Examining the Clinical Problems of Pathological Bias:

Syndrome, Disorder, or Social Norm?

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Abstract

The base rates and co-morbidity of pathological bias as a clinical problem were examined with 159 psychotherapy outpatients. Ratings were assigned for the Outgroup Hostility Scale (OHS), Outgroup Empathy Scale (OES), DSM-IV diagnoses, the MMPI-2, Gough's Pr scale, and MINI. 11.6% of the psychotherapy patients evidenced aversive and 12.6% empathic outgroup concerns. Outgroup aversive patients remained significantly longer in treatment and had higher MMPI-2 scale scores for F, Pa, and Pt. OHS scores were higher for men; OHS scores were correlated to lower GAF scores and MINI hypo-mania, hostility, and panic symptoms. Patients in committed inter-racial/ethnic relationships had higher OES scores. Establishment of a methodology that examines bias as a mental health problem is considered in terms of assessment, treatment, and legal concerns.

The significance of outgroup bias as a clinical problem has received scant attention from clinicians and researchers alike (First, Bell, Cuthbert, Krystal, Malisom, & Offord, 2002). Severe – i.e. pathological – bias can impair the functioning of the holder or target of the belief, may warrant mental health treatment (Frosh, 1998), and arguably constitutes a unique indicator of risk for violence. Pathological bias is characterized by hostile affects and aversive preoccupations concerning outgroups, as well as the manifestation of aggressive behavior in intergroup situations (Dunbar, 2004). Clinical problems of bias may be found amongst outpatient psychotherapy consumers, offender groups, and hospitalized patients evidencing acute psychopathology. The issue of how to identify pathological bias was examined in a sample of outpatient psychotherapy patients and a forensic sample of legal claimants in a class action law suit. These two studies examined the base rates of outgroup concerns and examined the relationship of pathological bias to DSM-IV diagnoses and patient reported symptoms.

Bias in the Consulting Room: Social Norm or Pathology?

As is evident from social psychological research, bias, inclusive of stereotypes, implicit attitudes (Greenwald & Banaji, 1995), and prejudice (Duckitt, 1992), constitute a normative psychological condition that is a product of ingroup identity (Tajfel, 1982), societal norms (Jones, 1997), and social learning (Pincus & Ehrlich, 1999). It is therefore important to recognize that bias in and of itself does not impute a pathological state. Additionally, the proposition that bias constitutes a discernible clinical disorder has not yet received sufficient attention to support such a position. What has not been considered however, and what is addressed in the current research, is the significance of bias amongst mental health consumers, that is, in patient groups with recognized psychopathology. Specifically, it is of interest to consider whether pathological bias is symptomatic of specific clinical disorders – such as Bi-

Polar Disorder - or whether it is indicative of a unique (and undefined) syndrome or disorder (Sullaway & Dunbar, 1996; Bell, 2003).

The investigation of pathological bias implicitly poses two questions in a clinical context, specifically, what is the impact and meaningfulness of the bias element? The first of these concerns whether impairment to the individual's level of functioning is directly attributable to the "bias element" – i.e., the beliefs, affects, and behaviors - of the patient. The impairment to occupational, social, or relational functioning includes the adverse impact to either the holder or target (Griffith, & Griffith, 1986; Clark, Anderson, Clark, & Williams, 1999) of the bias element. For example, patients who are terminated from a place of employment due to their use of hate speech in the workplace or who fail to seek medical care due to the race of the treating medical staff both evidence impairment of functioning of equivalent severity to that observed in patients suffering from social anxiety or agoraphobia. Likewise the violent racist may pose a unique social stressor to members of the denigrated outgroup (Pierce, 1978). In this view, pathological bias may constitute impairment to the self, the denigrated other, or the social environment.

On an altogether different level, pathological bias may constitute a risk for future violence. The past decade has seen the identification of a variety of actuarial and dynamic factors that reveal an increase risk for violence in general (Webster, Douglas, Eaves, & Hart, 1997) and in terms of commission of specific forms of violence – such as sex crimes (Boer, Hart, Kropp, & Webster, 1997). There is some evidence that an individuals' bias motivation and their intent to target specific victim groups are related to the extensiveness of the criminal history and the seriousness of the bias motivated index offense itself (Dunbar, Quinones, & Crevecouer, 2005). Therefore it may be that amongst individuals who commit acts of

intergroup aggression, the bias element may constitute a unique risk factor for future violence and additionally hinder offender rehabilitation.

A second important question in the study of pathological bias concerns whether the expressed bias of the patient is coherent to their social milieu. That is, the patient's attributions and stereotypes about the outgroup must be comprehensible to the larger community – inclusive of ingroup and outgroup persons. The expressed bias therefore must be meaningful to the patient and to their social context. The bias element may reveal important information concerning the mental state of the individual and their relationship to the social environment. In this sense pathological bias constitutes both an internalized and a relational dysfunction.

Diagnostic Issues in Identifying Pathological Bias

The identification of pathological bias entails the execution of three clinical tasks. These are: (1) determining the status of the patient's outgroup concerns, (2) documenting the presence of pathognomic signs of functional impairment related to bias element, and (3) identifying clinical symptoms that are attributable to bias element.

The identification of a patients' outgroup concerns shares much in common with the study of racial identity. As suggested by Helms (1990) an individual's racial beliefs constitute a discernible status or state (Rowe, Bennett, Atkinson, 1994; Mercer, 2003). Helms (1986) has additionally proposed that outgroup attitudes may be inferred from the patient's racial identity status. Racial identity status reflects the individual's conceptualization of ingroup and outgroup differences, perceptions of intergroup contact experiences, and expressed affects concerning racial outgroups. Findings in the study of black and white racial identity underscore how an individual's identity status is related to subjective distress, on the one hand and the endorsement of aversive outgroup attitudes on the other (Carter, 1990; Pope-Davis, & Ottavi,

1994). There is also some evidence that the behavioral intent of individuals in seeking mental health treatment can be a function of one's racial identity (Parham & Helms, 1981). In terms of clinical classification then, it is similarly important to identify a patient's outgroup concerns. In one study patient outgroup concerns were defined as positive, neutral, and aversive – in the later case inclusive of aversive-ambivalent, and aversive-hostile types (Dunbar, 1998). Therefore, patients may reflect one of three primary status types, positive relationally emphatic outgroup concerns, no expressed or unarticulated outgroup concerns, and aversive negative outgroup concerns, again, in the latter case the aversive bias element may be experienced by the patient as being inconsistent with other feelings and attitudes – i.e. ambivalent – or be consistent with the self-esteem of the patient and experienced as inherently consistent with their explicit self image.

