

## 4 Racism and its effects

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This chapter elaborates the bidirectional relationship between the many manifestations of racism and mental health diagnosis, prevalence and disparities in service delivery. The concept of “microaggressions” is utilized to understand the insidious effects of repeated manifestations of individual, institutional and structural and institutionalized racism on the well-being, including mental health, of People of Color.<sup>1</sup> Social factors such as housing discrimination, poverty and employment opportunities which all interface with racism to exacerbate the conditions of chronic mental illness are also considered. Psychological factors include the impact of racism on the emergent identity and mental health of People of Color. Though the discussion and case examples focus primarily on the experiences of racism of African American individuals, racism affects all racial and minority groups in similar, yet distinct ways. While evidence shows the experience of racial discrimination can influence the manifestations of many psychiatric disorders, we focus here on depression, post-traumatic stress disorder and schizophrenia, three conditions that tend to be both chronic and socially debilitating. Finally, the specific impact of various forms of racism on mental health is explored through the use of three case examples.

A number of working assumptions are critical in understanding the approach to this content. First, many African American, Latino, Asian, and other minorities have developed sound, strong networks in order to buffer some experiences of racism. So, it is clear that not all People of Color necessarily develop emotionally based psychological symptoms as a result of living in a racist society. Franklin, Boyd-Franklin, and Kelly (2006) state:

It is also important to recognize the impact of protective factors such as family and extended kinship networks, religion and spirituality, strong cultural values and racial identity, and personal strength and resiliency that may allow many People of Color to rise above the debilitating, ongoing trauma of racism.

(Franklin et al., 2006, p. 18)

Recognizing the resilience of many People of Color does not, however, diminish the impact of structural and institutional racism that is manifest in myriad ways (Miller & Garran, 2008).<sup>2</sup>

Second, racism in the United States continues to be a dominant factor that shapes multi-levelled interactions of individuals, groups, communities and organizations. People from the dominant white culture experience privilege and power in contemporary society. White individuals consciously or unconsciously position People of Color as an “other” who is inferior to White individuals. Positioning others as inferior enables White individuals to shore up their own identities, perhaps felt as necessary as a result of being threatened by multiple internal and external factors, including, for example, the current economic recession of 2009. Institutional and structural racism,

indicates systemic, societal, durable racism that is embedded in institutions, organizations, laws, customs, and social practices . . . It leads to a cumulative effect in which groups that are racially targeted are excluded from living in certain neighborhoods and working in numerous jobs and professions, have less access to social assets such as quality schools, and have greater health risks and other negative consequences and outcomes because of a variety of interacting legal, illegal, direct, and indirect practices.

(Miller & Garran, 2008, p. 29)

Further, Leonard Pitts (2009) suggests that in spite of the election of Barack Obama (a Black man) to the Presidency of the United States, “post-racial America” has not yet arrived. To accept the discourse that racism has become absent in contemporary U.S. society seems a somewhat naive response that is fueled by denial of the lived experiences of many People of Color in the United States. Indeed, Turner (1999) noted that White and Black Americans hold different views on the extent of change in race relations. Miehls (2001) comments on Turner’s ideas, writing:

African Americans believe, he purported, that racial bias has changed only modestly over time . . . in all aspects, including racial bias, discrimination, opportunities. He reported that some Whites react with shocked indignation or disbelief at the notion that Blacks might still consider themselves at all disadvantaged.

(Miehls, 2001, p. 234)

Citing Shipler (1997), Miller and Garran (2008) suggest:

To be sure, many white people are well aware of the persistence of racism in the United States. Still, whites and people of color show marked differences in their beliefs about the extent of racism today, and these disparities indicate a significant perceptual racial divide in this country.

(Miller & Garran, 2008, p. 62)

They suggest that many Whites think that the United States has moved to a colorblind society, implying that skin color has no impact on the lived experiences of People of Color. Scruggs (2009) also purports that colorblindness is a “new” form of racism. She suggests that privileged individuals who say they don’t see color in people are not promoting racial harmony (as they imagine) but rather are contributing to tension within People of Color who are very aware of the benefits of white privilege. Citing Bobo (2001), Miller and Garran (2008) discuss the different perceptions of white people and people of color when they note:

African Americans and Hispanics overwhelmingly believe that there is occupational discrimination in favor of whites, while less than a fourth of whites agree; and people of color view racism as a deeply entrenched, institutional phenomenon, while many whites see it as a question of attitudes and behaviors.

(Miller & Garran, 2008, p. 62)

## **Definitions of racism**

Biologists who created three categories of individuals – Mongoloid, Caucasoid, and Negroid – first defined race (Atkinson, 2004). These categories were based upon what these “scientists” considered to be distinguishing characteristics such as skin color, hair, and facial features (Howard-Hamilton & Frazier, 2005). However, contemporary theorists suggest that these

biological categories are ill-founded and not tenable in terms of accuracy. Marsiglia and Kulis (2009) suggest, “The persistence of racial distinctions in social life is remarkable given the fact that race, as a biological concept, has not survived the test of scientific scrutiny” (p. 9). These authors further suggest, “Humans cannot be categorized reliably based on phenotypical characteristics, such as those aspects of physical appearance like skin color, hair texture, and bone structure that are often thought to be markers of one’s racial background” (p. 9).

Most contemporary authors suggest that race, as a “designation,” is a social construction that privileges certain individuals while putting others at a disadvantage (Constantine, 2007; Franklin et al., 2006; Marsiglia & Kulis, 2009; Miehl, 2001, 2005; Miller & Garrañ, 2008; Tatum, 2000). Franklin et al. (2006) suggest that “Racism is complex and . . . based on erroneous principles of racial superiority, it bestows power and privilege on those who define, enforce, and establish the institutional mechanisms that maintain it” (p. 10). In other words, racism is a systematic implementation of stereotypes and discrimination and that privileges White individuals at the expense of People of Color who are marginalized and who do not have full access to the educational, financial, or employment opportunities that American society offers. Marsiglia and Kulis (2009) suggest that “The prime purpose of racial formation is to establish a hierarchy and target certain groups for discrimination” (p. 9). Even middle class Black Americans are open to discrimination – for example, being denied access to a certain apartment/neighborhood in spite of its clear availability (Pattillo-McCoy, 2007).

Tatum (2000) views racism not only as a manifestation of racial prejudice but also as more a system of practices that limits the opportunities of People of Color. Discrimination takes place at individual, institutional, and structural levels (Pincus, 2000). Oppression is manifest by targeted individuals systematically being exploited in myriad ways marginalized in society, having a sense of powerlessness, being subject to cultural imperialism (being made invisible by dominant society), and, last, by being victims of violence at a disproportionate level to individuals from the dominant culture (Young, 2000).

At the interpersonal level, many People of Color experience ongoing interactions with people from the dominant culture in which they have an experience of “being othered.” This term implies that People of Color are often objectified and positioned as “lesser-than” or “inferior” persons than their White counterparts. While there is no universal experience among Black individuals as they navigate the terrain of being “othered,” this practice has a long history for African Americans. Cushman (1995) describes the historical function of Negro Minstrelsy during the nineteenth century when Black men were often characterized as grotesque or clownish. This form of entertainment became extremely popular and the White audiences relied on these caricatures to frame their views of black individuals who were slaves or who were no longer legally held as slaves after the civil war. Often referred to as the Jim Crow era, this practice originated when a White minstrel performer, Thomas (Daddy) Rice, blackened his face and danced a ridiculous jig while singing the song “Jump Jim Crow” (Del Carmen, 2008). White America latched onto this imagery and began to create a discriminatory icon of African American “folks.” Cushman (1995) says:

The primary African-American character the White audience saw was a comic, foolish, empty-headed idiot: the Sambo of white folklore. Each act was framed by the taken-for-granted understanding that the White race was inherently superior, intellectually and morally, to the Black race.

