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The Unequal Distribution of Social Risk for Black Men Across the Life-Span. A Novel Framework

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Abstract

This conceptual overview offers a comprehensive summary of systemic pathways that negatively affect the mental health of Black men throughout their lives. My argument highlights the importance for counselors and mental health professionals to use a thorough social risk assessment that considers these pathways to effectively address the mental health needs of Black men while fostering positive working relationships. This overview strongly advocates for the use of context and social determinants when evaluating mental health symptoms. Without an appropriate understanding of social risk and determinants, counselors might inadvertently perpetuate disparities by decontextualizing symptomology and reproducing racist discourse.

KEYWORDS:
Men, African American, racism, social determinants, mental health

The Unequal Distribution of Social Risk for Black Men Across the Life-Span. A Novel Framework

Throughout the history of the United States (U.S.), Black men have been subjected to a disproportionate amount of abuse from multiple systems, including, but not limited to, education, health care, and criminal justice. This structural racism influences the amount of cumulative social risk Black men experience across the lifespan, resulting in adverse outcomes, such as mass incarceration (Shannon et al., 2017); medical disparities (Gaston & Alleyne-Green, 2012); and high all-cause mortality (Benjamins et al., 2021). These structural stressors manifest as distal causes that contribute to psychiatric pathology (Compton & Shim, 2015). These brutal injustices have created a social and institutional discourse of deficits, which locates Black men as pathological within society, because of either biological or cultural characteristics (Smiley & Fakunle, 2016). This discourse re-appeared during the COVID-19 pandemic. During the early stages of the pandemic, various medical authorities discussed many of the best practices associated with COVID-19, especially social distancing, as less than optimal in Black and other minority communities (Chowkwanyun & Reed, 2020). Without the attendant discourse of structural concerns that allowed for the best use of COVID-19 guidelines, minority communities risked being pathologized as non-compliant, because of attributions to race, color, and biology (Chowkwanyun & Reed, 2020). Chowkwanyun and Reed (2020) cautioned researchers and authorities to provide important context (namely, the structural determinants) to medical and mental health outcomes, or risk inadvertently reproducing racist discourse.

Building on Chowkwanyun and Reed's (2020) call for caution and context, the current manuscript aims to integrate the concept of social risk, which was pioneered by Beck (1992), with the perspective of social determinants of mental health (SDOMH) on accumulated advantage across the lifespan. This integration seeks to provide context for the many structural forces that contribute to mental health challenges among Black men and other minorities across the lifespan. This social risk approach builds on the growing movement to integrate SDOMH into counseling practice, education, and assessment, to improve counseling outcomes among adults (Jones et al., 2023). A more sophisticated social risk assessment might help mental health professionals build working alliances by providing accurate knowledge of clients' exposure to risk and stressors, which are mediated by these determinants. This knowledge could help develop meaningful working alliances that improve psychotherapy outcomes, which are poor for Black men and other racial minorities (Nadal et al., 2014; Wampold, 2015). Social risk conceptualization, early in the therapeutic relationship, heeds Barden et al.'s (2017) call for counselors to move beyond self-awareness of multicultural differences to specific knowledge of clients. I will integrate two paradigms, social risk and cumulative disadvantage from SDOMH, to detail the social risk threats to Black men. I describe how this approach improves and builds on existing assessments, along with why it could be vital in improving psychotherapy outcomes with Black men, by attending to structural forces that influence their social risk exposure through novel social risk assessments during the beginning of psychotherapy.

Positionality

I have several intersecting, minority identities and belong to communities that have long been subjected to pathological characterization by the professional literature. I have long lived and worked in these communities and have seen the results of substandard psychotherapy, firsthand, and the consequences they have for less-resourced communities. I am hopeful that the push to consider structural forces that contribute to mental health will improve outcomes for many minority groups, especially Black men, that are disproportionately exposed to stressors and social risk.