As has been suggested, it is important that clinical assessment can distinguish between normative and pathological forms of bias. In situations where outgroup bias becomes a focus of treatment, its impact upon the patients' level of functioning needs to be considered. It has been proposed that the clinical triad of pathological bias is characterized by: (1) marked ideation or preoccupation with outgroup persons, (2) aversive arousal to triggers – i.e. stimuli – associated with the denigrated outgroup, and (3) the patient's employment of relationship damaging behaviors in benign contact situations (Dunbar, 2004). The presence of one or more of these criteria has been proposed to signify a pathological state, i.e., in which the bias element impairs the level of functioning of the individual, the targeted outgroup person, or their social context. The clinical triad of pathological bias may be related to employment problems, familial conflict, criminal violations, or problems accessing healthcare resources. It would follow that

these criteria would be related to a general decrement in the patient's level of functioning as well.

The examination of pathological bias includes the identification of specific affects, cognitions, and behaviors that are related to the patient's outgroup concerns. These symptoms may be similar to other clinical problems, but are explicitly related to the bias element. Anger, for example, may be an issue of clinical concern generally, or it may be uniquely associated with a targeted outgroup. Social anxiety similarly may constitute a clinical disorder or it may be manifested solely in the context of intergroup contact situations. Clinical problems related to impulsivity (Reeves & Nagoshi, 1993; Ostow, 1996), relational failure (Pierce, 1978; Guindon, Green, & Hanna, 2003), of which most notably narcissism has been considered (Bell, 1980; Bell, 2003), psychological trauma (Bell, 1979; Sullaway & Dunbar, 1996), anxiety (Cotharin, & Milkulas, 1975; Cotharin, 1978), and paranoia (Dunbar, Krop & Sullaway, 2000) have all been considered in relationship to pathological bias. It would be worth determining whether symptoms of pathological bias co-occur with the diagnostic criteria for post-traumatic stress disorder, hypomania, anxiety, or cluster B personality disorders – the narcissistic, borderline, histrionic and anti-social categories.

There is limited information on the use of psychometric tests with mental health consumers who evidence outgroup bias. There is some evidence that biased psychotherapy patients have higher MMPI scale scores for F, PD, and Ma (Dunbar, 1997). Additionally, Dunbar, Sullaway and Kropp (2000) found that homicide offenders motivated by bias had elevated scales scores for F, Pa, and Sc. One of the few scales that have been developed explicitly to examine a trait-based "bias orientation" is Gough's Prejudice (Pr) scale, which consists of items from the MMPI. The Pr scale was standardized on a community sample and

composed of items that were criterion-reference keyed in terms of anti-Semitic attitudes (Gough, 1951). Pr was found to be significantly elevated amongst bias motivated homicide offenders when compared to other homicide offenders (Dunbar, Krop, & Sullaway, 2000). This measure may therefore be useful in the detection of patients likely to evidence bias in mental health treatment.

Determining the base rates of patient outgroup concerns and symptomatology of pathological bias would provide information on the prevalence of this problem amongst mental health consumers. Likewise determining the relationship of criteria of pathological bias to DSM-IV diagnostic categories could aid in understanding its co-occurrence with other symptoms of psychopathology.

Research Questions

The study of pathological bias addressed several inter-related issues. These included employment of a classification strategy to identify the patient's expressed outgroup concerns as well as the identification of specific symptoms – i.e., thoughts, affects, and behaviors - that distinguish between normative and pathological forms of bias. Additionally the criteria of pathological bias needs to be considered in terms of its adverse impact upon individual level of functioning. Such a system of investigation needs to demonstrate clinical utility and to evidence satisfactory reliability and validity.

This assessment model was examined in terms of five questions concerning the outgroup bias. These are summarized below:

1. Base Rates of Patients' Outgroup Concerns: Research question 1 examined the base rates of psychotherapy patients who evidenced aversive or empathic concerns about outgroups, as well as to clarify the prevalence of criteria of pathological bias.

2. Treatment Characteristics of Pathological Bias. Research question 2 examined the treatment characteristics of patients in terms of their expressed outgroup concerns. This included comparing the length of psychotherapy treatment by patients' expressed outgroup concerns. Determination was also made as to the number of treatment sessions when aversive outgroup concerns were initially expressed. That is, how far had psychotherapy treatment progressed when aversive outgroup bias was first identified? Additionally, the frequency and type of pharmacotherapy treatment employed was compared for the three outgroup concern groups.

3. Role of Patient Demographic Factors in Expression of Outgroup Concerns: The role of patient demographic factors of gender, race/ethnicity, age, and the patient's primary relationship status (i.e., whether their partner was of a race/ethnic ingroup or outgroup) was considered in terms of outgroup concerns and differences on the criteria for clinical bias. Research question 3 examined whether patient demographic factors were related to differences for the clinical triad of pathological bias, OHS, OES, and Pr scale scores.

4. Relationship between Clinical Triad of Pathological Bias and Patient Functioning: The relationship between ratings for the clinical triad of pathological bias (Dunbar, 2004) and indicators of patient functioning – as measured on the GAF and GARF scores was examined. Research question 4 sought to determine if patients who evidenced pathological bias had poorer overall adjustment – as measured on the GAF score -and if in general their interpersonal relationships – as measured on the GARF ratings - were more problematic.

5. *Co-occurrence of Symptoms of Pathological Bias with DSM IV Diagnostic Categories*: The relationship of the clinical bias criteria with DSM-IV diagnoses and patient-reported symptoms was examined. Research question 5 examined the relationship between DSM criteria

and four co-occurring symptom clusters. The four DSM symptom clusters were: (1) hypo-mania, (2) anxiety symptoms, (3) post-traumatic stress disorder, and (4) presence of an Axis 2 Cluster B Personality Disorder. These were examined in terms of four clusters of clinical problems of bias for outgroup hostility, outgroup anxiety, outgroup trauma victimization, and outgroup suspiciousness/fear. It was of interest to determine if symptoms of pathological bias were related to similar DSM-IV symptoms – i.e. whether or not the symptoms related to the bias element co-occurred with similar DSM symptoms.