(Cushman, 1995, p. 43)

In addition, the minstrel performances were filled with self-denigrating comments about African Americans and their physical appearance; skin color, nappy hair, and pejorative name

calling often were used as punchlines in a joke or dialogue among the actors. Cushman (1995) also notes that “Female African Americans were portrayed as slow-witted, lazy, ugly, vain, unclean, crude, and very sexual. They also ate prodigious amounts of ice cream and drank their dates under the table” (p. 47). These gross stereotypes laid the foundation for more contemporary stereotypes of African Americans. Though the forms of stereotyping in contemporary society might be somewhat more subtle, they still exist and are replicated in individual interactions and are enacted in various ways between white people and people of color.

In fact, Shome (1999) contends that one’s body has become the site of racist attitudes and discriminatory practices in contemporary interactions in the United States. She shares the experience with other women of color when she suggests that upon entering a room mostly populated by white people

there is that *thing in their look* . . . they welcome you, but then the way they look at you makes you feel as though your whole body is up for examination and scrutiny . . . it almost feels as though they hunt my body for differences . . . it’s such a systemic thing, they don’t even realize half the time that they do it.

(Shome, 1999, p. 121, italics in original)

hooks (1992) attributes this practice of “white gaze” to the historical era of slavery during which black individuals were punished if they looked directly at their white superiors. She contends that many whites still have the same working assumption that being that “people of color are bold, aggressive, and out of line if the gaze is returned” (Miehls, 2001, p. 234).

Historical experiences of racism become embedded in institutional racism, which Miller and Garran (2008) suggest is “manifested through laws, policies, and formal and informal practices” (p. 63). They write that there are at least nine types of institutional racism that include “residential, educational, employment, accumulation of wealth and upward mobility, environmental and health, mental health, criminal justice, political, and media” (p. 63). The person with mental illness is more likely than others to experience deleterious effects from the impact of racism, particularly related to housing, education, employment, criminal justice, and the access to health and mental health services.

Social workers, who are often employed by the agencies that have inadvertently developed institutional practices of racism, face the challenges of both identifying and eradicating those practices, on behalf of their clients. At the same time, they must understand and intervene with those clients on a micro level. For example, African American clients who experience discriminatory practices such as “racial microaggressions” (Constantine, 2007; Miller & Garran, 2008; Sue, Capodilupo, & Holder, 2008a; Sue, Capodilupo, Nadal, & Torino, 2008b) often experience an erosion of their self-esteem which leads to a complex sense of self that may include some aspects of internalized racism. For the person with mental illness, the internalized racism may manifest in a variety of ways which may give rise to or exacerbate psychological symptoms.

## **Racism and mental health/illness**

In addition to categorizing hundreds of psychiatric disorders, the *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR: American Psychiatric Association (APA), 2000) documents the prevalence rates of these disorders in the U.S. population. This manual tends to minimize racial differences in prevalence rates of most of the descriptions of mental disorders; other research points to racial differences in the prevalence of mental illness. Below are summarized prevalence and inpatient hospitalization rates for three mental conditions – schizophrenia, major depressive disorder, and post-traumatic stress disorder.

The American Psychiatric Association's DSM-IV-TR (2000) manual suggests that the national prevalence rate of *schizophrenia* ranges between 1.5 percent and 5 percent of the general population. The manual minimizes the differences of diagnosis across race suggesting, "Studies in the United Kingdom and the United States suggest that schizophrenia may be diagnosed more often in individuals who are African American and Asian American than in other racial groups (p. 307). However, whether these findings represent true differences among racial groups or whether they are the result of clinician bias or cultural insensitivity" is unclear. Other research notes discrepant findings. Citing Zeber's research, Vedantam (2005) notes that Blacks were more than four times as likely to be diagnosed with schizophrenia as Whites. Hispanics were more than three times as likely to be diagnosed with schizophrenia as Whites. Davis (1997) points out differences in rates of admission to state hospitals between 1980 and 1992. He notes:

- Rate of admission for all persons was 163.6 per 100,000
- Rate of admission for Whites was 136 per 100,000
- Rate of admission for Native Americans and Asians was 142 per 100,000
- Rate of admission for African Americans was 364.2 per 100,000
- Rate of admission for all persons to V.A. (veterans') Hospitals was 70.4 per 100,000
- Rate of admission for African Americans to V.A. Hospitals was 118.2 per 100,000.

He goes on to say:

Admissions of Blacks to state mental hospitals showed that 56 percent of these individuals received a primary diagnosis of schizophrenia, while only 38 percent of all individuals admitted received a similar diagnosis. Hispanics, too, received a disproportionately high (44 percent) rate of severe mental illness diagnosis on admission to state mental health institutions.

(Davis, 1997, p. 630)

DSM-IV (APA, 2000) reports that "The lifetime risk for *major depressive disorder* in community samples has varied from 10 to 25 percent for women and from 5 percent to 12 percent for men" (p. 372) and further that "The prevalence rates for major depressive disorder appear to be unrelated to ethnicity, education, income, or marital status" (p. 372). However, Riolo, Nguyen, Greden, and King (2005) found that:

- Prevalence of major depressive disorder differed significantly by race
- Highest prevalence was found in White participants
- Age of onset of disorder was significantly earlier for White and Mexican American participants in contrast to African American subjects
- Persons living in poverty had nearly 1.5 times the prevalence of major depressive disorder
- For Mexican American participants, lack of education was significantly associated with prevalence of major depressive disorder.

Cultural relativity is acknowledged in the DSM-IV manual for the *post-traumatic stress disorder* diagnosis, which has a lifetime prevalence rate of "approximately 8 percent of the adult population in the United States" (APA, 2000, p. 466). The manual also notes:

Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those

exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

(APA, 2000, p. 466)

Later in the chapter, the interface of post-traumatic stress disorder with the lived experiences of People of Color is more fully explored. A main argument suggests that People of Color develop symptoms of PTSD and complex post-traumatic stress syndrome in response to a number of societal and institutional experiences of racism.

The lack of awareness of cultural influences in the development of mental illness, the manifestation of symptoms and the life course, is only one of the limitations of our attention to race and mental illness. Many authors also suggest that People of Color have *restricted access to health and mental health services* (Johnson & Cameron, 2001; Leong, 2001; Leong & Lau, 2001; Miller & Garran, 2008; Ojeda & McGuire, 2006; Snowden, 2001, 2005; Stone, 2002; Swartz, Wagner, Swanson, Burns, George, & Padgett, 1998). In 1999, the Surgeon General of the United States (Dr. David Satcher) commissioned a report to examine mental health service delivery in the United States. Mrs. Tipper Gore, wife of the then Vice-President, Al Gore, was an ardent advocate of promoting mental health services for all Americans. Entitled *Mental health: A report of the Surgeon General* (Department of Health and Human Services (DHHS), 1999) the document was the product of a collaboration of two federal agencies – the Substance Abuse and Mental Health Services Administration and the National Institutes of Health. While this report was commissioned to examine the mental health needs of all Americans, it clearly exposed the reality that the needs of racial and ethnic minority populations were not being met adequately. In response to this information, the Department of Health and Human Services brought together myriad mental health experts to study the issues at hand and these individuals provided a supplement to the Surgeon General's report of mental health services that was entitled *Mental health: Culture, race, and ethnicity* (Department of Health and Human Services, 2001). The supplemental information describes how culture interfaces with mental health issues across minority populations. Moreover, it also contains detailed information about mental health care for four distinct groups – African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. At the time, the document spawned a great deal of interest in mental health disparities (Lopez, 2003; Manson, 2003).