Contemporary Context

Black men have disproportionate social risk exposure across the lifespan, leading to accumulated disadvantages that influence their mental and physical health. Their concentration in the unequal SDOMH is a historical legacy of racism, Jim Crow, and the modern political economy that exacerbates inequality. It is important to note that this accumulated social risk represents population health and is not necessarily predictive of individuals. For example, Black children, especially boys, are more likely to be diagnosed with conduct disorder, attention-deficit hyperactivity disorder (ADHD) and oppositional defiant disorder within their early childhoods (Atkins-Loria, 2014; Fadus et al., 2019). During the critical childhood ages, economic inequality and neighborhood disadvantage vital SDOMH appear to increase biological aging in young Black children, due to stress exposure (Raffington et al., 2021). Black children are disproportionately concentrated in disadvantaged neighborhoods throughout the U.S., dynamically interacting with urbanicity, which influences mental and physical health. As they age, men are more likely to commit suicide than women (Joe et al., 2006), yet Black men are less likely to be supported for their mental health (Hammond, 2012). Black men are more likely to die from police-related violence (*Washington Post*, 2024) and 33% have a felony charge

(Shannon et al., 2017). When Black men are unarmed and older, and in mental health crisis, they are more likely to be killed by police forces during encounters than other races (Thomas et al., 2021). As they continue to age, elderly Black men are more likely to have cognitive impairment than their White peers, reflective of the higher likelihood of experiencing inequality and adverse stressors throughout the lifespan (Zhang et al., 2016). Indeed, historical cohort effects appear to influence mental and physical health as well. For instance, racism experienced during southern segregation and Jim Crow might play a role in this observed disparity amongst the elderly, influencing Black men in particular (Black et al., 2015). The interaction with legal and psychiatric forces along with structural constraints (e.g., marginalized neighborhoods, riskier and precarious jobs, legal systems) contributes to Black men having some of the highest rates of all-cause mortality within the U.S. population (Benjamins et al., 2021). Therefore, it is not a surprise that cumulative stress, an indicator of lifelong physical and mental toll, was found to be a strong predictor of depressive symptomology for Black men when they reached retirement age (Thorpe et al., 2020). From youth to retirement ages, disproportionate social risk exposure drives the accumulative disadvantages that have mental and physical health outcomes across the lifespan for Black men.

Access to mental health services is often limited, and Black men are more likely to rely on informal networks of support (e.g., family, religious communities) than professional services (Woodward et al., 2010). This is understandable, as counseling and psychiatric outcomes are poor, and there might be difficulty in developing a working alliance and agreeing upon tasks and goals (Wampold, 2015) due to provider incompetence. Black patients are more likely to access emergency departments for their mental and physical health crises than their White peers due to the lack of quality outpatient services and the marginalized neighborhoods they might live in (Snowden et al., 2009). Indeed, mental health crises, along with waiting room challenges within the emergency department often lead to stress and disruption between patients and staff. Police are often called to emergency departments to respond to crises with Black patients (Snowden et al., 2009). This is due to the greater threat perception that non-Black staff and patients place on Black mental health crises than White ones (Snowden et al., 2009). Provider biases, few resources, and the mistrust of historically racist institutions (e.g., hospitals) leave Black men vulnerable to social risk, creating a vicious cycle when they finally do try to seek professional services.