Method

Participants

The sample consisted of 159 psychotherapy clients treated at a psychology group in the metropolitan Los Angeles area. All participants included in the current study voluntarily initiated psychotherapy treatment. This included private insurance, managed care, and out-of-pocket consumers of mental health services. Participants included 11.5% African-Americans, 10.8% Hispanics, 7.2% Asian-Pacifics, 5.8% multi-racial, and 64.7% White non-Hispanics. The sample included 71 women and 88 men; 92% identified themselves as heterosexual and 8% as gay or lesbian. The primary relationship status for these patients at time of treatment was 52.6% ethnic/race ingroup partner, 24.8% ethic outgroup partner, and 22.6% no primary relationship. Participant age ranged from 18 to 82 years of age with a median age of 39.21 (s.d. = 11.12 years). Participants excluded from the study included persons under the age of 18 or those whom were diagnosed with a condition which compromised gross intellectual functioning or reality testing (e.g. severe neuropsychological deficits such as dementia). An additional two cases were omitted from the analyses in which explicit outgroup bias was identified as a reason for the initiation of treatment.

Measures

Mini-International Neuropsychiatric Interview (MINI). The MINI (Sheehan, et. al. 1998) is a short structured diagnostic interview developed to identify DSM and ICD-10 disorders. MINI is a brief diagnostic tool that screens for several psychiatric disorders, including depression, obsessive-compulsive disorder, and substance abuse. In the current study, the MINI items were included as a patient-completed checklist, with responses listed for "Agree" – scored as 2 – "Somewhat/possible" – scored as 1 – and "No" – scored as 0.

MMPI-2 (Hathaway & McKinley, 1991). The MMPI-2 was administered to the patients upon initiation of treatment. Analyses of the 3 primary validity scales and of the 10 clinical scales were used in the study.

Prejudice (Pr) Scale. The original form of the Pr scale as employed by Gough (1951) derived from the MMPI was administered. In the current study, the Pr scale produced a mean T-score of 49.33 (s.d. = 10.59); 95% CI = 47.19 to 51.66.

Outgroup Hostility Scale (OHS). This clinician rating scale consists of 18 rating criteria developed by the author that reflect biased beliefs, affects, and behaviors of outgroup bias. An example of one of the rating items on the scale was "Panic and anxiety secondary to benign contact experiences with outgroup persons." These rating dimensions are each scored as overt/clearly present (2), implied/transient (1) or absent (0). Ratings for overt/clearly present were assigned for specific clinical problems which involved bias and that either were recurrent across treatment sessions or that were significant problems experienced by the patient outside of the treatment context – such as an on-going preoccupation with persons of a specific ethnic group or being the crime victim who reported trauma-based avoidance of outgroup persons. A rating of implied/transient was assigned when the clinical problem was isolated to a singular

treatment session or in which there was no obvious impact upon current life functioning of the patient – i.e., this rating was typically assigned when the patient expressed a stereotype or bias towards an outgroup and denied any behavioral correlate to the bias element. The mean for the OHS for the psychotherapy sample was .72 (s.d.=2.20); 95% CI = 48.30 to 51.70.

Outgroup Empathy Scale (OES). This clinician rating scale consists of 8 criteria which reflect positive attitudes concerning outgroups. An example of the rating criteria is "Positive Contact" – i.e., expression of positive relationships and experiences with outgroup persons. Each criteria is coded the same as the OHS; (M=1.27, s.d.=2.28); 95% CI = 48.30 to 51.65.

DSM-IV Diagnoses. Diagnoses were assigned for the five axes of the DSM-IV system. In addition, ratings for the GARF (Global Assessment of Relationship Functioning) Scale were assigned. The GARF measures patient relational functioning (Hilsenroth, et. al., 2000). In the current study, GARF ratings were assigned at termination of treatment in terms of the overall level of the patient's relationships. As with the GAF, higher scores for the GARF reflect more effective patient functioning.

Procedure

All patients were initially seen in an individual assessment interview. At the time of the initiation of treatment, patients signed a release of information, allowing for clinical information to be aggregated for research purposes. Prior to the initial interview, patients were administered the MINI and Gough Pr scale. The diagnostic interview included administration of the SCID-II Screening interview schedule (Spitzer, Williams, Gibbon, First, 1990). From the diagnostic interview, demographic information (e.g. client educational level, race/ethnicity) was recorded and a primary DSM-IV diagnosis and General Adaptive Functioning (GAF) score were assigned. The MMPI was individually administered as part of the patient assessment –

i.e., during the first two to three clinical assessments. The Pr scale, used in the current study was computed at the termination of treatment for all patients.

At the conclusion of treatment, the treating psychologist assigned ratings for patients' outgroup concerns. These were assigned as described by Dunbar (1997) into one of three categories. These were: (1) positive/relationally empathic concerns about outgroups, (2) no expressed outgroup concerns, and (3) ambivalent and explicit/hostile concerns about outgroups. In all cases ratings were made based upon patient-initiated discussion of their intergroup experiences and feelings concerning outgroups. Post-treatment ratings were also assigned for the OHS and OES.

Reliability analysis of the rating criteria for patient outgroup concerns, the clinical triad of pathological bias, the OHS, and the OES were computed. This involved the selection of a subset of cases to reflect patient outgroup concerns and independent ratings by the examining psychologist and two university research assistants. A subset of 34 cases were selected for review. These included four cases initially classified by the examining psychologist as aversive, four as empathic, and 26 as neutral in terms of outgroup attitudes. These cases were randomly selected from the larger sample. The author provided training and on-going consultation in the coding of the materials.

