to highlight the importance of the political as it may be replicated in clinical settings. While drawing upon a cross-fertilization of ideas and disciplines (e.g., the interface between critical race theory, social theory, Afrocentric models of psychological assessment, forms of relational ethics), my aim has been to show that psychological practice, particularly assessment, which is now becoming a more global enterprise, still carries with it many forms of racial oppression and violence as outlined by previous scholars (e.g., Michel Foucault, Frantz Fanon, W. E. B. Du Bois, Ngũgĩ wa Thiong'o). At the same time, psychological practices can also be a potential site of reversal, open contingency, and transformation if the community agency also supports this process. In that case, the unique relationship between client and clinician can be loaded with affirmative political agency and can actually support processes of becoming, which must reside to some degree in both the inclusion and in the ultimate transcendence of history. This is also to say that while the injustice of the overall situation is beyond comprehension especially from the privileged position of a clinician, we run the risk of unjustly using our power to condemn, marginalize and oppress the very clients we are supposed to care for if we only support the idea of victimhood and oppression. Historical and cultural context is important so that we are able to see the client as a full moral agent capable of making empowered choices.

Secondly, Thomas Parham (2002), in his book *Counseling Persons of African Descent: Raising the Bar of Practitioner Competence*, highlights the need for an African psychology with its own knowledge structures to take center stage, especially when dealing with behavioral or conduct issues. More specifically, he suggests that all clinicians need to have knowledge of the limitations of traditional European American psychological perspectives and of how the science used to support this view has also been used as a tool of oppression (p. 145). Parham further asserts that clinicians need specific "knowledge of the geopolitical view of African people and their condition in America throughout the diaspora, knowledge of models of nigrescense, knowledge of African psychology and history of ancient Kemetic, historical African, and contemporary African American societies" (p. 145). In summary, both sites of interventions seem necessary: agencies that are willing to include social and political contexts in their original mission statements and rigorously examine how they view the suffering of those they wish to serve, and clinicians who favor Afrocentric psychologies over Eurocentric perspective. In this way, it may be possible to overturn dominant paradigms in psychology that may reify suffering to in diagnostic categories such as conduct disorder.

## Conclusion

Therapeutic orientations that include the historical oppression and trauma within the United States when conducting psychological assessments with young African American men will decrease the power of the internal logic of psychological practice as the dominant discourse that may speak to human suffering. Such a model will also decrease the episodes of colorblindness that were born out of the attempt of political conservatives to continue racial segregation without using explicitly racist language. The purported intent of colorblindness was to enact Martin Luther King Jr.'s call to judge people not based on "the color of their skin, but by the content of their character" (Nobelprize.org 1964). Instead of combating prejudice, the rhetoric of colorblindness decontextualized and co-opted King's call to end discrimination and used it to invalidate negative racial experiences, dishonor diverse cultural heritages, and silence those voices that have acknowledged racism (Alexander 2012).

The denial of the historical realities and the cultural memories of oppression in our work with young African American men only leads to more subtle forms of linguistic violence. In our role that is ideally intended to alleviate suffering and facilitate healing, it is essential that we invite and make room for the expression of the client's full experience. The disproportionate number of young African American men diagnosed with conduct disorder fits seamlessly into the legacy of criminalizing Black men in the United States. This warrants ongoing exploration into the impact of historical oppression on clinicians, on young African American men, and within the psychological assessment process.

Furthermore, if we define historical discourse as human and inhuman forces, systems of desire, and events that are in themselves disruptive to ethical complacency, then the dialectic between memory and history may become a site of transformation, beyond fixed racial or other dehumanizing categories (Mbembe 2001). As Foucault (2008) has demonstrated, this dialectic occurs within language and semiotic processes in how we conceptualize others when their absence is due to violence (as in the archives of a genocide or slavery) or when we attempt to organize what was irreparable to begin with, where the historical catastrophe resides outside the pre-given symbolic order.

Clinicians are granted considerable power to define the suffering of their clients through the language of the *DSM*. Once defined, the reverberations of assigned labels echo in the far reaches of institutions within the systems of education, welfare, criminal or juvenile justice, and health. With this great power to define others' suffering comes the obligation to take the work seriously and to find ways to honor and respect the experience of each individual who comes before us. In turn, we must also know ourselves as well as the forces that shape our perceptions and affect how we hear our clients. We hope that the analysis presented in this paper will encourage clinicians to listen differently to the people who sit in front of us—to allow each person to define their own suffering and healing in their own language and on their own terms.

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