A main working assumption of the Surgeon General's (DHHS, 1999) report was that society should no longer view mental health as separate from an individual's general health. This assumption attempted to legitimize mental health treatment as an essential part of the overall health care service delivery. It was reported that the research literature reveals that mental health treatment works for a range of mental disorders. The efficacy of treatment strategies for mental health issues is correlated with a reduction of stigma of mentally ill people – in other words, if properly treated, individuals with mental illness are not necessarily ostracized or stigmatized by others. The main recommendation of the report to the American people was to seek help if you think you have symptoms of a mental disorder or if you have any mental health issues. This simple directive was an attempt to make services more available, without stigma. However, the report recognized that the mental health service delivery system is complex; therefore, differences in service delivery of public and private sectors affects the accessibility of mental health services. The influence of managed care companies limits the availability of services to all in the United States. In addition, an interface of other state and federal agencies (social welfare, housing, criminal justice, and education) with mental health service delivery puts impoverished People of Color at higher risk of not receiving adequate mental health services or indeed perhaps not receiving any mental health services.

Findings in the report that are related to African Americans who are overrepresented in high-need populations and are at particular risk for mental illness, are particularly relevant for social work. The Surgeon General's report (DHHS 1999) identifies the following at-risk groups:

- Homeless people – While 12 percent of the U.S. population was homeless at that time, African Americans make up 40 percent of that population.
- Incarcerated people – Nearly half of all prisoners in state and federal jurisdictions and almost 40 percent of juveniles in legal custody are African Americans.
- Child welfare – African American children constitute about 45 percent of children in public foster care and more than half of all children waiting to be adopted.
- People exposed to violence – African Americans of all ages are more likely to witness violence or be the victim of violence than are White individuals.
- Insurance – Nearly 25 percent of African Americans are uninsured (16 percent of the general population are uninsured).
- Medicaid covers nearly 21 percent of African Americans.
- Use of Mental Health Services – Only one-third of all Americans with mental illness receive care; however, the percentage of African Americans receiving needed care is only half that of Whites.
- African Americans of all ages are underrepresented in outpatient treatment but overrepresented in inpatient treatment.
- African Americans tend to be diagnosed more frequently with schizophrenia and less frequently with affective disorders.

These are staggering figures. As the United States makes its way through the significant economic downturn that began in 2009, we can expect that these vulnerable populations will be further affected and marginalized. Even at the time, the Surgeon General, taking into account these disparities, brought together many experts to complete further research about the inequities of mental health care delivery to People of Color. Lopez (2003) states that in his report to the American Psychological Association's annual meeting in 2001, Dr. Stacher, the Surgeon General, stated that "culture counts" and that this assumption "should echo through the corridors and communities of the nation" (p. 419). Lopez (2003) notes:

At that point, the large overflowing audience became still. They understood the significance of his words. Our nation's leading health professional recognized that the mental health status of our country's largest "minority" groups is most important to the welfare of the nation. Furthermore, the Surgeon General underscored the importance of culture by identifying key issues for four groups of People of Color – African Americans, Asian Americans and Pacific Islanders, American Indians and Alaska Natives, and Hispanic Americans. An executive summary of the report reported why "culture counts" in the following ways.

- The culture of racial and ethnic minorities influences aspects of mental illness, including how symptoms are manifest, how individuals cope with symptoms, and willingness to seek treatment.
- People of Color face social environments of inequality that includes greater exposure to racism, discrimination, violence and poverty.
- People in the lowest socioeconomic status group are two to three times more likely to

have a mental illness diagnosis (in contrast to those in the highest socioeconomic status group).

- People of Color often mistrust White institutions that provide mental health services.

Other authors also suggest difficulties in the mental health service delivery to People of Color. For example, People of Color may be misdiagnosed when mental health clinicians are unaware or insensitive to the cultural relativity of psychiatric symptomatology and thus assigning a more serious diagnosis more often to People of Color in contrast to White clients (Whaley, 1997).

In spite of the heightened consciousness of the disparities of service delivery to minority populations raised in the Surgeon General's Report (DHHS, 1999) and the Supplement to this report (DHHS, 2001), numerous studies continue to point out that discrepancies still exist. For example, Ghods, Roter, Ford, Larson, Arbelaez, and Cooper (2008) report that physicians did not assess for depression symptoms in Black individuals as much as they did with White clients. There were discrepancies even when physicians did discuss depressive phenomenology. They report "even when depression communication did occur, physicians recognized only two thirds of African Americans, but more than 90 percent of White patients, as having emotional distress" (p. 605). Similarly, DeCoster (1999) found that physicians tended to pay more attention to the "emotions" of White females and males more than they did with People of Color. This suggests a bias among the physicians who may consider Black individuals to be "overly emotional" and that their emotionality does not warrant any treatment.

Anglin, Alberti, Link, and Phelan (2008) suggest that "members of racial/ethnic minority groups are less likely than Caucasians to access mental health services despite recent evidence of more favorable attitudes regarding treatment effectiveness" (p. 17). They report that even though African Americans believe that mental health clinicians are able to assist individuals with major depression and schizophrenia, "they were also more likely to believe mental health problems would improve on their own" (p. 17). Ojeda and McGuire (2006) reported that Latinas and African American women and men exhibited lower use of substance abuse services and outpatient mental health services than did their White counterparts (p. 211). They suggest "Though efforts are being made to increase the detection of depression in minorities, systematic approaches in primary care settings where minorities are more likely to obtain care could prove helpful in eliminating race/ethnic gaps in service use" (p. 219). They speculate that "Minorities fear adverse consequences in the workplace or are embarrassed about discussing their problems with others, thus resulting in delayed or forgone care" (p. 219).

In certain instances, People of Color receive differential treatment for symptoms of their mental illness. Van Dorn, Swanson, Swartz, and Elbogen (2005) investigated prescriber's utilization patterns of a new generation of antipsychotic medication (widely known to be more expensive than previous medications) in a racially mixed group of individuals with schizophrenia. They wondered how race and/or involvement in a criminal justice system interacted with the utilization of the newer, more expensive drugs. The study revealed that "minority racial status (being African American) and arrest history both appear to play a significant role in determining which patients are least likely to receive atypical antipsychotics" (p. 130). They postulated that preconceived ideas about Black individuals may contribute to this discrepancy. For example, citing Garb (1997), they say "clinicians often rate black patients as being at higher risk than white patients for hospital readmission" (Van Dorn et al., 2005, p. 130), even though there is no real data to support this supposition. They acknowledge that the differences found in their study may be attributed to a range of factors including poverty or patients' attitudes about treatment, as examples, but they also suggest that differences are possibly related to "clinicians' subtle biases about which patients are most likely to benefit from atypical antipsychotics" (p. 131).