In this procedure, the two research assistants independently reviewed each case and assigned ratings for each measure. Their independent ratings were computed for inter-rater agreement. Subsequent review led to the resolution of differences to produce a single overall rating. This rating value was then employed in the computation of Kappa values for the examining psychologist with the research assistants. The inter-rater Kappa values for the two research assistants was 1.0 for classification of the 34 cases for outgroup concern status. The

clinical triad Kappa values were .65 for intrusive ideation, .84 for aversive arousal and 1.0 for relational/contact damaging behaviors. The mean inter-rater Kappa for the OHS items was .85; with a range of 1.0 to .72; the mean Kappa for the OES items was .87 (range of 1.0 to .71). The Kappa value between the examining psychologist and the final ratings of the research assistants was 1.0 for classification of patient outgroup concerns, .78 for intrusive ideation, .84 for aversive arousal and .65 for relational/contact damaging behavior. The mean Kappa for the examining psychologist and research assistant for the OHS items was .94; with a range of 1.0 to .65; the mean Kappa for the OES items was .60 (range of .81 to .32).

Analyses

Patient data was tabulated, entered, and analyzed in SPSS 10.5. Preliminary analyses of the outgroup concerns ratings revealed a very small number of patients (.6%) who were characterized as evidencing explicit/hostile bias. Tabulated findings for the outgroup concerns for explicit and ambivalent bias were collapsed in subsequent analyses into one category for aversive bias. The primary DSM Axis 1 diagnoses were collapsed for use in the subsequent analyses into categories for Adjustment Disorder, Dysthymia, Major Depressive Disorder, PTSD, Obsessive-Compulsive Disorder, Anxiety Disorders, and severe psychopathology - Bi-Polar Disorder and Schizophrenia. The scale scores for the OHS and OES were both converted to standardized T-scores, for ease of interpretation in the subsequent analyses.

Results

Base rates of outgroup concerns. In examining research question 1, it was found that 11.3% of the sample evidenced aversive outgroup bias – of these patients 10.7% revealed ambivalent outgroup concerns and .6% evidenced explicit-hostile bias concerns. Positive, relationally empathic outgroup concerns were found for 12.6% of the sample, 77.1% of the

sample were classified as evidencing no outgroup concerns. The base rates for the three criteria of pathological bias was 7.5% for outgroup ideation, 7.5% for affect dysregulation secondary to outgroup stimulus, and 1.3% for engagement in contact damaging behaviors.

Treatment characteristics of pathological bias. The primary Axis 1 diagnoses included Major Depressive Disorder (n = 41), Adjustment Disorder (n= 27), Dysthymia (n= 32), Obsessive-Compulsive Disorder (n = 11) PTSD (n = 11), Anxiety Disorders (n = 23) and severe psychopathology (n = 9). Thirty-two of the patients (20%) had an assigned Axis 2 diagnosis for a personality disorder. The GAF scale ratings had a mean score of 63.76 (SD. = 8.11); 95% CI= 62.30 to 65.21; the GARF score mean was 69.80 (SD= 9.81); 95%CI = 68.20 to 71.40.

The median number of treatment sessions for the entire sample was 50.23 (SD = 51.82). Significant differences in the length of treatment was found, based upon outgroup concerns. Results of a univariate analysis of variance (number of treatment sessions by patient outgroup concerns) revealed that the number of treatment sessions varied between the outgroup aversive patients (99.71, SD = 76.55) and the neutral (36.46, SD = 36.83), and outgroup empathic patients (47.41, SD = 48.25); *(F3*, 155 = 7.19, p<.001, η^2 = .14, power = .95). To determine if the role of psychopathology was a significant moderator on this finding, a separate ANOVA for outgroup concern by treatment length with both GAF and GARF ratings as covariates was run; results indicated that neither GAF *(F* = .22, p<.64, η^2 = .002, power = .08) nor GARF *(F* = 1.02, p<.31, η^2 = .007, power = .17) ratings were significant upon the outgroup concern by treatment length relationship. For outgroup aversive patients, the initial expression of bias had a median value of 5 sessions (SD= 9.60; range of 3 to 28). That is patients who evidenced aversive outgroup concerns typically did so within the first one to two months of treatment and

in all cases were identified significantly before patients usually terminated psychotherapy treatment.

For the entire sample, 40.3% of patients were prescribed psychotropic medication at some point during the course of psychotherapy treatment. This included 24.7% who were prescribed anti-depressant medications, 12.0% who were prescribed a combination of anti-anxiety and anti-depressant medications, and 3.2% who were prescribed more complex drug treatments for treatment of a thought disorder and/or mania. Medication treatment by the patients' outgroup concerns approached significance (X= 3.73, p<.15). For the aversive outgroup patients 61.1% were on psychotropic medication during the course of treatment; as compared with 40.0% for outgroup empathic and 37.2% for outgroup neutral patients.

Role of patient demographic factors in expression of outgroup concerns. Differences for the patients' outgroup concerns by their current relationship status approached significance (X = 7.22, p<.12); patients who were in relationships with racial/ethnic outgroup persons were almost four times (28.6%) as likely as aversive outgroup attitude patients (7.8%) to express empathic feelings about outgroups. The role of educational status was examined in a series of 1X5 Oneway ANOVAs for the OHS, OES, and clinical triad of outgroup bias. Results were not significant. This information is presented in Figure 1.

Patients who were in a primary relationship with a partner of a racial/ethic outgroup also had higher ratings on the OES (m= 54.985) than patients with no primary relationship (m= 50.13) or an ingroup partner (m= 49.04), ($F2$, 155 = 6.23, p<.002, η^2 = .08, power = .86). The OHS score did not vary based upon the patients' primary relationship status. On the OHS men had significantly higher scores (m= 53.59) than women (m= 48.30) t= 2.61, p<.01, 95% CI =

47.83 – 54.58. The OHS, OES, and Pr scale did not significantly differ by patient race/ethnicity, gender, age or sexual orientation.

Relationship between clinical triad of pathological bias and patient functioning. Correlations were computed for the clinical triad for pathological bias and the GAF and GARF scores. A modest relationship in the anticipated direction was found between the patient ratings for intrusive bias ideation and GAF ($r= -.30$, $p<.01$) and GARF ($r= -.27$, $p<.01$), as well as between bias-contingent aversive arousal and GAF ($r= -.22$, $p<.01$) and GARF ($r= -.18$, $p<.05$). Ratings for the third criteria of the clinical triad - relationship damaging behaviors in contact settings - were not significantly related to GAF and GARF scores.