This structural context is rarely discussed amongst mental health professionals, inevitably leading to the demonization of Black men along with a decontextualization of their stressors (Smiley & Fakunle, 2016). This discourse captures Black men as "brutes" and "thugs," not worthy of victimhood (Smiley & Fakunle, 2016), or as social behavioral problems. The dubious and historically pseudo-scientific diagnoses of drapetomania during slavery and protest psychosis during the civil rights era, demonstrate the dangers of racism cloaked in professional prestige which focuses on de-contextualized symptomology—without attention to structural factors that produce psychiatric symptomology (Metzl, 2011; Myers, 2014). Black men are still more likely to be diagnosed with psychosis than mood disorders than their White counterparts (Hankerson et al., 2015). Diagnoses carry subjective inferences that intertwine with cultural perceptions of how pathology is understood and treated within society (Fadus et al., 2019). There are modern echoes with how Black men's symptomology is perceived within professional establishments. For instance, Black boys are disproportionately diagnosed with oppositional defiant disorder, conduct disorder, and ADHD (Atkins-Loria, 2014; Fadus et al., 2019), leading to an intense regimen of psychiatric medicine, especially if they are poor and/or in the foster care system (Fitzgerald, 2009). This results in poor educational and social outcomes, including exposure to the legal system at an early age for Black boys. Normative playful and curious behaviors are pathologized, along with an inattention to the social environments where children's behavior may reflect environmental stressors (i.e., traumatic neighborhoods; Fadus et al., 2019; Fitzgerald, 2009). There is a danger of reproducing this historical legacy without sufficient attention paid to contextual SDOMH, known otherwise as the distal *cause of causes* within the literature (Alegría et al., 2018).

Social Risk Across the Life-Span: A Life-Course Approach

The life-course approach contextualizes SDOMH as affecting different developmental stages in the lifespan, from the pre-natal, childhood, and working adult stages, to the retirement and elderly ages (Allen et al., 2014). Individuals on the lower end of the distribution of opportunities in their society (i.e., in disadvantaged neighborhoods or engaged in precarious work) increase their likelihood of poor mental and physical health outcomes, accumulated through the life-course (Compton & Shim, 2015). Adverse events, traumas, and stressors play a dynamic role, influencing epigenetic and social processes that create the conditions of relative advantages and disadvantages that affect mental health (Allen et al., 2014). Cumulative advantage, the term designated to describe overall life-course advantages or disadvantages, reflects the dynamic relationship between the individual and the social determinants. Black men have some of the highest all-cause mortality in the United States, suggesting that they face greater social risk across developmental life-span stages.

Beck's (1992) social risk theory proposes that complex social hierarchies (around status, gender, race, religion, migration, income) and technological innovation in modern societies distribute social risk unequally to their populations. Social risk is defined as probabilities of harm caused by technological and social mechanisms (Beck, 1992). With the evolution of society and its complexity of social, economic, environmental, and identity relations, risk is dynamically influencing the wellness of populations within a nation-state. Thus, various systemic inequalities interact dynamically to create distributions of total risk for citizens. Not every citizen will be exposed to social risk equally. This framework ties together traditional understandings of inequity (e.g., race, sex) and holistically integrates them into a larger meta-understanding of social risk distribution, with SDOMH acting as distal, causal mechanisms. I review four mechanisms of social risk that Black men are vulnerable to that might influence mental health outcomes dynamically across the lifespan using Beck's (1992) social risk conceptualization. These mechanisms represent vital components of a social risk assessment that counselors should screen for to build a positive working alliance (Wampold, 2015), along with addressing specific factors that improve multicultural outcomes beyond self-awareness (Barden et al., 2017). It is important to note that these mechanisms influence symptomatology across the lifespan (i.e., mood disorders, trauma) but are not inclusive of all potential social risks.

Education

Higher education has rapidly become one of the best predictors of wellness, social and cultural capital, and economic privilege in society (Case & Deaton, 2022), exposing those who do not have a college education to greater inequality. Contemporary data on deaths of despair (i.e, suicide, addiction), which have lowered the life expectancy of non-college-educated, working-class Americans, confirms the stratification of college education to wellness outcomes (Case & Deaton, 2022). Beck's characterization of how the distribution of risk develops through complex and opaque institutions and leads to less trust in professionals and institutions also predicts the extreme political polarization of the contemporary U.S., where non-college-educated individuals are more likely to express distrust in institutions, professionals, and professional elites (Case & Deaton, 2022). This dynamic, combined with mistrust of professional institutions with historically racist practices, increases unequal risk distribution for many marginalized populations. Black men have fewer college degrees and poorer educational outcomes than their White peers, increasing their risk exposure to precarious employment (Bureau of Labor Statistics, 2019). Black boys face numerous challenges (e.g., disciplinary attention, teacher bias) to their well-being through the traditional P-12 system well before potential college education (Dumas & Nelson, 2016).