Barnes (2004) examined the correlation of race and admission rates to psychiatric hospitals with particular reference to individuals diagnosed with schizophrenia. He cites some historical data with regards to the percentage of African Americans who were hospitalized with a diagnosis of schizophrenia. Citing Thompson, Belcher, DeForge, Myers, and Rosenstein (1993), he suggests that the percentage of African Americans given the diagnosis of schizophrenia increased from 33 percent to 50 percent during the time period between 1970 and 1986. Regarding the influence of race in this process he writes, "research on the prevalence of mental disorders in the general population has found that there is no significant difference in the rate of schizophrenia between African Americans and Whites when socio-economic status is controlled" (Barnes, 2004, p. 242, citing Keith, Regier, & Rae, 1991). So, the economically disadvantaged African American client is likely being over-diagnosed as schizophrenic. Barnes (2004) suggests a number of factors that may be associated with this discrepancy. "Some of these factors are diagnostic bias of clinicians, lack of cultural understanding between clinicians and minority clients, and racial differences in the presentation of psychiatric symptoms" (p. 242).

Greenberg and Rosenheck (2003) question how managed care practices affect the accessibility and quality of mental health interventions with U.S. minorities. They note, "Managed care has typically introduced practices, such as utilization review, treatment guidelines, and disease management, which often constrain the delivery of services" (p. 32). They cite Provan and Carle (2000) and Scholle and Kellehar (2000), who suggested that "the introduction of managed care into mental health settings has been perceived by minorities to create barriers to care that were not experienced in fee-for-service systems" (Greenberg & Rosenheck, 2003, p. 41). One of Greenberg and Rosenheck's main findings (examining change in mental health service delivery in the Department of Veterans Affairs, nationally) was that Hispanic veterans demonstrated a declining access to outpatient care relative to their White counterparts (p. 40).

Children from minority populations are not immune to the patterns of poor accessibility and utilization of mental health services. Wood, Yeh, Pan, Lambros, McCabe, and Hough (2005) studied the relationship between race/ethnicity and at what age children use either school-based mental health services or specialty mental health care. They cite Kataoka, Zhang, and Wells (2002) when they state that their study

provided the first nationally representative assessment of child mental health use and reported that of their sample of children and adolescents who met criteria for needing services, almost 80 percent had not received mental health care in a 1-year period. This study found that, even when researchers controlled for other factors, Latino and uninsured youth were particularly unlikely to receive needed mental health services.

(Wood et al., 2005, p. 186)

Wood et al. (2005) found "that non-Hispanic White children were more likely to receive school-based services as compared to African American, Asian-Pacific Islander, and Latino children, and to begin use at an earlier age than the latter two groups" (p. 193).

There are numerous macro issues that contribute to racism in the United States. As noted, Miller and Garran (2008) refer to these factors as a web of institutional racism and these issues serve as the context for the individual experiences of many People of Color. Interpersonal racism can be as pervasive, entrenched and damaging. For example, the tendency for people from the dominant culture to deny any ill intentionality in cross-race interactions often leads to a sense of unreality within the African American individual. It is often difficult for African American individuals to hold onto a coherent sense of self when one is often told something like "Oh, I didn't mean that," "You must have misunderstood," and "You are exaggerating this."

This sort of invalidating experience can lead to confusion about one's own responses, especially if one receives this sort of message in a repetitive manner and from someone who has been legitimized in society with power and privilege. This is similar to Linehan's (1993) description of invalidating environments that people suffering with borderline personality experience when their parents disavow or reformulate interpersonal interactions. In that circumstance, parents often suggest that the child is misinterpreting anger that is actually being played out by the parent. These parents often question the feelings of the child or they may suggest to the child that her feeling of sadness is really anger, for example, and that she has no right to feel that way toward the parent.

For the Person of Color, this insistence that one is exaggerating or confusing one's own response can contribute to a subtle and insidious erosion of confidence and healthy ego ideal. This may be particularly true when individuals have internalized racism that has unconsciously but powerfully infiltrated the Person of Color's internal world. African American individuals may unfortunately internalize aspects of self-denigration if they adopt the stance and attitude of those of the dominant culture. Internalized racism can be understood as a manifestation of the notion that Whites exert more power in social relations and People of Color are subject to this unfair valence of influence, authority, and credibility. Foucault (1979) suggests that power cannot be minimized or removed from any social relationship. For Foucault, power is exercised "everywhere in a continuous way" (Foucault, 1979, p. 80). As such, African American individuals may question their own "sense of reality," colluding with the notion that "of course, the white (powerful) individual must have the corner on truth when it comes to interpersonal interactions between the two." In her article entitled "Surviving hating and being hated," Kathleen Progue White (2002) describes an incident that she experienced as dismissive, devaluing, and confusing. Progue White, a young black student who had been taught to read by her older sister, volunteered to read in her class that was being taught by a nun in her school. She writes:

I raised my hand with enthusiasm. "I can read!" The nun said, "Don't you tell a lie, you can't possibly be able to read." "Oh, Yes I can, too!" "Here, read this," she said. I read it. She said, "That's not reading; you're not reading it right, that is not the way to read. That's why *you people* never amount to anything. You make up lies when you don't know how to do things the right way! I'll have to teach you to read proper."

(Progue White, 2002, p. 404, italics in original)

This is a poignant example of how young Black children have to find ways to negotiate the mixed messages that they often receive while not denying their own sense of reality. This little girl knew she could read yet her sense of self was being contested by the powerful, authoritative, White adult. Progue White (2002) goes on to suggest that this sort of disavowal has a profound effect on one's view of oneself, causing confusion and perhaps self-hatred, at the extreme.

This author witnessed a similar dismissal of the voice of a woman of color who was being interviewed by a White student in a graduate social work class (reported previously in Moffatt & Miehl, 1999). In this instance a woman of color was trying to explain to her White colleague that she had experienced discrimination in her high-school setting when she was inappropriately assigned to basic (remedial) classes when she and her family first immigrated to Canada. In telling this to the White student, the student of color gave up on her own narrative in order to fit the appraisal of the White student. The student of color had said that she was told that she would have to take basic level courses in her program of studies. The author observed the following exchange between the two, when the White student was in the role of social worker, in a role-play exchange:

In responding to the student of color's use of the word basic, the White student said, "Oh, you mean general courses." The Latina student seemed confused and replied, "No, basic." Again, the interviewer said, "So, they wanted you to take general courses." The Latina student once again conveyed that the guidance counselor had positioned her in a class for vocational students and said, "No, it was basic." The interviewer ignored the Latina student and replied, "did you talk to the principal about this?"

(Moffatt & Miehl, 1999, p. 68)

Recognizing that the White student was altering the meaning of the narrative for the student of color, the classroom instructor attempted to have them reconstruct the dialogue. The following ensued:

The interviewer attributed the difficulty in the interaction to the Latina woman's inabilities to communicate in English. The interviewer explained that she knew that the Latina woman was using the "wrong" terminology. The apologetic Latina student commented by saying, "I am sorry, maybe I am not a right client." The interviewer said: "Don't worry, I know that I am a good interviewer."