Co-occurrence of symptoms of pathological bias with DSM IV diagnostic categories. Univariate analyses of variance were computed for the clinical triad criteria, OHS, OES, and Pr scale by the primary DSM Axis 1 diagnosis. Results for the clinical triad were significant for intrusive ideation by the DSM diagnoses ($F7, 151 = 2.85$, $p<.01$, $\eta^2 = .12$, power = .88) and aversive arousal ($F7, 151 = 2.20$, $p<.05$, $\eta^2 = .08$, power = .76), but not for relationship damaging behaviors ($F7, 151 = 1.28$, $p<.27$, $\eta^2 = 05$, power = .49). Results were significant for the OHS scores by Axis 1 diagnosis ($F7, 151 = 2.27$, $p<.05$, $\eta^2 = .12$, power = .78); Scheffe contrasts found that a diagnosis for Obsessive-Compulsive Disorder (m=59.75) was significantly different from patients diagnosed for Dysthymia (m=48.75) at the .05 level. Differences for the Pr Scale by Axis 1 diagnosis were also significant ($F7, 151 = 2.76$, $p<.05$, $\eta^2 = .21$, power = .84). Results for Axis 1 diagnosis and OES scores were not significant ($F7, 151 = .87$, $p<.52$, $\eta^2 = .04$, power = .33). These findings are presented in Table 2.

To examine the co-occurrence of symptoms of pathological bias with DSM diagnoses (research question 5), hierarchical multiple regression analyses (HMR)

were computed for the clinical criteria for pathological bias (the dependent variable) and the corresponding MINI patient-reported DSM-IV symptoms and clinician-assigned DSM-IV diagnoses. The HMR analyses tested the relationship of patient self-reported symptoms on the MINI on step one, followed on step two by the Pr scale. On step three clinician ratings for DSM diagnoses were entered. This strategy allowed for the determination of the independent contribution of patient symptom report and clinician diagnosis.

The first HMR model examined how DSM criteria predicted outgroup hostility – consisting of the OHS ratings for expressed hostility towards an outgroup, denigration of outgroup customs and behaviors, and the reported use of hostile behaviors in benign contact situations. The predictor variables were the MINI patient reported symptoms for hypomania and hypomania-hostility, the Pr scale, and diagnosis for severe psychopathology – i.e. Bi-Polar Disorder and Schizophrenia. The model was significant (R^2=.13, Adj. R^2=.11). The significant predictor variables were MINI Hypomania symptoms (*B*= .21, t=2.35, p<.05) and diagnoses for severe psychopathology (*B*= .45, t=3.60, p<.01).

The second HMR model examined outgroup trauma symptoms, measured by a single measure on the OHS, with the predictor variables consisting of the patient-reported symptoms for PTSD experiences and PTSD: flashbacks on the MINI (step one) followed by the Pr scale (step two), and the presence of a DSM-IV diagnosis of PTSD on step three. Results were significant (R^2=.19, Adj. R^2=.15), with both MINI PTSD: flashback symptoms (*B*= .49, t=3.95, p<.001) and clinician diagnosis for PTSD (*B*= .18 t=1.63, p<.05) predicting reported outgroup trauma victimization.

The third HMR model examined the relationship of DSM symptoms with outgroup anxiety – measured on the OHS ratings for expressed outgroup fears, avoidance of outgroup contact, and reported anxiety secondary to outgroup contact. The predictor variables were the MINI patient-reported symptoms for anxiety symptoms and social phobia (entered on step one), the Pr scale which was entered on step two, and on step three the presence or absence of an assigned DSM-IV diagnosis for an anxiety disorder – excluding Obsessive-Compulsive Disorder and PTSD. Results were significant (R^2=.13, Adj. R^2=.07), with patient-reported symptoms for social phobia (*B*= .36, t=3.23, p<.001) and panic (*B*= .15, t=1.50, p<.10) accounting for slightly less than ten percent of the ratings for outgroup anxiety. Neither the Pr scale score nor the clinician diagnosis for a DSM-IV anxiety disorder improved the model.

The fourth clinical cluster concerned the co-occurrence of outgroup suspiciousness/fears with patient-reported obsessions, the Pr scale score, and clinician-assigned diagnoses in predicting suspicions and fears of outgroups, based upon the OHS rating criteria. Results were not significant (R^2=.04, Adj. R^2=.01).

Differences between aversive bias psychotherapy patients and the remainder of the sample were also examined on the MMPI-2. Significance tests revealed that aversive outgroup patients had higher MMPI-2 scales scores for F (t= 2.10, p<.04), Pa (t= 1.95, p<.05), and Pt (t= 2.67, p<.03). None of the other clinical scales varied between the patient groups.

Post-hoc analyses of OHS and OES categorical Co-Occurrence. The co-occurrence of OHS and OES status was examined. Patients were classified into no outgroup symptoms (OHS score of 0) and outgroup symptoms present (OHS score of 1 or greater) and outgroup

empathy absent (OES score of 0) and outgroup empathy present (OES score of 1 or more). Results of a 2X2 contingency table ($X = 8.21$, $p<.004$) it was found that the majority of patients (74.2%) did not reveal either symptoms or empathic feelings concerning outgroups. Positive feelings about outgroups were expressed by another 14.2% of the patients; 5.2% of the patients evidenced both symptoms attributable to outgroup bias and expressed positive feelings about outgroups. It was also found that 6.5% of the patients evidenced symptoms attributable to outgroup bias and were absent positive feelings about outgroups.

Discussion

This study examined the problem of pathological bias amongst mental health consumers who sought treatment for problems unrelated to intergroup issues. Examination of pathological bias via categorical classification and dimensional symptom ratings was employed to determine how this clinical problem might co-occur with recognized clinical disorders. The assessment strategy examined three criteria of pathological bias, these were, the expressed outgroup concerns of the patient, the presence of pathognomic signs of severe bias, and the identification of psychological symptoms attributable to the patient's expressed outgroup concerns.

Pathological Bias, Syndrome or Disorder?