Non-college education creates risk through many pathways in contemporary capitalism, one of the most prominent being the increasing uncertainty in work and family lives that accompanies modern, blue-collar and gig-work. This is a dynamic for clients of all racial backgrounds; yet, Black men are less likely to have college degrees than their White counterparts (Austin, 2021). Beck's (1992) theory predicts how increasing globalization and losing labor protections through de-unionization would inevitably lead to greater risk exposure of non-college-educated individuals. This disproportionately affects the lives of Black men. Within the life-course approach of SDOMH, evidence suggests that poorer, less educated individuals in society are more likely to live in proximity to environmental stressors, such as pollution and extremely hot neighborhoods, along with low neighborhood trust, increased violence, and longer commutes (Alegría et al., 2018). These individuals also lack access to affordable mental and physical health care (Alegría et al., 2018). Beck's meta-theory on how risk exposure is a better predictor of wellness outcomes might help explain why Black men are consistently exposed to more risk through pathways of education and occupation, leading to poor overall mental health outcomes.

Employment

One of the most influential predictors of social risk is the type of employment an individual has. The American Psychological Association (APA, 2011) formulated an interdisciplinary collaboration of various experts detailing how certain jobs created higher forms of mental and physical health risk among their employees. These jobs include mining, service work, emergency response, construction, and trade work (APA, 2011). Hazardous work environments that contribute to risk involve a lack of worker control, inflexible arrangements, traumatic stress, and impaired sleep and eating arrangements (APA, 2011). Many of these jobs mentioned fall under the umbrella of blue-collar work. The Bureau of Labor Statistics (2019) noted that up to 20% of Black and Latino-identifying employed men work in service and production jobs that expose them to these risks, higher proportions than their White counterparts. Occupational exposure risk gained mainstream attention during the COVID-19 pandemic, as research demonstrated that service work, blue-collar work, and public-facing work were more likely to lead to COVID-19

exposure (Peckham & Seixas, 2020). These types of jobs place Black men structurally more at risk since they are more likely to be employed within these industries. Labor position is an important structural consideration for social risk exposure, yet it receives little attention in the counseling literature. Furthermore, blue-collar work comes with self-perceptions of inferior social status compared to white-collar work, which is predictive of mental health symptomology (Demakakos et al., 2008). Specific types of employment and their character are deeply instructive in how a society distributes risk unequally (Beck, 1992).

When Black men are not employed in high-risk occupations, they are more likely than any other racial group to be unemployed (Weller, 2019). Indeed, Black men's unemployment for the last 20 years is greater than any other racial group, and they are uniquely susceptible to job loss during recessions (Weller, 2019). High unemployment rates contribute to a host of mental and physical health problems, downstream outcomes and contribute to Black men's highest all-cause mortality numbers out of all racial groups. Thus, Black men's social risk is driven by a structural understanding of labor outcomes and how the political economy distributes power and income in U.S. society (Sami & Jeter, 2021). Black men are more likely to be unemployed than other racial groups, and when they are employed, they are more likely to work in riskier labor occupations that expose them to deleterious health outcomes, contributing to their social risk (Bureau of Labor Statistics, 2019). Assessing the nature of labor relations on a risk continuum could be a vital mechanism for improving the common factors approach (Wampold, 2015) through building trust in lived experiences.