(Moffatt & Miehl, 1999, p. 68)

This example demonstrates that the woman of color began to internalize the voice of the White student when she said, "maybe I am not a right client." The White student demonstrated a sense of arrogance and did not have any empathy for her colleague. Rather, she exercised her role as an "expert" when she gave advice to the student of color about how she should have proceeded. Questioning "did you talk to the principal," she implied that the student of color had done something wrong or perhaps had not acted on her own behalf – indeed People of Color often report that they do not act on their own behalf as they worry that articulating their concerns to a White person may add further conflict to a dialogue that is already experienced as troubling and undermining. Foucault (1980) would suggest that this sort of experience of systematically altering and devaluing the voice of the Person of Color represents an exercise of power strategies employed by the White individual. The White student fuels her sense of superiority in the exchange and leaves feeling righteous and "smart" – all at the expense of the student of color.

The interactions of being "othered" (as described above) or having one's own narrative questioned or altered occur for many reasons. Certainly the stereotypes of African American people that have been illustrated have long traditions in the United States, dating back to slavery and beyond. Levy and Karafantis (2008) suggest that all individuals are subject to and influenced by "lay theories" about individuals, groups, and institutions. Lay theories are culturally shaped and have far-reaching consequences in terms of interactions and views of interactions. Levy and Karafantis (2008) suggest that:

"Conceptions of the world" or "naïve" theories are often referred to as "lay theories," since they are used in everyday life. These lay theories may be captured by proverbs such as "Anyone can pull themselves up by their bootstraps" (J.S. proverb; refers to the Protestant work ethic).

(Levy & Karafantis, 2008, p. 111)

Lay theories have a profound impact in the development of prejudice since these commonplace theories filter social information and become "short-cuts" to casting judgment on others. They suggest "that when a lay theory is relevant in a given situation, people rely on that theory to support their either socially tolerant or prejudicial attitudes and behaviors" (p. 112).

The concept of “*microaggressions*” describes how the day-to-day experiences of being marginalized affects African American individuals. Sue et al. (2008a) suggest that the term racial microaggressions describes “the brief, commonplace, and daily verbal, behavioral, and environmental slights and indignities directed toward Black Americans, often automatically and unintentionally” (p. 330). Referring to these interactions as “microinsults,” Jackson (2000) suggests that “The subtle and indirect nature of these insults may result in feelings of powerlessness because of the incongruent experience between the individual’s feeling state and her perception of the event” (p. 7).

Microaggressions are similar but different to experiences of racial profiling (Del Carmen, 2008) that many African American individuals experience as well. Racial profiling is a term that describes the investigation and/or charges made against People of Color by police or other authorities in disproportionate numbers than White individuals. Targeted as a result of their race, African American individuals are stopped in automobiles to be investigated, as one example. Del Carmen says that racial profiling is

the selective targeting of individuals based on their race, ethnicity, or religious affiliation. Although the concept is often used to describe police-initiated behavior, it also pertains to individuals who are in a position to target others based on their racial, ethnic, or religious background.

(Del Carmen, 2008, p. xi)

Airport security personnel may also fall into racial profiling in doing security checks. The author has heard from a number of African American clients that they are often subjected to racial profiling. For the most part, these experiences contribute to a sense of anger and frustration within the client. However, these individuals seem to readily identify the injustice in these events and while angering, these sorts of experiences do not seem to infiltrate their internal worlds in the same manner as other microaggressions.

Sue et al. (2008a) reported the results of a qualitative study that they completed using focus groups to capture the “everyday” experience of individuals who self-identified as Black or African American. Four major themes emerged from their thematic analysis – healthy paranoia, sanity check, empowering and validating self, and rescuing offenders – which they described as forming a reaction domain (p. 329). Many of their participants identified that they needed to often question whether behavior of others was fueled by racist attitudes. They thought that a certain suspiciousness of the motivations of their White counterparts was a healthy adaptation to their perception of events. This defensive posture is more favorable than internalizing attitudes of inferiority in the face of such exchanges as, “Oh, I think this customer was ahead of you in the line” (waiting for service in a coffee-shop with White customers).

The participants noted that “checking out” their perceptions with other Black friends or family members was important. African American co-workers, for example, may non-verbally, but quickly, check out their response to comments made in a meeting or in the lunch-room of their business. Similarly, some participants suggested that they keep their responses “healthy” when they locate the site of the difficulty within the person from the dominant culture, leading to an empowered and validated sense of self for the African American. Last, these participants often responded by attempting to “rescue” the offender so as to minimize the impact of the microaggression or interaction. One participant reported his behavior by actually changing his physical behavior in the presence of a White woman. He noted, “Inside an elevator, a closed space being very conscious if there is a White woman, whether or not she’s afraid, or just sort of noticing me, trying to relax myself around her so she’s not afraid” (Sue et al., 2008a, p. 333). The participants interpreted the microaggressions in a number of ways, including receiving the

messages that you do not belong here, you are abnormal in some way, you are intellectually inferior, or you are not trustworthy. These participants seemed to come to this particular study with an awareness of how race dynamics shaped their interactions with a range of individuals from the dominant culture. As such, they were able to articulate some defensive strategies as noted above. And, even then, there was agreement that these sort of interactions take a toll on the African American individual as he/she needs to continuously be making decisions about how much to try and deconstruct these interactions. In this deconstructing, one can either question the attitudes of the White individuals or recognize the exchanges for what they are and attempt to move along, psychologically unscathed.

African American individuals, unsurprisingly, sometimes decide to minimize conflict-laden interpersonal interactions with White individuals as opposed to trying to have some resolution about the communication or microaggression. Many White individuals deny the existence of any racial transgression and think that the African American individual is exaggerating his response if he questions the White individual about an exchange. This dynamic of denial happens at an individual level and it also operates within the academy, at the professional level. Sue et al. (2008b) published an article entitled, "Racial microaggressions and the power to define reality" in response to some of the critique of their published work. For example, Thomas (2008) published an article entitled "Macrononsense in multiculturalism" suggesting that examples used by Sue et al. (2007) are exaggerated. He dismisses the idea that microaggressions would contribute to emotional distress and he says that "such stereotypes may be inappropriate, but they hardly necessitate the hand-wringing reactions described by Sue et al. (2007)." He further describes that Sue and his colleagues ought to see the *whole* person, not just race or ethnicity, when deconstructing points of miscommunication. This argument has been long used by White individuals and it serves the function of suggesting that they "don't see color" as all people are human beings, first, and a Person of Color only secondarily. Similarly, Harris (2008) in his "Racial microaggression? How do you know?" also questioned Sue's experiences. In his article, he questions the perception of Sue when he was asked to move to the back of an airplane. Sue had articulated his hypothesis that this series of events were examples of microaggressions (Sue et al., 2007).

These two articles are striking examples of the reaction that African Americans may engender when they confront others with their experience of racial microaggression in an interpersonal interaction. The author does not know the race or ethnicity of either Thomas or Harris but has heard a number of examples from his clients and students when they suggest that they did not "bother" raising any racialized issue as they did not have the "energy" to attempt to "educate" the aggressor in the microaggression experience. African American students are regularly reluctant to try and problem-solve difficult classroom situations that have components of race at the origin with colleagues and professors (Miehls, 2001). Dealing with racial microaggressions is difficult for any academic or student or individual; for the Person of Color who is experiencing problems with mental illness, this struggle may be overwhelming and defeating.