As noted, the considerable majority of psychotherapy patients did not evidence concerns or symptoms related to social outgroups. Patients who did express concerns about outgroups were nearly equally represented by aversive and empathic feelings. Patients who evidenced symptoms attributable to their outgroup concerns were markedly ambivalent about their biased beliefs. Put another way, patients in psychotherapy treatment who expressed negative outgroup concerns experienced their bias beliefs - and the attendant symptoms associated with their bias - to be aversive.

Pathologically biased patients revealed a range of symptoms related to their outgroup concerns. These included feelings of persecution by outgroups, fantasies of violence against their culturally different co-workers, recurring fears of their neighbors, paranoid ideation of non-English speakers, and denigration of outgroups seen as unclean, criminal, or sub-human. In some cases these pathologically biased patients were ostracized from their families, shunned by their co-workers, or suspended from their schools or worksites due to their hostile intergroup behaviors. Co-occurring clinical problems found with pathologically bias patients included mania and impulse disorders, anger, lability, and relational disturbance. The role of psychological trauma was also a factor in the manifestation of aversive biased beliefs of many of the clerical abuse claimants.

In all but the most severe cases, patients recognized the undesirable nature of their fears and preoccupations. For these patients the bias element may constitute a unique barrier in accessing mental health treatment (Sullaway & Dunbar, 1996). This may in turn underestimate the base rates of this clinical problem. It is to be expected that a variety of factors influenced patient disclosure of their biased and hostile concerns in the course of treatment. In the current studies it is likely that the stigma associated with the endorsement of racial stereotypes, for example, may have inhibited some patients. This is an issue addressed experimentally with non-clinical samples (Dunton & Fazio, 1997).

This study considered an issue – outgroup bias – that is conventionally the purview of social psychology. The current findings are in some instances consistent with these areas of study. Specifically, as has been indicated previously, men in the current psychotherapy sample evidenced greater symptomatology of pathological bias, as measured on the OHS. This is similar to findings in the area of social attitudes, which have found that men endorse more

explicit outgroup bias (Ehrlich, 1972). In many of these studies, men evidence greater social distance whereas women may regulate intimacy, friendship and other components more effectively in intergroup relationships (Howard Ehrlich, personal communication, September 12, 2005). Similarly, the issue of intergroup contact is important to the assessment of pathological bias. Contact may constitute a condition of behavioral exposure that elicits an array of symptoms due to the contact experience. Additionally, there is some evidence that patients in inter-racial and inter-ethnic relationships were more likely to be present both empathic and aversive concerns about social outgroups.

This study did not solicit patient attitudes concerning social outgroups. Similarly there was no therapeutic – i.e. externally-manipulated - effort to systematically sample psychotherapy patients in terms of their explicit attitudes concerning outgroups. Rather, the current research examined psychotherapy patients who spontaneously expressed concerns about outgroups and concomitantly evidenced affective and behavioral disturbance related to these concerns. In this sense it is more useful to consider that this study examined mental health consumers for whom race, gender and sexual orientation was salient to psychological well-being.

Implications for Treatment with Clinical Bias

Consistent with our lack of knowledge about how to examine bias as a mental health problem, there are no established practice guidelines for the treatment of pathologically biased patients. The problem is that simply examining this problematic topic may not result in any discernible practical implication for treatment. This, of course, is a challenge to any unexamined area of clinical investigation. At the same time, it has been proposed that mental health treatment may include talk therapy, behavioral stress inoculation treatment,

pharmacotherapy, and naturalistic milieu experiences that mitigate against the bias element (Dunbar, 2004). What this study has not considered is what therapeutic and contextual factors ameliorated the bias element. Future research may want to consider how therapeutic interventions may reduce or activate symptoms of pathological bias.

Research concerning pharmacotherapy efficacy in reducing symptoms of pathological bias is an important topic for clinical practice and hypothesis testing. For example, in more acute samples it would be possible to examine how psychotropic medication treatment may lead to a reduction of symptoms of outgroup ideation, arousal, or aggression; this would hold implication for the issue of the co-occurrence of pathological bias with other clinical problems, on the one-hand, and may provide indirect information on the bio-psychological processes that underpin the emergence of severe forms of outgroup bias on the other. Similarly, employment of the current classification model in a pre-post pharmacotherapy intervention could provide information on effective treatment outcome as well as identify treatment-resistant cases of pathological bias. It would be valuable to determine what symptoms of pathological bias are most amenable to treatment and which by comparison pose the greatest challenge to medication and behavioral intervention.

Towards a Research Agenda of Bias as a Mental Health Problem

The current study has sought to consider a variety of assessment issues in the examination of pathological bias. These have included the employment of multiple evaluative criteria, the relationship of these criteria to both patient and clinician impressions using the DSM-IV nosology, and the examination of pathological bias in terms of both a categorical and dimensional assessment strategy. This assessment model demonstrated sufficient reliability in

regards to classification and identification of symptomatology to allow for further study. Further examination of the issues of reliability and validity is needed in this regard.

Certainly the most contentious issue in the investigation of pathological bias is whether a recognized social problem – i.e. racism or homophobia - is being pathologized, whole cloth. Concerns have been voiced that this line of research can be employed in "excuse abuse" legal defenses such as racial paranoia and homosexual panic (Sullaway, 2004), the obfuscation of historical inequities, and the denial of institutional discrimination. This is a simplification of a complex and important issue. It is also an argument that minimizes the professional responsibility of mental health practitioners from dealing with racism in a context of their expertise – i.e., the consultation room.

It is important to determine whether symptoms of pathological bias are related to specific psychiatric disorders or whether symptoms related to outgroup bias co-occur in relationship to a broad array of DSM disorders. If future research indicates that clinical problems of bias are most likely to occur with patients evidencing Bi-Polar Disorder or the Cluster B Personality Disorders – such as Narcissistic Personality Disorder or Borderline Personality Disorder – then it might be more correct to consider pathological bias as a co-occurring syndrome to more pathological disorders. Conversely, if symptoms of outgroup bias are equally distributed across a spectrum of recognized disorders, in terms of severity of psychopathology, then it would indicate that pathological bias co-occurs randomly with any clinical problem. This distinction has both practical and theoretical implications. If pathological bias co-occurs with a relatively narrow band of more severe clinical disorders it may well be that specific treatment interventions such as adjunctive pharmacotherapy or multi-modal treatments would be required. Conversely, if symptoms of pathological bias are found across

the spectrum of mental disorders, then the focus of treatment will be dictated by the primary treatment goals of the primary diagnosis. Implicitly then, in this latter case, pathological bias would not evidence a clear pathogenesis nor indicate a unique treatment or case management concern for the clinician.