Urbanicity

Contributing to Black men's increased social risk is their likelihood of living in major metro-areas. The U.S. Census Bureau (2001) noted that African Americans are concentrated around 10 states, with major cities like New York, Chicago, and Atlanta having robust African American populations. Exposure to stressors in cities is well-documented and referred to as *urbanicity*, which encapsulates a variety of social and structural determinants that increase stressors (Heinz et al., 2013). Psychotic symptoms also seem to increase as societies urbanize and live in cities; it is theorized that this increase is caused by more adverse experiences within a city, which trigger symptomology (Heinz et al., 2013). SDOMH research has shown that certain neighborhoods in large metro areas are uniquely affected by environmental toxins and low neighborhood trust (Alegría et al., 2018). Substance abuse density increases in urban environments, creating a structural stressor and increasing social risk exposure (Prins et al., 2018). Indeed, city living might serve as a proxy to Black men's social risk exposures, which leads to deleterious mental health outcomes. Rural and suburban stressors also exist, but the distribution of risk could be disproportionately felt in urban areas through a variety of mechanisms.

Legal System

Black men are disproportionately incarcerated within the U.S. and have been historically controlled through a variety of legal and policing institutions (Hinton & Cook, 2021). Police involvement in shooting deaths remains disproportionately higher for Black men than White men (although half of police-related shootings involve White men), especially if they are older and present as mentally ill (*Washington Post*, 2024). The legal system is one of the most dangerous distributions of risk across the lifespan for Black men: 33% are estimated to have a felony conviction, which imposes enormous costs on jobs, housing, family formation, and political participation (Shannon et al., 2017). With such an incredible cost of legal system involvement and policing abuse, there is no doubt that Black men's social risks involve them confronting legal regimens that increase their social vulnerabilities. Even when not directly exposed to the legal system, Black men are likely to have family and/or close associates who are involved, increasing the perception of risk and chronic stress (Shannon et al., 2017). Legal and policing institutions disproportionally distribute social risk to Black men and other minorities.

Putting It All Together

All-cause mortality among Black men, greater than their White counterparts, has a variety of structural pathways (e.g., medical, legal, unemployment, psychiatric illness; Benjamins et al., 2021). Yet, Black men's use of professional services, specifically positive psychotherapy outcomes, reflects this inequality (Hannon & Vereen, 2016; Woodward et al., 2010). Hankerson et al. (2015) identified four pathways that contribute to clinical disparities for Black men: (a) structural racism, (b) cultural mistrust, (c) misdiagnosis and clinician bias, and (d) informal support networks of support. Therefore, applying a social risk assessment to counseling practice which locates Black men along a risk continuum could help address these mechanisms. This assessment

would provide knowledge of the structural disparities experienced through unequal SDOMH (e.g., poor housing, precarious labor) while building trust and allowing for richer therapeutic relationships that would reduce potential misdiagnosis and bias. The assessment can be provided alongside the traditional biopsychosocial intake for a new client. The assessment is not meant to replace traditional descriptive psychiatry; rather, it helps the clinician contextualize how symptomology is expressed. Due to the institutionally racist history of the U.S., a lack of attention to structural factors reproduces pathological descriptions of behavior as having antecedents in culture or racial dynamics (Chowkwanyun & Reed, 2020). Understanding structural factors that make up social risk across the lifespan might help counselors engaged in psychotherapy with Black men (and other individuals) build stronger relationships that influence positive psychotherapy outcomes. This is done primarily through the mechanisms of helping counselors potentially relate to the lived experiences and perceptions of social factors that make up many Black men's experiences, forging the common factors needed for successful psychotherapy outcomes (Wampold, 2015). This also specifies how SDOMH can be used to support positive common factors for psychotherapy outcomes (Wampold, 2015).