Franklin et al. (2006) suggest that the insidious and repetitive nature of race-related stress and emotional abuse that leads to an experience of psychological trauma often contributes to a state that they term "the invisibility syndrome." These authors suggest: "Symptoms of the syndrome are an outcome of the psychological conditions produced when a person perceives that his or her talents and identity are not seen because of the dominance of preconceived attitudes and stereotypes" (p. 13). They suggest that African American children and adults often are managing confusion or other unsettled feelings when they are systematically being ignored or invalidated. Being rendered invisible is being rendered powerless and without a sense of agency. These authors also suggest that a normative response to these sorts of ongoing interactions is

anger and that the African American individual has the additional burden of finding ways to modulate and manage the anger that is precipitated as a result of these unfair, repetitive and frequent microaggressions.

However, African Americans are continuously positioned in a double-bind experience when it comes to managing their anger. Anyone experiencing so many ongoing slights would naturally feel anger. And, many White individuals carry a stereotype that Black individuals (especially Black men) are filled with anger and rage. This stereotype is another example of a residual effect of slavery with White people continuously trying to “stamp out the (life) anger” of the enslaved individuals. The notion that Black men are dangerous, angry, and explosive fueled and legitimized practices in which people from the dominant culture suppressed the anger of African Americans; African Americans were severely punished and/or killed if they showed any anger towards Whites. One of the author’s young adolescent African American clients, Michael, described his dismay and frustration when others are fearful of him when he is simply walking down the street. He recounted many instances when he and his father witnessed White people crossing the street, in an attempt to avoid any direct face-to-face interaction. With some hesitation, Michael told the social worker that he and his father occasionally “played a game” during these interactions. Michael reported that he and his father developed a non-verbal signal with each other and that in some instances they would cue each other to also cross to the other side of the street, after observing White individuals doing this. Michael acknowledged that this was somewhat “mean-spirited” and he somewhat woefully said, “What do these fools expect? We get tired of constantly being thought of as muggers or ‘angry black men’.”

Michael’s disclosure was illustrative in many ways. He spoke of the complexity of having to manage one’s responses to the racism of others. Not only was his experience to be confused and hurt, but also he was angry at the frequency of these types of interactions. He also recognized that these experiences were fueled by racism and he spoke of his adaptation to these experiences. Michael had the benefit, in this “game”, of his father’s validation of his experience. While some might argue that he and his father were further fueling the stereotype of the angry Black men (when they playfully would also cross the street), the author understood this as a coping strategy that they sometimes employed so as to maintain some psychological equilibrium in the face of ongoing experiences of racism. Shortly, the chapter discusses the interface of race, trauma, and complex PTSD but first the specifics of how these sorts of microaggression affect the identity of African American adolescents, a particularly vulnerable population, is illustrated.

## **Illustration and discussion**

The following cases illustrate how various forms of discrimination and/or stereotypes influenced the psychological well-being and hence, mental health, of an African American individual. In the first, Michael, an adolescent, struggles with depression. Charles, a middle-aged recovering substance abuser, struggles with the effects of multi-determined PTSD, and Lashonda, a biracial young adult, presents with an eating disorder.

The ongoing experience of racism can be particularly challenging for the adolescent. Michael (mentioned earlier) is an 18-year-old African American young man who was referred for therapy as a result of his worsening depressive symptoms. His parents became concerned about his increasingly poor academic performance, his withdrawal from friends and family and his suicidal thoughts. The social worker had been working with Michael for approximately six months and had a fairly solid therapeutic alliance, when in one session, Michael seemed despondent and withdrawn. The social worker noted his observation to Michael and he simply shrugged his shoulders in response, saying he really didn’t want to be in the session today. The social worker agreed that it

can be tough sometimes to talk about one's painful experiences. Michael agreed and said, "Yeah, especially when you don't hear what I am saying." The worker encouraged Michael to say more. Michael was encouraged to go on and he was reassured that this was exactly what he needed to do in order for the worker-client dyad to get back on track. Michael became somewhat tearful and told the social worker that he could never understand what he went through. He reported that the worker kept asking him about his relationship with his father (which the therapist had formulated as being conflict-laden) and that Michael didn't want to talk about this. He went on to say that he felt disloyal to his father when he discussed their relationship. He then said, "You never ask me about why my boss at work thinks I am lazy, or why my teachers only show interest in my athletic abilities, or why White people cross to the other side of the street when they see me approaching them."

Even though the clinician had asked Michael in a general way how he experienced living in a predominantly White community as a young Black man, the youngster had mostly denied any overt racism in his interactions with others. In this moment, he let the social worker know that his family wasn't the only source of tension for him but rather he experienced stressors on a day-to-day basis from a myriad of people. Rather than saying that he had not told the clinician about these experiences before (which would have been likely perceived as chastising and/or disbelieving) the therapist simply said that he was sorry that Michael had to be the object of such discrimination and "stupidity" at the hands of so many White individuals. Michael latched on to the word "stupidity" and said, "You haven't heard anything yet – but, yeah, he could talk about stupidity!" The clinician acknowledged this statement. They then went on to discuss, in a more authentic way, the client's lived experiences of being targeted as a young Black man in a predominantly White community. His depressive symptoms started to lessen over the next few weeks as he told the clinician about many examples of being misunderstood, being reduced to a stereotype, and being the recipient of discrimination, based upon race.

In fact, Cooper, McLoyd, Wood, and Hardaway (2008) suggest that "African American adolescents are more likely to report experiences with racial discrimination than other ethnic minority adolescents" (p. 281). These authors suggest that adolescents who perceive racial discrimination and also worry about race-related interactions "are predictive of several negative indicators of psychological functioning among African American adolescents" (p. 284). These authors cite the work of many others to support this claim. They cite references that substantiate that African American adolescents experience lowered self-esteem (Fisher, Wallace, & Fenton, 2000; Wong, Eccles, & Sameroff, 2003), increased depressive phenomenology (Simons, Murry, McLoyd, Link, Cutrona, & Conger, 2002; Wong et al., 2003), psychological distress (Fisher et al., 2000), feelings of hopelessness (Nyborg & Curry, 2003), anxiety (Gibbons, Gerard, Cleveland, Wills, & Brody, 2004), and lower life satisfaction (Brown, Wallace, & Williams, 2001).

In recent years, there has been considerable discussion in the literature that about the use of a "trauma" diagnosis for individuals who experience racism. Franklin et al. (2006) cite a number of clinicians, scholars, and researchers who have argued for an expansion in the definition of PTSD as a result of racism directed towards People of Color (I. Allen, 1996; Butts, 2002; Root, 1992; Sanchez-Hucles, 1998). However, the American Psychiatric Association (2000), in its DSM-IV-TR manual, suggests that a diagnosis of PTSD can be used only if:

The person has been exposed to a traumatic event in which both of the following are present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and (2) the person's response involved intense fear, helplessness, or horror.

(APA, 2000, p. 467)

The following clinical example typifies the experience of an African American man who experienced symptoms of PTSD as a result of experiencing many traumatic events in his childhood and adult environments. Charles and his wife, Deborah, were being seen for couple therapy as a result of having numerous difficulties in the relationship that were characterized by an inability to problem-solve any conflict, no sexual relationship, and Charles' experience of many symptoms of PTSD including night terrors, flashbacks, and rage storms. These manifestations of PTSD affected the stability of the couple's day-to-day living. He had a very difficult time regulating his affect, especially any angry affect. Charles was currently on a medical leave of absence from his janitorial job in a large office complex and Deborah worked as a nursing assistant in a senior retirement housing complex. Charles had been born and raised in a housing project in Boston, Massachusetts in the early 1960s. He was raised in poverty and he withdrew from school when he was in the eighth grade. At that time, he moved out of his grandmother's home, where he had been living, and became part of a large gang that supplied drugs in the greater Boston neighborhood. He disclosed a series of traumatic events that included being physically abused by his alcoholic stepfather, witnessing his brother's death by gunshot, and being forced to prostitute himself as a gay hustler to earn money to support his own drug habit.