Future research is needed that considers the distinction between pathological bias as a syndrome associated with severe forms of psychopathology vis-à-vis a more broad spectrum of clinical disorders. This would help to consider the clinical utility and diagnostic relevance of pathological bias in the current diagnostic system.

The notion that pathological bias constitutes a stand-alone disorder would need to demonstrate construct validity that is agreed to by scholars in the areas of psychopathology and intergroup bias. Additionally, the identification of specific symptoms of such a diagnostic category would need to demonstrate via clinical research an independence from other recognized diagnostic categories and to impute serious impairment to the individual such as to warrant mental health treatment. Such a line of research would additionally need to be replicated in various clinical and cultural contexts.

Future validation research of pathological bias needs to address the challenge of determining the clinical sensitivity of the assessment criteria, given the substantial social desirability associated with denying outgroup bias. It follows that the reluctance to discuss bias as a personal problem will therefore require alternative methods of validation study than the employment of explicit stereotype checklists or social distance scales. Instead, the use of both implicit attitude methods and neuro-diagnostic techniques should be considered. Research techniques using Implicit Association Tests or functional magnetic resonance imaging technology may be useful to corroborate clinical and behavioral indicators of bias. In the case

of anti-social behavior, the role of pathological bias in the perpetration of violence and failure to benefit from diversion interventions may also prove fruitful.

Does Racism Make You Crazy?

Research needs to explicitly consider differences between majority and minority groups in regards to the identification of outgroup bias as a mental health problem. There may well be meaningful differences in the etiology of pathological bias for majority group and minority group individuals. These may be due to personal experiences of being the victim of bias and belonging to a social group that historically has been the target of institutional racism and discrimination. In such instances the presence of "healthy paranoia" needs to be seriously considered as a healthy response to intergroup contact – particularly in institutional settings – rather than as an indicator of psychopathology (Ridley, 1984).

Conversely, experiences of ingroup privilege amongst members of cultural majority groups may produce highly maladaptive behaviors in intergroup interactions. Social privilege – i.e., the assertion of ingroup power and status - may additionally result in markedly poor capacity to learn from contact experiences. Such interpersonal failure may mimic problems typically encountered by patients with personality disorders. Clinical problems related to "Entitlement Dysfunction" (Pierce, 1978; Pierce & Profit, 1991), for example, may result in hostile and ineffective intercultural behaviors by individuals who are otherwise absent severe psychopathology.

The as yet insufficiently examined question remains whether racism and discrimination may create psychopathology, at least amongst individuals with other co-occurring mental health disorders. The issue therefore that remains to be answered by multi-site studies using a reliable and valid methodology concerns whether entitled majority group individuals – as well

as patients who evidence coping strategies of outgroup suspiciousness - reflect social conventions or a clinical problem likely to benefit from mental health intervention.

The current study examined pathological bias with an outpatient psychotherapy sample. The current findings are preliminary, with some caution needed as to the conclusions being drawn, given that effect size is compromised by the small sample numbers. These findings are additionally reflective of the range of psychopathology in these groups. How effective the assessment system that was used here – as well as the reported base rates for pathological bias – would be with an offender group, or a more severely compromised psychiatric sample, is uncertain.

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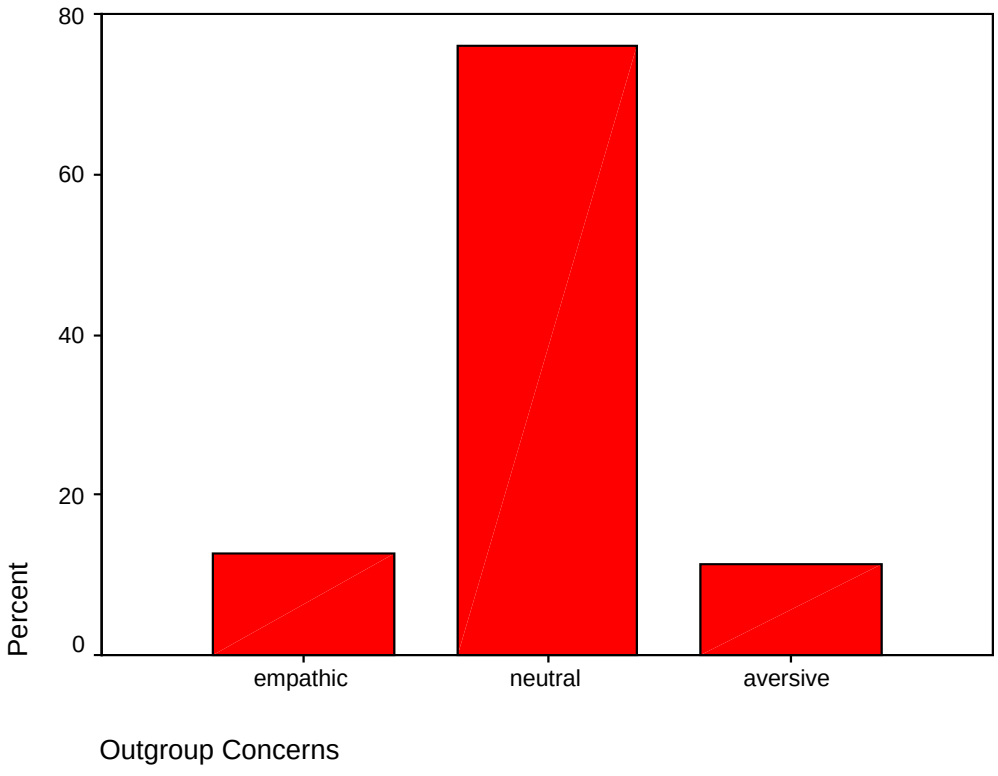
Figure 1: Patient Outgroup Concerns by Demographic Status