Existing SDOMH assessments rarely cover nuances and might be an important thing for counselors to assess for as they attempt to encapsulate the social risks their clients face. Existing tools, such as the Health-Related Social Needs (HRSN) tool, developed by the Center for Medicare and Medicaid Services (2019), offer important insight into the structural challenges of clients and patients. Yet, their next iterations should include more complex and detailed information that might yield more information for mental health professionals. For instance, the HRSN's section on employment asks if the patient is unemployed over a time span. Yet, the character of employment and its class relationship matters a great deal with risk exposure or mitigation. black men are more likely to be employed in positions that expose them to environmental and social risk (e.g., service work, industry; Bureau of Labor Statistics, 2019). Thus, the HRSN misses an opportunity to document knowledge that could improve provider competence, making agreed-upon tasks and goals more difficult to attain for positive psychotherapy (Wampold, 2015). Further, the HRSN does not feature a section on city living as neighborhood quality, yet urbanicity increases the likelihood of developing mental and medical illnesses because of the intensity of stressors (Heinz et al., 2013). Likewise, there is no section on legal exposure. This is an important space to investigate how the legal system plays a role in the client's life (Shannon et al., 2017). Assessing and noting these dynamics at the beginning of the therapeutic relationship will likely increase positive outcomes through building trust and empathy and allowing clients to feel that their counselor understands their assumptive worlds (Wampold, 2015). These should be standard practices for mental health professionals working with clients of all backgrounds and might disproportionately help Black men and others who have higher social risk across the lifespan.

Case Example: Antonio Walker

The case example describes the background, relationship, and application of a social risk assessment to Antonio Walker, a 39-year-old Black man from a large city in the Northeast U.S. With a focus on how to cultivate relationships while acquiring information about social risk exposure, I document how this information can be used to build a working alliance between a mental health professional and their client.

Background Information

Antonio is a 39-year-old Black man, who has been referred to you for anger management from his employer, the city's municipal sanitation department. This is not Antonio's first citation from his employer. He has received a written warning for his workplace outbursts before.

Antonio is part of a labor union at his job, which negotiates mandatory counseling for workers before they face disciplinary action, to protect their job status. Antonio has lived most of his life in the city, having grown up there in the social housing projects until about age 11, before his mother sent him to live with his father in a more rural part of the state to attend better schools. He only stayed with his father briefly before coming back to live with his mother. His parents married but separated shortly after his birth, when his father left the city to seek better employment opportunities in the more rural parts of the state. Antonio was raised primarily by his mother and her parents, and his grandfather died when he was 5. Antonio struggled with being bullied throughout his childhood and teenage years, frequently fearing for his safety from peers at school and around his neighborhood, which was violent. As Antonio grew older, he learned that his frustrations and stress, when bottled up and exploding into rage, protected him from his peers by intimidating them. However, this volatility followed him through most of his life, making forming close friendships with male friends difficult, along with forming stable romantic relationships. He has a 7-year-old son and currently does not live with his son's mother. He notes that the birth of his son motivated him to seek

stability, and he found a job with benefits in the municipal sanitation department. However, the stresses of the job along with a recent union contract fight have aggravated his stress, and he has received many warnings from his job about his volatility.

Application of the Social Risk Assessment

Antonio presents as skeptical and uninterested in the therapy process. While polite, he is guarded. Antonio mentions he has had one counseling experience before with his ex-partner, but that it did not go well. He noted that he felt the therapist took his partner's side too quickly, and he found it difficult to relate to the therapist, challenging the development of a working alliance. He felt that the therapist's discourse and style were alienating, so he did not feel comfortable sharing his stressors. Antonio mentions he is worried about losing his job and will attend only the minimum number of sessions required but would prefer to "work things out himself" since he can only rely on himself. You decide to administer a social risk assessment alongside the traditional biopsychosocial to better understand the intersection of risk exposure in Antonio's life. Throughout the assessment, you use questions related to broad social risk exposure to develop rapport and build a working alliance. Antonio is guarded and offers minimal details when conducting initial rapport building, and you hope that the social risk assessment will unveil important and complex information that can be used as a starting point for a working alliance.