Desperate to leave this situation, he enlisted in the army when he was a young adult and he recounted that he experienced a great deal of racism at the hands of his senior officers and also his peers in his unit. His experiences in boot camp contributed to his first experiences of PTSD symptoms and he eventually received a medical discharge from the army for mental health issues. Charles and Deborah had met at a twelve-step meeting a number of years ago and each had achieved sobriety from alcohol and drugs for six years. Charles started to attend Alcoholics Anonymous after he experienced a number of episodes of black-outs when he was putting himself in life-threatening situations, including driving while intoxicated. He credited his beginning sobriety to a young social work intern who worked with him in an inpatient mental health unit in a V.A. hospital – he found her compassion and empathy for him to be genuine and he made an internal pledge to stay sober. In spite of this pledge, he often relapsed and had an ongoing struggle to stay employed or in any long-term relationship. He had a series of girlfriends and considered himself to be lucky to have found his current wife, Deborah, who seemed committed to him and the long-term nature of the relationship.

As noted above, and in spite of his six-year sobriety, Charles continued to show many symptoms of PTSD and the current social worker was able to assist him to begin to deal with his traumatic history. As part of the couple therapy, Charles began to eventually understand and re-narrate his trauma history. This long-term work was fundamental in Charles moving away from the legacies of his childhood and adolescent traumas. The phase-oriented couple work (Karusaitis Basham & Miehl, 2004) assisted him to deal with the many traumatic events that he had experienced. Most recently, Charles disclosed to the therapist that he also experienced racism in his workplace and that this had contributed to his need for a medical leave of absence, due to life stressors (Gitterman & Germain, 2008).

Charles clearly had symptoms of PTSD and he also fit the diagnostic category of complex post-traumatic stress syndrome as described by Herman (1992).<sup>3</sup> The diagnosis of PTSD of the DSM-IV-TR captures some of the responses of Black individuals experiencing ongoing racism; however, the exclusionary criteria of experiencing a "life-threatening experience" or experiencing a "threat to the physical integrity of self" does not always accurately capture the experience of traumatic experiences, based on racism. Charles certainly fit these diagnostic criteria but not all African Americans do fit these criteria. Rather, their experiences of microaggressions are insidious and long term in nature. This chapter suggests that the concept of complex post-traumatic stress syndrome, described by Herman (1992) more closely describes the experiences of African American people when they experience ongoing microaggressions in their day-to-day lives. Herman championed the

need for a broader, more inclusive diagnosis concerning trauma, especially as related to survivors of childhood (physical or sexual) abuse. She developed her argument by suggesting that a key residual component of survivors of childhood trauma was the tendency of these individuals to have persistent difficulties in maintaining a positive sense of self and/or identity. She explained that many survivors of childhood trauma often blamed themselves for their abusive histories and that this insidious process affected their ability to form completely healthy self-concepts.

Lenore Terr (1991) suggested that individuals who experience a discrete traumatic event such as a natural disaster or sexual assault experience what she referred to as a Type I trauma. These discrete events often lead to an appropriate use of the DSM-IV-TR diagnosis of PTSD. She also describes Type II traumas in which the survivor of childhood trauma was subjected to ongoing, persistent, and repetitive traumatic relationships. For example, this would be the description of a young child who was sexually abused, over a number of years, by the same perpetrator. The after effects of this sort of trauma are more persistent and likely far-reaching. It is very likely that these repetitive childhood traumas lead to symptoms more consistent with Herman's (1992) description of complex post-traumatic stress syndrome. Here the sense of self is eroded and a shattered identity becomes intertwined with a range of complex defensive structures that often lead to myriad mental health symptoms.

The chapter's hypothesis is that African American individuals often experience repetitive experiences of racism which sometimes lead to an erosion of self-confidence that may lead to a confused and perhaps shaky identity. So, in addition to the development of myriad mental health symptoms that have been described in this chapter and elsewhere (Pierre, Mahalik & Woodland, 2001; Utsey, 1997; Utsey & Payne, 2000) it is likely that the core of one's "personhood" can be challenged when living with repeated and chronic situations of being "othered," of being invalidated through "microaggressions" and other racialized interpersonal interactions. In her contribution, "The courage to hear: African American women's memories of racial trauma," Jessica Daniel (2000) discusses the many ways that African American women experience trauma. The author now offers a clinical illustration that will highlight the process of this young woman's identity being challenged on many levels as a biracial Black woman. Daniel's (2000) contribution is cited, where relevant to the clinical material.

Lashonda, a 25-year-old biracial woman (African American father and White mother) was referred to the clinician by a colleague from a mid-western city. Lashonda had been in therapy for two years with another therapist when she was an undergraduate student. She moved to Western Massachusetts to attend a graduate program and she was anxious to continue her therapy. She had had a favorable experience with her previous therapist. Lashonda identified as Black and she reported that most people viewed her as Black, in spite of her biracial identity. Her stated goals at the time of the therapy were to continue to work on her issues of anxiety, depression, and uncertainty about her future career goals.

Her family history revealed that she was the only child born to professional parents. She reported that her parents had high expectations of her and that she had a difficult time pleasing them. Her father, a prominent physician in their home community, encouraged her to be proud of her African American heritage. Her mother, also a professional, experienced problems with depression throughout her adult life. She had disclosed a sexual abuse history to Lashonda who reported to the social worker that her mother had been in therapy "forever." Lashonda quipped that this was perhaps her fate as well – that being, a lifelong therapy client. This "tongue-in-cheek" self-description, however, was played out in numerous ways in her work with the social worker.

The social worker viewed Lashonda's self-description as a "lifelong client" as reflective of her belief in an impoverished sense of self that is complex, troubled, and complicated by her racial identity. Lashonda and the worker developed a strong alliance, agreeing to keep focused on her racial identity as one source of information about her strengths and her difficulties in a number of

areas in her interpersonal relationships. Early in the work, Lashonda shamefully reported to the therapist that she was a binge eater and that she purged. She had had a long history of bulimic activity but had not disclosed this to her previous therapist. Lashonda recounted the painful history of her interactions with her mother when she was an adolescent. She reported that her mother was obsessed with diet regimes and imposed these on Lashonda. Her mother also noted to Lashonda that her task to stay attractive to men would be especially difficult, especially since she inherited many of her father's physical characteristics. Jessica Daniel (2000) refers to the plight of African American women in terms of appearance. She notes the image distortion of Black women in popular culture and how challenging it is for a Black woman to disavow her wish to be the American icon of womanhood – that being a White, thin, blond, and sexually appealing woman. Lashonda's identity was particularly confused as her mother was white. Lashonda told the social worker about her shame about her weight (she did not appear overweight) and that she could never get her hair to look right – she went on to describe her shame about her “frizzy” hair. She shared many examples of being teased as a child by other children when her hair would go “really frizzy” on rainy days.