Median Age	38.65	39.21	43.06
Men	10.2%	77.35	12.5%
Women	15.5%	74.6%	9.9%
Heterosexual	12.9%	76.2%	10.9%
Gay/Lesbian	10%	70%	20%
<u>Race/ethnic</u>			
African-American	14.3%	85.7%	0%
Asian-Pacific	33.0%	66.7%	0%
Euro-White	14.7%	68.0%	17.3%
Latino	0%	92.3%	7.7%
Multi-Ethnic	22.2%	44.4%	33.3%
<u>Relationship status</u>			
No relationship	19%	69%	11.9%
Ingroup partner	3.8%	87.3%	8.9%
Outgroup partner	25%	58.3%	16.7%
<u>Educational level</u>			
High School	7.1%	78.6%	14.3%
College	12.4%	76.30%	11.3%
Post-Graduate	15.2%	76.1%	8.7%

Table 1. Frequencies for Clinical Triad OHS, OES and Correlations with GAF and GARF Scores.

	Freq.	GAF Scores	GARF Scores
Clinical Triad:			
Intrusive ideation of outgroups	7.5%	-.30**	-.27**
Aversive arousal via exposure to outgroups	7.7%	-.22**	-.18*
Contact-damaging behaviors in benign settings	1.3%	-.09	-.03
OHS:			
Fears and preoccupations of outgroups	2.1%	-.15	-.26**
Hostility towards outgroups	3.1%	-.15	-.22**
Denigration of outgroup behaviors	2.5%	-.17*	-.15
Implausible victimization by outgroup	.6%	-.14	-.19*
Aversive ideation concerning outgroup	3.8%	-.23**	-.17*
Victimization by outgroup persons	2.0%	-.06	-.08
Hostility/lability secondary to contact	3.8%	-.16	-.19*
Endorses values promoting intergroup conflict	0		
Endorses violence to solve intergroup problems	0		
Panic secondary to intergroup contact	2.1%	-.10	-.06
Provocation in intergroup contact	.6%	-.14	-.08
Avoidance of contact experiences	3.5%	-.06	-.04
Physical aggression targeting outgroup persons	.6%	-.13	-.04
Damage to property of outgroup persons	0		
Behaviors promoting intergroup conflict	0		
Participates in groups promoting intergroup violence	0		
Marked suspiciousness of outgroups	4.2%	-.17*	-.05
Bizarre paranoid ideation regarding outgroups	.6%	-.25**`	-.29**
OES:			
Social comparison of in- and outgroup status	4.7%	.03	.05
Tolerance of outgroup differences	4.1%	-.04	-.01
Valuing Diversity of differing cultural groups	6.3%	.09	.10
Empathy of outgroup persons' experiences	3.8%	.05	.08
Positive contact experiences with outgroups	5.6%	.05	.02
Meta-categorization of all groups as being equal	3.9%	.01	.02
Acknowledgement of societal inequity/discrimination	5.0%	.03	.06
Valuing social justice laws to end discrimination	1.9%	.11	.12

Table 2: ANOVA Results for Primary Axis 1 Diagnoses by Pathological Bias Criteria, OHS, OES, and Pr Scale scores

	PB-Id. mean	F	PB-Ar. mean	F	PB-RD. mean	F	OHS mean	F	OES mean	F	PrScale mean	F
		2.85**		2.20*		1.28		2.24*		.87		4.12***
Adjustment Disorders (n= 27)	.04		.05		.00		49.93		48.81		43.73	
Major Depression (n= 41)	.10		.05		.00		49.00		51.20		53.73	
Dysthymia (n= 32)	.03		.03		.03		48.50		50.00		44.29	
Obsessive Compulsive (n= 11)	.20		.10		.10		59.75		53.15		41.43	
PTSD (n= 11)	.10		.20		.00		50.01		53.21		49.57	
Anxiety Disorders (n= 23)	.04		.09		.00		49.07		46.56		48.85	
Severe Psychopathology (n= 9)	.50		.38		.00		56.77		50.50		61.20	

*** p <.001 ** p <.01 * p <.05

PB-Id. = Bias ideation, PB-Ar. = Arousal secondary to outgroup exposure, PB-RD = Contact-based relationship damaging behaviors

Table 3. Hierarchical Multiple Regression Results of DSM Criteria in Predicting Outgroup Hostility and History of Outgroup Trauma

Step	R^2	Adj. R^2	F	B	t
Dependent VariableOutgroup Hostility					
1. MINI:	.06	.04	2.71**		
Hypomania				.21	2.35*
Hostilty				.09	1.55
2. Pr scale	.06	.02	1.21		
				.04	.72
3. DSM Dx.	.20	.15	3.45**		
Severe psychopathology				.45	3.60**
Presence of Cluster B P.D.				.10	.95
Dependent Variable History Outgroup Trauma					
1. MINI:	12	.10	4.98**		
PTSD history				-.14	-1.25
PTSD intrusions				.49	3.95***
2. MMPI	.16	.13	3.65*		
Pr Scale .				.25	2.20*
3. DSM Dx.	.19	.15	4.23**		
Presence of PTSD				.18	1.63*

*** $p < .001$ ** $p < .01$ * $p < .05$

Table 3: Hierarchical Multiple Regression Results of DSM Criteria in Predicting Outgroup Anxiety and Fears/Suspiciousness (cont.)

Step	R^2	Adj. R^2	F	. B	t
Dependent Variable: Outgroup Anxiety					
1. MINI:	.11	.08	3.18**		
Panic Disorder				.15	1.50
Social Phobia				.36	3.23***
2. MMPI	.09	.04	1.57		
Pr Scale				-.14	-1.27
3. DSM Dx.	.08	.04	.09		
Anxiety Do.				.01	.10
Dependent Variable	Outgroup Fears/Suspicions				
1. MINI:	.01	-.01	.06		
OCD Cognitions				.08	.66
2. MMPI	.02	.008	1.73		
Pr Scale				.11	1.52
3. DSM Dx.	.04	.001	1.66		
Severe psychopathology				.06	.60
Presence of Cluster B P.D.				.14	1.64

*** $p < .001$ ** $p < .01$