During the housing section of the assessment, you ask Antonio about specific features of his neighborhood, including the one he grew up in and where he lives now (Rolfe et al., 2020). Specifically, you ask him if his family mostly rented, what their relationships were like with landlords, and if anyone in his family owns property. Antonio is surprised about this line of questioning and responds with how he grew up in public housing, watching the city's subcontractor frequently abuse and mistreat the tenants who lived on the property. You probe Antonio on how he experienced that housing stress. Antonio discusses being worried about how his mother seemed under perpetual stress about the property in which they lived, which was frequently infested with rodents and lacked working outlets. He notes his father's mission was to work several jobs and "hustle" until they could afford a townhouse upstate where housing prices were cheaper. However, his father could never save the money to do so, with he and his mother frequently arguing over how money should be distributed to the children. You ask him about the density of easy access to alcohol stores and drugs within his neighborhood, since substance abuse is often more common in poorer neighborhoods due to this density (Prins et al., 2018).

Antonio mentions how it was normal for people he knew to use drugs and abuse alcohol growing up to cope with environmental stressors. Antonio mentions how helpless he felt; he wished he could grow up quicker to support and help his mom with the finances at home. Antonio and you build rapport over difficulties experienced with landlords currently. Antonio, who now lives in a small apartment, mentions he feels they are an inevitable part of life. Antonio appears to be less guarded and more animated when he speaks about these environmental stressors. It appears easier for him to speak about things that are challenging in the environment rather than directly mention his feelings. From the housing dilemmas experienced in his youth and to his current state of uncertainty, you note Antonio experienced childhood stressors during crucial stages that must have affected his mental health and his sense of helplessness.

Because Antonio's presenting concern is related to workplace volatility, you assess the nuances of his working relationships through the social risk assessment. Within the assessment, you use McArthur's subjective social status step ladder (Singh-Manoux et al., 2005), which is a ladder with rungs labeled 1–10, with a higher score indicating a greater sense of subjective status (Singh-Manoux et al., 2005). This is broadly predictive of health and well-being. Antonio identifies himself as a 3 out of 10, conferring you with predictive knowledge of his health and mental health functioning at the moment (Singh-Manoux et al., 2005). The ladder rating provides insight into how Antonio views himself with his social position in society. You ask him for more details about how he feels in relation to others. Antonio notes he has always felt a lack of confidence and happiness, and while he has a stable job now, he is still feeling shame and embarrassment from the smells and labor of the sanitation department. The social risk assessment also includes questions about whether the client is unionized and if the union has collective bargaining power. Because labor unions historically mitigate stressors and improve health, and you are interested in seeing what Antonio's position is in the union (Malinowski et al., 2015). The social risk assessment opens up avenues to explore with the client that are non-direct and provides a wealth of information in building a working alliance. Although Antonio seemed reluctant to share about his workplace challenges when asked directly, he can speak at length about the challenges he faces with the union, which are adding to his stressors. The employment section in the social risk assessment also covers the length of employment; bouts of unemployment; and whether work provides community, meaning, and economic security (Blustein, 2006).

This complex and nuanced view of how job precarity and employment often shape the material stressors of clients' lives provide you with an opportunity to connect with Antonio and build competency within the intersection of social risks he lives

in. During the next session, you ask about what work meant for him and his family growing up and how he relates to it now. Antonio's information reveals that he struggled with unemployment on and off in his 20s, which led to inconsistent healthcare coverage, and he struggled to complete school past his associate degree. You gently ask if there is a relationship between how he experienced risk in the past and how he experiences his mental health in the present. Antonio discusses how he had never thought of his life stressors and his work having a connection before, but he notes how his feelings of helplessness and struggles to maintain consistent relationships mirror the core beliefs and experiences of his childhood. During the third session, you have robust information on how Antonio's life is representative of the disproportionate social risk burden that Black men frequently encounter through structural mechanisms. You can weave in discussions and processing around his work, his family, and his living situations that are authentic and relevant, and you note that Antonio is much more engaged and animated. He notes that your questions and rapport building during the initial sessions relaxed him and put him at ease since he felt like he could open up about things he felt that "therapists don't really talk about." Your questions about how he lived and the stressors he experienced growing up in particular ways through the social risk assessment provide you with actionable knowledge. They also mitigate the social class differences between you and Antonio, which often harm working alliances in therapy (Trott & Reeves, 2018).