Her concern about her appearance clearly marks a shaky identity and her many experiences of microaggressions enacted on her by her mother, her school chums and her potential boy-friends made her particularly vulnerable to developing a shamed sense of self. The social worker understood this sense of herself as being related to a form of complex post-traumatic stress syndrome – she experienced ongoing, insidious, and repetitive insults about her appearance and this profoundly shaped how she views herself as a Black woman in a predominantly White geographic area. This theme was played out consistently in terms of her comfort level in meeting and dating men. Daniel (2000) discusses the fears that African American women carry with regards to sexual assault. This young client often talks about how she feels scrutinized sexually by many men and she feels low-level anxiety about being the object of a sexual assault, on a regular basis (recall Shome, 1999, discussed above).

Daniel also discusses the notion that African American women experience trauma in educational institutions. Here too, Lashonda had much to discuss and to work through. She attended a primarily White elementary school and she was often taunted, being called names that denounced her biracial status and her appearance as a Black child. High school was somewhat better as she was in a more heterogeneous mix but again, she shares the experiences of other People of Color. She did not have many teachers with whom to identify and/or who encouraged her to excel academically. Her father was a gentle and firm supporter of her talents and abilities to do well educationally. Her relationship with her father has set the tone for her to have a positive transference relationship towards her current therapist. She was able to use her therapy relationship to discuss her apprehensions about her school performance and her interactions with professors with whom she suspects some racial bias against her.

In summary, her therapy appeared to work well in spite of the many legacies that she has had to withstand in order to re-shape a sense of herself as a strong, vibrant, resilient woman who has had to modulate her reactions to what seems like a never-ending “assault” to her personhood on many levels. She most recently described to the clinician that she had the unfortunate experience of going to a “walk-in, emergency” medical clinic to secure treatment of a decidedly uncomfortable skin rash of poison ivy. She unhappily reported that she was there for over three hours and that she had had to ask the White receptionist why other White clients were being processed before her. She is able to be assertive but she reports to me how much energy it takes and how she wishes she could just “blend in” like everyone else. Again, the reader can hear the resilience of Lashonda and can empathize with the injustices that she faces on a regular basis.

## **Conclusion**

People of Color experience racism at the institutional and interpersonal level. Racism has both direct and insidious effects on the quality of their lives. The web of institutional racism described by Miller and Garran (2008) clearly demonstrates the extent of racism in contemporary U.S. society. Social workers have a responsibility to attempt to dismantle racism and this must happen both systematically and also in micro-practice settings as well. In the broadest sense, social workers follow a Code of Ethics that directly challenges oppressive practices of any sort. The Council on Social Work Education, which accredits Schools of Social Work across the United States, also mandates that social work curriculum in required Human Behavior and Practice courses integrates content concerning issues of diversity and racism; in addition, many Schools of Social Work offer courses related to how to combat discrimination and racism.

While clearly institutional practices contribute to racism and barriers exist for People of Color in accessing useful services, some authors make suggestions for strategies that will reduce disparities in mental health service utilization. For example, Copeland (2006) suggests that disparities may lessen if mental health providers become more knowledgeable about the sociocultural environments and interpersonal barriers to treatment of African American youth. She specifically suggested that services could be enhanced if providers better understood the complex racial identity process of African American adolescents. Miranda, Bernal, Lau, Kohn, Hwang, & LaFromboise (2005) also suggest that cultural sensitivity of linguistic adaptations of providers may decrease disparities in service delivery with ethnic populations.

All social workers must assume responsibility for being culturally responsive and competent clinicians. Increasingly, authors are addressing issues of developing expertise in cross-cultural interventions (Altman, 1995, 2000; Holmes, 1992; Jackson, 2000; Leary, 1995, 1997, 2000; Perez-Foster, 1996; Ringel, 2005; Roland, 1998; Sue & Sue, 1990). Culturally responsive clinicians accept, as a given, that one's culture, ethnicity and/or race fundamentally shapes one's view of oneself and that any assessment or social work intervention needs to fully integrate the social identities of the client. This integration of cultural factors aids the social worker to initiate relationships that are accepting of differences for a range of individuals and families. In other words, the notion that there is a "right" or "normal" cultural background (read White middle-class America) is continuously challenged by the culturally competent social worker. Rather, the customs, the belief systems, and the strengths of any particular ethnic group or race are honored by the social worker so that the client is free to fully express her own value system. While this seems to be an obvious stance that social workers would adopt with clients – that is, starting where the client is, and respecting the strengths of the client, it is only since the late 1990s that matters of cultural competence have been fully articulated in social work and psychotherapeutic literature.

As noted above, it is important for social workers to be aware of racial identity development models in order to better understand the complexity of their clients' identities. A number of authors (Cross, 1991; Helms, 1990; Tatum, 1992) have suggested that People of Color experience a developmental pathway in terms of racial identity and social workers need this knowledge base in order to be effective practitioners with a diverse client caseload. Social workers who are aware of racial identity developmental theory have a better appreciation of the various responses that People of Color might have in response to White institutions, as an example. Helms (1990) also suggests that White individuals also develop a racial identity as people from the dominant culture and it is vitally important that White practitioners approach their clients with an attitude of reflexivity – that being, approaching clients with a great deal of self-awareness so as to not abuse the inherent power imbalance that may be set up between social worker and client. Miehls and Moffatt (2000) suggest that reflexive practitioners are open to self-examination and also value the differences found in diverse populations.

In conclusion, racism continues to be a major social problem in the United States. Regardless of one's role(s) in the social work profession, all have a responsibility of enacting the Code of Ethics to try to dismantle racism at every level. Social workers can do this in their interpersonal interactions with each other. If one identifies as White, one can keep a dialogue open with colleagues and friends of color so as to initiate conversations about race and the insidious impact of race on People of Color. One can trust that colleagues of color are not exaggerating their experiences when they tell about systemic racism and about their experiences of micro-aggressions. Social workers can and should initiate conversations about race in their clinical work. Perhaps, their most important task as White individuals is to truly be open to self-examination about their white privilege so they can better become an ally with others to challenge racist practices in their families, groups, organizations, and communities.

## Notes

- 1 It is suggested that this generic term implies homogeneity among "all" People of Color whereas in fact, there is great heterogeneity among different ethnic groups that are discussed. These differences will be noted, as appropriate, throughout the chapter. The term People of Color is utilized to denote any individual who self-identifies as a non-White person.
- 2 Miller and Garran (2008) recognize that racism intersects with other social oppression in the United States (for example, sexism, heterosexism or classism) but their focus is on what still needs to be accomplished in the United States to dismantle institutional racism.
- 3 Numerous resources describe complex post-traumatic stress syndrome. For examples, see Allen (2001) and Karusaitis Basham and Miehl (2004).

## Web resources

Antiracism.com: Deconstructing Racism, Reconstructing our Humanity  
[www.antiracism.com](http://www.antiracism.com)

Anti-Racism Resources  
[www.hopesite.ca/rekindle/links/racism\\_hrights.html](http://www.hopesite.ca/rekindle/links/racism_hrights.html)

Anti-Racist Alliance  
[www.antiracistalliance.com](http://www.antiracistalliance.com)

Health and Human Services  
[www.raceandhealth.hhs.gov](http://www.raceandhealth.hhs.gov)

Health Statistics  
[www.phpartners.org/health.stats](http://www.phpartners.org/health.stats)

National Center for Children in Poverty  
[www.nccp.org](http://www.nccp.org)

National Mental Health Association  
[www.nmha.org](http://www.nmha.org)

White Privilege and Anti-Racism  
[www.edchange.org/multicultural/sites/white.html](http://www.edchange.org/multicultural/sites/white.html)

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