You process how Antonio has experienced cumulative stress throughout his life that has led to unhealthy attachments with close relationships that are often the result of an uncertain political economy. Throughout the next sessions, you frequently return to the information you gathered through the initial social risk assessment, learning specifics of his housing stressors growing up and how he experiences them currently. The social risk assessment also includes a section on inflation and legal challenges, as Antonio notes that the labor union contract struggle is rooted in raising wages to meet the national inflation forecast, which is provoking a clash with the city government, re-triggering his feelings of helplessness about the future. After the sixth session, Antonio and you can connect how these feelings of helplessness experienced through unequal social risk distributions result in depression, which is masked with irritability and outbursts. The social risk assessment serves an important function of helping you evaluate the data about specific stressors and their nuanced mechanisms in a client's life. Indeed, the assessment provides a wealth of information that allows for a working alliance to be formed by connecting you with Antonio and the conditions he faces with intimate detail. Although mental health professionals might have self-awareness of the differences they have with their client, bridging the gap from awareness to action requires the critical component of knowledge (Barden et al., 2017), which the social risk assessment plays a role in delivering. Antonio is more motivated and committed to personal therapy as he feels comfortable connecting the environmental and personal stressors with you through a positive working alliance.

Discussion

It is important to note that, although I have described the daunting social risk potentially incurred across the lifespan from structural forces by Black men to reduce racist biases, an over-fixation on deficits could inadvertently create another pathological deficit discourse. As Hannon and Vereen (2016) suggested, it is important to understand the irreducibility of clients, especially Black men, since they have been uniquely vulnerable to reductionist and pathological constructions within the history of helping professions. This irreducibility must be held dialectically with the potential, disproportionate social risk exposure across the lifespan. Mental health professionals are challenged within multicultural and social justice frameworks to develop treatment programs and research agendas that improve services for clients from diverse backgrounds (Ratts et al., 2016). Previous researchers have demonstrated that mental health professionals gain a reasonable amount of self-awareness in their training programs for issues related to diversity but struggle to implement working alliance relationships with Black men and working class or poor clients. Outside of ethnic matching or specific life events that help a therapist relate to their client, the psychotherapy outcome data are poor between therapists and Black men (Stare & Fernando, 2020). This might be because of structural challenges within the U.S. that expose Black men and other vulnerable groups to disproportionate social risk incurred through many pathways and mechanisms along with historical racist biases and practices. Therefore, developing knowledge and competencies around the risk clients are vulnerable to (or have been exposed to historically) creates an opportunity for therapists to connect with their clients and improve working alliances. Current SDOMH competencies and instruments do a reasonable job assessing the basics of structural forces in a client's life but do not provide the nuance and rigor needed to make an accurate inference over the variety of pathways discussed by Beck (1992) in his understanding of social risk inequalities.

Conclusion

Without an accurate understanding of the structural forces across the lifespan that create social risk exposure, mental health professionals risk re-creating the historical dynamics noted with diagnoses of drapetomania and protest psychosis. Namely, this includes symptomology that is divorced from structural and political forces and context (Chowkwanyun & Reed, 2020). This dynamic mirrors the historical prejudice and racism experienced by Black men and prevents positive psychotherapy outcomes. Therefore, research agendas that prioritize creating, validating, and pilot testing a social risk assessment and assessing whether therapeutic outcomes improve after its implementation is an important next step in psychotherapy outcomes for Black men and other minority clients.

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